Aspire Wellness, LLC

New Client Information Sheet

Welcome to Aspire Wellness!
Please help me serve you better by taking a few minutes to provide the following information

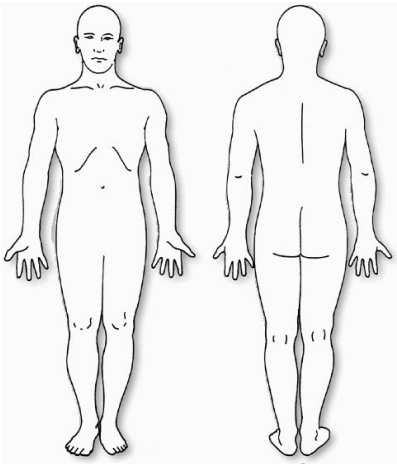
Name:				Today's date:					
Address:									
City / State / ZIP:									
Phone #	MOBILE		HOME		WORK				
DOB:		Age:		Marital status:	M	S	W	D	
Email:									
Occupation:		Employer:							
Emergency Contact	Name:		Phone:						
Primary Care Physician	Name:		Who referred You						
Specialist Physician	Name:								

What are your goals for our time together (ex. Walk dog, garden, pick up grandchildren)

Please fill out these forms as specifically as possible to provide me with a clear picture of your present pain and functional status.

Do you have any current pain or discomfort? Initial date?
Location: Date:
If yes, please rate your pain or discomfort:
None 1 2 3 4 5 6 7 8 9 Throw me off a bridge!
The first thing you'll do when you our out of discomfort
Please rate your stress level/emotional well-being
Chill 1 2 3 4 5 6 7 8 9 Horrible
If you could change one thing about your current situation

Please shade in areas where you have pain, discomfort, or tension.



What other types of treatment have you had in the past?											
	Massage		Bodywork		Physical Therapy		Myofascial Release		Chiropractic		Surgery
Other Medical Treatment: (Please Describe)											

Check the box if you have had any of the following medical conditions?											
	Diabetes		Lung disease		Weight change		Varicose veins		Neurological problems		Pregnancy
	Rheumatic fever		Osteoporosis		Migraine headaches		Epilepsy / seizures		Stroke		Blackouts
	Heart Murmur		Malignancy		Arthritis		Broken bones (fracture		Metal implants		High blood pressure
	Circulatory problems		Liver disease		Heart disease / pacemaker		Kidney disease		**Others (explain below)**		
Other past medical history (surgiers, accidents or traumas)											

List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).			
Medication	For treatment of	Dose / Amount per day	Effectiveness

Do you smoke?	Yes	No	If "Yes" – How much?	
When did you quit?			If not, Would you like to quit?	

Is there a chance you may be pregnant at this time?	Yes	No

Do you engage in regular exercise?	Yes	No
What type and how often?		
Are you able to exercise now?	Yes	No

If sleep is a problem, answer these questions:

Do you have trouble falling asleep?	Yes	No	Do you find it difficult to change positions in bed?	
Is your sleep restful?	Yes	No	How many times do you wake in the night?	
Do you find it difficult to lie down?	Yes	No	How long before you fall back to sleep?	

Informed Consent

I understand that Aspire Wellness andPhysical Therapy will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

Photographs taken during initial evaluation, progress evaluation and discharge summary will be used for postural comparison purposes and as educational tools. By signing below I consent to the use of these photographs in a professional manner.

I do hereby agree and give my consent for Aspire Wellness and Physical Therapy to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.
I hereby certify that all the above information is true to the best of my knowledge.

Patient/Parent/Guardian Signature:

Date:_____