

Future practice member,

**Please Print fill these next 4 pages ONE SIDED**

Please fill out in full and bring with you to your first appointment. Please remember this appointment may take up to 90 minutes as our evaluation is very thorough and we want to give ample time to answer any questions you may have. We are so excited to see you and to see all of the improvements you will have under principled neurologically-based chiropractic care. What you are about to experience will be a whole new take on health care. We can't wait to get started!

You have received one of very few open times available in our office! If you need to reschedule your appointment time please do so at least 24 hours in advance!

In good health,

Dr. Gabriel & The Awaken Chiropractic Team

Awaken Chiropractic

[www.awakenomaha.com](http://www.awakenomaha.com)

402 -881-0883

14135 Q St.

Omaha, NE 68137

TODAY DATE \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**NEW PRACTICE MEMBER APPLICATION**

**PATIENT DEMOGRAPHICS**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Do you have Insurance:  Yes  No SS#: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Single/Married/Divorced/Widowed Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

# of children \_\_\_\_\_ Names and Ages: \_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Whom may we thank for referring you to this office? \_\_\_\_\_ Best Communication Style: Call Text E-Mail

Circle best days for adjustments: M T W TH Circle best times for adjustments: 10am 11am 12pm 3pm 4pm 5pm 6pm Other: \_\_\_\_\_

**HISTORY of COMPLAINT**

DO YOU HAVE PAIN, STIFFNESS, OR ACHINESS IN YOUR BODY? IF YES, PLEASE CIRCLE AREAS:

➔

**NECK**

**MID-BACK**

**LOW-BACK**

**HEADACHES**

←

What is your #1 Goal for care? \_\_\_\_\_

Please identify the condition(s) that brought you to this office:

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints and answer the other questions:

Health Concerns: List according to severity	Rate of Severity: 0 (zero) = no pain 10 = worst pain	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant "C" or Intermittent "I"?	Is this problem worse in the AM Mid-Day, or PM
1. _____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____

If due to an injury, how did the injury happen? \_\_\_\_\_

Have condition(s) been treated by anyone in the past?  No  Yes If yes, when: \_\_\_\_\_ by whom? \_\_\_\_\_

Name of Previous Chiropractor: \_\_\_\_\_  N/A

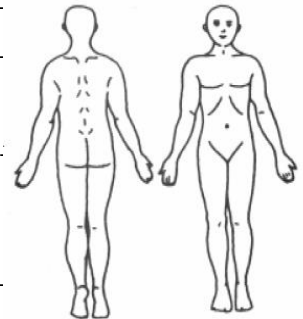
If so, how long were you under care: \_\_\_\_\_ What were the results? \_\_\_\_\_

PLEASE MARK the areas on the Diagram (to the right) with the following letters to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling

What make your symptoms better? \_\_\_\_\_ worse? \_\_\_\_\_

Is your problem the result of ANY type of accident?  Yes,  No



LIST RESTRICTED ACTIVITIES BELOW: ➔ LIST THAT CURRENT ACTIVITY LEVEL: ➔ LIST THAT USUAL ACTIVITY LEVEL:

1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Consultation Completed By: \_\_\_\_\_

Evaluation Cost (If Applicable): \_\_\_\_\_

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

**PAST HISTORY**

Have you suffered with any of these or similar problems in the past?  No  Yes **If yes, how many times?** \_\_\_\_\_  
When was the last episode? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_

Other forms of treatment tried:  No  Yes **If yes, please state what type of treatment:** \_\_\_\_\_, and who provided it: \_\_\_\_\_ **How long ago?** \_\_\_\_\_ What were the results.  Favorable  Unfavorable → please explain. \_\_\_\_\_

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have or **N** for **Never** have had:

\_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Fracture \_\_\_ Disability \_\_\_ Cancer  
\_\_\_ Heart Attack \_\_\_ Osteo Arthritis \_\_\_ Diabetes \_\_\_ Cerebral Vascular \_\_\_ Other serious conditions: \_\_\_\_\_

**PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:**

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES	→		
SURGERIES	→		
CHILDHOOD DISEASES	→		
ADULT DISEASES	→		

List Prescription & Non-Prescription drugs you take: \_\_\_\_\_

**SOCIAL HISTORY**

- Smoking:**  cigars  pipe  cigarettes **How often?**  Daily  Weekends  Occasionally  Never
- Alcoholic Beverage:** consumption occurs  Daily  Weekends  Occasionally  Never
- Recreational Drug use:**  Daily  Weekends  Occasionally  Never

**FAMILY HISTORY:**

- Does anyone in your family suffer with the same condition(s)?  No  Yes  
**If yes, please list which conditions:** \_\_\_\_\_  
**If yes, whom:**  grandmother  grandfather  mother  father  sister(s)  brother(s)  son(s)  daughter(s)  
Have they ever been treated for their condition?  No  Yes  I don't know
- Any other hereditary conditions the doctor should be aware of?**  No  Yes: \_\_\_\_\_

I hereby authorize payment to be made directly to **AWAKEN CHIROPRACTIC**, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to **AWAKEN CHIROPRACTIC** for any and all services I receive at this office.

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Date Form Reviewed**

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ Date: \_\_\_\_\_

## ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lift Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Read/Concentrate	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Please mark **P** for in the **Past**, **C** for **Currently** have, or **N** for **Never** (or leave blank)

___ ADD/ADHD	___ Fainting	___ Loss of Balance	___ Shoulder Pain
___ Allergies	___ Foot/Knee Problems	___ Low Back Pain	___ Sinus/Drainage Problem
___ Anxiety	___ Frequent Colds/Flu	___ Low Blood Pressure	___ Skin Problems
___ Asthma	___ Gall Bladder Trouble	___ Lung Problems	___ Swollen/Painful Joints
___ Back Curvature	___ Headache	___ Menopausal Issues	___ Tremors
___ Bed Wetting	___ Hearing Loss	___ Menstrual Problem	___ Trouble Sleeping
___ Blurred Vision	___ Heart Problem	___ Mid Back Pain	___ Ulcers
___ Chest Pain	___ Heartburn	___ Mood Changes	___ Upper Back Pain
___ Colon Trouble	___ Hepatitis (A, B, C)	___ Neck Pain	___ Other _____
___ Convulsions/Epilepsy	___ High Blood Pressure	___ Numb/Tingling Hands	___ Other _____
___ Depression	___ Hip Pain	___ Numb/Tingling Toes	___ Other _____
___ Diarrhea/Constipation	___ Impotence/E.D.	___ Pain w/Cough/Sneeze	___ Other _____
___ Difficulty Breathing	___ Irritable	___ PMS	
___ Digestive Problems	___ Jaw Pain, TMJ	___ Pregnant (Now)	
___ Dizziness	___ Kidney Trouble	___ Prostate Problems	
___ Double Vision	___ Learning Disability	___ Ringing in Ears	
___ Eating Disorder	___ Liver Trouble	___ Scoliosis	

**Patient signature:** \_\_\_\_\_ **Today's Date:** \_\_\_/\_\_\_/\_\_\_

PATIENT'S NAME: \_\_\_\_\_ HR#: \_\_\_\_\_ Date: \_\_\_\_\_

# QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name \_\_\_\_\_

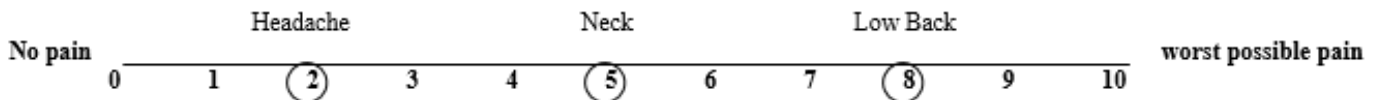
Date \_\_\_\_\_

**Please read carefully:**

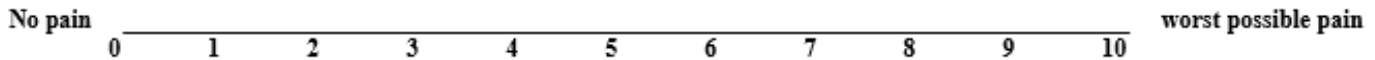
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

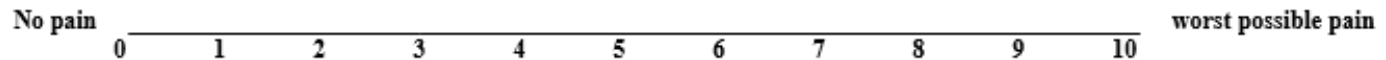
**Example:**



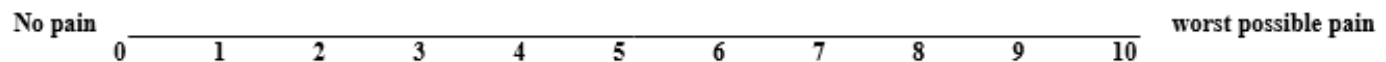
**1 – What is your pain RIGHT NOW?**



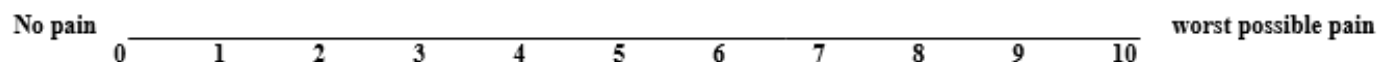
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?**



**4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?**



**OTHER COMMENTS:**

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Examiner \_\_\_\_\_

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.