T 1 2 3

AWAKEN
CHIROPRACTIC

In: _____ Out: _____

TODAY DATE ____ - ____ - _____

NEW PRACTICE MEMBER APPLICATION

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Home Phone: _____Mobile Phone: _____

SS#: _____ Occupation/ Employer: _____ Employer Address : _____

Name & Emergency Phone Number: _____Relationship: _____

****IT IS OFFICE POLICY THAT THE ABOVE PORTION IS FILLED OUT TO COMPLETION****

Single/Married/Divorced/Widowed Spouse's Name _____Spouse's Employer _____

# of children _____ Names and Ages: _____

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:

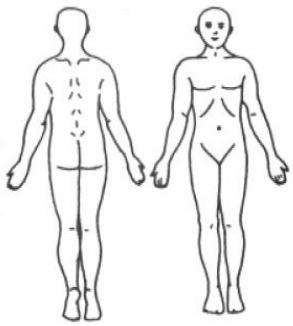
Health Concerns: List according to severity	Rate of Severity: 0 (zero) = no pain 10 = worst pain	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant "C" or Intermittent "I"?	Is this problem worse in the AM Mid-Day, or PM
1.	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

If due to an accident/injury, how did it happen? _____

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

Name of Previous Chiropractor: _____ Dates under care: _____ to _____

What were the results? _____ ☐ **NO PREVIOUS CHIROPRACTIC CARE**



PLEASE MARK the areas on the Diagram (to the right) with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling

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

1. Smoking: ☐cigars ☐ pipe ☐ cigarettes **How often?** ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

FAMILY HISTORY:

1. 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
2. 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 Name **Patient or Authorized Person's Signature** **Date Completed**

_____ _____ - _____ - _____ _____
Doctor's Signature **Date Form Reviewed** **Patient's HR #**

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	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

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

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

Patient Name: _____ **Patient signature:** _____

Today's Date: ____/____/____

HR#: _____

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:

Headache Neck Low Back

No pain — **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

---

1 – What is your pain RIGHT NOW?

No pain — **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain — **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

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

No pain — **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

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

No pain — **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____
Examiner