TODAY DATE ____ - ____ - _____

AWAKEN CHIROPRACTIC
NEW PRACTICE MEMBER APPLICATION

IN _____:_____ A / P

PATIENT DEMOGRAPHICS

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

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

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

SS#: _____ Occupation: _____ Employer: _____

Single/Married/Divorced/Widowed Spouse's Name _____Spouse's Cell Phone _____

# of children _____ Names and Ages: _____

Name & Emergency Phone Number: _____Relationship: _____

Whom may we thank for referring you? _____ Other: Google / Facebook / Walk-In / Lunch & Learn / Public Event

Have you seen a chiropractor before? Yes / No Chiropractor's Name: _____ Dates: _____to_____

Circle best <u>days</u> for adjustments: M T W TH *Circle best <u>times</u> for adjustments:* 10am 11am 12pm 3pm 4pm 5pm 6pm

MESSAGING PREFERENCES

Awaken Chiropractic will at times make calls or send texts that will include but is not limited to confirming appointments, alerting the practice member of missed appointments, giving the practice member updates, and to discuss the practice member's case or concerns.

Please <u>check</u> one of the following. If neither are checked Awaken Chiropractic will leave messages and text the numbers provided.

[ ] I give Awaken Chiropractic permission to text me and leave a detailed voicemail at the numbers on my form.

[ ] Please only leave a basic voicemail if unable to reach me.

<u>Preferred</u> Communication Style: Call Text E-Mail Best time to contact you if necessary: _____

MEDICAL INFORMATION (HIPAA) RELEASE FORM

Please **<u>initial</u>** one of the two options. This Release of Information will remain in effect until terminated by me in writing.

[ ] My information is **not to be released** to anyone.

[ ] I **authorize** the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to: Name: _____ Name: _____

TERMS OF ACCEPTANCE – WHAT IS CHIROPRACTIC?

In order to provide the most effective healing environment, application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate this goal of optimum health through chiropractic care. To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

1. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs; chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
2. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of repositioning misaligned spinal segments. This is a safe, effective procedure that is applied over one million times each day in the United States alone by doctors of chiropractic.
3. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
4. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
5. Your compliance with care plans, home and self-care, etc., is essential to maximize healing and optimal health though chiropractic care.
6. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____	_____	_____	_____	_____
Patient's Name	Patient's Signature	Date	HR #	TM Initial

JDD, DC 5/2011 modified GOL, DC 3/2022

HEALTH CONCERNS

Please mark ALL areas you have pain, stiffness, or achiness: **P** = **Past and C = Current**

___ Neck __ Mid-Back ___ Low-Back ___ Headaches

Please mark **ALL** applicable symptoms you experienced: **P** = **Past and C** = **Current**

___ ADD/ADHD	___ Diarrhea/Constipation	___ Impotence/E.D.	___ Problems with Kidney
___ Allergies	___ Digestive Problems	___ Jaw Pain, TMJ	___ Prostate Problems
___ Anxiety	___ Fainting	___ Loss of Balance	___ Sinus/Drainage Problem
___ Asthma	___ Frequent Colds/Flu	___ Low Blood Pressure	___ Skin Problems
___ Bed Wetting	___ Gall Bladder Trouble	___Lung Problems	___ Scoliosis/Spine Curvature
___ Blurred/Double Vision	___ Hearing Loss	___ Menopausal Issues	___ Tinnitus
___ Chest Pain	___ Heart Problem	___ Menstrual Problem	___ Tremors
___ Colon Trouble	___ Heartburn	___ Numb/Tingling	___ Trouble Sleeping
___ Convulsions/Epilepsy	___ Hepatitis (A, B, C)	___ Pain w/Cough/Sneeze	___ Trouble Learning
___ Depression	___ High Blood Pressure	___ Pregnant (Now)	___ Ulcers

Please mark **ALL** applicable symptoms you experienced in your extremities: **P** = **Past and C** = **Current**

___ Arm Pain	___ Shoulder Pain	___ Elbow Pain	___ Wrist Pain	___ Hand Pain
___ Leg Pain	___ Hip Pain	___ Knee Pain	___ Ankle Pain	___ Foot Pain

Please mark **ALL** conditions you have ever been diagnosed with: **P** = **Past, C** = **Current, N = Never**

___ Broken Bone	___Dislocations	___ Tumors	___Rheumatoid Arthritis
___ Heart Attack	___Osteo Arthritis	___ Diabetes	___ Cerebral Vascular Disease
___ Cancer	___ Fracture	___Disability	Other: _____

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

Health Concerns: List according to Severity / Importance	Rate of Severity: 0 (zero) = no pain 10 = worst pain	When did this most recent problem start?	When did you first experience this problem?	Did this problem start with an injury? Y or N?	Are your symptoms constant "C" or Intermittent "I"?	Is this problem worse in the AM Mid-Day, or PM
#1. _____	_____	_____	_____	_____	_____	_____
#2. _____	_____	_____	_____	_____	_____	_____
#3. _____	_____	_____	_____	_____	_____	_____
#4. _____	_____	_____	_____	_____	_____	_____

Quadruple Visual Analog Scale (QVAS): Please circle the number that best describes the question asked about your pain. If you have more than one complaint, please indicate the score of each complaint separately.

#1 Symptom: _____ **0 = NO PAIN** **10 = WORST PAIN EVER**

1. How would you rate the level of your pain RIGHT NOW?	0	1	2	3	4	5	6	7	8	9	10
2. What is your TYPICAL or AVERAGE pain level?	0	1	2	3	4	5	6	7	8	9	10
3. What is your pain level at its BEST?	0	1	2	3	4	5	6	7	8	9	10
4. What is your pain level at its WORST?	0	1	2	3	4	5	6	7	8	9	10

_____	_____	_____	_____	_____
Patient's Name	Patient's Signature	Date	HR #	TM Initial

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)

Were treated for their condition? ☐ No ☐ Yes ☐ I don't know Explain Outcomes: _____

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

PAST HISTORY

Describe any accidents/injuries that may have caused your concerns: _____

_____

List Prescription & Non-Prescription drugs you take: _____

_____

Previous Surgeries: _____

What makes your symptoms better? _____worse? _____

Have you seen anyone else for these concerns? Medical Doctor / Physical Therapist / Massage / Chiropractor / Other: _____

What were the dates and results? _____

RESTRICTED ACTIVITIES OF DAILY LIVING

Please check off any activities below that re limited affected by your condition:

ACTIVITIES:	LEVEL OF EFFECT:			
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Of the activities above, please list your top 3 below with their current and desired level of activity:

LIST RESTRICTED ACTIVITIES BELOW: ➡	LIST YOUR CURRENT ACTIVITY LEVEL: ➡	LIST THAT USUAL ACTIVITY LEVEL:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

#1 Goal for Care: _____

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's Name	Patient's Signature	Date	HR #	TM Initial

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

FOR OFFICE USE ONLY **FOR OFFICE USE ONLY** **FOR OFFICE USE ONLY**

Lat Cervical (F/E)	Lateral Thoracic:	Lateral Lumbar:
APOM	A-P Thoracic:	A-P Lumbar:
Lower Cervical	Accessory View #1	Accessory View #2:

SEX: M / F

DOB:

Notes: _____

FOR OFFICE USE ONLY - DO NOT WRITE ABOVE THIS LINE - FOR OFFICE USE ONLY - DO NOT WRITE ABOVE THIS LINE

INFORMED CONSENT FOR A MINOR

I authorize Dr. Gabriel Long and any and all Awaken Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child without parental supervision. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Awaken Chiropractic.

_____	_____	_____	_____	_____
Name of Minor/Child	Guardian Name	Guardian Signature	Date	Witness

INFORMED CONSENT FOR X-RAYS AND TREATMENT

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one instance per two million, have been associated with chiropractic adjustments. Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at **AWAKEN CHIROPRACTIC** have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition to include but not limited to Chiropractic Adjustments, Modalities, and Therapeutic Procedures any time throughout the entire clinical course of care.

Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

FEMALES ONLY:
The first day of my last menstrual cycle was on _____-_____-_____, and to the best of my knowledge, I am not pregnant.

_____	_____	_____	_____	_____
Patient's Name	Patient's Signature	Date	HR #	Witness

NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception or at the front desk. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company, collections, or any other collateral source. If sent to collections there is a Processing fee of $50.00 that will be added to the bill.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your paper records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one paper copy** of your records at no charge, when 72 hours notice is provided. **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate. However, **you are responsible for the cost of $15 to cover cost of production**.

I have received a copy of AWAKEN CHIROPRACTIC Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, if you wish to make a formal complaint about how we handle your health information, please call Magdalene Long at 402-881-0883. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: DHHS, Office of Civil Rights on 200 Independence Ave. SW Room 509F HHH Building in Washington DC 20201. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____	_____	_____	_____	_____
Patient's Name	Patient's Signature	Date	HR #	TM Initial

THANK YOU! PLEASE RETURN TO FRONT DESK!