Awaken
Chiropractic and Wellness Center

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Adult New Patient Application

"A Healthy Spine Means a Healthier You!"

Name_____Home Phone_____
Address_____Work Phone _____
City, State, Zip_____Cell Phone _____
E-mail Address _____
Birth date_____Age_____SS# _____
Occupation_____Employer _____
Status: ❍Married ❍Widowed ❍Separated ❍Divorced ❍Single Spouse Name_____No. of Children _____
To conserve resources we generally utilize email and text for regular communication. May we communicate with you via?
❍Email: ❍Text: ❍ Carrier (like AT&T, Etc.): _____
Most patients are referred to our office by a caring family member or friend. What made you to decide to visit our office?
❍Friend ❍Family Member Name: _____
❍Telephone Call ❍Yellow Pages Sign ❍website ❍presentation ❍Email

Please answer the following questions:

1. Spinal problems can cause a variety of health problems. Please check the health complaint(s) you are currently experiencing or experience on a periodic basis:

❍ Low Back Pain	❍ Arm or Hand Pain	❍ Carpal Tunnel Syndrome	❍ Indigestion
❍ Upper/Mid Back Pain	❍ Leg or Foot Pain	❍ Ear Infections	❍ Chronic Fatigue
❍ Neck Pain	❍ Asthma	❍ Frequent Colds	❍ Arthritis
❍ Shoulder Pain	❍ Allergies/Sinus	❍ Spinal Curvature	❍ Fibromyalgia

❍ Others _____

2. Please list your primary health concern you are experiencing:
   1. _____ 2._____ 3._____
3. Auto and work injuries can cause serious spinal problems. Is this visit related to an auto or work injury? ❍ Yes ❍ No
4. Research shows that you spine should be checked regularly. When was your last complete Spinal examination? including X-rays? ❍within the last year ❍ 1 - 5 years ❍ 5 years or longer ❍ Never
5. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem?
   ❍ YES ❍ NO If yes, circle one
6. Long term spinal misalignments can cause decay and arthritis in the spine which may result in grinding or popping noises. Do you ever hear grinding or popping noises when you move your head or neck? ❍ YES ❍ NO
7. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to twist, stretch or crack your neck, mid or lower spine? ❍ YES ❍ NO
8. Poor posture can lead to poor health and usually indicates a spinal problem. How would you rate your posture?
   Poor - 1 2 3 4 5 6 7 8 9 10 - Very Good
9. Stress can cause or aggravate spinal problems. Please rate your stress levels over the last 90 days.
   Low - 1 2 3 4 5 6 7 8 9 10 - High
10. Are you currently taking prescription medication? ❍ YES ❍ NO If so, how many? _____
11. Spinal health is especially important during pregnancy. If female, is there any chance that you are pregnant?
    ❍ YES ❍ NO ❍ MAYBE If yes, when is your due date?_____Or Date of Last Cycle? _____
12. Have you ever been diagnosed with cancer? ❍YES ❍NO If so, what kind?_____Year diagnosed _____
13. Have you ever had spinal surgery? ❍ YES ❍ NO If yes, where?_____
14. If the doctor feels that you will benefit from chiropractic care, are you willing to follow his/her recommendations?
    ❍ YES ❍ NO
15. How will you be paying for today's visit? ❍ Credit/Debit Card ❍ Cash ❍ Check ❍ Other_____
16. Are you Medicare eligible? ❍ YES ❍ NO
17. What activities would you like to do that your health is impairing you to doing? _____
18. How would your life change if you have optimal health? _____
19. What needs to happen in order for you to have optimal health? _____

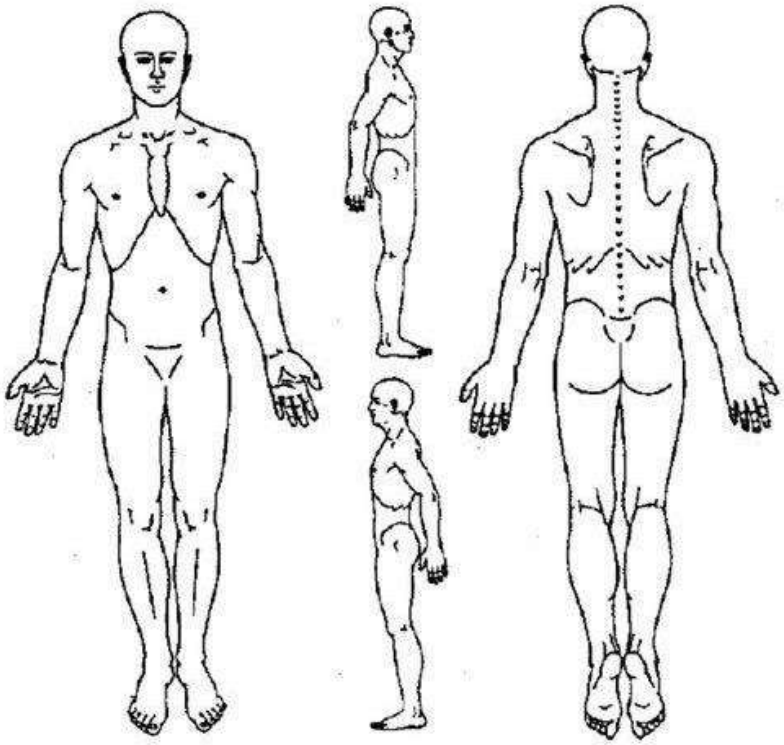
20. How do you feel about your current condition? (please **CHECK ONE** that BEST describes your feelings.

I feel helpless, nothing works____
I don't like what I am feeling, I hope you can fix it _____
I feel this is a pattern that has happened to me before, it is back again____
I feel there is a message my body is trying to give me____
I am looking for assistance in becoming healthier so I can move past my health concern____
I realize my condition may be a necessary experience in getting to the real problem___
I don't know how I feel, I am too preoccupied with my present condition____
I am looking for something to enhance my quality of life and further enhance my wellness____

21. **Please describe any car accidents, slips, falls or repetitive injuries and when they occurred.** (*Even minor ones. You may have acquired injuries to your spine even if you didn't Feel injured*.)

_____
_____
_____

Please mark the area on the diagram with the following letters to describe your symptoms: R=Radiating, **B**=Burning, **D**=Dull, **A**=Achy, **N**=Numbness, **S**=Stabbing/sharp, **T**=Tingling



Is there anything else which may help us to better understand you which has not been discussed?

_____
_____-
_____
_____
_____
_____

The above information is accurate and true to the best of my knowledge. I have been informed evaluation is not for neuromusculoskeletal conditions or evaluation of presenting complaints, but for spinal and neurological functional capacity, spinal alignment, and presence of spinal subluxation. Procedures recorded represent the limited evaluation procedures chosen to assess this particular patient. Appropriate informed consent documents have been signed to proceed. I also understand That any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Patient Name _____ Date: _____
Patient Signature (parent/guardian) _____
Doctor Signature: _____ Date: _____

Activities of Daily Living

To properly assess your condition, we must understand how much your health problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1.	Static Sitting	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
2.	Sleeping	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
3.	Personal Care (washing, Dressing, etc.)	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
4.	Travel (driving, etc.)	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
5.	Work	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
6.	Recreation	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
7.	Household Chores (Vacuuming, Cleaning, Etc.)	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
8.	Lifting	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
9.	Walking	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain
10.	Standing	0 No pain	1 Mild pain	2 Moderate pain	3 Severe pain	4 Worst possible pain

Patient's Signature: _____ Today's Date: _____

Consent to Treat

Self Pay: I understand that I will be held responsible for the services that I receive from Awaken Chiropractic and Wellness Center.

_____ _____
Name Patient/Guardian Signature Date

Consent to Examination and Treatment: I give the doctors and staff of Awaken Health and Wellness Center permission to perform all examinations, x-rays, and treatments, deemed necessary by the doctor. I understand that some of these procedures may be performed by either the staff or the doctors.

_____ _____
Name Patient/Guardian Signature Date

HIPPA: A copy of the full Health Information Privacy Policy for our office can be requested at the front desk. In brief, it states as our patient your privacy is protected. By signing you are stating that you understand that Awaken Health and Wellness Center may use or disclose your protected health information for treatment, payment, or health care operations-which means for providing health care to me, the patient; handling billing and payment; and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

_____ _____
Name Patient/Guardian Signature Date

Pregnancy Waiver (x-rays): By my signature below, I am stating that to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this time for the purposes of taking X-rays.

_____ _____
Name Patient/Guardian Signature Date

Video/Feedback Material: I give the doctors and staff at Awaken Health and Wellness Center permission to use video/record/photograph office visits and procedures performed with your consent. I also give the doctors and staff at Awaken Health and Wellness Center permission to use feedback I give (google, Facebook, Daocloud, in office feedback). I understand that this material will be used for at least one year for all media platforms unless I request it to not be used. I must give the doctors and staff at Awaken CWC a minimum of 7 days to remove the material.

_____ _____
Name Patient/Guardian Signature Date

Metabolic Assessment Form™

Name: ______________________ **Age:** ____ **Sex:** ____ **Date:** ____________

PART I

Please list your 5 major health concerns in order of importance:

1. ______________________ **4.** ______________________

2. ______________________ **5.** ______________________

3. ______________________

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting proteins and meats; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Difficulty digesting roughage and fiber	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	Yes	No		

Category VIII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes	No		

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful between meals	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*

Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

_____

Please list any natural supplements you currently take and for what conditions:

_____