

**Awakening Chiropractic North PLLC**

12 Yeaton RD Unit A1 Plymouth, NH 03264 (603)238-9044

**NEW PATIENT APPLICATION**

*Welcome to our Practice! Please thoroughly complete all questions. Thank you.*

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex M / F E-Mail \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_  
Cell Carrier \_\_\_\_\_ Ok to receive text messages: yes no

Occupation \_\_\_\_\_ Your Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_

Marital Status M/W/D/S/P Their Name \_\_\_\_\_ Their Employer \_\_\_\_\_  
Children's Names & Ages \_\_\_\_\_

Prior Chiropractor \_\_\_\_\_ Last appointment \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

General Practitioner \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

May we send a report of your findings to this Practitioner? \_\_\_Yes \_\_\_ No

Favorite Hobbies or Interests \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Please check the boxes next to any social media platforms you saw our practice on:

Google  Facebook  Instagram  Youtube

Health Reasons For Consulting Our Office:

- 1. \_\_\_\_\_ 3. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_

Current Complaint (how you feel today): Please Circle

\_\_\_\_\_

0 1 2 3 4 5 6 7 8 9 10  
No Pain Unbearable Pain

How often are your symptoms present?

(Occasional) \_\_\_ 0-25% \_\_\_ 26-50% \_\_\_ 51-75% \_\_\_ 76-100% (Constant)

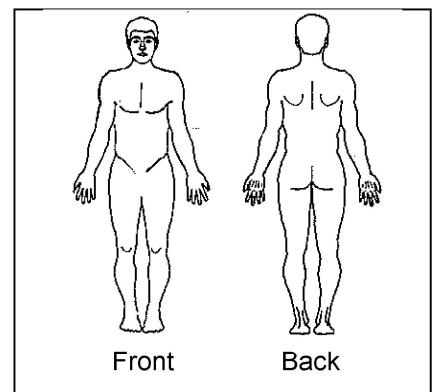
In the past week, how much has your pain interfered with your daily activities?

(for example work, social activities, household chores) Please Circle

\_\_\_\_\_

0 1 2 3 4 5 6 7 8 9 10  
No Interference Unable to carry on any activities

Mark area of Health Concerns



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Have you had any X-rays, MRI, CT Scan for your area(s) of complaint?  Yes  No

Date Taken \_\_\_\_\_ What areas were taken? \_\_\_\_\_

Is this the result of an auto injury?  Yes  No work injury?  Yes  No

If so, when? \_\_\_\_\_

Other Doctors who have treated this problem \_\_\_\_\_

Father/Mother/Brother/Sister/Children, with similar problems? \_\_\_\_\_

Please check all of the following that apply to you.

- |   |  |
|---|--|
| <input type="checkbox"/> Alcohol/Drug Dependence                          | <input type="checkbox"/> Prostate Problems   |
| <input type="checkbox"/> Recent Fever                                     | <input type="checkbox"/> Menstrual Problems  |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Urinary Problems  |
| <input type="checkbox"/> High Blood Pressure                              | <input type="checkbox"/> Currently Pregnant, # Weeks _____   |
| <input type="checkbox"/> Stroke (Date) _____                              | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Corticosteroid Use (Cortisone, Prednisone, etc.) | <input type="checkbox"/> Marked Morning Pain/Stiffness   |
| <input type="checkbox"/> Taking Birth Control Pills                       | <input type="checkbox"/> Pain Unrelieved by Position or Rest   |
| <input type="checkbox"/> Dizziness/Fainting                               | <input type="checkbox"/> Pain at Night   |
| <input type="checkbox"/> Numbness in Groin/Buttocks                       | <input type="checkbox"/> Visual Disturbances   |
| <input type="checkbox"/> Osteoporosis                                     | <input type="checkbox"/> Epilepsy/Seizures   |
- Tobacco Use – Type \_\_\_\_\_ Frequency \_\_\_\_\_ /Day
- Cancer/Tumor (Explain) \_\_\_\_\_
- Surgeries \_\_\_\_\_
- Medications \_\_\_\_\_
- Other Health Problems (Explain) \_\_\_\_\_
- None of the Above

What have you heard about chiropractic? \_\_\_\_\_

Do you know what a subluxation is?  Yes  No

If yes, please describe \_\_\_\_\_

What daily rituals for spinal health do you presently practice? \_\_\_\_\_

Do you have health insurance?  Yes  No Insurance Plan \_\_\_\_\_

Method of Payment for First Visit:  Cash  Check  Credit Card

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**AUTHORIZATION:** The process of determining suitability for Chiropractic Services involves answering fully and truthfully all questions presented to you either written or spoken regarding your past and present health status. If warranted, a physical examination will be performed that can include but is not limited to vitals measurement, systems evaluation, orthopedic tests, and maneuvers (tests that move and stress parts of the body), neurological test (tests using sharp or dull instruments, smells, or sounds, gently tapping) as well as physical touching. These test and maneuvers will help the Chiropractor determine what may be causing your complaints. Occasionally some temporary soreness and/or stiffness may occur due to the examination, less frequently aggravation of presenting symptoms or initiation of new symptoms. By signing below, you have authorized the performance of a consultation and examination.

**ACKNOWLEDGEMENT:** We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters and thank you notices for referrals using your first name in the following manner: phone-work-home or mobile, e-mail and regular mail to include sealed envelopes and postcards. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also, in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliging to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient.

*I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF:  
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.*

\_\_\_\_\_  
Patient Name Printed Date

\_\_\_\_\_  
Patient Signature Authorized Provider Rep.

\_\_\_\_\_  
Personal Representative Printed Personal Rep. Signature

Description of personal representative's authority to act for the patient: