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?_____

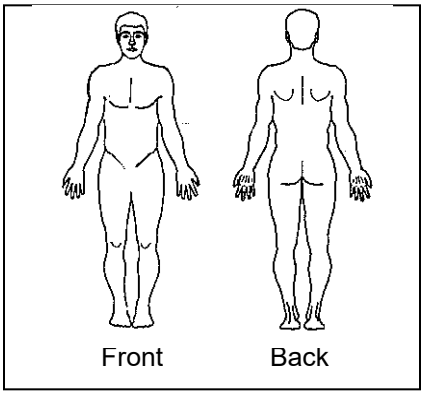
Please check the boxes next to any social media platforms you saw our practice on:
Google☐ Facebook ☐ Instagram☐ Youtube ☐

Health Reasons For Consulting Our Office:

1._____ 3._____

2._____ 4._____

Mark area of Health Concerns



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

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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.

___Alcohol/Drug Dependence
___Recent Fever
___Diabetes
___High Blood Pressure
___Stroke (Date)_____
___Corticosteroid Use (Cortisone, Prednisone, etc.)
___Taking Birth Control Pills
___Dizziness/Fainting
___Numbness in Groin/Buttocks
___Osteoporosis
___Prostate Problems
___Menstrual Problems
___Urinary Problems
___Currently Pregnant, # Weeks ___
___Abnormal Weight ___Gain ___Loss
___Marked Morning Pain/Stiffness
___Pain Unrelieved by Position or Rest
___Pain at Night
___Visual Disturbances
___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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Privacy Policy

In order to provide you with care in our facility, you have provided personal information about yourself, some of which may be nonpublic in nature. We have a high regard for the privacy of our patients and want you to know how we handle your personal information. The following contains a description of the types of information we collect about you, and how the information is used and protected. This privacy statement describes our privacy practices for both our current and/or former patients.

Types and Sources of Information We Collect About You

We collect information about you, including nonpublic personal information, from the following sources:

Information we receive from you on your case history form, as well as other forms related to your patient files.

Information about your transactions with us, which may include your payments and payment history.

Information we receive from your current and former physicians.

Information we receive in reference to your current medical insurance policies.

Our Use of the Information That We Collect About You

We use the information we collect about you, including the nonpublic, personal information, only for the purposes of evaluating, effecting and administering, enforcing, and servicing your care with our facility. We do not disclose any non-public personal information about your to any non-affiliated third parties, except as provided by law. **We do not forward or otherwise share your information with anyone without prior written consent from you, the patient.**

Protection of Your Information

We restrict access to the nonpublic information about you to only necessary employees, unless requested from the patients themselves. Our facility has adopted an information security program that includes administrative, technical, and physical safeguards to protect the security and integrity of your nonpublic information.

_____ _____

Patient/Guardian Signature **Date**