Awakenings Health Institute

110 North Rios Ave.
Solana Beach, CA 92075-1238
+1 858-794-9956

____
Last Name

PERSONAL INFORMATION

Legal Name____
Last *First* *Middle (complete)* *Jr etc*

Prefer to be called (nickname)______________________________ Gender______________
M/F

Are you applying for a ☐ sample week or ☐ permanent client position? For the date beginning__________________

Birthdate__________/______/__________ E-mail Address________________
mm/dd/yyyy

Permanent Home Address____
Number and Street

____

____
City or Town *State* *Country* *Zip Code*

If different from above, please give your mailing address for all admission correspondence

Mailing Address (from _____/________ to _____/________)______________________
(mm/yyyy) *(mm/yyyy)* *Number and Street*

____

____
City or Town *State* *Country* *Zip Code*

Phone at mailing address (_____)______________ Permanent home phone (_________)__________
Area Code *Number* *Area Code* *Number*

Other phone (_____)______________
Area Code *Number*

Will you be a candidate for financial aid? ☐Yes ☐No

MEDICAL INFORMATION

Disability______________________________
Nature of Disability______________________________
Exclude if SCI

Date of Injury______/______/______ Level of injury______________
Mm/dd/yyyy

Cause of injury______________ Head injury ☐Yes ☐No

☐Complete ☐Incomplete

Current therapy
☐ Yes ☐ No
type______________ frequency______________

Surgeries since injury

Date	*Type*	*Location*
Date	*Type*	*Location*
Date	*Type*	*Location*
Date	*Type*	*Location*

Type of wheelchair ☐Manual ☐Electric______________ ☐Power Assisted/Manual
specify

Assistive standing/walking device
☐Yes ______________________________
Briefly explain type
☐No ______________________________
Briefly describe gait

Hospitalization of initial trauma______________
Name
____
Address
____
City *State* *Zip Code*
(______)______________
Area Code *Number*

Length of stay

from______/______/______
mm/dd/yyyy

to ______/______/______
mm/dd/yyyy

Location of rehabilitation______________
Name
____
Address
____
City *State* *Zip Code*
(______)______________
Area Code *Number*

Length of stay

from______/______/______
mm/dd/yyyy

to ______/______/______
mm/dd/yyyy

Height______________
Weight______________

Please list all current medications

#	Name	Dose	Freq	Start mo/yr
1				
2				
3				
4				
5				
6				
7				

Sensory and Motor Conditions

Please briefly describe locations that have *normal* sensation below level of injury

Please briefly describe locations that have *little to no* sensation below level of injury

Please briefly describe muscles that have *norma*l movement below level of injury

Please briefly describe muscles that have *weakness to no* movement below level of injury

Any spasms? ☐ Yes ☐ No

If Yes, briefly explain locations

Any pain? ☐ Yes ☐ No

If Yes, briefly explain locations

Any Autonomic Dysreflexia? ☐ Yes ☐ No

If Yes, briefly explain symptoms

Any **U**rinary **T**ract **I**nfections? ☐ Yes ☐ No

If Yes, briefly explain

Any Pressure Sores/Skin Breakdowns? ☐ Yes ☐ No

If Yes, briefly explain symptoms

Any Heterotrophic Ossification? ☐ Yes ☐ No

Location

Do you smoke cigarettes? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No
Do you drink carbonated beverages? ☐ Yes ☐ No

Have you been diagnosed with Osteoporosis? ☐ Yes ☐ No

How long ago was your bone scan?

Deep Vein Thrombosis? ☐ Never ☐ Past ☐ Present

Location____________________
Treatment____________________

Bladder:
Do you have Bladder control? ☐ Yes ☐ No

Do you have a sensation to void? ☐ Yes ☐ No

How do you eliminate the Bladder? ______

Do you have any complications? ☐ Yes ☐ No

Bowel:
Do you have Bowel control? ☐ Yes ☐ No

Do you have a sensation to void? ☐ Yes ☐ No

How do you eliminate the Bowels? ______

Do you have any complications? ☐ Yes ☐ No

Sexual Function? ☐ Normal ☐ Semi- functional ☐ Non-functional
If comfortable, please explain

Ventilator Dependent? ☐ Never ☐ Past ☐ Present

Major illness/injuries/complications that required hospitalization other than initial disability/injury?
☐ Yes ☐ No
If Yes, explain:

What are your goals and / or health concerns for coming to A.H.I.?

What experiences have you had with alternative medicine?

What kinds of alternative medicine are you practicing currently?

Nutrition

Please describe your typical diet

Breakfast____

Lunch____

Dinner____

Snacks____

Do you feel the sensation of hunger? ☐ Yes ☐ No

Do you skip meals? ☐ Yes ☐ No

☐ Breakfast ☐ Lunch ☐ Dinner

How many glasses of fluids do you drink per day?

☐ ≥1 ☐ 2-4 ☐ 5-8 ☐ 9≤

Do you drink coffee/tea/soda or any fluids containing caffeine? ☐ Yes ☐ No

How many?

☐ ≥1 ☐ 2-4 ☐ 5-8 ☐ 9≤

List the vitamins/minerals/supplements you are presently taking

Name	**Reason**	**When you started**	**Dosage**
Ex: Vitamin E	*Improve skin*	*~4 months ago*	*400 IU*

List major stressors in your life

Describe your sleeping patterns

What do you do to relax?

What hobbies do you have?

Describe your support system (family, friends, pets, religion, groups, etc):

____
____
____

The following questions are applied to our strategy to train our clients as close to elite athletes status as possible. These questions will help us know you better as a person and evaluate the view you take upon yourself. Goal setting, concentration, relaxation, imagery are some of the key factors to our program. The general goal is to teach our clients the mental skills necessary to perform consistently in training and to help them realize their potential as people and athletes striving for a common goal.

Evaluate a significant experience, achievement, or risk you have taken and explain your actions and its impact on you.

____
____
____
____
____
____
____
____
____
____

MENTAL TOUGHNESS

Mental toughness is not a quality that you are born with. Instead, mental toughness is a set of mental skills that can be learned. If you are a mentally tough competitor then you learned it through your life experiences. If you are not mentally tough, you haven't learned it yet. This is a process, just the same as physical skills. It requires: understanding, hard work and practice.

The following questions are taken from the Athletes Advisory Board of Boston Massachusetts:

I maintain poise, concentration and emotional control under the most demanding conditions. I control anger, frustration and fear so that these emotions do not control me. **Number________**

1 2 3 4 5 6 7

☐ Never ☐ Sometimes ☐ Always

I am able to concentrate under pressure and distraction. I tune into what is important and focus completely on the task at hand. **Number____________**

1 2 3 4 5 6 7

☐ Never ☐ Sometimes ☐ Always

I view pressure situations as challenges and opportunities and as a way to explore the limits of my potential. I want to be the "go to" guy or girl when the game is on the line. **Number______________**

1 2 3 4 5 6 7

☐ Never ☐ Sometimes ☐ Always

I perform best under pressure. When the chips are down I am at my best. **Number**____________

1 2 3 4 5 6 7
☐ Never ☐ Sometimes ☐ Always

I am eternally optimistic and maintain my self-confidence. I never have self-defeating thoughts and nothing shatters my confidence as an athlete. **Number**____________

1 2 3 4 5 6 7
☐ Never ☐ Sometimes ☐ Always

I am self motivated and directed a self-starter who does not have to be pushed to pay the price for excellence. **Number**___________

1 2 3 4 5 6 7
☐ Never ☐ Sometimes ☐ Always

I am a consistent athlete. My performance does not vary much from day to day. **Number**________

1 2 3 4 5 6 7
☐ Never ☐ Sometimes ☐ Always

Thank you for your time in filling out Awakenings Health Institute's application. We will review the information you have entered and contact you in a timely matter.

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laura@awakeningshealthinstitute.org