

WELCOME

to our office.....



**3000 Breckenridge Lane
Louisville, KY 40220
502 454 3500**

We are happy you have chosen us for you and your family's professional Wellness and Chiropractic Care.

Please fill out these forms so the Doctor can establish a complete record of your own personal health needs. **PLEASE PRINT.**

ABOUT YOU

Today's Date: _____

First Name: _____ M.I. _____ Last Name: _____

Phone: (____) _____ Cell Phone: (____) _____ Email address _____

Birth date: ____/____/____ Address: _____ City: _____ State: _____ Zip: _____

Soc. Sec. Number: _____ Marital Status (S M W D P) _____ How many children? _____

Occupation: _____ Employer: _____ Work # (____) _____

Name of Spouse: _____ B/day: _____ Spouses Employer: _____

Whom may we thank for referring you to our office? _____

Person to contact in emergency? _____ Phone: (____) _____

Family Physician _____ Do you have a pacemaker? Yes No

OFFICE POLICY

Our goal is to serve you with exceptionally friendly and prompt service, and provide the best family well care available.

This office is a place of healing. In consideration of other patients all cell phones must be turned off during your time in our office.

APPOINTMENT SCHEDULING:

Doctors and wellness coaches will design a specific course of action to allow proper care for you. It is important for your wellness to keep all scheduled appointments. If an appointment must be changed, 24 hours notice is requested. All missed appointments should be made up within 7 days. Occasionally the office is closed while the staff is attending seminars. We will build your schedule around those times.

NOTICE OF PRIVACY PRACTICES:

The below named patient acknowledges they have received a copy of Notice of Privacy Practices.

PATIENT NAME (please print) _____

PATIENT SIGNATURE _____

(Parent or legal guardian if patient is under 18 years of age)

STANDARD AUTHORIZATION OF USE AND / OR DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I hereby voluntarily authorize Awaken to Wellness / Carpenter Chiropractic Center to release any and all medical information, until this authorization is further revoked, to:

_____ Relationship: _____

_____ Relationship: _____

_____ Medical Doctor

I understand that if the person or organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Signature of Patient: _____ Signature of Patient Representative: _____

Signed and Dated: _____

You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization.

FAMILY & FRIENDS:

Once you understand that the nervous system controls and coordinates all functions of the body and Subluxation interferes with nerve flow, we expect that you will want everyone you know checked. We offer a cost effective family program. We extend an opportunity for you to have your family and friends' health and wellness examined.

Insurance Information:

Awaken to Wellness/Carpenter Chiropractic Center is dedicated to our members and committed to providing the highest quality wellness care. Awaken to Wellness is an excellent investment in an individual's well being. We believe financial considerations should not be an obstacle to obtaining the care and coaching you desire.

You are considered a cash practice member until our office "qualifies" your coverage to determine the extent of benefits under your policy. Members and their guardians are responsible for the payment in full of all fees for service. Unless other arrangements are made, payment is expected at the time of service regardless of insurance coverage.

At Awaken to Wellness/ Carpenter Chiropractic Center, we never want a financial challenge to get in the way of a family receiving care in our office. Therefore, we have established a fee schedule that creates affordable options for members. We are ready, willing, and able to assist you!

Printed Name: _____ **Date** _____

Signature: _____

MALE HEALTH HISTORY QUESTIONNAIRE

Name _____ Age: _____ Today's date: _____

Birth Date: _____ Weight: _____ Height: _____ Occupation: _____

1. What is the reason for this visit?

2. List medications you are currently taking:

3. Any known drug allergies? _____

4. Do you or have you used hormone replacement therapy? Yes No

If so, what? _____ When? _____ Dosage? _____

5. List natural supplements, herbs, remedies, including athletic performance supplements you are currently taking:

6. List any significant health issues (diabetes, surgeries, heart disease, etc.)

7. What was the date of your last physical exam? _____

LIFESTYLE INDICATORS < = less than > = greater than

1. Do you use any of the following? (circle responses)

Alcohol	None	<2 drinks/day	>2 drinks/day
Coffee	None	<2 cups/day	>2 cups/day
Soda	None	<2 cans/day	>2 cans/day
Sweets/refined carbs		<twice/day	>twice/day

2. Do you smoke cigarettes/cigars or use nicotine gum? Yes No When/How often? _____

3. How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10

4. How would you rate your stress handling? (1=Poor, 10=Excellent) 1 2 3 4 5 6 7 8 9 10

5. How often do you exercise? never rarely sometimes regularly competitively

1. Have you had a vasectomy? Yes No When? _____

2. Have you had a reverse vasectomy? Yes No When? _____

3. Have you experienced symptoms related to the vasectomy? Yes No

Explain: _____

4. Do you have a history of prostate problems? Yes No

Explain: _____

Date of last Prostate Exam _____

Most recent PSA results _____ Date _____

SLEEP HABITS

1. How do you sleep? Well Trouble falling asleep Trouble staying asleep Insomnia

How long has this been happening? _____

2. How many hours do you sleep a night on average? _____

3. Do night sweats wake you up? Yes No How often? _____

4. Do you wake up tired? Yes No How long has this been happening? _____

5. Is your room completely dark when you sleep at night? (*no night light, street lamp, TV, etc.*) Yes No

6. Do you get at least 30 minutes of outside daylight time, several days each week? Yes No

SIGNS & SYMPTOMS	MILD	MODERATE	SEVERE	ADDITIONAL COMMENTS
Low mood / Depression				
Irritability				
Anxiety				
Anger / Aggression				
Discouragement / Pessimism				
Decreased interest in activities / relationships				
Decreased initiative / motivation / drive				
Decreased productivity at work				
Concentration problems				
Memory problems				
Foggy thinking				
Increased fatigue				
Decrease in strength / stamina				
Decrease in athletic performance				
Decreased lean muscle mass				
Muscle soreness / weakness				
Body / joint aches				
Weight loss				
Weight gain				
Increased fat on hips / breasts / thighs				
Low blood sugar / hypoglycemia				
Sweet cravings (carbs/chocolate)				
Caffeine/Stimulant cravings				
Salt cravings				
Constant hunger				
Elevated cholesterol				
Elevated blood pressure				
Digestive problems				
Head hair loss				
Need to shave less frequently				
Body hair loss				
Dry skin / thinning skin				
Decreased spontaneous morning erections				
Lowered Libido				
Erectile Dysfunction (ED)				
Pain with ejaculation				
Frequent need to urinate				
Urination is delayed/strained/incomplete				
Pain with urination				
Blood in the urine				
Bone loss/osteoporosis				
Other				