

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: _____

YOUTH HEALTH HISTORY QUESTIONNAIRE

Name _____ Today's date: _____

Age: _____ Birth Date: _____ Weight: _____ Height: _____

This questionnaire is designed to assist in providing a general overview of your child's health habits and history. Please be as detailed as possible when answering these questions!

1. What is the reason for this visit?

2. Please list any known health conditions that your child has been diagnosed with:

3. List any **medications** your child is currently taking, or has taken in the past.

4. Please indicate any history of **antibiotic** use, listing when, what, and for what purpose.

5. Are there any known drug allergies?

6. List supplements, herbs, remedies, including athletic performance supplements that your child is currently taking:

7. Do you suspect your child to use recreational drugs? If so, what:

8. List any hospital procedures/surgeries that your child has had:

LIFESTYLE INDICATORS (please fill in or circle the appropriate answer)

1. Does your child consume any of the following?

Soda	none	< 2 cans / day	> 2 cans / day	
Sweets / Carbs	none	< twice / day	> twice / day	
White Flour	none	< twice / day	> twice / day	
Milk/Dairy Products	none	< twice / day	> twice / day	
Juice	none	< twice / day	> twice / day	
Meat/Fish	none	rarely	< once a week	every day

2. How much water does your child drink each day? _____

3. Are there smokers in the child's home? Yes No

4. Does your child get consistent physical activity? Yes No

5. Please list any regular exercise or sports that your child participates in:

History (please fill in or circle the appropriate answer)

1. Did your child have colic as an infant? Yes No

2. How was your child fed as an infant? Breast Bottle

What brand / kind of formula? _____

3. Has your child had any respiratory infections? Yes No

How often? _____

4. Does your child ever complain of back or neck pain? Yes No

Please explain: _____

5. Does your child ever complain of arm or leg pain? Yes No

Please explain: _____

6. Does your child ever complain of headaches? Yes No

How often? _____

7. Has your child had ear infections? Yes No

Age of the first occurrence and frequency: _____

8. Do they typically occur in the same ear? Yes No Which ear? Right Left Both

9. Please list any illnesses that your child has had and approximate dates of occurrence:

10. Has your child been vaccinated? Yes No Recently? Yes No

11. Please describe any reactions that your child has had to past or recent vaccinations:

12. Please list any other concerns you have regarding your child's health:

Sleep Habits (please fill in or circle the appropriate answer)

1. How well does your child sleep?
Well Trouble falling asleep Trouble staying asleep Insomnia
2. Does your child wake up tired? Yes No
3. How many hours does your child sleep on an average night? _____
4. Does your child take naps? Yes No
5. Does your child have nightmares? No Sometimes Often

For Cycling Females Only (please fill in or circle the appropriate answer)

1. Age of onset of menarche (first period): _____
Approximate Date: _____
2. Is your child currently using any method of birth control? Yes No
What kind? Oral Pill Injected Patch Ring
3. How long has your child been using birth control? _____
4. Please describe any symptoms that your child may have experienced while using birth control (i.e. yeast infections, heavy / light bleeding, moodiness, weight gain, acne, sweet cravings, palpitations, fatigue):

5. First day of last period: _____
6. Length of typical period: _____
7. Is menstrual cycle regular? Yes No Not Always
Details: _____
8. How many pads and / or tampons (please circle) are used on heavy days?

9. Any knowledge of passing clots? Yes No
How often? _____
10. Any spotting between periods? Yes No
At what point in cycle? _____
11. Does your child experience cramping? None Mild Moderate Severe
At what point in the cycle? _____

**INSTRUCTIONS: Please mark the following symptoms as they apply.
Please be as detailed as possible.**

SIGNS & SYMPTOMS	MILD	MODERATE	SEVERE	MORE INFORMATION
Low Mood				
Lowered Self-Esteem				
Discouragement				
Sadness / Crying				
Reserved / Withdrawn				
Decreased Interest in Activities				
Decreased Initiative / Motivation				
Behavior Problems				
Aggression				
Anger				
Anxiety				
Fear				
Difficulty Concentrating				
Foggy Thinking				
Memory Problems				
Constant Hunger				
Never Hungry / Anorexia				
Weight Loss				
Weight gain				
Decrease in Strength / Stamina				
Decrease in Athletic Performance				
Fatigue				
Anemia				
Headaches / Migraines				
Body / Joint / Backaches				
Digestive Problems				
Irritable Bowel				
Constipation				
Loose Stool / Diarrhea				
Bloating				
Frequent Urination				
Bedwetting				
Allergies				
Asthma				
Throat Clearing				
Excessive Mucous / Runny Nose				
Dry Skin				
Acne				
Cold Sores				
Infections / Lowered Immunity				