

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: _____

Welcome to our wellness center,

Today we are here to discover your goals and priorities as it relates to your health and wellness. Your answers will help us determine how we can best help you.

Let's get started...

On a scale of 1 – 10, rate the importance for you to achieve the following:

1 = not important 10 = necessary

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|----|
| Get fit | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Eat better | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Reduce stress | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Stop smoking | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Reduce pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Increase my mobility | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Improve my posture | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Improve my sleep | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Learn about wellness | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Learn about wellness products that are right for me | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Other _____ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Which of the above would you say is the most important goal for you to achieve and why?

Have you ever attempted to accomplish this goal in the past? Yes No

If yes, what happened and what prevented you from maintaining your results? _____

Do you have any questions or comments? _____

Remember: your health is your greatest asset, the more of it you have the healthier you are.

We look forward to helping you Awaken to Wellness!

Do you have any current complaints? _____

Is this condition due to an: A) Automobile Accident B) Work Injury C) Other Accident D) Unknown cause E) Illness

Date symptoms appeared: _____ Have you had these symptoms before? Y / N If so, when? _____

Circle any activities, which aggravate your condition:

A) Standing B) Walking C) Sitting D) Lying E) Bending F) Lifting G) Twisting H) Coughing I) Other _____

Circle any of the following that describe your symptoms: Dull Achy Numbness Sharp Tingling Stabbing Throbbing

Rate your major complaint on a scale of 1-10 (with 10 being the worst): _____

Are the symptoms: A) Improving B) Getting Worse C) About the same D) Intermittent (come & go)

1. What are your favorite hobbies or activities to do now? _____
2. Are your current problems affecting these activities or hobbies? _____
3. What activities are you looking forward to doing in retirement? _____

Previous Chiropractic? Y / N Doctor's Name: _____ Were X-rays taken? Y / N

Have you seen another Doctor for this condition? Y / N if yes, by Physician Physical Therapist Other

Doctor's Name: _____ Date consulted: _____ Were X-rays taken? Y / N

What did they recommend? _____

PLEASE MARK THE FOLLOWING CONDITIONS IF THEY PERTAIN TO YOU.

Mark an "O" if it is a Past Condition or an "X" for a Present Condition.

- | | | |
|---|--|---|
| <input type="checkbox"/> Auto Accidents | <input type="checkbox"/> Headache | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> (a) 0-1 years ago | <input type="checkbox"/> Jaw Pain/ click (TMJ) | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> (b) 1-5 years ago | <input type="checkbox"/> Shoulder Pain R / L | <input type="checkbox"/> Frequent colds/ Flu |
| <input type="checkbox"/> (c) More than 5 yrs ago | <input type="checkbox"/> Neck pain/ stiffness | <input type="checkbox"/> Back Curvature |
| <input type="checkbox"/> Other Accidents/ Falls | <input type="checkbox"/> Mid -Low back pain | <input type="checkbox"/> Head seems too heavy |
| <input type="checkbox"/> Fractured Bones | <input type="checkbox"/> Hip Pain R / L | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Knocked Unconscious | <input type="checkbox"/> Foot trouble R / L | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Convulsions/ Epilepsy | <input type="checkbox"/> Impotence | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Light headed upon rising |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Menopausal problems | <input type="checkbox"/> Light bothers eyes |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Menstrual problems / PMS | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Breast Lumps, soreness, discharge | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Heartburn | <input type="checkbox"/> AIDS / HIV |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Belching/ Bloating | <input type="checkbox"/> Dyslexia |
| <input type="checkbox"/> Difficult breathing | <input type="checkbox"/> Excessive Gas | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diarrhea / Constipation | <input type="checkbox"/> Stutter |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Depressed |
| <input type="checkbox"/> Gall Bladder trouble | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Itching | <input type="checkbox"/> Trouble concentrating |
| <input type="checkbox"/> Liver Trouble | <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Under Stress |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Mood changes |
| <input type="checkbox"/> Hearing Loss R / L | <input type="checkbox"/> Ringing in ears R / L | <input type="checkbox"/> Crave sweets/salt |
| <input type="checkbox"/> Blurred or Double Vision R / L | | <input type="checkbox"/> Mental/Emotion disorders |

Do you have pain with coughing, sneezing, or straining during stools? Yes / No

Do you have difficulty in excessive: standing _____ walking _____ sitting _____ riding _____ bending _____ lifting _____ twisting _____

Do you have numbness, tingling, or pain in the... buttocks _____ thighs _____ legs _____ feet _____ toes _____ Right / Left

Do you have numbness, tingling, or pain in the... arms _____ hands _____ fingers _____ Right / Left

Are you currently wearing : Heel lifts? Yes / No Arch supports? Yes / No

FOR WOMEN ONLY:

Is there any possibility you might be pregnant? (Please check one)

_____ No _____ Yes _____ Unsure

FAMILY HEALTH HISTORY: (circle all that apply)

Mother: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

If deceased—Age at death: _____

Father: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

If deceased—Age at death: _____

Siblings: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

If deceased—Age at death: _____

SOCIAL HISTORY: (circle all that apply)

Do you: 1) Exercise regularly Y / N 2) Eat a balanced diet Y / N 3) Obtain sufficient rest Y / N

What is your typical breakfast? _____

What is your typical lunch? _____

What is your typical dinner? _____

What do you typically have for snacks? _____

Do you smoke- (packs/day): 1) No 2) Less than 1 3) 1-2 4) 2-3 5) 3-4 6) More than 5

Do you drink coffee/tea- (cups/day): 1) No 2) Less than 1 3) 1-2 4) 2-3 5) 3-4 6) More than 5

Do you drink alcohol- (drinks/day): 1) No 2) Less than 1 3) 1-2 4) 2-3 5) 3-4 6) More than 5

Do you drink soda? - regular or diet and how much per day? _____

Are you stressed out? _____

MEDICAL HISTORY:

Immunizations: (circle) 1) Tetanus 2) Pertussis 3) Diphtheria 4) German Measles 5) Measles 6) Mumps 7) Polio

Childhood Illnesses: 1) Measles 2) Mumps 3) Chickenpox 4) Tuberculosis 5) Rheumatic fever 6) Diabetes 7) Cancer

List any serious childhood illnesses not recorded above:

_____ Age (____)

_____ Age (____)

_____ Age (____)

List any birth defects:

Hospitalizations & Surgeries: If you have ever been hospitalized, list reason, and dates:

_____ M/D/Y ____/____/____

_____ M/D/Y ____/____/____

_____ M/D/Y ____/____/____

Adult Illnesses/ Injuries: List all serious diseases & injuries for which you have not been hospitalized; include approximate dates.

_____ M/D/Y ____/____/____

_____ M/D/Y ____/____/____

MEDICATIONS:

Medications: (include home remedies) List all medications that you are or have taken on a regular basis in the last 6 months.

A) _____

B) _____

C) _____

D) _____

Medications to which you are allergic:

A) _____

B) _____

C) _____

D) _____

I certify that the information on these forms is correct to the best of my knowledge. I will not hold Dr. Kim Carpenter or any member of her staff responsible for any errors or omissions that I may have made in the completion of these forms.

Patient Signature _____ **Date:** _____