

# 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:** \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. List your history of GYN procedures or surgeries (ovaries, hysterectomy, tubal ligation, breast, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Date of last pelvic/gynecological exam: \_\_\_\_\_ Last Pap Test: \_\_\_\_\_ Last mammogram: \_\_\_\_\_

7. Last thermography? \_\_\_\_\_ Unusual results? \_\_\_\_\_

8. List significant non-GYN health issues (diabetes, surgeries, etc.):

\_\_\_\_\_  
\_\_\_\_\_**LIFESTYLE INDICATORS**      < = less than    > = greater than

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

Alcohol	None	<2 drinks/day	>2 drinks/day	or stopped recently	_____ (when?)
Coffee	None	<2 cups/day	>2 cups/day	or stopped recently	_____ (when?)
Soda	None	<2 cans/day	>2 cans/day	or stopped recently	_____ (when?)
Sweets/refined carbs		<twice/day	>twice/day	or stopped recently	_____ (when?)

2. Do you smoke cigarettes/cigars or use nicotine gum or other stimulants? (circle) Y N Amount \_\_\_\_\_

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

**INSTRUCTIONS: Check either "Ongoing" or "Just w/ Period" for each problem that applies to you. Check both if the problem is ongoing and worse with your period. Then rate the severity.**

SIGNS & SYMPTOMS	SEVERITY			MORE INFORMATION
	ONGOING	JUST W/ PERIOD	MILD MODERATE SEVERE	
Mood swings				
Anxiety/Nervousness/Irritable (circle)				
Overly Reactive/Short fuse/Anger (circle)				
Low Mood/Depression (circle)				
Low Blood Sugar/High Blood Sugar				
Lowered self-esteem/self-image (circle)				
Care for others before yourself				
Sadness/Crying (circle)				
Trouble Concentrating				
Memory difficulties				
Fatigue/Anemia (circle)				
Increased Appetite/Constant hunger (circle)				
Sweet cravings/Carbs/Chocolate (circle)				
Caffeine/Stimulant cravings (circle)				
Salt cravings				
Headaches/Migraines (circle)				
Muscle Pain/Joint Aches/Backache (circle)				
Weight gain/Trouble Losing Weight (circle)				
Weight loss				
Water Retention				
Bloating/Belching/Gas (circle)				
Stomach Burning/Nausea/Indigestion (circle)				
Constipation				
Light colored stool				
Loose stool/Diarrhea/IBS (circle)				
Acne/Rashes/Brown Spots (circle)				
Excessive facial hair/body hair (circle)				
Body/Head hair loss (circle)				
Infertility				
Lowered libido/Heightened libido (circle)				
Hot flashes/Night Sweats (circle)				
Palpitations				
Breast tenderness/Breast cysts (circle)				
Nipple discharge				
Vaginal infections/Yeast Infections (circle)				
Urinary Frequency/Incontinence/Infections (circle)				
Dry eyes/Dry skin/Overall dryness (circle)				
Changes to Labia/Clitoral tissue (atrophy, thinning, discoloration, itching, burning) (circle)				
Vaginal changes (dryness, tearing, decreasing size) (circle)				

Any other symptoms? \_\_\_\_\_

**REPRODUCTIVE HEALTH HISTORY** (please fill in or circle the appropriate answer)

1. Age at onset of menarche (first period): \_\_\_\_\_ Approximate date of onset: \_\_\_\_\_
2. Are you currently using a method of birth control? Yes No  
If yes, what method? \_\_\_\_\_
3. Are you, or have you used (please circle) oral, injected, patch, or ring hormone contraceptives, or used Emergency Contraception (aka "the day after" pill)? Yes No  
When and for how long? \_\_\_\_\_
4. Are you, or have you used an IUD? Yes No If yes, when and for how long? \_\_\_\_\_  
What type of IUD did you use? copper hormone other \_\_\_\_\_
5. Please describe problems that you may have experienced associated with the use of any and all birth control methods (such as yeast, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue, depression, palpitations, etc.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Have you used, or are you currently using fertility or treatment? Yes No  
If yes, please explain. \_\_\_\_\_
7. Have you used, or are you currently using, bioidentical hormones (such as DHEA, pregnenolone, progesterone, estrogen, testosterone, etc.)? Yes No If yes, what hormone(s), dosage, & for how long? (Specify dates of use)  
\_\_\_\_\_

8. Have you been pregnant before? Yes No Age(s) of children: \_\_\_\_\_  
Number of pregnancies? \_\_\_\_\_ Details/ Complications: \_\_\_\_\_  
Number of live births: \_\_\_\_\_  
Miscarriages: \_\_\_\_\_  
Premature births: \_\_\_\_\_  
Cesarean births: \_\_\_\_\_  
Stillbirths: \_\_\_\_\_  
Abortions: \_\_\_\_\_  
Ectopic pregnancies \_\_\_\_\_
9. If you have had a miscarriage, how many weeks pregnant were you? \_\_\_\_\_
10. Have you had an abnormal Pap Test? Yes No Diagnosis/Reason: \_\_\_\_\_  
Treatment and/or Medication: \_\_\_\_\_
11. Have you had a vaginal infection? Yes No If yes, what? \_\_\_\_\_  
Treatment and/or Medication: \_\_\_\_\_
12. Any history of... Ovarian cysts? Yes No Uterine fibroids? Yes No  
Fibrocystic Breasts? Yes No Endometriosis? Yes No  
Polycystic Ovarian Syndrome (PCOS)? Yes No Lichen Sclerosis? Yes No  
Vulvodinia? Yes No

**FOR CYCLING-AGE WOMEN** (please fill in or circle the appropriate answer)

1. First day of last menstrual period (LMP): \_\_\_\_\_ Have you had a tubal ligation? Yes No When? \_\_\_\_\_
2. Has there been any recent change in your cycle or symptoms associated with your cycle? Yes No  
If yes, please give details. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. How many days is your current cycle? (Counted from the first day of your period to the first day of your next period)  
<20 \_\_\_\_\_ 20-30 \_\_\_\_\_ 30-40 \_\_\_\_\_ 40-50 \_\_\_\_\_ >50 \_\_\_\_\_
4. How many days does menstruation typically last? \_\_\_\_\_
5. Is your cycle regular? Yes No Not Always Details: \_\_\_\_\_
6. Typical menstrual flow: Light Medium Heavy Details: \_\_\_\_\_
7. How many pads and/or tampons (circle) are used on heavy days? \_\_\_\_\_
8. Do you pass clots? Yes No How often? \_\_\_\_\_
9. Do you spot? Yes No At what point in your cycle? \_\_\_\_\_
10. Do you experience cramping? None Mild Moderate Severe  
At what point in your cycle? \_\_\_\_\_
11. Do you experience abnormal vaginal discharge? Yes No If yes, when? \_\_\_\_\_
12. Do you experience vaginal itching and/or odor? Yes No If yes, when? \_\_\_\_\_
13. Do you experience breast tenderness? None Mild Moderate Severe  
At what point in your cycle? \_\_\_\_\_ Change in breast size? Yes No
14. Do you experience nipple discharge? Yes No If yes, when? \_\_\_\_\_ Color? \_\_\_\_\_

**FOR MENOPAUSAL WOMEN** (please fill in or circle the appropriate answer)

1. Your age at the onset of menopause: \_\_\_\_\_ Year of onset: \_\_\_\_\_
2. Have you had a hysterectomy? complete (ovaries AND uterus) partial (uterus only)
3. Date of hysterectomy: \_\_\_\_\_ Reason for hysterectomy: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. List any other GYN related surgeries: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Describe your experience transitioning into menopause (symptoms, strong emotions, thoughts, unusual stressors, etc.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MENOPAUSAL WOMEN, CONT'D**

6. Have you used, or are you currently using, conventional hormone replacement therapy (HRT)? Yes No  
 If yes, what were you prescribed? \_\_\_\_\_  
 What dosage? \_\_\_\_\_ For how long? \_\_\_\_\_
7. Have you used, or are you currently using bioidentical hormone creams/gels/sublingual, troche, oral? Yes No  
 If yes, what? \_\_\_\_\_  
 What dosage? \_\_\_\_\_ For how long? \_\_\_\_\_
8. Have you utilized any alternative, complementary, or natural remedies in your management of menopause? Yes No  
 If yes, what? \_\_\_\_\_  
 For how long? \_\_\_\_\_
9. Have you had, or do you have any vaginal spotting or bleeding since menopause? Yes No  
 If yes, when? \_\_\_\_\_ Were you evaluate and/or treated by a GYN? Yes No  
 Treatment: \_\_\_\_\_

**PLEASE DESCRIBE YOUR CYCLE HISTORY.**

10. How would you have described your menstruation?  
                     Easy                    Uncomfortable                    Difficult                    Debilitating
11. What was your typical menstrual flow?                    Light                    Medium                    Heavy
12. When you were cycling would you consider your cycle regular? Yes No  
 If no, explain. \_\_\_\_\_
- Please describe any 'treatment' ever received for cycle issues. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**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