

WELCOME

Awaken to Wellness
3000 Breckenridge Lane
Louisville, KY 40220
502 454 3500

to our office.....

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) Illness D) Pregnancy E) Other F) Unknown cause

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)

How do you want us to handle your problem?

____ TEMPORARY RELIEF (HELP THE SYMPTOM ONLY)

____ MAXIMUM CORRECTION (CORRECT THE CAUSE OF THE PROBLEM FOR MAXIMUM STABILITY)

____ I DON'T KNOW AND WOULD LIKE THE DOCTOR TO DECIDE

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.

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

PREGNANCY HISTORY:

How many times have you been pregnant before? _____

Were there any problems during your past pregnancies? Please Explain

Were there any problems during past labor and deliveries? Please Explain

Third Trimester Presentation of Baby (circle): Normal Breech Transverse Face/Brow

Type of Birth (circle): Normal Vaginal Forceps Planned Cesarean Suction/Vacuum Emergency Cesarean

Any Other Obstetrical Interventions? _____

CURRENT PREGNANCY:

What is the term of your pregnancy? _____ Weeks

CHECK WHICH OF THE FOLLOWING YOU ARE EXPERIENCING and EXPLAIN:

- Abnormal Bleeding _____
- Motor Vehicle Accidents _____
- High Blood Pressure _____
- Diabetes _____
- Falls _____
- Swollen Ankles _____
- Morning Sickness _____
- Indigestion _____
- Thyroid Problems _____
- Seizures _____
- Heart Problems _____
- Back Pain _____
- Hospitalizations _____
- Other _____

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 WHILE PREGNANT: (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 (____)

List any birth defects:

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

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 WHILE PREGNANT:

List all including vitamins, home remedies, prescription meds, non-prescribed drugs, and over-the-counter meds.

- _____
- _____
- _____
- _____
- _____
- _____

I certify that the information on these forms is correct to the best of my knowledge. I will not hold Dr. Heather Yost 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: _____