WELCOME

to our office..........

161 St. Matthews Avenue, Suite #13
Louisville, Kentucky 40207
phone: 502-454-3500
fax: 502-891-0085
www.awakentowellnesscenter.com

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? ⑧Yes ⑧ 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 Center/Carpenter Chiropractic Center is a non participating provider with all insurance carriers.

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:

____

____

____

____

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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:

____

____

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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? ____________________

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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				

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