CARTER FAMILY CHIROPRACTIC

Dr. Lauren Carter & Dr. Steven Carter
101 West College, Suite 2
Troy, MO 63379
636.775.2500

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

What name do you prefer to be called? _____Date of Birth:_____

Social Security # _____ Sex: □ Male □ Female Marital Status: □ Single □ Married □ Minor

Home Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Email Address_____

Please indicate the best time of day to contact you:_____

We utilize text and email for appointment reminders and agreed upon communication with the doctor and front desk.

Appointment text reminders are sent the day before your appointment at 1:00 PM.

Do you consent to receive communication via text and email? Y N

How did you hear about the doctor: _____

Employer: _____ Occupation: _____

Emergency Contact Name and Number: _____

Responsible Party: *Indicate who is responsible for charges related to the patient's care.*

Name of person responsible for this account: _____

Relationship to patient: _____ DOB: _____ Phone Number: _____

Address: _____ City, State, Zip: _____

YOUR HEALTH PROFILE

	Yes	No	Unsure	Comments
Do you drink water daily?	□	□	□	How much:_____
Do you drink caffeine?	□	□	□	How much:_____
Do/did you smoke?	□	□	□	How much:_____
Do/did you drink alcohol?	□	□	□	How much:_____
Do you take any supplements?	□	□	□	What kind/which:_____
Do/did you play any adult sports?	□	□	□	Which:_____
Do you exercise regularly?	□	□	□	Type:_____

Do you sleep on your back / front / side (circle all that apply)

On a scale of 0 – 10 describe your stress level (0 = none / 10 = extreme) Occupational _____ Personal _____

On a scale of Poor / Good / Excellent please describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____ Mental State _____

Please share any preferences you would like the doctor to be aware of

_____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

Please briefly describe your chief complaint:_____

When did you first notice the symptoms?_____

What are these symptoms preventing you from doing?_____

Do your symptoms interfere with: □Work □Sleep □Walking □Sitting □Bending □Lifting

If you are experiencing pain, is it: □Sharp □Dull □Comes and Goes □Travels □Constant

Since the problem started, it is: □About the Same □Getting Better □Getting Worse

What makes it worse? And better, if anything?_____

Other Doctors seen for this problem (please list):_____

CHECK THE HEALTH SYMPTOMS WHICH HAVE OCCURRED:

□AIDS/HIV	□Emphysema	□Migraine Headaches	□Scarlet Fever
□Alcoholism	□Epilepsy	□Miscarriage	□Skin Problem
□Allergy Shots	□Fractures	□Mono	□Stroke
□Anemia	□Gout	□Multiple Sclerosis	□Suicide Attempt
□Appendicitis	□Hearing Problems	□Mumps	□Thyroid Disorder
□Arthritis	□Heart Disease	□Osteoporosis	□Tonsillitis
□Asthma	□Hepatitis	□Pacemaker	□Tuberculosis
□Bleeding Disorders	□Hernia	□Parkinson's Disease	□Tumors/Growths
□Tissue Lumps	□Herniated Disc	□Pinched Nerve	□Typhoid Fever
□Bronchitis	□High Cholesterol	□Pneumonia	□Ulcers
□Cancer	□High Blood Pressure	□Polio	□Venereal Disease
□Chemical Dependency	□Infertility	□Prostate Problem	□Vision/Eye Problem
□Chicken Pox	□Kidney Disease	□Prostheses	□Whooping Cough
□Depression	□Liver Disease	□Psychiatric Care	□Other (please list)
□Diabetes	□Lung Disorder	□Rheumatic Fever	_____
□Eating Disorders	□Measles	□Rheumatoid Arthritis	_____

□Surgical History: _____

Please circle the number to select the most appropriate statement. 0 = Able to function / 10 = Unable to function

Family/Home Responsibilities (chores, duties around the house): 0 1 2 3 4 5 6 7 8 9 10

Recreation/Social Activity (hobbies, sports, social functions): 0 1 2 3 4 5 6 7 8 9 10

Occupation (activities directly related to one's job): 0 1 2 3 4 5 6 7 8 9 10

Self Care (personal maintenance and independent daily living): 0 1 2 3 4 5 6 7 8 9 10

Women: Are you pregnant? □Yes □No Taking birth control pills? □Yes □No

List any medications you are currently taking:_____

We are not only interested in your health and well-being, but also about your family and loved ones. Please mention below any health conditions or concerns for your: Children: _____

Spouse/Partner/Significant Other: _____

Parents/Siblings: _____

The statements made on this form are accurate to the best of my knowledge.

_____ _____

Signature Date