Carter Natural Health Center

Kevin C. Carter, DC, FCAMI

136 Walton Ferry Rd, Suite 1B
PO Box 1129
Hendersonville, TN 37077
615-289-5823 Fax 615-826-8480
drcarter@drcarteronline.com
W W W . D R C A R T E R O N L I N E . C O M

Name:______________________________ Date: __________

Address:______________________________

City State Zip

Home #: ( )__________Work #:( )__________Cell #:( )__________

Social Security # __________Date of Birth: __________ Age:__________

Occupation: __________Employer: __________

Sex: ☐ Male ☐Female Height______Weight______ Email Address: __________

Referred By or Found By?__________

YOUR HEALTH PROFILE

Chief Complaint (reason you are here): (use a separate sheet if needed):__________

____

____

Previous treatments for this complaint: __________

Other complaints: (use a separate sheet if needed):__________

____

Please list any **prescription**, **over-the-counter medications**, **vitamins**, and **herbs** you are presently taking:

Taking	Reason	How Long

Use a separate sheet if needed

Are you currently under the care of a physician or other health care professional? If yes, list date last seen

Chiropractor__________

Medical Doctor__________

Other__________

Do you drink caffiene? .... ☐ Yes ☐ No ☐ Did in the past How much per day__________

Do you smoke?................................. ☐ Yes ☐ No ☐ Did in the past How much per day__________

Do you drink alcohol? .... ☐ Yes ☐ No ☐ Did in the past How much per day__________

Have you had chiropractic care before?................................ ☐ Yes ☐ No Last Treatment__________

Have you had any surgery? ☐ Yes ☐ No if Yes, please list type and date of surgery:

Surgical Procedure	Reason	Date

Use another sheet of paper if needed

HEALTH RATING 1-3 low 4-6 moderate 7-9 high 10 unbearable

On a scale of 1 to 10 describe your stress level: Occupational ____________ Personal ____________________

On a scale of Poor, Good, Excellent, describe your:

Diet: ______________ Exercise:______________ Sleep:_____________ General Health________________

List Major Illnesses and Past Accidents or Injuries

Illness, Accident or Injury	Date

Marital Status: ☐Single ☐ Married ☐ Separated ☐ Divorced ☐Widowed ☐ Partnered

Spouse's Name: ______________________________________ Spouse's Birth Date:____________________

Spouse's Occupation: __________________________________Spouse's Employer: ____________________

Name of Children	Age	Any Physical Conditions or Health Concerns?

Any Family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other__________

____

Any household pets or other animals you or your family members are in close contact with:__________________

____

What can we do to make you happier?____

____

Signed:____ Date:_____________________

ADDRESSING THE ISSUES THAT BROUHT YOU TO THE OFFICE

Are you experiencing pain? ☐YES ☐NO If so when did it begin____________________

If you are experiencing pain, is it… ☐ Traveling ☐ Constant

☐ Coming and Going; When?____________________

Since the problem started, is it... ☐About the Same ☐Getting Better ☐Getting Worse

What makes it worse?____

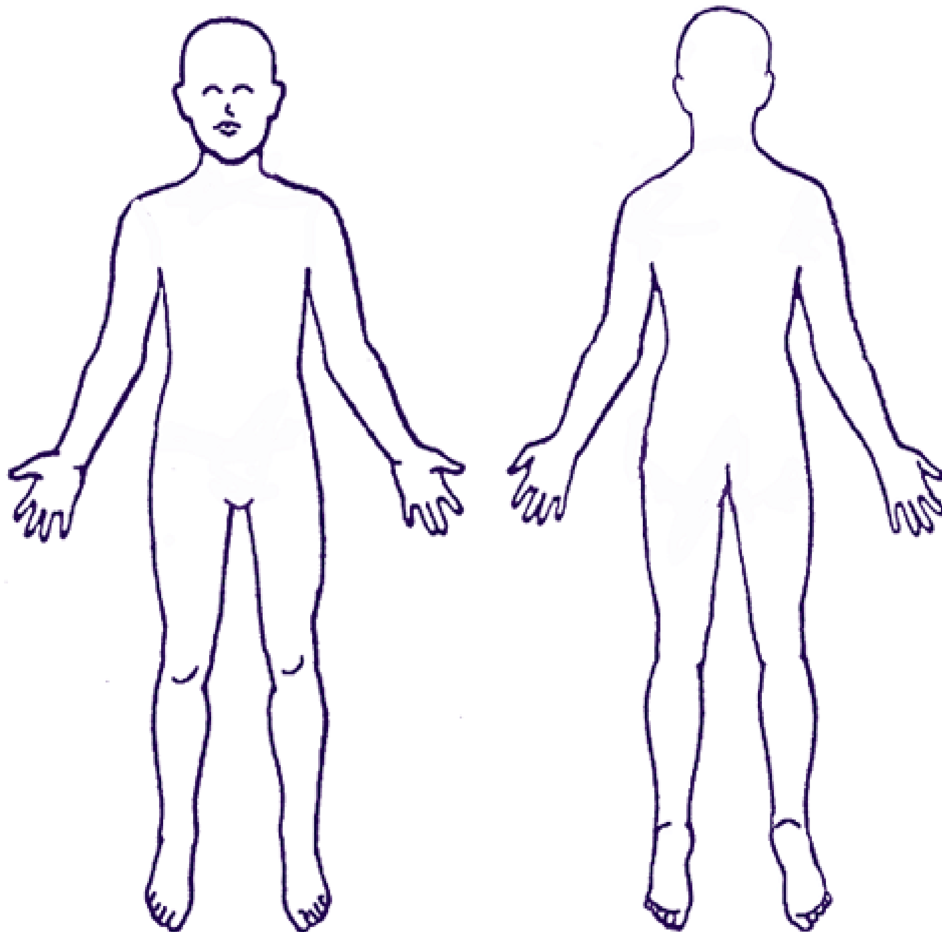
What makes it better?____

What does it interfere with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐Leisure

Mark below your issues using the following letters:

A=Aches B=Burning N=Numbness

P=Pins and Needles R=Radiating S=Stabbing O= Other ____________



FAMILY HEALTH PROFILE:

At the office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children____

Spouse____

Mother____

Father____

Self____

CONCLUSION

We are a *FRAGRANCE FREE OFFICE*

Please refrain from wearing your fragrance before you come to the office. You would lessen the possibility of a sensitive person having a reaction.

Thanks for your help in this matter and please don't be offended if we need to remind you and possibly ask you to return at another time. We wouldn't want you to be responsible for someone else's allergic reaction.