# Carter Natural Health Center

## Kevin C. Carter, DC, FCAMI


136 Walton Ferry Rd, Suite 1B
Hendersonville, TN 37075
Text Only 615-492-4316
615-289-5823 Fax 615-826-8480
info@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:__________Date of Birth: ____________ Age:__________
Home # (     )______________Work #(     )______________Cell #(     )______________
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 caffeine? .................... ☐ 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? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Vaccine History**

**COVID Vaccine Y/N Date of Vaccine:______________ Booster #________ Manufacture: _____________**

**Please list all others to the best of your knowledge:**

| **Type** | **Year** |
|---|---|
| | |
| | |
| | |
| | |
| | |

***ADDRESSING THE ISSUES THAT BROUGHT 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?________________________

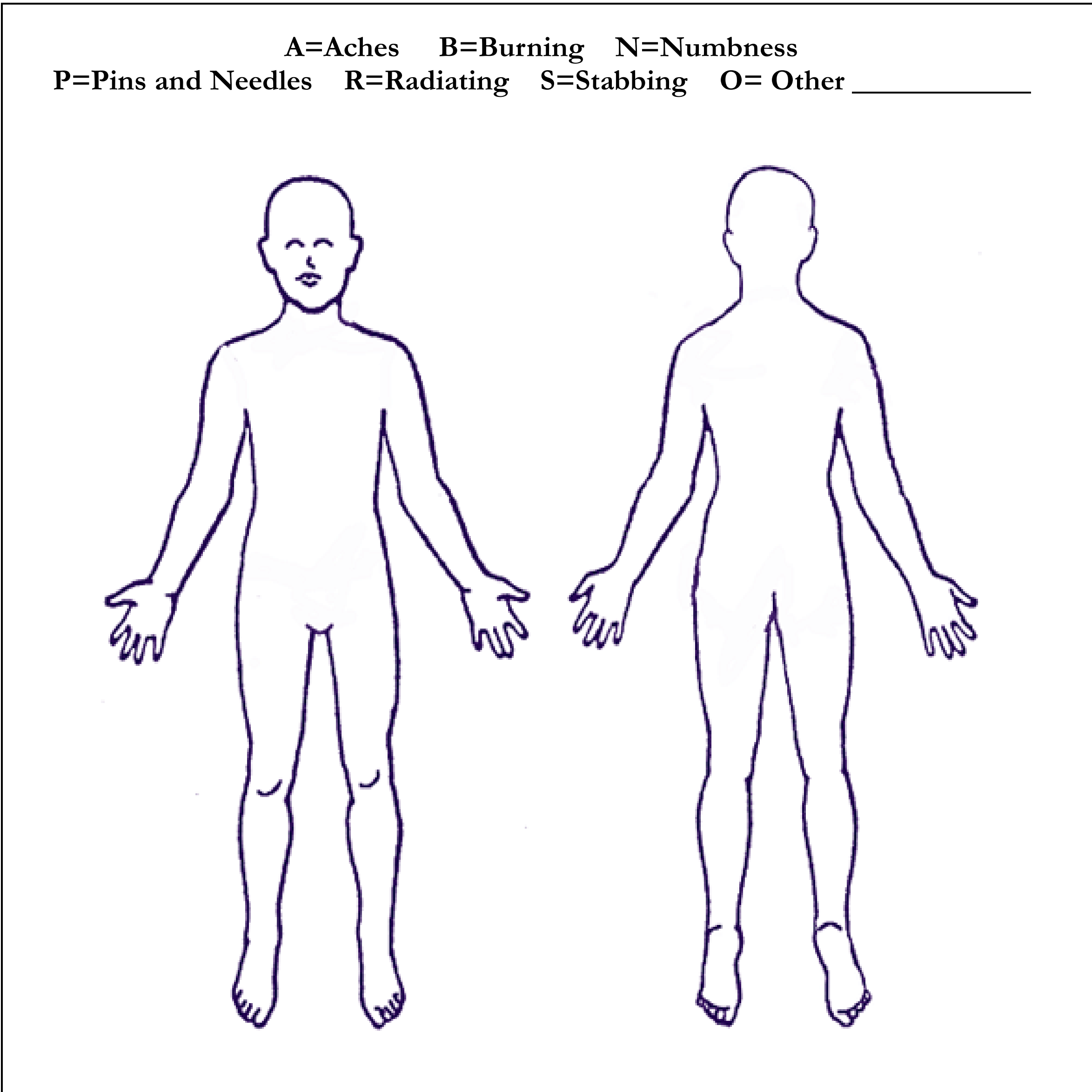
Since the problem started, is it... ☐ About the Same ☐ Getting Better ☐ Getting Worse

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:**



***FAMILY HEALTH PROFILE***:

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?________________________________________

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.

## SIGNATURE

Signed:______________________________ Date:________________