Today's date:	Emergency Contact person:								
			Р	hone:					
	PA	TIENT		ORMATI	ION				
Patient's last name: First:	First: Middle Initial: Nickname: Date						Date of	Birth:	Sex: M F
Street address:	Preferred Phone: Cell Phone: □Cell □Home □Work						: :	Home Phor	ne:
Address Line 2:	Would you like to receive appointm reminders? Choose ONE: □Email □None						ent	Work Phon	e:
City: S	tate:	Zip Cod	de: Email:						
Preferred Language: □English □Spa □Japanese □Korean □Vietnames								□Chinese	
Please check ALL races that apply: ☐ Asian ☐Native Hawaiian/Pacific	lWhite □B Islander □	lack or A Decline t	Africa to An	ın Amerio Iswer	can □Am	erican Ind	ian or Al	laska Nativ	е
Ethnicity: ☐Hispanic or Latino ☐No	n-Hispanio	nor Lati	ino 🗆	Decline	d to Ansv	ver			
Preferred Communication: □Cell Pho	ne □Home	Phone	□Wo	rk Phone	e □Mail □	⊒Email □I	n Persor	n	
Smoking Status: □Current everyday	□Current	some da	ys 🗖	Former	□Never S	Start Year	C	Quit Date	
Frequency (e.g. once daily)		Date	Star	rted:				ab)	
2. Drug Name: Frequency (e.g. once daily)	Drug Name: Dose (e.g. 1 tab) requency (e.g. once daily) Date Started:								
Frequency (e.g. once daily)Date Started: 3. Drug Name:Dose (e.g. 1 tab) Frequency (e.g. once daily)Date Started:									
4. Drug Name:		Stre	ngth	(eg. 10M	1G)	Dose	(e.g. 1 t	tab)	
Frequency (e.g. once daily) 5. Drug Name: Frequency (e.g. once daily)		Stre	ngth Star	(eg. 10M rted:	1G)	 Dose	(e.g. 1 t	tab)	
Drug Allergies: 1. Drug Name 2. Drug Name 3. Drug Name	R	eaction (e.g.	hives)			Date Sta	ırted:	
Referred by:				Referring	g Physicia	an:			
Blood Pressure: / Heart Rate:	Weight:		1	Height:		Last Phys			

	FAMILY HISTORY						
Please indicate which conditio				marking	the boxes	below.	
	Self	Mother	Father	Sister	Brother	Son	Daughter
Bone Cancer							
Brain Cancer							
Breast Cancer							
Colon Cancer							
Esophageal Cancer							
Gastric Cancer							
Kidney Cancer							
Leukemia							
Liver Cancer							
Muscle Cancer							
Other Cancer							
Ovarian Cancer							
Pancreatic Cancer							
Prostate Cancer							
Rectal Cancer							
Skin Cancer							
Thyroid Cancer							
Clotting Disorder							
Deep Vein Thrombosis							
Pulmonary Embolism							
Unknown Clotting Disorder							
Dementia/Alzheimer's							
Diabetes							
Gestational Diabetes							
Impaired Fasting Glucose							
Insulin Resistance							
Maturity onset Diabetes (MODY)							
Pre-Diabetes							
Type 1 Diabetes							
Type 2 Diabetes							
Colon Polyp							
Crohn's Disease							
Familial adenomatous polyposis (FAP)							
Gastrointestinal Disorder							
Irritable Bowel Syndrome							
Ulcerative Colitis							
Lynch Syndrome							
Angina							
Coronary Artery Disease							
Heart Attack							
Heart Disease							
Unknown Heart Disease							
Hypertension							
Cystic Kidney Disease							
Chronic Kidney Disease (assoc. Diabetes Type 2)							
Congenital Kidney Disease							
Kidney Nephrosis							
Nephritis							
Nephrotic Syndrome							
Other Kidney Disease							
Unknown Kidney Disease							
Asthma							

Chronic Obstructive Pulmonary Disease					[1			
Chronic Bronchitis					[_			
Chronic Lower Respiratory Disease					[_			
Emphysema					[_			
Influenza					[1			
Pneumonia					[_			
Osteoporosis					[]			
Anxiety					[1			
ADHD					[_			
Autism					[_			
Bipolar Disorder					[_			
Dementia					[_			
Depression					[
Eating Disorder					[]			
Mental Disorder					[]			
OCD					[]			
Panic Disorder]			
Personality Disorder						_			
PTSD]			
Schizophrenia									
Social Phobia									
Septicemia									
Stroke/Brain Attack									
Sudden Infant Death Syndrome					[
PATIENT HISTORY Please describe your past accidents: 1.Accident:									
2.Accident:		J.c	b Auto Ot	her Dat	с e:				
3.Accident:			ob □Auto □Ot						
Please describe your past surgeries:									
1. Surgery:			Da	ate:					
2. Surgery:			Da	ate:					
3. Surgery:	es, please de	scribe	Da	ate:					
	Do you have any implants? □Yes □No If yes, please describe								
Are you currently pregnant? □Yes □No If									
Please indicate which conditions YOU (the patient) have experienced by marking the boxes below.									
Please indicate which conditions Y		t your	r due date:				ooxes b	elow.	
AIDS		t your ent) h	r due date: nave experie Anem	nced by r	mark	ing the l	ooxes b		
AIDS	OU (the pati rgies Pain	ent) h	r due date: nave experie Anem Bladder Tr	nced by r ia ouble	mark	ting the k			
AIDS	OU (the pati	ent) h	r due date: nave experie Anem	nced by r ia ouble	mark	ting the k	Arthritis	ure	
AIDS	OU (the patingles Pain	ent) h	r due date: nave experie Anem Bladder Tr	nced by r ia rouble sion	mark	king the I	Arthritis e Fract	ure	
AIDS Alle Asthma Back Cancer Ches Convulsions Depr	OU (the pati rgies k Pain et Pain	ent) h	r due date: nave experie Anem Bladder Tr Concuss	nced by r ia rouble sion ea	mark	king the to A Bon Co	Arthritis e Fract nstipati	ure on oints	
AIDS Alle Asthma Back Cancer Ches Convulsions Depr Epilepsy Fibror	OU (the pati rgies c Pain et Pain ession	ent) h	r due date: nave experie Anem Bladder Tr Concuss Diarrhe	nced by r ia rouble sion ea easles	mark	king the to A Bon Co	Arthritis e Fract nstipati cated J eadach	on oints	
AIDS Alle Asthma Back Cancer Ches Convulsions Depr Epilepsy Fibror Heart Trouble Hep	OU (the pati rgies c Pain et Pain ession myalgia patitis	ent) h	r due date: nave experie Anem Bladder Tr Concuss Diarrho German M	nced by ria rouble sion ea easles	mark	ing the I Bon Co Disloc Hi	Arthritis e Fract nstipati cated J eadach ood Pr	on oints e essure	
AIDS Alle Asthma Back Cancer Ches Convulsions Depr Epilepsy Fibror Heart Trouble Hep High Cholesterol HIV	OU (the patingles Repair Pain Pain Passion Pain Pain Passion P	ent) h	r due date: nave experie Anem Bladder Tr Concuss Diarrho German M Herniated	nced by ria rouble sion ea easles Disk	mark	cing the background and background a	Arthritis e Fract nstipati cated J eadach ood Pr	on oints e essure Control	
AIDS Alle Asthma Back Cancer Ches Convulsions Depr Epilepsy Fibror Heart Trouble High Cholesterol HIV Lung Disease Menstrua	OU (the pati rgies c Pain et Pain ession myalgia patitis	ent) h	r due date: nave experie Anem Bladder Tr Concuss Diarrho German M Herniated Kidney Dis	nced by ria rouble sion ea easles Disk sorder adaches	mark	Bon Co Disloc High Bl Loss of Multip	Arthritis e Fract nstipati cated J eadach ood Pr Bowel	on oints e essure Control	
AIDS Alle Asthma Back Cancer Ches Convulsions Depr Epilepsy Fibror Heart Trouble Hep High Cholesterol HIV Lung Disease Menstrua Muscular Dystrophy Neck	OU (the pati rgies c Pain et Pain ession myalgia eatitis /ARC al Cramps	ent) h	r due date: nave experie Anemi Bladder Tr Concuss Diarrho German Mo Herniated Kidney Dis Migraine Hea	nced by ria rouble sion ea easles Disk sorder adaches	mark	Bon Co Disloc High Bl Loss of Multip	Arthritis e Fract nstipati cated J eadach ood Pr Bowel	on oints e essure Control	
AIDS Alle Asthma Back Cancer Ches Convulsions Depr Epilepsy Fibror Heart Trouble Hep High Cholesterol HIV Lung Disease Menstrus Muscular Dystrophy Parkinsor	rgies Repair Rep	ent) h	r due date: nave experie Anem Bladder Tr Concuss Diarrho German M Herniated Kidney Dis Migraine Hea Nervousr	nced by ria rouble sion ea easles Disk sorder adaches ness		Bon Co Dislor High Bl Loss of Multip	Arthritis e Fract nstipati cated J eadach ood Pr Bowel ble Scle umbnes Polio	on oints e essure Control erosis	
AIDS Alle Asthma Back Cancer Ches Convulsions Depr Epilepsy Fibror Heart Trouble Hep High Cholesterol HIV Lung Disease Menstrus Muscular Dystrophy Neck Osteoporosis Parkinsor Poor circulation Reproduct	rgies C Pain Et Pain E	ent) h	r due date: nave experie Anem Bladder Tr Concuss Diarrhe German M Herniated Kidney Dis Migraine Hea Nervousr Pinched N	nced by ria rouble sion ea easles Disk sorder adaches ness Nerve Fever		Rh	Arthritis e Fract nstipati cated J eadach ood Pr Bowel ble Scle umbnes Polio eumatis	e essure Control erosis	
AIDS Alle Asthma Back Cancer Ches Convulsions Depr Epilepsy Fibror Heart Trouble Hep High Cholesterol HIV Lung Disease Menstrua Muscular Dystrophy Neck Osteoporosis Parkinsor Poor circulation Reproduct Rheumatoid Arthritis Scarle	rgies Repair Rep	ent) h	r due date: nave experie Anem Bladder Tr Concuss Diarrho German M Herniated Kidney Dis Migraine Hea Nervousr	nced by ria rouble sion ea easles Disk sorder adaches ness Nerve Fever		Rh	Arthritis e Fract nstipati cated J eadach ood Pr Bowel ble Scle umbnes Polio	cure on oints e essure Control erosis ess	

SYMPTOMS							
Plea	se fill out the form below to			your cu	urrent s	sympto	ms.
Owner to go (Francisco)	SYM	PTO	M 1				
Symptom (Explain):							
Pain rating (1-10, with 10 bei □1	ing worst imaginable): □2 □3 □4 □5		1 6	□ 7	□8	□9	□ 10
Main impaired activity made							
Pain Quality:	Pain Frequency:		Pa	in radi	iates ii	nto:	Pain Cause:
□Aching □Burning □Cramping □Deep □Diffuse □Dull □Numbness □Radiating □Sharp □Shooting □Stiffness □Tight □Tingling	□Constant □Frequent □Intermittent □Occasional Pain Pattern: □Better in Morning □Better in Afternoon □Better in Evening □Worse in Morning □Worse in Afternoon □Worse in Evening □Consistent		Lee Lee Lee Charles River Char	ft Arm ft Foot ft Hand ft Leg ft Shoul ght Arm ght Foo ght Han ght Leg ght Sho her: hat has efore to	der t d ulder been d treat t ptom? ure on medi	one his	□ A Fall □ Work Injury □ Auto Accident □ Illness □ Lifting Injury □ Unknown □ Gradual Onset Pain Duration: □ Day(s) □ Week(s) □ Month(s) □ Year(s)
Dain an	Unchanged					-:I	iarrad hvr
Pain agg ☐Bending	gravated by: □Coughing		 F	ercise	Pa		ieved by: □Heat
□ Driving □ Driving □ Getting up/down □ Increased Activity □ Looking down □ Overhead activities □ Reaching □ Sitting □ Standing □ Typing	□Exercising □House Work □Lifting □Lying down □Preparing food □Resting □Sneezing □Twisting □Walking		□lbu □Kn □Ly □No □Re □Sta	uprofen uprofen uees Ber ing Dow o Moven esting anding upport alking	/n		□ leat □ lce □ Lifting □ Medication □ Reaching □ Sitting □ Stretching □ Turning Head
For Doctor's Use Only: What restrictions relate to	the main impaired activity	for th	nis syr	mptomí	?		

	SYMP	TOI	W 2				
Symptom (Explain):	<u> </u>						
Pain rating (1-10, with 10 be	,						_
Main instantian de adicide de adi			1 6	1 7	□8	□9	□ 10
Main impaired activity made	more difficult by above sympto	m :					
Pain Quality:	Pain Frequency:		Р	ain rad	iates i	nto:	Pain Cause:
□Aching				eft Arm			□A Fall
□Burning	□Constant			eft Foot			□Work Injury
□ Cramping	□Frequent			eft Hand			□Auto Accident
□Deep	□Intermittent			eft Leg			□Illness
□Diffuse	□Occasional			eft Shou			□Lifting Injury
□Dull □Norship and				ight Arm			□Unknown
□Numbness				ight Foo ight Har			□Gradual Onset
□Radiating □Sharp				ight Leg			
□Shooting				ight Sho			
□Stiffness				ther:	uluei		
□Tight	Pain Pattern:			hat has	been o	lone	Pain Duration:
□Tingling	□Better in Morning			efore to			
	□Better in Afternoon			sym	ptom?		□Day(s)
	☐Better in Evening						□Week(s)
	■Worse in Morning			cupunct			☐ Month(s)
	■Worse in Afternoon			rescripti	on med	icine	☐ Year(s)
	☐Worse in Evening			assage			=1 car(s)
	□Consistent			Surgery TC Med	:-:		
	□Unchanged			TC Med	icines		
Pain aggravated by:					Р	ain rel	leved by:
□Bending	□Coughing		□F	xercise	•	aiii ici	□Heat
□ Driving	□Exercising			uprofen			□lce
□Getting up/down	□House Work			nees Be			□Lifting
☐Increased Activity	□Lifting			ying Dov	vn .		□Medication
☐Looking down	□Lying down		□N	o Mover	nent		□Reaching
□Overhead activities	□Preparing food			esting			□Sitting
□Reaching	□Resting			tanding			□Stretching
□Sitting	□Sneezing			upport			□Turning Head
□Standing	□Twisting			/alking			
□Typing	□Walking						
For Doctor's Use Only:			1				
_	the main impaired activity for	or th	nis sv	mntom	?		
That room one rolate to	The main impaired delivity is	O. (1)	3 3		•		

	S	YMPTON	1 3			
Symptom (Explain):			. •			
Pain rating (1-10, with 10 be	,					
Main imposing display the model		<u>□5</u>	6 □7	□8	□9	□ 10
Main impaired activity made	more difficult by above sy	mptom :				
Pain Quality:	Pain Frequency	Pain radiates into:			Pain Cause:	
□Aching			□Left Arm			□A Fall
□Burning	□Constant □		□Left Foot			□Work Injury
□Cramping	□Frequent		□Left Hand	d		□Auto Accident
□Deep □Diffuse	□Intermittent		□Left Leg □Left Shou	ıldar		□Illness
□Dull	□Occasional		□Right Arr			□Lifting Injury □Unknown
□Numbness			□Right Fo			□Gradual Onset
□Radiating			□Right Ha			20raduar Onset
□Sharp			□Right Leg			
□Shooting			□Right Sh			
□Stiffness			□Other:			
□Tight	Pain Pattern:		What has			Pain Duration:
□Tingling	■Better in Morning		before t		his	
	☐Better in Afternoon		sym	ptom?		□Day(s)
	☐Better in Evening		□Acupunc	tura		□Week(s)
	□Worse in Morning □Worse in Afternoon		□ Prescript		icine	□Month(s)
	□Worse in Evening		□Massage			□Year(s)
	□Consistent		Surgery			
	□Unchanged		□OTC Med	dicines		
	gravated by:		- ·	Pa		ieved by:
☐Bending	□ Coughing		□Exercise			□Heat □Ice
□Driving □Getting up/down	□Exercising □House Work		□Ibuprofen □Knees Be			□Lifting
☐Increased Activity	□Lifting		Lying Do			□ Medication
□Looking down	□Lying down		□No Move			□Reaching
□Overhead activities	□Preparing food		Resting			□Sitting
□Reaching	□Resting		□Standing			□Stretching
□Sitting	□Sneezing		□Support			☐Turning Head
□Standing	□Twisting		□Walking			
□Typing	□Walking					
For Doctor's Use Only:						
What restrictions relate to	the main impaired activ	ity for thi	e evmntom	2		
what restrictions relate to	me main impaned activ	ity ioi tili	o oynipioiii			

PATIENT OFFICE POLICY

Welcome to Fountain Chiropractic and Wellness. We are honored to be a part of your health care. Below is a list of what we agree to in our relationship with you and a list of what we ask of you in return. Please read thoroughly, sign at the bottom and return to the front desk. Thank you and we look forward to working together to improve your health.

PURPOSE OF OUR CLINIC: to help as many people as possible improve their health through natural means.

OUR RESPONSIBILTY TO YOU:

- To provide the best quality care we can at all times.
- To be respectful of your time and attempt to stay on schedule to the best of our ability.
- To verify your Chiropractic insurance benefits.
- To bill your insurance company for these covered services.
- To provide referrals to other providers when necessary.
- To always get you in the day you call if you are having an emergency.
- To return all calls within 24 business hours.
- To provide excellent "customer services" because you are important to us and we appreciate you.

YOUR RESPONSIBILITY TO US:

- To show up for your appointment on time.
- To call 24 business hours in advance should you need to reschedule your appointment.
- To be personally responsible for your health care and follow your treatment plan and recommendations.
- To pay for services in full at the time they are rendered, unless a personal payment plan has been authorized.
- Once insurance billing has been done it is your responsibility to follow-up with your insurance company if reimbursement is not what you expected.
- If you miss an appointment without calling we understand the first time, however if it occurs more than one time you will be responsible for a "no show visit" charge of \$40.00 for chiropractic care, and \$50.00 or the prepaid amount for Nutrition appointments. This policy is in place out of respect to other patients that are trying to get in. We appreciate your understanding and respect.
- To make your next appointment before leaving your last visit if you have not pre-scheduled.
- If the doctor chooses to take your case on and you decide to discontinue care, we ask that you notify the office of your plans.
- To give us feed-back on how we can better serve your needs.

Patient Signature and Date:	
-	
Authorized Personnel Signature and Date:	

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I,	, have received a copy of this office's Notice of
-	ractices. I understand that I have certain rights to privacy regarding my protected health n. I understand that this information can and will be used to:
_	plan and direct my treatment and follow-up among the health care providers who may be and indirectly involved in providing my treatment.
Obtain pay	ment from third-party payers.
Conduct no	ormal health care operations such as quality assessments and accreditation.
Patient	
Signature	
Date	
	For Office Use Only
	pted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but edgment could not be obtained because:
	Individual refused to sign
	Communications barriers prohibited obtaining the Acknowledgment
	An emergency situation prevented us from obtaining Acknowledgment
	Other (Please Specify)
Staff	signature Date