# Fountain Chiropractic and Wellness

An Integrated Approach to Natural Health

| | | | | | |
|---|---|---|---|---|---|
| Today's date: | | | Emergency Contact person:<br><br>Phone: | | |
| **PATIENT INFORMATION** | | | | | |
| Patient's last name: | First: | Middle Initial: | Nickname: | Date of Birth: | Sex:<br>❑M<br>❑F |
| Street address: | | | Preferred Phone:<br>❑Cell ❑Home<br>❑Work | Cell Phone: | Home Phone: |
| Address Line 2: | | | Would you like to receive appointment reminders?<br>Choose ONE: ❑Email ❑None | | Work Phone: |
| City: | State: | Zip Code: | Email: | | |

Preferred Language: ❑English ❑Spanish ❑German ❑French ❑Italian ❑Russian ❑Portuguese ❑Chinese ❑Japanese ❑Korean ❑Vietnamese ❑Decline to Answer ❑Other _____

Please check ALL races that apply: ❑White ❑Black or African American ❑American Indian or Alaska Native ❑Asian ❑Native Hawaiian/Pacific Islander ❑Decline to Answer

Ethnicity: ❑Hispanic or Latino ❑Non-Hispanic nor Latino ❑Declined to Answer

Preferred Communication: ❑Cell Phone ❑Home Phone ❑Work Phone ❑Mail ❑Email ❑In Person

Smoking Status: ❑Current everyday ❑Current some days ❑Former ❑Never Start Year _____ Quit Date _____

Current Medications:
1.Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____
2. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____
3. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____
4. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____
5. Drug Name: _____ Strength (eg. 10MG) _____Dose (e.g. 1 tab)_____
Frequency (e.g. once daily) _____Date Started: _____

Drug Allergies:
1. Drug Name _____ Reaction (e.g. hives) _____ Date Started: _____
2. Drug Name _____ Reaction (e.g. hives) _____ Date Started: _____
3. Drug Name _____ Reaction (e.g. hives) _____ Date Started: _____

| | | |
|---|---|---|
| Referred by: | Referring Physician: | |
| Blood Pressure:<br>/ Heart Rate:<br>$Sp0_2$: | Weight: Height: | Last Physical:<br>Reason for going: |

| FAMILY HISTORY | | | | | | | |
|---|---|---|---|---|---|---|---|
| Please indicate which conditions exist or have existed by 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 | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Chronic Bronchitis | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Chronic Lower Respiratory Disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Emphysema | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Influenza | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Pneumonia | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Osteoporosis | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Anxiety | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| 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: _____❑Job ❑Auto ❑Other Date: _____
2.Accident: _____❑Job ❑Auto ❑Other Date: _____
3.Accident: _____❑Job ❑Auto ❑Other Date: _____

Please describe your past surgeries:

1. Surgery: _____ Date: _____
2. Surgery: _____ Date: _____
3. Surgery: _____ Date: _____

Do you have any implants? ❑Yes ❑No If yes, please describe _____

Are you currently pregnant? ❑Yes ❑No If yes, please list your due date: _____

Please indicate which conditions **YOU** (the patient) have experienced by marking the boxes below.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS | ❑ | Allergies | ❑ | Anemia | ❑ | Arthritis | ❑ |
| Asthma | ❑ | Back Pain | ❑ | Bladder Trouble | ❑ | Bone Fracture | ❑ |
| Cancer | ❑ | Chest Pain | ❑ | Concussion | ❑ | Constipation | ❑ |
| Convulsions | ❑ | Depression | ❑ | Diarrhea | ❑ | Dislocated Joints | ❑ |
| Epilepsy | ❑ | Fibromyalgia | ❑ | German Measles | ❑ | Headache | ❑ |
| Heart Trouble | ❑ | Hepatitis | ❑ | Herniated Disk | ❑ | High Blood Pressure | ❑ |
| High Cholesterol | ❑ | HIV/ARC | ❑ | Kidney Disorder | ❑ | Loss of Bowel Control | ❑ |
| Lung Disease | ❑ | Menstrual Cramps | ❑ | Migraine Headaches | ❑ | Multiple Sclerosis | ❑ |
| Muscular Dystrophy | ❑ | Neck Pain | ❑ | Nervousness | ❑ | Numbness | ❑ |
| Osteoporosis | ❑ | Parkinson's disease | ❑ | Pinched Nerve | ❑ | Polio | ❑ |
| Poor circulation | ❑ | Reproductive disorder | ❑ | Rheumatic Fever | ❑ | Rheumatism | ❑ |
| Rheumatoid Arthritis | ❑ | Scarlet Fever | ❑ | Scoliosis | ❑ | Serious Injury | ❑ |
| Sinus Trouble | ❑ | Stroke | ❑ | Thyroid Problems | ❑ | Tuberculosis | ❑ |
| Tumors or Growths | ❑ | Ulcers | ❑ | Venereal Disease | ❑ | _____ | ❑ |

## SYMPTOMS

Please fill out the form below to describe your current symptoms.

### SYMPTOM 1

Symptom (Explain):

Pain rating (1-10, with 10 being worst imaginable):

❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Main impaired activity made more difficult by above symptom:

**Pain Quality:**

❑Aching
❑Burning
❑Cramping
❑Deep
❑Diffuse
❑Dull
❑Numbness
❑Radiating
❑Sharp
❑Shooting
❑Stiffness
❑Tight
❑Tingling

**Pain Frequency:**

❑Constant
❑Frequent
❑Intermittent
❑Occasional

**Pain radiates into:**

❑Left Arm
❑Left Foot
❑Left Hand
❑Left Leg
❑Left Shoulder
❑Right Arm
❑Right Foot
❑Right Hand
❑Right Leg
❑Right Shoulder
❑Other: _____

**Pain Cause:**

❑A Fall
❑Work Injury
❑Auto Accident
❑Illness
❑Lifting Injury
❑Unknown
❑Gradual Onset

**Pain Pattern:**

❑Better in Morning
❑Better in Afternoon
❑Better in Evening
❑Worse in Morning
❑Worse in Afternoon
❑Worse in Evening
❑Consistent
❑Unchanged

**What has been done before to treat this symptom?**

❑Acupuncture
❑Prescription medicine
❑Massage
❑ Surgery
❑OTC Medicines

**Pain Duration:**

❑_____Day(s)
❑_____Week(s)
❑_____Month(s)
❑_____Year(s)

**Pain aggravated by:**

❑Bending
❑Driving
❑Getting up/down
❑Increased Activity
❑Looking down
❑Overhead activities
❑Reaching
❑Sitting
❑Standing
❑Typing
❑Coughing
❑Exercising
❑House Work
❑Lifting
❑Lying down
❑Preparing food
❑Resting
❑Sneezing
❑Twisting
❑Walking

**Pain relieved by:**

❑Exercise
❑Ibuprofen
❑Knees Bent Up
❑Lying Down
❑No Movement
❑Resting
❑Standing
❑Support
❑Walking
❑Heat
❑Ice
❑Lifting
❑Medication
❑Reaching
❑Sitting
❑Stretching
❑Turning Head

**For Doctor's Use Only:**

What restrictions relate to the main impaired activity for this symptom?

## SYMPTOM 2

Symptom (Explain):

Pain rating (1-10, with 10 being worst imaginable):

❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Main impaired activity made more difficult by above symptom :

### Pain Quality:

❑Aching
❑Burning
❑Cramping
❑Deep
❑Diffuse
❑Dull
❑Numbness
❑Radiating
❑Sharp
❑Shooting
❑Stiffness
❑Tight
❑Tingling

### Pain Frequency:

❑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
❑Unchanged

### Pain radiates into:

❑Left Arm
❑Left Foot
❑Left Hand
❑Left Leg
❑Left Shoulder
❑Right Arm
❑Right Foot
❑Right Hand
❑Right Leg
❑Right Shoulder
❑Other: _____

### What has been done before to treat this symptom?

❑Acupuncture
❑Prescription medicine
❑Massage
❑ Surgery
❑OTC Medicines

### Pain Cause:

❑A Fall
❑Work Injury
❑Auto Accident
❑Illness
❑Lifting Injury
❑Unknown
❑Gradual Onset

### Pain Duration:

❑_____Day(s)
❑_____Week(s)
❑_____Month(s)
❑_____Year(s)

### Pain aggravated by:

❑Bending
❑Driving
❑Getting up/down
❑Increased Activity
❑Looking down
❑Overhead activities
❑Reaching
❑Sitting
❑Standing
❑Typing
❑Coughing
❑Exercising
❑House Work
❑Lifting
❑Lying down
❑Preparing food
❑Resting
❑Sneezing
❑Twisting
❑Walking

### Pain relieved by:

❑Exercise
❑Ibuprofen
❑Knees Bent Up
❑Lying Down
❑No Movement
❑Resting
❑Standing
❑Support
❑Walking
❑Heat
❑Ice
❑Lifting
❑Medication
❑Reaching
❑Sitting
❑Stretching
❑Turning Head

**For Doctor's Use Only:**

What restrictions relate to the main impaired activity for this symptom?

## SYMPTOM 3

Symptom (Explain):

Pain rating (1-10, with 10 being worst imaginable):

❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Main impaired activity made more difficult by above symptom :

### Pain Quality:

❑Aching
❑Burning
❑Cramping
❑Deep
❑Diffuse
❑Dull
❑Numbness
❑Radiating
❑Sharp
❑Shooting
❑Stiffness
❑Tight
❑Tingling

### Pain Frequency:

❑Constant
❑Frequent
❑Intermittent
❑Occasional

### Pain radiates into:

❑Left Arm
❑Left Foot
❑Left Hand
❑Left Leg
❑Left Shoulder
❑Right Arm
❑Right Foot
❑Right Hand
❑Right Leg
❑Right Shoulder
❑Other: _____

### Pain Cause:

❑A Fall
❑Work Injury
❑Auto Accident
❑Illness
❑Lifting Injury
❑Unknown
❑Gradual Onset

### Pain Pattern:

❑Better in Morning
❑Better in Afternoon
❑Better in Evening
❑Worse in Morning
❑Worse in Afternoon
❑Worse in Evening
❑Consistent
❑Unchanged

### What has been done before to treat this symptom?

❑Acupuncture
❑Prescription medicine
❑Massage
❑ Surgery
❑OTC Medicines

### Pain Duration:

❑_____Day(s)
❑_____Week(s)
❑_____Month(s)
❑_____Year(s)

### Pain aggravated by:

❑Bending
❑Driving
❑Getting up/down
❑Increased Activity
❑Looking down
❑Overhead activities
❑Reaching
❑Sitting
❑Standing
❑Typing
❑Coughing
❑Exercising
❑House Work
❑Lifting
❑Lying down
❑Preparing food
❑Resting
❑Sneezing
❑Twisting
❑Walking

### Pain relieved by:

❑Exercise
❑Ibuprofen
❑Knees Bent Up
❑Lying Down
❑No Movement
❑Resting
❑Standing
❑Support
❑Walking
❑Heat
❑Ice
❑Lifting
❑Medication
❑Reaching
❑Sitting
❑Stretching
❑Turning Head

**For Doctor's Use Only:**

What restrictions relate to the main impaired activity for this symptom?

Fountain Chiropractic and Wellness
An Integrated Approach to Natural Health

# 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:_____

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An Integrated Approach to Natural Health

# ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient

_____

Signature

_____

Date

**For Office Use Only**

**We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment 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**