Fountain Chiropractic & Wellness Center
468 N. Santa Fe Ave
Fountain, Co 80817

PLEASE PRINT DATE_____

PERSONAL INFORMATION

NAME_____

ADDRESS_____CITY_____ STATE_____ZIP_____

PHONE (H) _____ PHONE (C) _____ RECEIVE TXT REMINDERS? Y/N

EMAIL_____ SOC SEC # (last 4)_____ DATE OF BIRTH_____

MARITAL STATUS_____ SEX_____ AGE_____ NUMBER OF CHILDREN_____

OCCUPATION_____ EMPLOYER_____

ADDRESS_____ CITY/ZIP_____ TELEPHONE_____

NAME OF SPOUSE_____ SPOUSE'S OCCUPATION_____

EMPLOYER_____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

EMERGENCY NOTIFICATION

NAME _____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

REFERRED BY_____

FINANCIAL AGREEMENT

I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the $20 returned check charge in the event that my check is returned.

Date_____ Patient's Signature_____

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES

I hereby authorize Fountain Chiropractic to release any information required in the course of my examination or treatment necessary to satisfy medical insurance claims.

Date_____ Patient's Signature_____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT_____

HOW DID IT HAPPEN?_____

_____

TODAYS CONDITION STARTED WHEN?_____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION?_____

WHAT ACTIVITIES LESSEN YOUR CONDITION?_____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY?_____

IS THIS CONDITION INTERFERING WITH WORK?_____ SLEEP?_____ ROUTINE? _____

IS CONDITION GETTING PROGRESSIVELY WORSE?_____

OTHER DOCTORS SEEN FOR THIS CONDITION_____

TYPE OF TREATMENT_____RESULTS_____

Habits

- ❑ Alcohol: Type_____ Amount_____ Diet: Salt intake_____ Fat intake_____ Other_____
- ❑ Sleep:Difficulty falling asleep_____ Continuity disturbances_____ Early morning awakenings___ Daytime drowsiness_____ Other_____
- ❑ Smoking: Packs daily_____ How long_____ Interested in stopping?_____
- ❑ Exercise routine:____ _____ _____
- ❑ Caffeine: Coffee, cups daily_____ Other_____

MEDICATIONS:_____

DRUG ALLERGIES:_____

Medical History

- ❑ Ringing In Ear_____
- ❑ Ear Infections - *Frequent* _____
- ❑ Dizziness/Fainting _____
- ❑ Failing Vision _____
- ❑ Eye Infections _____
- ❑ Nose Bleeds_____
- ❑ Sinus Trouble _____
- ❑ Sore Throats - *Frequent* _____
- ❑ Hayfever/Allergies _____
- ❑ Pneumonia _____
- ❑ Bronchitis/Chronic Cough_____
- ❑ Asthma/Wheezing _____
- ❑ Chest Pain _____
- ❑ High Blood Pressure _____
- ❑ Heart Murmur _____
- ❑ Swollen Ankles _____
- ❑ Leg Pain - *Walking*_____
- ❑ Varicose Veins/Phlebitis _____
- ❑ Loss of Appetite _____
- ❑ Difficulty Swallowing _____
- ❑ Indigestion or Heartburn _____
- ❑ Persistent Nausea/Vomiting _____
- ❑ Peptic Ulcers _____
- ❑ Abdominal Pain - *Chronic*_____
- ❑ Gall Bladder Trouble _____
- ❑ jaundice/Hepatitis _____
- ❑ Change in Bowel Habits _____
- ❑ Diarrhea ❑ Constipation _____
- ❑ Diverticulosis ❑ Crohn's/Colitis ____
- ❑ Bloody or Tarry Stools _____
- ❑ Hemorrhoids _____
- ❑ Hernia _____
- ❑ Urine Infections - *Frequent* _____
- ❑ Blood In Urine _____
- Urination-❑ Overnight > than twice
  - ❑ Painful ❑ Loss of Control
  - ❑ Decrease in Force/Flow
- ❑ Kidney Stones _____
- ❑ Venereal Disease_____
- ❑ Urethral Discharge _____
- ❑ Chronic Fatigue _____
- ❑ Weight Loss - *Recent* _____
- ❑ Anemia ❑ Bruise Easily _____
- ❑ Cancer _____
- ❑ Diabetes _____
- ❑ Thyroid Disease _____
- ❑ Convulsions/Seizures _____
- ❑ Stroke _____
- ❑ Tremor/Hands Shaking _____
- ❑ Muscle Weakness _____
- ❑ Numbness/Tingling Sensations _____
- ❑ Headaches - *Frequent* _____
- ❑ Arthritis/Rheumatism _____
- ❑ Osteoporosis _____
- ❑ Back Pain - *Recurrent* _____
- ❑ Bone Fracture/Joint injury _____
- ❑ Gout _____
- ❑ Foot Pain ❑ Cold Numb Feet _____
- ❑ Rashes ❑ Hives _____
- ❑ Psoriasis ❑ Eczema _____
- ❑ Nervousness ❑ Depression_____
- ❑ Memory Loss _____
- ❑ Moodiness - *Excessive* _____
- ❑ Phobias _____
- ❑ Mental Illness_____
- ❑ Lactose Intolerance _____
- ❑ Prostate Disease _____
- ❑ Sexual/Menstrual Dysfunction ____
- ❑ Frequent Infections _____
- ❑ Diphtheria _____
- ❑ Tetanus _____
- ❑ Chicken Pox ❑ Polio ❑ Mumps ❑

Measles ❑ Rubella ❑ Rheumatic Fever
❑ Scarlet Fever ❑ Tuberculosis ❑ Herpes
❑ Other _____
❑ Other _____

Females - *Please Complete*
Pregnant? ❑ Yes ❑ No
Planning Pregnancy? ❑ Yes ❑ No
Menstrual Flow:
❑ Regular ❑ Irregular ❑ Pain/Cramps
____Days of Flow ____Length of Cycle
Date-1st day of last period_____
❑ Pain/Bleeding during or after sex
Number of:
____Pregnancies ____Abortions
____Miscarriages ____Live Births
Birth Control Method_____
B.C. Pill (Name) _____
❑ Flushing/Menopause
Date of Last PAP Test _____
❑ Normal ❑ Abnormal
Date of Last Mammogram
❑ Normal ❑ Abnormal

HOSPITALIZATIONS:

Date	Reason	Date	Reason

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:

HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP:

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH	ILLNESS	FAMILY MEMBER
FATHER				DIABETES	
MOTHER				CANCER	
BROTHERS AND SISTERS	_____	_____	_____	BLOOD DISEASE	_____
	_____	_____	_____	GLAUCOMA	_____
	_____	_____	_____	EPILEPSY	_____
SPOUSE				RHEUMATOID	
				ARTHRITIS	
CHILDREN	_____	_____	_____	TUBERCULOSIS	_____
	_____	_____	_____	GOUT	_____
	_____	_____	_____	HIGH BLOOD PRESSURE	_____
				HEART DISEASE	
				BACK PROBLEMS	

Welcome to

Fountain Chiropractic & Wellness Center

Our Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information.

We may share your information in order to:
• Treat you, collect payment, or referral to another health provider

You have the right to:
• Request a copy of your health record

We may use your health information in the following ways:

• Health and safety reasons
• Reporting victims of abuse
• Court hearings and filings
• Reporting to worker's compensation
• Request a list of whom we share your health information
• Ask us to limit the information we share
• Advise our management if you believe your privacy rights have been violated
• Request confidential communications
• Amend your protected health information

These privacy practices are effective at the time this form is signed

Consultation & Exam

To begin today's visit, we will collect some confidential health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests. If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition. We will always inform you of associated fees before we perform any procedure or service.

Report of Findings

Patients who are examined will receive a report of our findings from the recorded history, consultation, and examination. If we believe we can help, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan may be created to address your short and/or long-term goals.
As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

_____ _____
Patient or Guardian signature Date

Fountain Chiropractic & Wellness Center

Informed Consent to Treatment

The State of Colorado requires that every patient be informed of the risks of treatment and the alternatives to treatment prior to the beginning of treatment. The following is Fountain Chiropractic's informed consent. We intend this consent form to cover the entire course of treatment for your present, and for any future conditions for which you seek treatment at this office or any other office under the direction of Dr. Jarod K. Waters. The nature of treatment: The doctor will use his/her hands in order to manipulate your joints, muscles, tendons, or ligaments. You may hear a "click or pop" similar to when one "cracks" a knuckle. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or traction, as well as exercise instruction may be utilized at this office. There are inherent risks in any and all treatments delivered by any health care provider. This Facility is no exception. Although we take every precaution, there are indeed some slight risks to manipulation. The risk is very minor in any treatment of extremities. The risks involved in treatment of the spine are several, **including but not limited to**: muscular strain, ligamentous sprain, fractures, and injury to the discs, nerves, or spinal cord. The risks involved in the treatment of the neck **include but are not limited to**: any of the preceding list, but also include the remote possibility of a cerebral vascular accident leading to death. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary physical therapy procedures can produce skin irritation, burns, or other minor complications.

Other treatment options that could be considered may include the following: Over the counter analgesics. The risks of these medications include irritation to stomach, liver, kidneys, and other side effects in a significant number of cases.

Medical Care: Typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include numerous undesirable effects, usually more serious than those listed above and patient dependence in a significant number of cases.

Surgery in conjunction with medical care: adds the risks of adverse reaction to anesthesia (which includes death) as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and include chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult. If you have any concerns or questions please contact Dr. Waters who has gone to great lengths to make your health and safety our top priority. We will be glad to explain any concern about treatment or treatment options with you and your family. We will only recommend treatment for you that we would feel comfortable having performed on ourselves.

I have read the above explanation of treatment. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment, I have freely decided to undergo treatment, and hereby give my full consent to treatment.

_____ _____

Signature of Patient or Guardian of Patient Date