Fontaine Center
maintaining health through preventative medicine 1 Thes. 5:23

INFORMATION FORM

Date:_____

DEMOGRAPHIC INFORMATION

Name:_____ Date of Birth: _____/____ / _____

Address: _____

City:_____ State: _____ Zip: _____

Home Phone ( ) _____Work Phone ( ) _____

Cell Phone ( ) _____SSI # _____-_____-_____

Marital Status: Single _____Married _____Divorced _____Widowed _____

Spouse's Name:_____ Email address _____

Emergency Contact Person:_____ Relationship:_____ Phone Number: ( ) _____

☐ Some Form of Identification on medical record file (IE: Driver's License)

ADVANCED DIRECTIVES (This includes items such as a Living Will, or Power of Attorney)

☐ I **Do Not** Have an Advance Directive. Do you want more information : YES NO

☐ I **Do** Have an Advance Directive. Please write down a general overview of your wishes: _____

_____

_____

HOW DID YOU HEAR ABOUT THE FONTAINE CENTER? (Referral, friend, website, etc.) _____

_____

_____

PLEASE READ BEFORE SIGNING

The Fontaine Center/F.I.T. Properties are Fee For Service Providers. Payment is due at the time services are rendered. We **DO NOT** accept insurance, and Dr. Allen has opted out of Medicare. We accept cash, checks, Care Credit and all major credit cards. Returned checks will be subject to a $30.00 collection fee and will not be re-processed. A **$150.00 cancellation fee** will be billed to your account if we do not receive at least **48-hour notice of cancellation** for all appointments.

I understand that no specific claims or representations are made that the services provided will be effective or resolve any conditions I have. I hereby acknowledge and understand that no guarantees or warranties for improvement are being made. The Fontaine Center/F.I.T. Properties do not replace treatment(s) rendered by my primary care physician and/or specialists currently treating any medical issues I may have.

_____ _____

Signature Date

INFORMATION FORM

Date:_____

CHIEF COMPLAINT

What is your purpose for coming – what TOP THREE issue(s) are you hoping the Fontaine Center can help you with (please list in order of priority/importance to you)?:

1. _____
2. _____
3. _____

If issue(s) have been going on for a while, what prompted you to seek help at *this particular time*?

_____
_____
_____

HISTORY OF PRESENT ILLNESS

Describe what is causing you the *most* concern. Include how you think it began. Start at the beginning from your point of view to the present. Continue on the back of form if necessary.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

CURRENT MEDICAL CARE and MEDICAL HISTORY:

Do you have a primary care physician (PCP)? Who? _____ Last Visit? _____

Are you currently seeing any specialists? Check all that apply: □ Endocrinologist □ Gastroenterologist □ Cardiologist □ Rheumatologist □ OB/Gyn □ Orthopedist □ Dermatologist □ Neurologist □ Psychiatrist/Counsellor □ Other

Name of Doctor _____ Reason: _____ Last Visit: _____

Name of Doctor _____ Reason: _____ Last Visit: _____

Name of Doctor _____ Reason: _____ Last Visit: _____

Current diagnosed medical condition(s) List: _____

Are you currently receiving any treatments? (i.e., Chemotherapy, Radiation, IV Therapy, etc) YES / NO

Type of treatment: _____ Reason: _____ Last Visit: _____

Type of treatment: _____ Reason: _____ Last Visit: _____

Type of treatment: _____ Reason: _____ Last Visit: _____

Are you currently in remission for any medical disease(s)/diagnosis? List and include how long in remission:

_____
_____

INFORMATION FORM

Date:_____

MEDICATION ALLERGIES: List: _____

_____

_____

OTHER ALLERGIES: Circle all that apply. DUST / POLLEN / PERFUME / FOOD / LATEX / OTHER: _____

_____

MEDICATIONS PRESCRIBED BY OTHER PHYSICIANS: List **ALL** prescription medications that you are currently taking:

Prescription Medications	Frequency	How long have you taken RX?	Physician Name Prescribing Medication
EXAMPLE: XYZ Drug, 500mg	Every morning	3 years	Dr. Kildare
1			
2			
3			
4			
5			
Continue on back if needed			

NUTRITIONAL / VITAMIN SUPPLEMENTS: List all herbs, vitamins, supplements, etc. that you are currently taking.

Nutritional Supplements	Brand/ Manufacturer	Form (Tablets, Capsules, liquid, powder)	Dosage	Frequency
EXAMPLE: Vitamin C	Bronson	Tablet	500 mg	2 per day
1				
2				
3				
4				
5				
Continue on back if needed.				

OVER-THE-COUNTER MEDICATIONS: List all OTC medications you are taking (i.e., Tylenol, Advil, cough/cold/hay fever products, Aspirin, Tums, Reflux products, Benadryl, etc)

Over-the-Counter Medications	Brand/ Manufacturer	Form (Tablets, Capsules, liquid, powder)	Dosage	Frequency
EXAMPLE: Aspirin	Bayer	Tablet	325 mg	2 per day
1				
2				
3				
4				
5				
Continue on back if needed.				

NOTE: please bring **all** prescription medication and supplement **bottles** with you to the New Patient Consult.

INFORMATION FORM

Date:_____

DENTAL HISTORY: Please place an **(X)** in the column next to any procedures you have EVER had performed.

X	TREATMENT	X	TREATMENT	X	TREATMENT
	Amalgam Removal (Year:)		Difficulty chewing		Dental Bridge
	Amalgam Fillings (Silver)		Dentures – Full Set		Caps / Crowns #_____
	Gold Fillings		Dentures - Upper / Lower		Veneers
	White Fillings		Dentures - Partial		Wisdom Teeth Removal #:_____
	Decay at gum line / gum disease		Dental Implants		Night Guard / Bite Plate / Orthotic
	TMJ		Root Canal #: _____		Other:

Please list any problems currently being addressed by your dentist: _____

_____

What is your gender? □ Male □ Female □ Other: _____

What is your sexual orientation? □ Straight □ Gay □ Bisexual □ Other: _____

Have you ever been abused: □ Physically □ Mentally □ Emotionally □ Sexually □ Other: _____

FEMALE MEDICAL HISTORY: **(Circle applicable issues and fill in the frequency or date):**

Breast Masses YES NO N/A Frequency: _____

Nipple Discharge YES NO N/A Frequency: _____

Ovarian Cysts YES NO N/A Frequency: _____

Fibroids YES NO N/A Frequency: _____

Breast Mammography YES NO Date Last Performed: _____/ Never performed

Breast Thermography YES NO Date Last Performed: _____/ Never performed

Breast Ultrasound YES NO Date Last Performed: _____/ Never performed

Pap Smear YES NO Date Last Performed: _____/ Never performed

Bone Density YES NO Date Last Performed: _____/ Never performed

Please list any issues currently being addressed by your OB / GYN Physician:_____

_____

_____

MENSTRUATION:

ONSET: Age at first menses (period): _____ Date of last period: _____ or, □ N/A

FLOW: □ Regular □ Irregular # of days of last flow: _____ Length of cycle: _____

PAIN: □ Painful □ Cramping □ Pain / bleeding during or after sex

Do you have, or have you had, problems with infertility? (circle): YES NO

Please give the number of: Pregnancies: _____ Miscarriages: _____ Live births: _____ Abortions: _____

Did you ever breast feed? (circle): YES NO

Have taken hormone replacements? YES NO If yes, what type: _____

Current form of birth control: □ IUD □ Birth control pills / shots □ Other: _____

MALE MEDICAL HISTORY: **(Circle applicable and date):**

Have you had a PSA blood test drawn? YES NO NOT SURE

Have you had a prostate exam? YES NO Date Last Performed: _____/ Never performed

Are you currently receiving testosterone injections? YES NO

(**Check the boxes that apply to your condition.**)

□ Male pattern baldness
□ Prostate cancer
□ Problems with infertility
□ Use of Prescription for Erectile Dysfunction periodically (ie: Viagra)
□ History of sexually transmitted diseases
□ Premature ejaculation
□ Hesitancy in starting urine stream
□ Prostate problems
□ Penile or scrotal lesions
□ Concerns with impotence
□ Penile discharge

INFORMATION FORM

Date:_____

INFECTION HISTORY (circle applicable answers):
Have you used antibiotics over the past year? YES NO If so, how many times: _____ For: _____
Have you used antibiotics for consecutive months in your lifetime (acne treatment, chronic infection, etc.)?: YES NO
If so, describe when and why: _____
Does you or someone you live with have TB? YES NO
Do you or your partner have history of genital herpes? YES NO
Do you have Hepatitis B or C? YES NO _____
History of Sexually Transmitted Disease (Gonorrhea, Chlamydia, HPV, HIV, Syphilis etc.) YES NO Explain: _____
_____
_____

INJECTIONS (circle any injections you are currently receiving)**: B12 Steroid Cortisone Epidural Hormone Other**

DETOX:
Have you done any type of detox in the last twelve months? YES NO

Please check the type of detox you have done and the location where it was performed:

- □ Oral Detox List Products Used and Date of Last Detox:_____
- □ Colonics / Colon Hydrotherapy Location: Home / OTHER: _____
- □ Far Infrared Sauna Location: Home / OTHER: _____
- □ Dry / Steam Sauna: Location: Home / OTHER: _____
- □ Detox Foot Bath
- □ OTHER & Describe: _____

TOXIN EXPOSURE Have you had exposure to any of the following toxins:

- □ Farm Chemicals □ Asbestos □ Mold □ Sick Building Syndrome
- □ Lead/ other heavy metals □ Herbicides □ Pesticides □ Agent Orange
- □ Other (please clarify): _____

DIAGNOSTIC TESTING / PROCEDURES (circle the tests you have had performed, indicate why, and write the dates below):

Colonoscopy EGD / X-Ray / MRI / MRA / CT SCAN / PET SCAN / Heart Cath / Sleep Study / Ultrasound / Other

Dates: _____
_____
_____

Do you have any implants? YES NO

Check the applicable implant types you have had:

□ Breast □ Other Cosmetic Procedures □ Stents (Coronary Artery) □ Joints □ Dental
□ Pace Maker/Implanted Defibrillator □ Harrington Rods □ Other: _____

Have you been to the emergency room in the past three years? YES NO Date/Reason: _____
Have you been hospitalized in the past three years? YES NO Date/Reason: _____

INFORMATION FORM

Date:_____

PAIN:

Have you had an accident (car, athletic/sports, fall, cycle, horse, work, etc)? YES NO

If your answer is yes, please write the type(s) and date(s): _____

_____

_____

_____

Did you sustain any injuries from the accident? YES NO

If your answer is yes, please describe your injuries:_____

_____

_____

_____

Are you currently experiencing any pain? YES NO

Have you had a change in your job because of your medical condition? YES NO

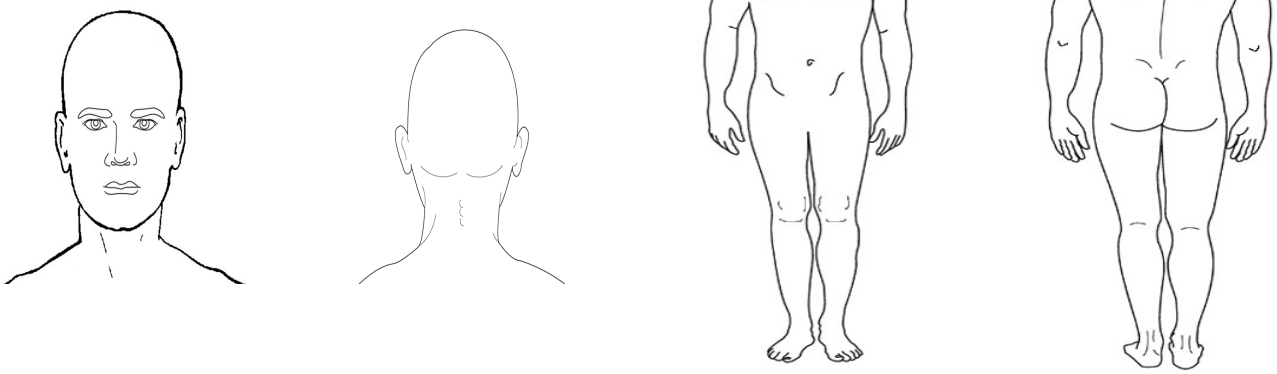
Have you had to stop any activities because of your medical condition? YES NO

Circle the words which describe your pain:

Numb Sharp Stabbing Dull Aching Pins and Needles Burning Spasms Cramping

Is your pain Mild / Moderate / Severe? Does your pain interfere with your sleep? Yes No

Circle the areas of your body where you are experiencing pain



SURGERY:

Have you ever had surgery performed? YES NO (circle applicable surgeries, add others not listed, and add date)

Appendectomy Brain Surgery Colectomy Cataract Extraction C-Section Fracture/Bone Gallbladder Removal

Heart Surgery Hysterectomy Hip Surgery Knee Surgery Mastectomy Pacemaker Shoulder Surgery

Tonsillectomy Thyroidectomy Tubal Ligation Vasectomy Wisdom Teeth

Other Surgeries: _____

List Dates: _____

INFORMATION FORM

Date:_____

IMMUNIZATION HISTORY:

When was your last flu shot? _____

When was your last pneumonia shots? _____

When was your last tetanus shot? _____

When was your last shingles shot? _____

When was your last COVID shot or booster? _____ How Many Total have you had? _____

Have you had any other vaccinations (for travel or military)? Please list: _____

FAMILY MEDICAL HISTORY (please fill out the family medical history form below):

Birth Father:
Still living? YES NO If yes, current age: _____
Below, check medical conditions which apply/applied:

□ Heart Disease	□ Dementia	□ Depression
□ Stroke	□ Diabetes (type ____)	□ Cancer
□ Thyroid Disease	□ Other: _____	□ Other: _____

Birth Mother:
Still living? YES NO If yes, current age: _____
Below, check medical conditions which apply/applied:

□ Heart Disease	□ Dementia	□ Depression
□ Stroke	□ Diabetes (type ____)	□ Cancer
□ Thyroid Disease	□ Other: _____	□ Other: _____

Birth Brother(s):
Still living? YES NO If yes, list current age(s): _____
Below, check medical conditions which apply/applied:

□ Heart Disease	□ Dementia	□ Depression
□ Stroke	□ Diabetes (type ____)	□ Cancer
□ Thyroid Disease	□ Other: _____	□ Other: _____

Birth Sister(s):
Still living? YES NO If yes, list current age(s): _____
Below, check medical conditions which apply/applied:

□ Heart Disease	□ Dementia	□ Depression
□ Stroke	□ Diabetes (type ____)	□ Cancer
□ Thyroid Disease	□ Other: _____	□ Other: _____

Please describe any other significant family medical issues (cancer, surgery, chronic illnesses, auto-immune, etc.):

_____

_____

_____

_____

_____

_____

INFORMATION FORM

Date:_____

YOUR MEDICAL HISTORY:

INSTRUCTIONS: Please **circle** the following conditions which are applicable:

GENERAL:	Chills Decline in health Fatigue Fever Weakness Weight gain Weight loss
HEAD:	Dizziness Fainting Head injury Headaches Pain Sweats
EYES:	Blurry vision Cataracts Double vision Eye pain Eyeglasses Glaucoma Infections Recent eye injury Redness Vision loss
ENT:	Frequent colds Infections Nasal obstructions Nosebleeds Sinus infections Bleeding gums Hoarseness Postnasal drip Voice changes Dizziness Hearing aid Hearing impairment Ear pain Ringing in ears Frequent sore throats Tonsils enlarged
RESPIRATORY:	Asthma Cough Wheezing Bronchitis Coughing blood Pain Pleurisy Chest x-ray Shortness of breath Sputum Tuberculosis
CARDIOVASCULAR:	Chest pain Palpitations Varicose veins Extremities cold Extremities discolored Heart murmur High blood pressure History of heart attack Leg pain on walking Electrocardiogram Rheumatic fever Shortness of breath – on exertion | lying flat | sleeping Swelling of legs Ulcers on legs
GASTROINTESTINAL:	Abdominal pain Constipation Diarrhea Heartburn Liver Disease Rectal bleeding Abdominal x-ray Antacid use Black tarry stools Change in bowel movement frequency Change in stool caliber Change in stool color Change in stool consistency Decreased appetite Excessive hunger Excessive thirst Gallbaldder disease Hemorrhoids Hepatitis Infections Laxative use Nausea Rectal pain Swallowing problem Vomiting Vomiting blood
MUSCULOSKELETAL:	Arthritis Joint pain Gout Back problems Deformities Joint stiffness Muscle cramps Muscle stiffness Paralysis Restricted motion Weakness
PSYCHIATRIC:	Depression Behavioral change Disorientation Disturbing thoughts Excessive stress Hallucinations Memory loss Mood changes Nervousness Psychiatric disorders
BREASTS:	Discharge Lumps Pain Tenderness
SKIN:	Eczema Itching Dryness Easy bruisability Hair dye Hair texture change Hives Lumps Moles Nail texture change Rashes Skin color change
NEUROLOGICAL:	Loss of consciousness Blackouts Burning Dizziness Fainting Head injury Headaches Memory loss Numbness Paralysis Speech disorders Strokes Tingling Tremors Unsteady gait
ENDOCINE:	Weakness Weight gain Weight loss Cold intolerance Excessive urination Fatigue Goiter Heat intolerance Increased thirst Neck pain Sweats Thyroid trouble
HEMATOLOGIC/LYMPH:	Anemia Bleeding easily Blood clots Easy bruisability Lumps Radiation exposure Swollen glands Transfusion reaction
ALLERGY/IMMUNOLOGIC:	Coughing Coughing with exercise Hives Itchy eyes Itchy nose Recurrent infections Runny nose Sneezing Stuffy nose Watery eyes Wheezing Wheezing with exercise
URINARY:	Awakening to urinate Bed-wetting Blood in urine Burning Difficulty starting stream Excessive urination Flank pain Urinary tract infections Retention Stones Urgency Urine discoloration Urine odor

INFORMATION FORM

Date:_____

PERSONAL/SOCIAL HISTORY (complete the form below):

What is your current **stress level**? None Minimal Moderate High

Do you have **HIV** or **Hepatitis**? YES NO

Do you currently **smoke**? YES NO If yes, provide # of cigarettes/packs per day: _____

Have you smoked in the past? YES NO Date quit: _____

Circle any other tobacco use: Dipping Snuff Chewing Other

Do you currently **VAPE**? YES NO Nicotine or THC amount per day _____

Do you currently use **marijuana/cannabis/CBD products**? YES NO Explain:_____

Do you regularly consume **alcoholic beverages**? YES NO

If so, circle types of alcoholic beverages used: Beer Wine Mixed Drinks Other: _____

How frequently? Occasionally Weekly Daily Other: _____

Have you served in the **military**? YES NO If so, what branch: _____

Describe your job/position in the armed forces: _____

What is the highest level of **education** you have completed? □ High School □ College □ Post Graduate □ Other

Are you currently **employed**? YES NO

What is your profession/job?: _____

If retired, what was your profession/job?: _____

Is **spirituality** important to you? YES NO

Please list your church/spiritual/religious preference: _____

Please list your current **interests and hobbies**, pursued in your free time to relax?: _____

_____

_____

Have you had to stop any activities due to your medical condition? YES NO

Please circle which of following **exercises** you engage in:

Swim / Run / Walk / Dance / Bike / Garden / Golf / Tennis / Ski / Weight Lifting / Stretching / Pilates / Yoga

Egoscue Stretching / Other Sport: _____ / Hiking

Total # hours per week you engage in non-work associated exercise (circle one):

< 2 hours per week 3-5 hours per week >6 hours per week

Have you had any type of **body work/manual therapy** performed on you in the last 12 months? YES NO

Check the types of body work you have participated in:

□ Massage □ Chiropractic □ Accupuncture

□ Physical Therapy □ Myofascial Release □ OTHER:_____

SLEEP (part one)**:**

Check the boxes that are applicable to your sleep patterns.

□ Tossing and turning □ Require Medication to sleep. List_____

□ Nap during the day □ Frequent nightmares □ Late riser, difficulty awakening

□ Other: _____

SLEEP (part two)**:**

INFORMATION FORM

Date:_____

1. Do you frequently have trouble falling sleep? YES NO
2. Do you often wake up in the middle of the night and have trouble falling back to sleep? YES NO
3. How long have you experienced these symptoms?_____
4. On average, how many nights per week do you have trouble sleeping? _____
5. Average hours of sleep each night: _____
6. Average time to Rise: Weekdays:_____ Weekends: _____

WEIGHT/DIET: Do you describe yourself as a: □ life long dieter □ frequent dieter in the past □ on weight loss diet now

What is your current: Height _____ Weight _____

What was your weight in High School / Age 18? Weight _____

Are you comfortable with your current weight? YES NO If no, desired weight:_____

Year last achieved desired weight _____

LIQUID CONSUMPTION:

Water: # of oz. per day _____ TYPE: filtered / purified / distilled / tap / flavored / reverse osmosis

Coffee: # cups per day _____ TYPE: caffeinated / decaffeinated / organic / instant / herbal

Tea: # cups per day _____ TYPE: caffeinated / decaffeinated / organic / herbal / green / black / flavored / white

Soda: # oz per day _____ TYPE: caffeinated / decaffeinated / diet / regular

Milk: # oz per day _____ TYPE: cow / rice / soy / almond / coconut / other _____

Sports Drinks: # oz per day _____TYPE: _____

Energy Drinks: # oz per day _____TYPE: _____

Protein Drinks: # oz per day _____TYPE: _____

Other: _____

DIET:

Circle applicable: gluten free / dairy free / vegetarian / no special diet / other: _____

Do you eat organic foods when possible? YES NO

How often do you consume fresh vegetables? daily / weekly / rarely / never

How often do you consume fresh fruit? daily / weekly / rarely / never

Do you eat breakfast? YES NO

Do you eat after 7pm? YES NO

How frequently do you eat restaurant/take out foods per week? _____

Do you use artificial sweeteners? Circle applicable: Nutra Sweet / Equal / Splenda / Sweet 'N Low / Other: _____

Do you have cravings? YES NO If yes, what do you crave: Salty / Sweet / Caffeine / Other: _____

Is your kitchen generally stocked to prepare meals? YES NO _____

BOWEL MOVEMENTS:

Number of times per day: _____

Do you have problems with your bowel movements? YES NO If yes, describe:_____

Do you require a laxative? YES NO

Do you have Irritable Bowel Syndrome? YES NO _____