The Wellness Center For Sport & Spine
Dr. Gil Z. Coleman, D.C.
181 W. Boardwalk Drive
Suite 204
Fort Collins, CO 80525
970-493-3100
Blue Federal Building 2nd Floor
Located between REI & Olive Garden

Directions to Our Office

Directions from Fort Collins

Our office is located in the **BLUE Federal Credit Union Building** on West Boardwalk between REI and the Olive Garden Restaurant.

Please use the elevator in the lobby at the South side of the building. We are on the 2nd floor.

If you get lost, please call 970-493-3100.

Directions from Denver

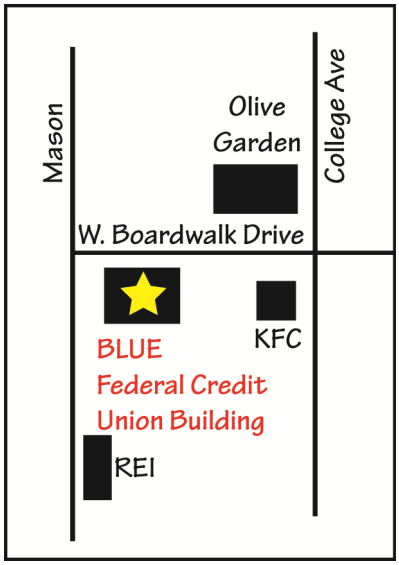
Merge onto I-25 N/US-87 N toward FT COLLINS
Take the HARMONY ROAD exit, EXIT 265.
Turn LEFT onto E HARMONY RD/CO-68 W. 4.5 miles
Turn RIGHT onto S COLLEGE AVE/US-287 N. 0.6 miles
Turn LEFT onto W BOARDWALK DR. 0.1 miles
181 W BOARDWALK DR Suite 204 is on the LEFT in the **BLUE Federal Building** 2nd Floor.

Directions From Cheyenne, Wyoming

Merge onto I-25 S/US-87 S toward DENVER
Take the HARMONY ROAD exit, EXIT 265.
Turn RIGHT onto E HARMONY RD/CO-68 W. 4.4 miles
Turn RIGHT onto S COLLEGE AVE/US-287 N. 0.6 miles
Turn LEFT onto W BOARDWALK DR. 0.1 miles
181 W BOARDWALK DR Suite 204 is on the LEFT in the **BLUE Federal Building** 2nd Floor.

If you get lost, please call 970-493-3100.

Please drive safely.



Thank you for choosing The Wellness Center For Sport & Spine and Dr. Gil Coleman. We look forward to meeting you and promise to provide a great experience and do our best work for you.

The Wellness Center For Sport & Spine offers our new patient forms online so they can be completed it in the comfort of your home or office.

These forms require Adobe Reader. http://get.adobe.com/reader/ to install the Adobe Reader application.

We have blocked off **60 minutes** for your appointment with Dr. Coleman. Please arrive 15 minutes early to process your paperwork.

What to bring:

1. **completed new patient intake forms**
2. **Copies of imaging DVD media, x-rays, MRI/CT scans, radiology reports, and or surgical reports**
3. **Typed chronological detail (in outline form) of your personal health history**

In chronological order past to present, please type an outline of your personal health history that includes details of your medical history, injuries, accidents, broken bones, surgery, treatment, imaging studies, and other health information.

How to download your new patient forms
Please download, print, and complete the new patient forms prior to your office visit by following the steps below: NOTE: DO NOT EMAIL SENSITIVE HEALTH INFORMATION.

Go to www.PremierFortCollinsChiropractor.com.

1. Click on **Forms** on the menu
2. Click on: **Adult New Patient Forms**
3. Print, fill out, and sign forms

Thank you for choosing The Wellness Center for Sport and Spine. We look forward to meeting with you! ***Congratulations!*** You're one step closer to a happier and healthier life!

Dr. Gil Z. Coleman - Sports & Family Chiropractor
The Wellness Center For Sport & Spine
181 W. Boardwalk Drive
Suite 204
Fort Collins, CO 80525
970-493-3100 Office
970-237-4802 Fax
www.PremierFortCollinsChiropractor.com
gilcoleman@gmail.com
"Making Great Athletes Better"

Name: _____ Age: _____ Birthday ____/____/____Today's Date ___/____/ _____

Address: _____ City_____ State _____ Zip _____

Home Telephone (____) ____-_____ Work Telephone (____) ____- _____ Cell Phone (____) ____-_____

Social Security #_____-____-_____ Driver's License # _____ E-mail _____

Occupation/Employers Name and address _____

❑Male ❑ Female ❑ Single ❑ Married ❑ Divorced ❑ Widowed #of children _____

Name of Spouse_____ Name(s) of Children _____

Reason for consulting our office? _____

Who may we "Thank" for referring you to our office? _____

****Please check if you are here for any of the following: ____Motor Vehicle Accident ____Work Injury _____ Other Injury __**

Your Health Profile

Your answers to the following questions will give us a general view of the stresses you have faced in your lifetime, thus allowing us to better assess your current status and more accurately determine your true health potential.

The Beginning Years: Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

Birth History: Please check those items that apply to you.

- ☐ Mother smoked/drank/drugs while pregnant
- ☐ C-Section
- ☐ Labor Induced
- ☐ Epidural/Meds in labor
- ☐ Forceps Delivery
- ☐ Complications
- ☐ Breech Vaginal Delivery
- ☐ Vacuum Extractor used
- ☐ Other _____

Childhood Years (Age 0-17 yrs): Please check those items that apply to you.

- ☐ Childhood Illness
- ☐ Very Inactive
- ☐ Alcohol/Drug Abuse
- ☐ Vaccinated
- ☐ Serious Falls
- ☐ Car Accident(s)
- ☐ Smoker
- ☐ Severe Emotional Trauma(s)
- ☐ Active in Sports
- ☐ Surgery/Stitches
- ☐ Antibiotics/Other Meds
- ☐ Broken Bones

Adult Years (Age 18 to present): Please check those items that apply to you.

- ☐ Present Smoker
- ☐ Alcohol Use
- ☐ Car Accidents
- ☐ High Personal Stress
- ☐ Poor Sleep
- ☐ No Exercise
- ☐ Hard Falls
- ☐ Former Smoker
- ☐ Surgery/Stitches
- ☐ Work Injury
- ☐ Drive a lot
- ☐ Not Enough Sleep
- ☐ Wear Orthotics/Lifts
- ☐ Severe Health Problems
- ☐ OTC/Prescription Meds
- ☐ Play Sports
- ☐ High Job Stress
- ☐ Sit a lot
- ☐ Poor/Inadequate Diet
- ☐ Flat Feet
- ☐ Broken Bones

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem. **P=Past; C=Current**

P	C		P	C		P	C		P	C	
☐	☐	Headaches	☐	☐	Pins & Needles Legs	☐	☐	Fainting	☐	☐	Neck Pain
☐	☐	Pins & Needles Arms	☐	☐	Loss Of Smell	☐	☐	Back Pain	☐	☐	Loss Of Balance
☐	☐	Dizziness	☐	☐	Buzzing In Ears	☐	☐	Ringing In Ears	☐	☐	Nervousness
☐	☐	Numbness In Fingers	☐	☐	Numbness In Toes	☐	☐	Loss of Hearing	☐	☐	Upset Stomach
☐	☐	Fatigue	☐	☐	Depression	☐	☐	Irritability	☐	☐	Tension
☐	☐	Sleeping Problems	☐	☐	Stiff Neck	☐	☐	Cold Hands	☐	☐	Cold Feet
☐	☐	Diarrhea	☐	☐	Constipation	☐	☐	Fever	☐	☐	Hot Flashes
☐	☐	Cold Sweats	☐	☐	Sensitive Eyes	☐	☐	Problem Urinating	☐	☐	Heartburn
☐	☐	Mood Swings	☐	☐	Menstrual Pain	☐	☐	Menstrual Irregularity	☐	☐	Ulcers

List any medications you are taking: _____

_____

The Wellness Center For Sport & Spine Inc. • Dr. Gil Z. Coleman, D.C.
181 W. Boardwalk Drive • Suite 204 • Fort Collins, CO 80525 • 970-493-3100
Blue Federal Building 2nd Floor • Between REI & Olive Garden
www.PremierFortCollinsChiropractor.com

1. **Health problem**: _____

The pain is:
Intensity ❑ Mild……❑ Moderate …….. ❑ Moderately Severe…….. ❑ Severe …… ❑ Intolerable
Quality ❑ Sharp ……❑ Dull …….. ❑ Constant ……. ❑ Traveling… ❑ Radiating
Frequency ❑ 0-25% of time....❑ 25-50% of time..❑ 50-75% of time…… ❑ 70-100% of time
Since this problem began my symptoms are: ❑ About the same ❑ Getting better ❑ Getting worse ❑ Variable

What makes it better? _____

What makes it worse? _____

This problem interferes with… ❑ Work ❑ Sleep ❑ Walking ❑ Sitting ❑ Exercise ❑ Hobbies ❑ Leisure Activities
Other Doctors seen for this problem (please list) ☐ Chiropractor ☐ Medical Doctor ☐ Other

2. **Health problem**: _____

The pain is:
Intensity ❑ Mild……❑ Moderate …….. ❑ Moderately Severe…….. ❑ Severe …… ❑ Intolerable
Quality ❑ Sharp ……❑ Dull …….. ❑ Constant ……. ❑ Traveling… ❑ Radiating
Frequency ❑ 0-25% of time....❑ 25-50% of time..❑ 50-75% of time…… ❑ 70-100% of time
Since this problem began my symptoms are: ❑ About the same ❑ Getting better ❑ Getting worse ❑ Variable

What makes it better? _____

What makes it worse? _____

This problem interferes with… ❑ Work ❑ Sleep ❑ Walking ❑ Sitting ❑ Exercise ❑ Hobbies ❑ Leisure Activities
Other Doctors seen for this problem (please list) ☐ Chiropractor ☐ Medical Doctor ☐ Other

3. **Health problem**: _____

The pain is:
Intensity ❑ Mild……❑ Moderate …….. ❑ Moderately Severe…….. ❑ Severe …… ❑ Intolerable
Quality ❑ Sharp ……❑ Dull …….. ❑ Constant ……. ❑ Traveling… ❑ Radiating
Frequency ❑ 0-25% of time....❑ 25-50% of time..❑ 50-75% of time…… ❑ 70-100% of time
Since this problem began my symptoms are: ❑ About the same ❑ Getting better ❑ Getting worse ❑ Variable

What makes it better? _____

What makes it worse? _____

This problem interferes with… ❑ Work ❑ Sleep ❑ Walking ❑ Sitting ❑ Exercise ❑ Hobbies ❑ Leisure Activities
Other Doctors seen for this problem (please list) ☐ Chiropractor ☐ Medical Doctor ☐ Other

Please write anything else you would like to express: _____

_____

_____

_____

By signing my name below, I hereby certify that all statements and answers given on this form, and all future communications, written and verbal, are and will be accurate and truthful. I understand that any false statements made to the doctor could potentially result in the worsening of my condition for which the doctor is not responsible. If this information is for a minor, I state I am the legal guardian for the child and give permission to Dr. Gil Z. Coleman to render a chiropractic examination and treatment.

_____ _____
Signature Date

The Wellness Center For Sport & Spine Inc. • Dr. Gil Z. Coleman, D.C.
181 W. Boardwalk Drive • Suite 204 • Fort Collins, CO 80525 • 970-493-3100
Blue Federal Building 2nd Floor • Between REI & Olive Garden
www.PremierFortCollinsChiropractor.com

Name: _____ Date: _____

AUTO ACCIDENT INFORMATION:

What was your position in the vehicle?
☐ driver ☐ front passenger ☐ rear passenger ☐ rear passenger

What type of vehicle were you driving
☐ compact car ☐ mid size car ☐ full size car
☐ compact truck ☐ full size truck
☐ mini van ☐ full size van
☐ compact SUV ☐ full size SUV
☐ motorcycle ☐ motorhome ☐ bicycle

What speed were you traveling at the time of the accident
☐ stopped at a stop light
☐ slowing down for an intersection
☐ at a complete stop
☐ moving slowly
☐ merging into traffic
☐ traveling at approximately _____ mph

Who hit you
☐ compact car ☐ mid size car ☐ full size car ☐ compact truck ☐ full size truck
☐ mini van ☐ full size van
☐ compact sport utility vehicle ☐ full size sport utility vehicle ☐ motorcycle ☐ motorhome ☐ bicycle

What was your vehicles point of impact
☐ front ☐ right front ☐ left front ☐ middle front
☐ rear ☐ right rear ☐ left rear ☐ middle rear
☐ right side ☐ front right side ☐ rear right side ☐ middle right side
☐ left side ☐ front left side ☐ rear left side ☐ middle left side

What speed was the other vehicle traveling

_____ mph

What was the other vehicles point of impact
☐ front ☐ right front ☐ left front ☐ middle front
☐ rear ☐ right rear ☐ left rear ☐ middle rear
☐ right side ☐ front right side ☐ rear right side ☐ middle right side
☐ left side ☐ front left side ☐ rear left side ☐ middle left side

Were you wearing seat restraints
☐ was wearing a full lap and shoulder restraint
☐ was wearing a lap restraint
☐ was wearing a shoulder restraint
☐ was not wearing any seat restraints

What position were your vehicles head rests in
☐ did have a head rest which was adjusted in the highest position
☐ did have a head rest which was adjusted in the middle position
☐ did have a head rest which was adjusted in the lowest position
☐ was not equipped with a head rest

Patient Signature: _____ Date: _____

Did your vehicles airbag deploy
☐ Air bags were deployed ☐ Air bags did not deploy

Were you prepared for the impact
☐ was completely surprised by the accident
☐ saw the collision coming
☐ saw the collision coming and braced appropriately

What position was your body in just prior to the impact
☐ a straight position
☐ a tilted forward position
☐ a position rotated to the left
☐ a position rotated to the right
☐ a position that cannot be remembered

What happened to your body at the moment of the impact
☐ body was tensed for impact
☐ body whipped violently forward and backward
☐ body violently torqued and twisted
☐ body was thrown over the seat
☐ body was thrown from the vehicle
☐ body was pinned in the vehicle
☐ body was thrown violently from side to side
☐ body was badly cut and bruised

What was your mental/emotional state immediately following the accident
☐ was not rendered unconscious by the impact of the accident
☐ was not rendered unconscious but was shaken and disoriented
☐ was not rendered unconscious but was shaken up
☐ was not rendered unconscious but was disoriented
☐ was rendered unconscious by the impact of the accident

Did you receive medical attention at the scene of the accident
☐ did not receive medical attention
☐ did receive medical attention

Were did you go immediately following the accident
☐ was taken to the hospital
☐ was taken home
☐ was taken to a personal physician
☐ was taken to this office
☐ resumed activities

List all body parts that struck the following areas within your vehicle:
☐ Dashboard ☐ Winshield ☐ Steering wheel ☐ Right door ☐ Left door ☐ Seat frame ☐ Unknown object

NOTICE OF PRIVACY PRACTICE SUMMARY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) affords individuals certain rights to privacy regarding protected health information. While we've always protected your privacy concerning your personal health information, this summary discloses how your health information may be used. An expanded notice of your privacy rights is available for review upon request. Be aware that the terms of this notice may change from time to time and that you may contact us at anytime to obtain the most current copy of this notice.

The Wellness Center For Sport & Spine Inc. (TWCFSS) uses your health information for your treatment (including direct or indirect treatment by other healthcare providers), to obtain payment for treatment from third party payors (for example, an insurance company), to evaluate the quality of care that you receive, and for administrative purposes.

TWCFSS may use your health information in the day-to-day operations of our practice. This may include, but not be limited to daily sign in sheets, sending appointment reminders, phone messages, birthday cards, newsletters, holiday greetings and information about treatment alternatives or other health related issues.

TWCFSS may disclose your health information for public health activities, research, health and safety, governmental function in order to comply with worker's compensation laws and other pertinent legislative rules and regulations. TWCFSS will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. You have a right to request restrictions on how your health information may be used and disclosed to carry out treatment, reimbursement, and healthcare operations. TWCFSS may not be required to agree with these requested restrictions, however if we do agree with these requests then we are bound to comply with them. Further, you have a right to request and retain a copy of your health record, request communication of your information by alternative means at alternative locations when appropriate, revoke your authorization and request an accounting of your healthcare records. However, any use or disclosure that occurred prior to the date of revocation is not affected.

You may talk to the Privacy Officer of TWCFSS and/or to the Department of Health and Human Services if you believe your privacy rights have been violated. In the event that a complaint is filed, you will not experience any retaliation.

TWCFSS must maintain the privacy of protected health information as provided by this Privacy Practice Summary. We are obligated to obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under current law.

This office is a semi-private facility. If you wish to discuss clinical or financial information privately, please notify a staff member and we will provide a private setting for that discussion.

In the interest of protecting the privacy of your personal health information, there may be instances when you are asked additional questions to verify your identification. Further, you will not be allowed access into areas designated as "authorized personnel only".

By my signature below, I acknowledge that I have reviewed this information and understand its contents.

_____ _____

Patient Signature **Date**

_____

Patient Name (Printed)

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____