NEW PATIENT

Curis FUNCTIONAL HEALTH
2121 NORTH FM 1417 SUITE R
SHERMAN, TX 75092
PH: 903-893-2388

PATIENT INFORMATION

Date: _____

Legal Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Mobile Ph: _____ SS# _____

Alt. Ph: _____

Date of birth: ____/____/____ Age _____ Sex _____

○ Married ○ Single ○ Divorced ○ Widowed

Email Address: _____

Whom may we thank for referring you? _____

EMPLOYMENT INFORMATION

Occupation: _____

Employer: _____

Address: _____

Phone # _____

EMERGENCY INFORMATION

Contact Name: _____

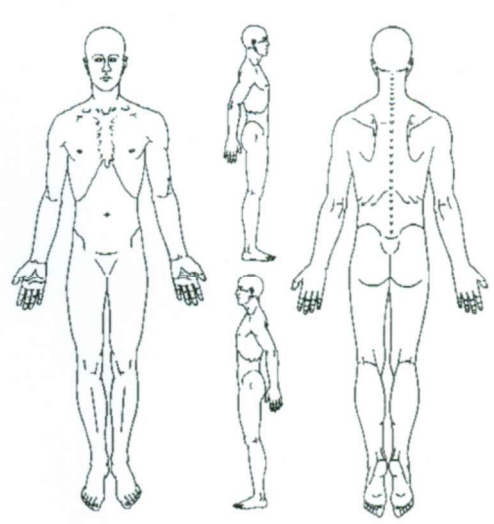
Relationship: _____ Ph. # _____

CURRENT HEALTH CONDITION

CHIEF COMPLAINT: _____

When did symptoms first appear? _____

Mark your areas of concern



Has this condition occurred before? ○ Yes ○ No

How often do you experience the symptoms?
○ Constant 100% ○ Frequent 75%
○ Intermittent 50% ○ Occasional 25%
○ Rare 10%

What makes the symptoms worse? _____
What relieves the symptoms? _____

How would you describe the pain?
☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Numb
☐ Throbbing ☐ Radiating ☐ Deep ☐ Other

Rate the pain on a scale of 1-10 (10 being unbearable pain)
Right now Select One
At its worst Select One
Other Doctors seen for this condition ○ Yes ○ No
If so, please list the name(s) of physician(s) seen for this condition:

_____

Type of treatment? _____ Results _____

Is this condition: ○ Job related ○ Auto Accident ○ Home Injury ○ Fall ○ Other _____

Do you wear a shoe lift? ○ Yes ○ No

Do you suffer from any condition other than which you are now consulting us? ○ Yes (explain) ○ No

_____

Are you in litigation for any accidents (Auto, Workmens Comp. Etc.) at this time? ○ Yes ○ No

Female Patient: Is there any possibility you are pregnant? ○ Yes ○ No

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD

☐ AIDS/HIV	☐ Arthritis	☐ Diabetes	☐ Gout	☐ Osteoporosis
☐ Anemia	☐ Cancer	☐ Epilepsy	☐ Multiple Sclerosis	☐ Rheumatic Fever

CHECK ANY YOU HAVE HAD IN THE PAST 6 MONTHS

Musculoskeletal Code
- ☐ General Stiffness
- ☐ General Weakness
- ☐ Swollen Joints
- ☐ Spinal Curvature
- ☐ Neck Pain
- ☐ Arm Pain

General Code
- ☐ Fatigue/Weakness
- ☐ Allergies
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Weight Change
- ☐ Fever/Chills

C-V-R Code
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Asthma
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems

Genitourinary Code
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urine
- ☐ Discolored Urine

Nervous System Code
- ☐ Nervous
- ☐ Numbness
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Depression
- ☐ Cold/Tingling in extremities
- ☐ Stress
- ☐ Twitching
- ☐ Other Endocrine problems
- ☐ Change in sex characteristics
- ☐ Neck/Surgery/Irradiation
- ☐ Diabetes

Gastrointestinal Code
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Vomiting
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Abdominal Cramps
- ☐ Gas/Bloating/Belching
- ☐ Heartburn
- ☐ Black/Bloody/Stools

EENT Code
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose
- ☐ Frequent Colds
- ☐ Nose Bleeds
- ☐ Sinus Trouble
- ☐ Hoarseness

Family History

The following members have the same or similar problem(s) as I do:
- ☐ Father
- ☐ Mother
- ☐ Brother
- ☐ Sister
- ☐ Other _____

For Women Only
- ☐ Pain b/w shoulders
- ☐ Low back pain
- ☐ Foot trouble
- ☐ Walking Problems
- ☐ Jaw Problems
- ☐ Heat & Cold Intolerance
- ☐ Thyroid Problems
- ☐ Height Change
- ☐ Sweats
- ☐ Bleeding/Bruising
- ☐ Lung Problems
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke
- ☐ Cramps
- ☐ Irregular Cycle
- ☐ Painful Periods
- ☐ Pregnant (now)

OCCUPATIONAL INFORMATION

Job involves ☐ Sitting ☐ Standing How long? _____

☐ Bending ☐ Stooping ☐ Twisting ☐ Turning ☐ Lifting – How much weight _____
Physical activity at work: ☐ Sedentary ☐ Light manual labor ☐ Heavy Labor

Telephone use at work ☐ None ☐ Moderate ☐ Heavy ☐ Traditional receiver ☐ Headset

Do any work activities aggravate your complaints? _____

_____

_____

HEALTH HABITS

Exercise/Sports/Hobbies:
1.) Type _____ Frequency _____ 2.) Type _____ Frequency _____
3.) Type _____ Frequency _____ 4.) Type _____ Frequency _____

Sleep:
Hours/Night _____ Sleep Quality _____
Do you sleep on your: ☐ Back ☐ Side ☐ Stomach

Smoking/Drinking/Diet: (how much and how often)
Tea/Coffee: _____ Liquor/Beer: _____ Cigarettes/Tobacco: _____

HEALTH HISTORY

Please list ALL surgeries, hospitalizations, fractures/dislocations you have had

Type _____ Date _____
Type _____ Date _____
Type _____ Date _____

Please list ALL previous accidents and falls

What _____ When _____
What _____ When _____
What _____ When _____

Please list ALL medications and / or vitamins you take

Name _____ For What _____ Name _____ For What _____
Name _____ For What _____ Name _____ For What _____
Name _____ For What _____ Name _____ For What _____

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). The doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **Relief Care** ☐ **Corrective Care**

☐ Check here if you want the doctor to select the type of care appropriate for your condition.

METHOD OF PAYMENT

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my medical status.

In addition, I understand that it is my full responsibility to inform this office of any changes to my medical insurance policy if I choose to use said insurance for the treatment I will receive. I also understand that most insurance policies have an annual visit limitation for the individual benefits I receive, and it is my sole responsibility to keep track of these visits throughout the duration of my treatment.

_____ _____
Print Patient Name Date

_____
Patient/Legal Guardian Signature

Patient General Questionnaire

Patient Name:_____ DOB: _____

Do you have any of the following conditions?

	Yes	No		Yes	No
Implanted Pacemaker	☐	☐	Are you allergic to latex	☐	☐
			Are you pregnant	☐	☐
Thrompophlebitis	☐	☐			
			Are you under treatment for any		
Epilepsy	☐	☐	Acute medical condition	☐	☐
Malignant Lesions	☐	☐	Are you suffering from any chronic muscle or nerve disorder other than currently being treated	☐	☐
Varicose Veins	☐	☐			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform this office of any changes in medical status.

_____ _____

Print Patient Name Date

_____

Patient/Legal Guardian Signature

Patient Comments: _____

_____

_____

_____

_____

Consent to Release Confidential Information

This document authorizes Curis Functional Health to disclose information concerning _____to the following person(s):

_____(client name)

☐ Insurance Company/Managed Care/EAP_____

☐ Primary Care MD _____

☐ Psychiatrist _____

☐ Other / Emergency Contact _____

(Name) (Phone) (Email)

☐ Refused

The purpose of this disclosure is as follows:

☐ Authorization/Utilization Review

☐ Payment/Billing

☐ Coordination of Care

☐ Other_____

I understand that I may revoke, in writing, my consent to allow the above-named organization to release this information at any time, except to the extent that action will have been taken on information released prior to the revocation of my consent. Otherwise, this consent begins _____ and is valid for 12 months, renewing automatically until therapy terminates.

(Today's Date)

_____

Client Signature Printed Name Date

_____

Parent/Guardian Signature Printed Name Date
(if client is a minor)

Informed Consent

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is a legal requirement in California. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of machine. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office we used trained staff personal to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Stroke: Stroke means that a portion of the brain or spinal cord does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The literature is mixed or uncertain as to whether chiropractic adjustments are associated with stroke or not. The most recent evidence suggests that it is not (2008, 2015, 2016), although the same evidence suggests that the patient may be entering the the chiropractic office for neck pain/headaches or other symptoms that may in fact be a spontaneous dissection of the vertebral artery. If we think this is happening, you will be immediately referred to emergency services.

Anecdotal stories suggest that chiropractic adjustments may be associated with strokes that arise from the vertebral artery; this is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is suggested increase the strain on the vertebral artery is called the "extension-rotation-thrust atlas adjustment." We do not do this type stroke ranges between 1 per every 400,00-3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the final cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. These problems occur so rarely that there are no available statistics to quantify their incidence.

Cauda Equina Syndrome: Cauda Equina Syndrome occurs when a low back disc problem puts pressure on the nerve that control bowel, bladder, and sexual function. Representative symptoms include leaky bladder, or leaky bowels, or loss of sensation (numbness) around the pelvic sexual organs (the saddle area), or the inability to urinate or to start a bowel movement. Cauda Equina Syndrome is always a medical emergency because the nerves that control these functions can permanently die, and those functions may be lost or compromised forever. The standard approach is to surgically decompress the nerves, and the window to do so is only 12-72 hours, depending. If you have any of these symptoms, tell us immediately, and if we cant be reached, go to the emergency department.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may overstretch some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their incidence.

Rib and other Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their incidence.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, both heat or ice can burn or irritate that skin. The result is a temporary increase in pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their incidence. Never put a home ice pack directly on the skin, always have an insulating towel between.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely rear it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

Client Signature Printed Name Date

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Federal law requires that we obtain your written acknowledgement of receipt of the Notice of Privacy Practices. Please sign or initial below.

I acknowledge that I have received the Notice of Privacy Practices.

_____

Patient Name (Print)

_____

Patient Signature

_____

Patient Date of Birth

_____

Legal Representative Name (if patient is unable to sign) (Print)

_____

Legal Representative Signature

Date: _____

For Internal Use Only

_____ Patient refused to provide signature for acknowledging receipt of privacy practices _____

Staff signature and date

_____ Patient was incapacitated and unable to provide signature for acknowledging receipt of privacy practices

_____ Staff signature and date

Patient Name _____ ***Date*** _____

Neck Index

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

I have no pain at the moment.

Sleeping

I have no trouble sleeping.

Reading

I can read as much as I want with no neck pain.

Concentration

I can concentrate fully when I want with no difficulty.

Personal Care

I can look after myself normally without causing extra pain.

Work

I can do as much work as I want.

Lifting

I can lift heavy weights without extra pain.

Driving

I can drive my car without any neck pain.

Recreation

I am able to engage in all my recreation activities without neck pai

Headaches

I have no headaches at all.

Patient Name _____ ***Date*** _____

Back Index

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

I have no pain at the moment.

Sleeping

I have no trouble sleeping.

Sitting

I can sit in any chair as long as I like.

Standing

I can stand as long as I want without pain.

Walking

I have no pain while walking.

Personal Care

I do not have to change my way of washing or dressing in order to

Lifting

I can lift heavy weights without extra pain.

Traveling

I get no pain while traveling.

Social Life

My social life is normal and gives me no extra pain.

Changing degree of pain

My pain is rapidly getting better.

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Notice of Doctor's Lien and Irrevocable Assignment and Directive of Proceeds

I hereby authorize my health care provider, Curis Functional Health, hereinafter "Provider," to furnish to my attorney, insurance company or other person or entity involved in my claim with a full report of my case history, examination, diagnosis treatment, prognosis, or other medical/billing resulting in my treatment by Provider. I also authorize Curis Functional Health to disclose such information to its attorney and any billing or collection entity that it may retain.

I further, for good and valuable consideration of which is hereby acknowledged, assign and transfer, irrevocable, to provider all rights, title and interest that I may now have or that I may have in the future to any and all benefits, proceeds, and/or monies that may be due me from any third-party and/or payer, including but not limited to third party liability payers, personal injury protection (PIP) coverage, underinsured/ uninsured coverage, third partied and group health plans as a result of the accident or injury event for which Provider has rendered and/or will render medical goods and services on my behalf.

I further irrevocably assign entitlement to benefits, proceeds and/or monies to Provider and irrevocably grant a lien to the extent of my indebtedness to Provider and irrevocably direct any third – partied and/or payers, including but not limited to third-party liability payers, personal injury protection (PIP) coverage, Medpay, underinsured/uninsured coverage, homeowners coverage, third parties and group health plans to make benefits, proceeds and/or monies payable to include Provider. I additionally issue this directive that no money, check, draft, electronic transfer, or any other payment is to be made to myself or my attorneys or my heirs or assigns from the above listed third-parties and payers without including Curis Functional Health as a payee on such disbursements.

I further irrevocably direct my attorney representing me as a result of the accident, occurrence, or injury-causing event to protect Provider's total charges out of any recovery that is obtained on my behalf by directing and forwarding payment of said recovery to Provider to the extent of my total indebtedness to Provider. I fully understand that my attorney shall abide buy this irrevocable assignment, directive, and notice without further consultation with me and shall disclose to Provider and/or its representatives, agents, independent contractors and attorneys any and all information related to my claim(s) and settlement, judgment, verdict or recovery.

I further agree to fully inform Provider to any and all potential third-parties and/or payers, personal injury protection (PIP) coverage, underinsured/uninsured coverage, third parties or group health plans that may be liable for my injuries and to provide the names and addresses of any attorney(s) that may represent me nor or in the future concerning this accident, occurrence or injury event. I fully understand that this irrevocable assignment, directive and notice or lien shall remain with respect to any future attorney that I retain.

I further agree to defend, indemnify, and hold harmless Provider against any payer(s) and its agents, representatives, employees, officers, directors, partners, shareholders, affiliates, attorneys, subcontractors, independent contractors, heirs, assigns and all other persons, firms, corporations, associations, or partnerships or other entities from any and all claims, actions, cause of actions, damages, costs, expenses, compensation, or otherwise on account of or in any way growing out of the direct payment to provider. I fully understand that it is my sole responsibility to maintain any and all claims, causes of action, appeals, and conditions to recover against any and all potential third-parties and/or

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payers, including but not limited to third-party liability payers, personal injury protection (PIP) coverage, underinsured/uninsured coverage, third parties and group health plans.

I further fully understand and agree that regardless of my execution of this agreement, that I am directly and fully responsible to Provider for medical goods and services provided and/or that will be provided to me and that this agreement is made solely for additional protection to Provider and in consideration of Provider awaiting payment. It is hereby understood and agreed that my responsibility for payment is not contingent upon any settlement, claim, judgment, verdict, recovery or otherwise that I may obtain. I also understand that any payments made on my behalf, whether by insurance companies, attorneys, or myself, if less than the full amount of my outstanding balance, is only partial payment toward my account. Any such partial payment is not and will not be considered and "offer in compromise: or release me from my remaining balance owed to Curis Functional Health.

It is further understood and agree that I shall fully inform and notify any third parties and payers, including but not limited to third-party liability payers, personal injury protection (PIP) coverage, underinsured/uninsured coverage, third parties and group health plans and/or my attorneys, or Irrevocable Assignment, Directive and Notice.

I further agree to waive for two years after any settlement is reached the statute of limitations applicable to Provider's claims, causes of action, rights and/or remedies in collecting its total charges pursuant to this Irrevocable Assignment, Directive and Notice, or pursuant to any remedy available to Provider in collecting its total charges, damages, interest, court costs of collection and any other relief to which Provider in collecting its total charges, damages, interest, court costs of collection and any other relief to which provider may be entitled. In addition to any cause of action available under Texas law or any other applicable state's laws, I understand and agree that Provider may seek a recovery from me and my attorney, agents, heirs, or assigns for breach of contract if I do not comply with this agreement.

This Irrevocable Assignment, Directive and Notice of Lien shall be irrevocable upon execution by me.

_____ _____

Patient/Responsible Party/Guardian Date

_____ _____

Print Name Date of Injury

_____

_____

Print Address and Phone Number