ACCIDENT INFORMATION

Please PRINT clearly.

PATIENT INFORMATION

Name: (Last, First, MI) ____**Date**: ________________

ACCIDENT INFORMATION -- *Please use back of this page if needed.*

Date of accident: _________________ Time of Accident: _____________ Number of people in accident vehicle: ___________

Location/street of Accident:____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger -- Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row

Name of Driver, *if not you* ____________________________ Name of Driver of other Vehicle: ______________________________

Make/Model of Vehicle you were in: ____

Is vehicle equipped with airbags? ☐ Yes ☐ No Did airbags inflate? ☐ Yes ☐ No Were you wearing a seatbelt? ☐ Yes ☐ No

Where did the impact come from? ☐ Front ☐ Rear ☐ Driver side ☐ Passenger Side

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At the base

In what direction were you headed? ☐ North ☐ South ☐ East ☐ West

In what direction was the other vehicle headed? ☐ North ☐ South ☐ East ☐ West

During impact were you facing: ☐ Forward ☐ Backward ☐ Right ☐ Left

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No (Describe):____________________________________
____

Were you rendered unconscious? ☐ Yes ☐ No If yes, for how long? ___________

What was the approximate speed of your vehicle? ________ The other vehicle? ___________

Were you ☐ Aware ☐ Surprised by the impact? What did your vehicle impact? ☐ Another vehicle ☐ Other:_______________

Please list the name of the other victims in the accident, if any:____
____

In your own words please describe the accident in detail: ____
____

INSURANCE INFORMATION

Your Auto Ins: ________________________Policy #_________________ Claim#__________________ Phone#_______________

Address:____

Other's Auto Ins:______________________Policy #_________________ Claim#__________________ Phone#_______________

Address:____

MEDICAL INFORMATION

BEFORE THE ACCIDENT:

Have you had complaints in the involved area? ☐ Yes ☐ No

Were they present at the time of the accident? ☐ Yes ☐ No

Describe: ____

Were you able to work without restrictions before the accident? ☐ Yes ☐ No

AT THE TIME OF THE ACCIDENT:

Did you feel pain immediately after the accident? ☐ Yes ☐ No ☐ Later that Day ☐ Next Day ☐ When? ___________________

Did you go to a hospital or seen any other doctor? ☐ Yes ☐ No When did you go? ☐ Immediately ☐ Next Day ☐ Other_____

How did you get there? ☐ Ambulance ☐ Private Transportation Was medication prescribed? ☐ Yes ☐ No

Describe the treatment you received: ____

Name of hospital and/or attending doctor:____

Was he/she a : ☐ DDS ☐ MD ☐ DC ☐ DO Were any x-rays taken? ☐ Yes ☐ No

SINCE THE ACCIDENT:

Are your symptoms: ☐ getting better ☐ getting worse ☐ staying the same

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

LEGAL INFORMATION

Did the police come to the scene of the accident? ☐ Yes ☐ No Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No Was a traffic violation issued? ☐ Yes ☐ No To whom? ______________________

Have you retained an attorney? ☐ Yes ☐ No If yes, whom? ________________________Phone:_________________________

Signature of Patient/Guardian ____ **Date**_________________

AUTOMOBILE MEDICAL BENEFITS

A lot of people have medical benefits ("medpay" or "PIP") included in their automobile policies, and don't even realize it. Our office highly recommends that you use these benefits, if you have them, in the event that you've been injured in an automobile accident, regardless of who was at fault.

Here are several reasons why we recommend that we file your medpay or PIP.

1. **Medpay and PIP are exactly like health insurance – using either form of coverage doesn't cause your rates to increase.** If your rates increase, it's not because you filed your medpay or PIP, It's most likely because: (a) the accident was determined to be your fault by your insurance company, (b) you received a police citation or ticket, or (c) you've been involved in numerous reported auto accidents within a brief period of time, and therefore are now considered to be "high risk."

2. **Filing your medpay or PIP doesn't relieve the other party from having to pay in full for your loss.** Filing medpay/PIP doesn't relieve the other party from being responsible for payment. If the other driver's laibility insurance refused to make payment to you for whatever reason, filing your medpay/PIP will help to ensure that you are not left to pay the medical bills out of your own pocket.

3. **If you have medpay or PIP coverage and choose not to file it, then you are paying for an option, but not receiving the benefit.**

4. **We do not charge for filing your medpay or PIP!**

OUR OFFICE FINANCIAL POLICY

As long as our office is filing your PIP or Medpay, and these companies are continuing to cover your charges, we will waive collection of payment at the time of service. If we receive overpayment to your account, we will be happy to refund you the difference, provided we are not under a duty to refund the insurance company.

Next Level Chiropractic
554 W. Ralph Hall Parkway
Rockwall, TX 75032
(972) 771-3388   FAX (972) 722-3398

Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Next Level Chiropractic, a lien and assignment of any and all benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority.

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and upon violation, I further instruct my carrier to make all checks payable to Next Level Chiropractic and send to 554 W. Ralph Hall Parkway, Rockwall, TX 75032.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to: Next Level Chiropractic and send any and all checks to 554 W. Ralph Hall Parkway, Rockwall, TX 75032.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collections, including attorney fees and court costs incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf, I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disabiltiy granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

Signature of Patient and/or Responsible Parties:
I declare under penalty of perjury that the foregoing is true and correct. (CPRC: Sec. 132.001(a))

____ Date: ____________________________

____ Date: ____________________________

CONFIDENTIAL PATIENT HEALTH HISTORY

Please PRINT clearly.

Today's Date: ________________________

PATIENT INFORMATION

Name: (Last, First, MI) ____ **Preferred Name**: ______________

Address: ________________________________ **City**: ______________________ **State**: _________ **Zip**: ___________

Home: ______________________ **Mobile**: ______________________ **Mobile Carrier**: __________ **Work**: ____________________

Email: ____ **Gender**: M / F **Marital Status**: Married / Single / Other

Best way to reach you: home / cell / work / email Date of Birth: ______________________ Age: ________________________

Preferred patient reminders: email / text Occupation: ________________________ Employer: ___________________

Who may we thank for referring you to our office? ____

CMS requires providers to report both race and ethnicity

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer **Preferred Language**: __________________

Race: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian) / Native Hawaiian or Pacific Islander Other / Decline to Answer

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: ____________________________________ **Name of Previous Chiropractor**: ______________________________

Home: _______________ **Mobile**: __________________ **Date of Last Chiropractic Adjustment**: _________________________

Relationship: Child / Parent / Spouse / Other: ________ **Primary Care Physician**: ____________________________________

Doctor's Phone: ____

FINANCIAL INFORMATION -- *Please allow our staff to photocopy your insurance card.*

Texas State law requires that we inform you in writing of your charges at each visit. Please initial below indicating your choice of receiving a paper receipt detailing the charges for each visit.

_____ **Yes**, I would like a printed Appointment Receipt at each visit. I understand that it is my responsibility to request this at check out.

_____ **No**, I do not wish to receive any of my printed Appointment Receipts. I understand that I may request any Appointment Receipt for any date of service at any point in the future.

List all medications, Dosage and Frequency (i.e. 5 mg once a day, etc.) *Did you bring a list? Can we make a copy?*

____

____

____

Describe Major Complaint for seeking care today: ____

CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS*

Onset of Symptoms: ____________ Descrie how it began: ____

____

Grade Intensity/Severity of Complaint: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

Is the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Numb / Other: _______________

How frequent is the complaint present? Come & Go / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)*____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both *Leg* - Hip / Thigh-Knee / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers R / L / Both *Other Area:*____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: ___________________________

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: ______________________________

How does this condition affect your daily activities? *(Describe)* ____

Have you received any prior treatment for this condition?

DC / MD / PT / Massage / ER / Other: ___________________________ Where? ____________________________________

Surgery? *(Describe)*____

Medications? OTC / Prescriptions *(Describe)*____

Diagnostic testing? X-rays / MRI / CT / Other:______________When and Where? ___________________________________

❑ Acupunture ❑ Massage ❑ Other:____

Describe any Secondary Complaints: ____

HEALTH HISTORY *(PLEASE USE REVERSE SIDE OF PAGE IF NEEDED)*

FAMILY HISTORY:

Heart Disease Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather

Stroke Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather

Cancer Mother / Father / Siblings / Maternal Grandmother / Maternal Grandfather / Paternal Grandmother / Paternal Grandfather

Type of Cancer: ____

Any other family history that might be relevant: ____

MEDICATION:

Allergies to Medications: *(List and reactions)* ______________

____

____

Vitamins & Supplements: *(List all and frequency)* __________

____

____

PAST HEALTH HISTORY: *(List even if it was 20 years ago…)*

Surgeries – Date, Type and Reason:______________________

____

____

Major Injuries/Traumas: *(List even if it was 20 years ago or more…)*

____

____

Major Hospitalizations including year:

____

____

____

LIFESTYLE:

Lifestyle: *(Your Hobbies, Rec. Activities, Exercise, Diet, Health Goals)*

____

____

____

____

Habits:

Cigarettes – (#/day) ___________________________________

Alcohol – (amount/day)_________________________________

Coffee/Tea – (cups/day)________________________________

Rec. Drugs: (list) ______________________________________

Are you *currently* experiencing any of these symptoms? (Check all that apply)
Many of the following conditions respond to Chiropractic treatment.

General: (constitutional)
- ❑ Recent Weight Change
- ❑ Fever
- ❑ Fatigue
- ❑ *None in this Category*

Musculoskeletal:
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Arm Problems ______________
- ❑ Leg Problems ______________
- ❑ Painful Joints
- ❑ Stiff/Swollen Joints
- ❑ Sore/Weak Muscles or Joints
- ❑ Muscle Spasms/Cramps
- ❑ Broken Bones
- ❑ Other: ____________________
- ❑ *None in this Category*

Neurological:
- ❑ Numbness or Tingling Sensations
- ❑ Loss of Feeling
- ❑ Dizziness or Light Headed
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or Seizures
- ❑ Tremors
- ❑ Stroke
- ❑ Have you ever had a head injury?
- ❑ Ever been in an auto accident?
- ❑ Other: ____________________
- ❑ *None in this Category*

Mind/Stress:
- ❑ Nervousness
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ Other: ____________________
- ❑ *None in this Category*

Genitourinary:
- ❑ Sexual Difficulty
- ❑ Kidney Stones
- ❑ Burning/Painful Urination
- ❑ Change in Force/Strain w/Urination
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Incontinence or Bed Wetting
- ❑ Other: ____________________
- ❑ *None in this Category*

Gastrointestinal:
- ❑ Loss of Appetite
- ❑ Blood in Stool
- ❑ Change in Bowel Movements
- ❑ Painful Bowel Movements
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Frequent Diarrhea
- ❑ Constipation
- ❑ Other: ____________________
- ❑ *None in this Category*

Cardiovascular & Heart:
- ❑ Chest Pains
- ❑ Rapid or Heartbeat Changes
- ❑ Blood Pressure Problems
- ❑ Swelling of Hands, Ankles, or Feet
- ❑ Heart Problems
- ❑ Other: ____________________
- ❑ *None in this Category*

Respiratory:
- ❑ Difficulty Breathing
- ❑ Persistent Cough
- ❑ Coughing Blood
- ❑ Asthma or Wheezing
- ❑ Lung Problems
- ❑ Other: ____________________
- ❑ *None in this Category*

Eyes and Vision:
- ❑ Wear contacts/glasses
- ❑ Blurred or Double Vision
- ❑ Glaucoma
- ❑ Eye Disease or Injury
- ❑ Other: ____________________
- ❑ *None in this Category*

Ears, Nose and Throat:
- ❑ Bleeding gums/Mouth sores
- ❑ Bad Breath or Bad Taste
- ❑ Dental Problems
- ❑ Swollen Throat or Voice Change
- ❑ Swollen Glands in Neck
- ❑ Ringing in the Ears
- ❑ Ear-Ache/Ringing/Drainage
- ❑ Sinus/Allergy Problems
- ❑ Nose Bleeds
- ❑ Hearing Loss
- ❑ Other: ____________________
- ❑ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Excessive Thirst or Urination
- ❑ Cold Extremities
- ❑ Heat or cold Intolerance
- ❑ Change in hat or glove size
- ❑ Dry Skin
- ❑ Glandular or Hormone Problem
- ❑ Swollen Glands
- ❑ Anemia
- ❑ Easily Bruise or Bleed
- ❑ Phlebitis
- ❑ Transfusion
- ❑ Immune System Disorder
- ❑ Other: ____________________
- ❑ *None in this Category*

Skin and Breasts:
- ❑ Rash or Itching
- ❑ Change in Skin Color
- ❑ Change in Hair or Nails
- ❑ Non-healing Sores
- ❑ Change of Appearance of a Mole
- ❑ Breast Pain
- ❑ Breast Lump
- ❑ Breast Discharge
- ❑ Other: ____________________
- ❑ *None in this Category*

Women Only:

Are you pregnant?
- ❑ Yes-Due Date ______________
- ❑ No-Last Menstrual Period ______
- ❑ Infertility
- ❑ Painful or Irregular Periods
- ❑ Vaginal Discharge
- ❑ Other: ____________________
- ❑ *None in this Category*

Pregnancies with Outcome & Date

____
____
____
____

Is there anything else you would like the doctor to know? ______________________________

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient or Guardian Signature ______________________________ Date ____________

Treating Doctor Signature ______________________________ Date ____________

QUADRUPLE VISUAL ANALOGUE SCALE

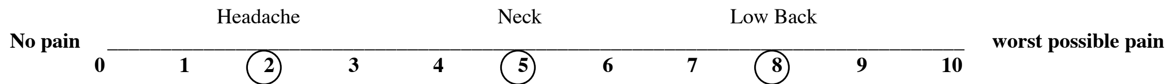
Patient Name ____ Date _________________________

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

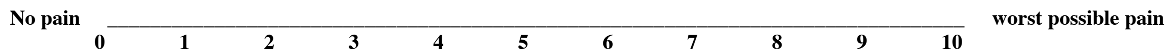
Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

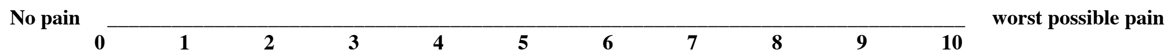


---

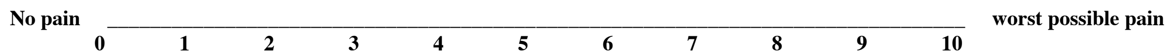
1 – What is your pain RIGHT NOW?



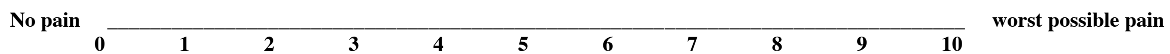
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

____

____

____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

CURIS FUNCTIONAL HEALTH
Informed Consent

Please read this entire document prior to signing. Ask questions before you sign if there is anything that is unclear.

Based on my complaints and the history I have provided, I hereby authorize Curis Functional Health ("the Practice") and its licensed doctors and assistants to undertake an examination and provide an evaluation and treatment plan that may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I understand that state law entitles me to receive information concerning my condition and proposed treatment and refuse any treatment to the extent permitted by law. With that knowledge and with my consent, I wish to rely on the Curis Functional Health doctors to make those decisions about my care, based on the facts that they believe are in my best interest.

As a part of the analysis, examination, and treatment, you are consenting to services that may include: Chiropractic adjustment, palpation, massage therapy, spinal decompression, intersegmental traction, vital signs, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, hot/cold therapy, EMS, and radiographic studies. The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments, and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

Based on current findings, the Practice doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment, and the reasonable alternatives to the proposed treatment. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and the costs of reasonable alternatives to the proposed treatment to the extent practicable.

Practice doctors have also explained that my diagnosis and treatments may change during the course of care. They will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those that relate to physical aberrations unknown or reasonably undetectable by the doctor. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor’s attention, it is your responsibility to inform the Doctor.

The availability and nature of other treatment options may include self-administered, over-the-counter analgesics and rest, medical care and drugs such as anti-inflammatory, muscle relaxants, and pain-killers, hospitalization or surgery. If you choose to use one of the above noted “other treatment” options you should be aware that there are risks and benefits of such options, and you may wish to discuss these with your primary medical physician.

The risks and dangers to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility, setting up a pain reaction and further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

This document is intended as a general, broad-based consent applies to any and all contemplated procedures. I have discussed all of the above risks and benefits with the Practice, and, if applicable, have made an informed decision that the potential benefits outweigh the risks in my case.

____

I understand and accept that:

1. l have the right to withdraw from or discontinue any treatment at any time and that the Practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve making judgments based upon the facts known to the doctor during my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent {or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment l may receive. My signature below acknowledges my consent to the Practice's examination, evaluation, and proposed course of care and treatments.

__________________ Witness

__________________________________ Patient's Printed Name

__________________________________ Patient's Signature

____________________________ Signature of Doctor

For use and/or disclosure of Protected Health Information (PHI)

To carry out Treatment, Payment, and Healthcare Operations

______________________________, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. Curis' Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for Curis to provide treatment to me, and it is also required for Curis to obtain payment for that treatment and to carry out its health care operations. Curis explained to me that the Privacy Notice would be available to me in the future at my request. Curis has further described my right to obtain a copy of the Privacy Notice before signing this Consent and has encouraged me to read the Privacy Notice carefully before my signing this Consent.
2. Curis reserves the right to change its privacy practices described in its Privacy Notice in accordance with applicable law.
3. Curis' "Notice of Privacy Practices" is also provided in the front lobby. I may also request a copy from this office at any time via US Mail or email.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understood the preceding notice, and all of my questions have been answered to my complete satisfaction in a way that I can understand.

______________________________	______________________________
Name of Individual (Printed)	Signature of Individual
______________________________	______________________________
Signature of Parent/Guardian	Date Signed

____
Witness