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?*

_____

_____

_____

CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS*

Describe Major Complaint for seeking care today: _____
Onset of Symptoms: _____ Describe 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: _____

FAMILY HISTORY:

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

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:

	Headache				Neck				Low Back		
No pain											**worst possible pain**
0	**1**	**(2)**	**3**	**4**	**(5)**	**6**	**7**	**(8)**	**9**	**10**	

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1 – What is your pain RIGHT NOW?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

2 – What is your TYPICAL or AVERAGE pain?

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

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

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

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

No pain											**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

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

Curis
FUNCTIONAL HEALTH
COUNSELING • CHIROPRACTIC • NUTRITION

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