Treatment Goals

___ I want to find the problem and do whatever it takes to fix it. I don't want this to affect my long-term health.

___ I want to know what the problem is and see what it will take to fix it. I am tired of hurting. I would like to fix it but money could be an issue.

___ I just want an adjustment so I feel better.

NEW PATIENT

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: _____

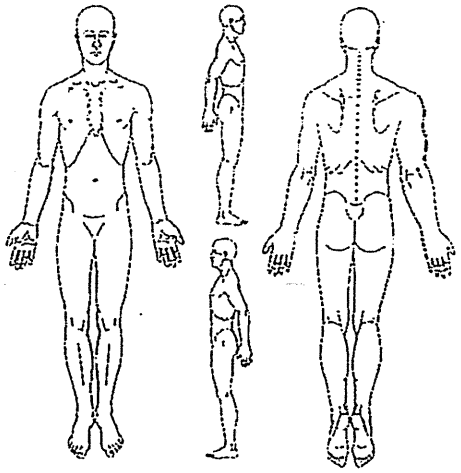
Relationship: _____ Ph. # _____

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 1---2---3---4---5---6---7---8---9---10
At its worst 1---2---3---4---5---6---7---8---9---10

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	☐	☐
Varicose Veins	☐	☐	being treated		

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: _____

_____

_____

_____

_____

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

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