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Name: _____ Date: _____

Age: _____ Date of Birth: _____ □ Male □ Female

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

E-mail: _____

Occupation: _____ Employer's Name: _____

• Single • Married • Partner • Divorced • Widowed

Spouse/Partner's Name: _____ # of Children: _____

In Case of an Emergency, who can we contact to give information?

Emergency Contact Name	Relationship	Telephone Number

We greatly appreciate referrals to our office. So we may thank them, who referred you to our office or how did you hear of our office? _____

Circle All *Current* Problems You Have:

Headaches
• Asthma
• Heart disorder
• TMJ pain
• Shoulder pain
• Migraines
• High blood pressure
• Stomach disorder
• Neck pain
• Hip pain
• Dizziness
• Chronic fatigue
• Gastric reflux
• Numbness in arms
• Leg pain
• Vertigo
• Chest pain
• Ulcers
• Numbness in hands
• Knee pain
• Nausea
• Nervousness
• Irritable bowel
• Mid back pain
• Arm pain
• Anxiety
• ADD/ADHD
• Constipation
• Low back pain
• Kidney problem
• Allergies
• Sinus problems
• Diarrhea
• Numbness in legs
• Thyroid problem
• Infertility
• Loss of energy
• Sleeping issues
• Numbness in feet
• Liver disease
• Depression
• Throat issues
• Bladder issues
• Sciatica
• Fibromyalgia
• Ear infections
• Epilepsy
• Menstrual issues
• Carpal tunnel
• Weight Gain
• _____

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Circle Any Conditions You Have or Have Had:

- Stroke
- Cancer
- Heart Disease
- Spinal Surgery
- Rheumatoid arthritis
- Scoliosis
- Diabetes
- Seizures
- Spinal Bone Fracture

Have you ever seen other doctors for these conditions? • Yes • No

If yes: • Chiropractor • Medical Doctor • Other _____

Name of Primary Care Physician: _____

Please list ALL surgeries	Year of Surgery

Do you have any metal, hardware, or implants? **YES** or **NO**

If yes, what kind and location? Plates Screws Rods Staples Other _____ Location _____

List all Prescriptions, Supplements, and OTCs	**Dosage**

Any allergies to medications, food, supplements, other? (e.g. Latex) _____

Family History	Diseases in the Family? (Arthritis, Heart Disease, Cancer, Diabetes, MS?)	Living or deceased?
Mother		
Father		
Brothers		
Sisters		
Grandmother(s)		
Grandfather(s)		

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Social History (Circle all that apply)

Smoker	Never	Occasionally	Daily	Former. Year quit _____
Alcohol	Never	Occasionally	Daily	Former
Caffeine	Never	Occasionally	Daily	Former
Recreational Drugs	Never	Occasionally	Daily	Former

Females Only: Do you believe, or are you pregnant? □ Yes □ No

By signing below, I acknowledge that I have filled out all the above accurately and to the best of my ability.

*Print Name*_____

*Signature*_____ *Date* _____

Permission to Treat a Minor Child
If this health profile is for a minor/child, please fill out and sign below.

*Name of Member Who is a Minor/Child:*_____
I authorize Curis Functional Health and any and all doctors and staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child as legally allowed. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority care is revoked or altered, I will immediately notify Curis.

*Guardian Signature*_____ *Relationship to Child*_____

*Date*_____

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History of Health Concerns
Please start at the top of your body and work your way down.

Symptom #1:

_____

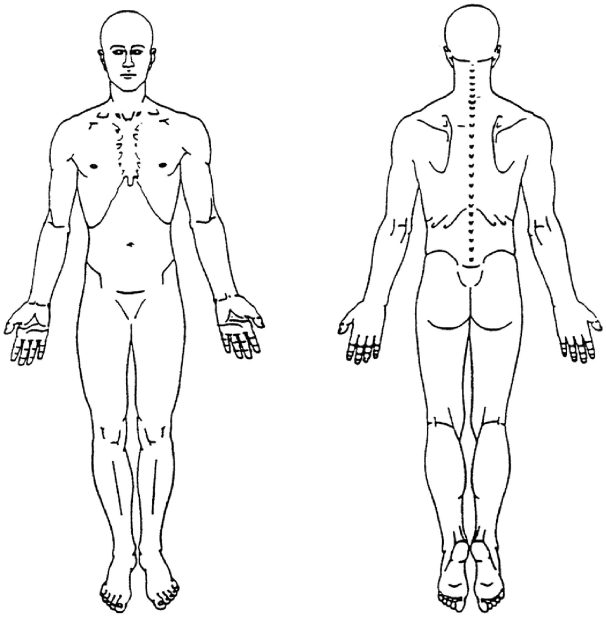
- On a scale of 1 – 10, 10 being the worst pain you've ever felt, what is the severity of your symptoms?
  1 2 3 4 5 6 7 8 9 10
- What percent of the time do you feel the symptom?
  0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- When did this episode begin? _____
- Did it begin: • Suddenly • Gradually
- Describe how it began: _____
- Have you had the symptoms in the past? • Yes • No
- If yes, when was the first time you've ever felt the symptom: _____
- What makes the symptoms worse? (circle all that apply)
  Sleeping • Walking • Lying • Sitting • Overuse • other_____
- What makes the symptom better? (circle all that apply)
  Rest • Ice • Heat • Chiropractic • Massage • other_____

Does the pain radiate? • Yes • No

- If yes, describe in detail where it radiates: _____
- Does the pain feel worse at a particular time of day?
  • Morning • Afternoon • Early evening • Late at night
  • Unchanged by time of day

Please mark on the diagram with the following letters to describe your symptoms:

R=Radiating **B**= Burning **D**=Dull **A**=Aching
S=Sharp/Shooting **T**=Tingling **N**=Numbness



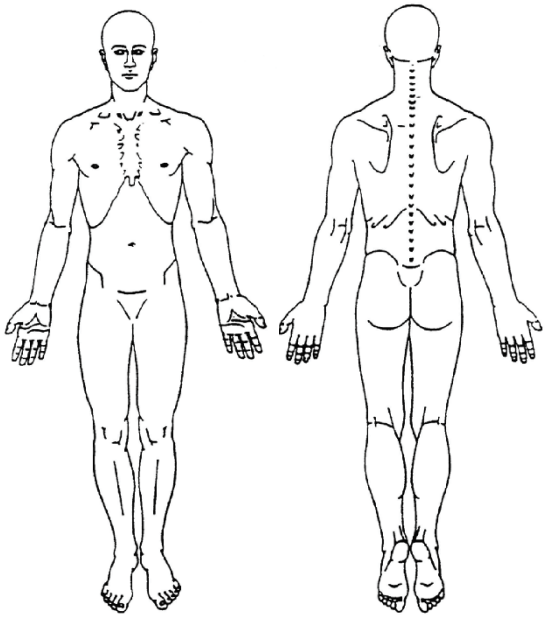
Symptom #2:

_____

- On a scale of 1 – 10, 10 being the worst pain you've ever felt, what is the severity of your symptoms?
  1 2 3 4 5 6 7 8 9 10
- What percent of the time do you feel the symptom?
- 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- When did this episode begin? _____
- Did it begin: • Suddenly • Gradually
- Describe how it began: _____
- Have you had the symptoms in the past? • Yes • No
- If yes, when was the first time you've ever felt the symptom: _____
- What makes the symptoms worse? (circle all that apply)
  Sleeping • Walking • Lying • Sitting • Overuse • other_____
- What makes the symptoms better? (circle all that apply)
  Rest • Ice • Heat • Chiropractic • Massage • other_____
- Does the pain radiate? • Yes • No
- If yes, describe in detail where it radiates: _____
- Does the pain feel worse at a particular time of day?
  • Morning • Afternoon • Early evening • Late at night
  • Unchanged by time of day

Please mark on the diagram with the following letters to describe your symptoms:

R=Radiating **B**= Burning **D**=Dull **A**=Aching
S=Sharp/Shooting **T**=Tingling **N**=Numbness



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History of Health Concerns
Please start at the top of your body and work your way down.

Symptom #3:

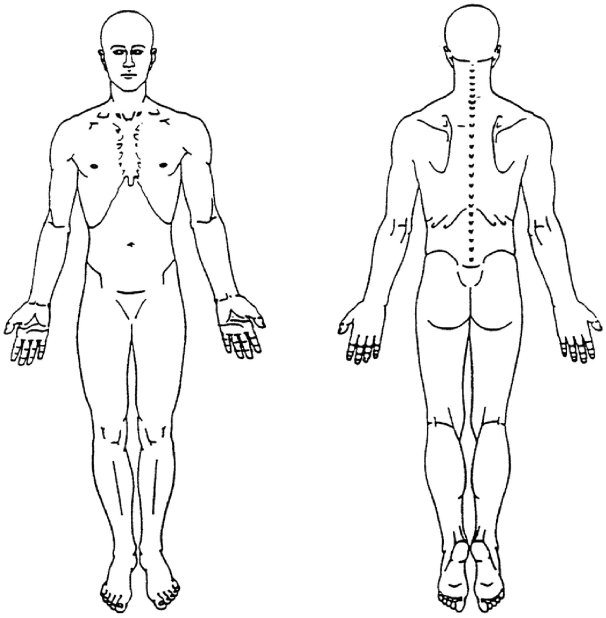
_____

- On a scale of 1 – 10, 10 being the worst pain you've ever felt, what is the severity of your symptoms?
  1 2 3 4 5 6 7 8 9 10
- What percent of the time do you feel the symptom?
- 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- When did this episode begin? _____
- Did it begin: • Suddenly • Gradually
- Describe how it began: _____
- Have you had the symptoms in the past? • Yes • No
- If yes, when was the first time you've ever felt the symptom: _____
- What makes the symptoms worse? (circle all that apply)
  Sleeping • Walking • Lying • Sitting • Overuse • other_____
- What makes the symptoms better? (circle all that apply)
  Rest • Ice • Heat • Chiropractic • Massage • other_____

Does the pain radiate? • Yes • No

- If yes, describe in detail where it radiates: _____
- Does the pain feel worse at a particular time of day?
  • Morning • Afternoon • Early evening • Late at night
  • Unchanged by time of day

Please mark on the diagram with the following letters to describe your symptoms:
R=Radiating **B**= Burning **D**=Dull **A**=Aching
S=Sharp/Shooting **T**=Tingling **N**=Numbness



Symptom #4:

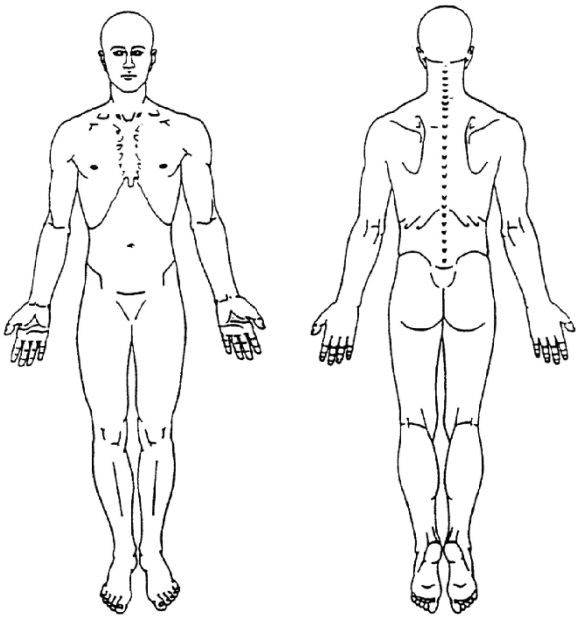
_____

- On a scale of 1 – 10, 10 being the worst pain you've ever felt, what is the severity of your symptoms?
  1 2 3 4 5 6 7 8 9 10
- What percent of the time do you feel the symptom?
- 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- When did this episode begin? _____
- Did it begin: • Suddenly • Gradually
- Describe how it began: _____
- Have you had the symptoms in the past? • Yes • No
- If yes, when was the first time you've ever felt the symptom: _____
- What makes the symptoms worse? (circle all that apply)
  Sleeping • Walking • Lying • Sitting • Overuse • other_____
- What makes the symptoms better? (circle all that apply)
  Rest • Ice • Heat • Chiropractic • Massage • other_____

Does the pain radiate? • Yes • No

- If yes, describe in detail where it radiates: _____
- Does the pain feel worse at a particular time of day?
  • Morning • Afternoon • Early evening • Late at night
  • Unchanged by time of day

Please mark on the diagram with the following letters to describe your symptoms:
R=Radiating **B**= Burning **D**=Dull **A**=Aching
S=Sharp/Shooting **T**=Tingling **N**=Numbness



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NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU,

PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT-DAY SITUATION.

SECTION 1 - PAIN INTENSITY

- ❑ **I have no pain at the moment.**
- ❑ **The pain is very mild at the moment.**
- ❑ **The pain is moderate at the moment.**
- ❑ **The pain is fairly severe at the moment.**
- ❑ **The pain is very severe at the moment.**
- ❑ **The pain is the worst imaginable at the moment.**

SECTION 2 - PERSONAL CARE

- ❑ **I can look after myself normally without causing extra pain.**
- ❑ **I can look after myself normally, but it causes extra pain.**
- ❑ **It is painful to look after myself, and I am slow and careful.**
- ❑ **I need some help but manage most of my personal care.**
- ❑ **I need help every day in most aspects of self -care.**
- ❑ **I do not get dressed. I wash with difficulty and stay in bed.**

SECTION 3 – LIFTING

- ❑ **I can lift heavy weights without causing extra pain.**
- ❑ **I can lift heavy weights, but it gives me extra pain.**
- ❑ **Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.**
- ❑ **Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.**
- ❑ **I can lift only very light weights.**
- ❑ **I cannot lift or carry anything at all.**

SECTION 4 – WORK

- ❑ **I can do as much work as I want.**
- ❑ **I can only do my usual work, but no more.**
- ❑ **I can do most of my usual work, but no more.**
- ❑ **I can't do my usual work.**
- ❑ **I can hardly do any work at all.**
- ❑ **I can't do any work at all.**

SECTION 5 – HEADACHES

- ❑ **I have no headaches at all.**
- ❑ **I have slight headaches that come infrequently.**
- ❑ **I have moderate headaches that come infrequently.**
- ❑ **I have moderate headaches that come frequently.**
- ❑ **I have severe headaches that come frequently.**
- ❑ **I have headaches almost all the time.**

SECTION 6 – CONCENTRATION

- ❑ **I can concentrate fully without difficulty.**
- ❑ **I can concentrate fully with slight difficulty.**
- ❑ **I have a fair degree of difficulty concentrating.**
- ❑ **I have a lot of difficulty concentrating.**
- ❑ **I have a great deal of difficulty concentrating.**
- ❑ **I can't concentrate at all.**

SECTION 7 – SLEEPING

- ❑ **I have no trouble sleeping.**
- ❑ **My sleep is slightly disturbed for less than 1 hour.**
- ❑ **My sleep is mildly disturbed for up to 1-2 hours.**
- ❑ **My sleep is moderately disturbed for up to 2-3 hours.**
- ❑ **My sleep is greatly disturbed for up to 3-5 hours.**
- ❑ **My sleep is completely disturbed for up to 5-7 hours.**

SECTION 8 – DRIVING

- ❑ **I can drive my car without neck pain.**
- ❑ **I can drive as long as I want with slight neck pain.**
- ❑ **I can drive as long as I want with moderate neck pain.**
- ❑ **I can't drive as long as I want because of moderate neck pain.**
- ❑ **I can hardly drive at all because of severe neck pain.**
- ❑ **I can't drive my care at all because of neck pain.**

SECTION 9 – READING

- ❑ **I can read as much as I want with no neck pain.**
- ❑ **I can read as much as I want with slight neck pain.**
- ❑ **I can read as much as I want with moderate neck pain.**
- ❑ **I can't read as much as I want because of moderate neck pain.**
- ❑ **I can't read as much as I want because of severe neck pain.**
- ❑ **I can't read at all.**

SECTION 10 – RECREATION

- ❑ **I have no neck pain during all recreational activities.**
- ❑ **I have some neck pain with all recreational activities.**
- ❑ **I have some neck pain with a few recreational activities.**
- ❑ **I have neck pain with most recreational activities.**
- ❑ **I can hardly do recreational activities due to neck pain.**
- ❑ **I can't do any recreational activities due to neck pain.**

PATIENT NAME _____ **DATE** _____

SCORE _____ **[50]**

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PATIENT NAME _____ **DATE** _____

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE ONE CHOICE, WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1 – Pain Intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

SECTION 2 – Personal Care

0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increases the pain, but I manage not to change my way of doing it.
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4. Because of the pain, I am unable to do some washing and dressing without help.
5. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it causes extra pain.
2. Pain prevents me from lifting heavy weight off the floor.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights, at the most.

SECTION 4 – Walking

0. Pain does not prevent me from walking any distance.
1. Pain prevents me from walking more than one mile.
2. Pain prevents me from walking more than ½ mile.
3. Pain prevents me from walking more than ¼ mile.
4. I can only walk while using a cane or on crutches.
5. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting

0. I can sit in any chair as long as I like without pain.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting for more than one hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting for more than ten minutes.
5. Pain prevents me from sitting at all.

SECTION 6 – Standing

0. I can stand as long as I want without pain.
1. I have some pain while standing, but it does not increase with time.
2. I cannot stand for longer than one hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than ten minutes without increasing pain.
5. I avoid standing, because it increases the pain straight away.

SECTION 7 – Sleeping

0. I get no pain in bed.
1. I get pain in bed, but it does not prevent me from sleeping well.
2. Because of pain, my normal night's sleep is reduced by less than one quarter.
3. Because of pain, my normal night's sleep is reduced by less than one-half.
4. Because of pain, my normal night's sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

SECTION 8 – Social Life

0. My social life is normal and give me no pain.
1. My social life is normal but increases the degree of my pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, My dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

SECTION 9 – Traveling

0. I get no pain while traveling.
1. I get some pain while traveling, but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
3. I get extra pain while traveling which compels me to seek alternative forms of travel.
4. Pain restricts all forms of travel.
5. Pain prevents all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain

0. My pain is rapidly getting better.
1. My pain fluctuates, but overall is definitely getting better.
2. My pain seems to be getting better, but my improvement is slow at present.
3. My pain is neither getting better nor worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening

(For Office Use Only)

SCORE: _____

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Health Insurance Portability and Accountability Act

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

To carry out Treatment, Payment, and Healthcare Operations

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

1. Curis' Privacy Notice has been made available 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, in certain circumstances, 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 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 prior notice, and all of my questions have been answered satisfactorily in a way I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Parent/Guardian Date Signed

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Curis Functional Health
Informed Consent

Please read this entire document before signing. Ask questions before you sign if anything needs to be clarified.

Based on my complaints and the history I have provided, I now authorize Curis Functional Health and its licensed doctors and assistants to examine 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 consent, I wish to rely on the Curis Functional Health doctors to make those decisions about my care based on the facts they believe are in my best interest.

As a part of the analysis, examination, and treatment, I am 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, radiographic studies and other procedures as necessary. The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments, and the different methods that may be recommended during my care have been explained and described to my satisfaction.

Based on current findings, I understand that the Practice doctors will discuss my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment, and the reasonable alternatives to the proposed treatment. They will also explain the cost of my proposed care (or provide me with a current fee schedule).

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 difficulties 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 severe complications, including stroke. Some patients will feel 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 I have a condition that would otherwise not come to the Doctor's attention, I understand that it is my responsibility to inform the Doctor before treatment.

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-inflammatories, muscle relaxants, painkillers, hospitalization, or surgery. If one chooses to use one of the above-noted "other treatment" options, one should be aware of the risks and benefits of such options, and I understand that I may wish to discuss these with my primary medical physician.

The risks and dangers of 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 for any contemplated procedures. I have discussed 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 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 results concerning 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	the Patient’s Printed Name
_____	_____
Signature of Doctor	Patient’s Signature