



Name:

Welcome to Curis Functional Health

At Curis Functional Health it is our mission to help you achieve all of your health goals and needs. Whether your main reason for seeing us is to get out of pain, increase your energy, lose weight or simply take your health to that next level we are here to provide you with the tools and knowledge to help you on your journey to optimal health.

The first step is to establish your current state of health and overall function of your body. In order for us to assess this and to understand the root cause of your symptoms, we will be taking you through a series of non-invasive examinations on your initial visit. This will include a full case history, nerve and muscle tests, postural analysis, functional movement assessment, heart rate variability and blood pressure.

On the day of your visit we ask that you wear clothing that you are comfortable moving in for the physical portion of the examination. We will be taking a postural photo of you so please don't wear bulky clothing or multiple layers. Ladies, if you have full tights or pantyhose on, we'll ask that you remove those. In addition to this, if you have any previous X-ray or MRI reports please bring these along on this visit for our records if we need to refer to these during the case history.

Simple steps to follow before your examination:

- No alcohol within 24 hours
- No exercise for 4 hours
- Avoid caffeine or food for 4 hours
- Consume 2-4 glasses of water within 2 hours

The initial assessment will take between 45-60 minutes so we ask that you allow sufficient time and if you have any concerns please speak to our reception before your visit if time is a constraint.

PLEASE NOTE:

We do enforce a 24 hour cancellation policy where the agreed upon initial exam fee will be charged if prior notice has not been given. If you are running late, you do run the risk of our Doctor being unable to see you. If this is the case, please contact our reception staff at 940-668-8755.



Name: _____

Please fill out our history forms *completely* and *accurately* to the best of your ability so that we can quickly get you on the road to health.

Date: _____ Social Security # _____

Name: _____
Last First M.I

Address _____

E-mail (Drs will communicate with you via email) _____

Cell Phone: _____ Home Phone: _____

Preferred method of communication: (Check one) Email ___ Text ___ Carrier Name _____

Please note that you are responsible for any charges incurred in receiving our communications. For example, if you provide a cell phone number as a method of contact, then you are responsible for any charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

Sex: ___ Male ___ Female Age: _____ Birthdate: _____

___ Married ___ Separated ___ Widowed ___ Divorced ___ Single ___ Partnered for ___ Yrs ___ Minor

Patient Employer/School _____

Address: _____

Phone: _____ Occupation: _____

Spouse's Name: _____ SS# _____ - _____ - _____ Phone: _____

Birthdate: _____ Spouse's Employer: _____

Emergency Contact: _____ Relationship: _____ Phone _____

ACCIDENT INFORMATION: Is condition due to an accident? Yes ___ No ___ Date of Accident _____

Type of Accident: Auto ___ Work ___ Home ___ Other ___



Name: _____

INSURANCE INFORMATION:

Even if you are here through a non-referral source such as a external workshop, we are happy to verify your insurance coverage. We will NEVER bill your insurance without your permission. It means we will verify your benefits and have that information prepared for you. Thank you for providing.

Who is responsible for this account? _____ Relationship to patient: _____

Insurance Co: _____ ID# _____

Subscriber Name _____ Birthdate: _____

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Jami West, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative Date

Please print name of above signature Relationship to Patient

X-Ray Consent

I hereby give my consent to West Functional Chiropractic and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant. I have read and understood all the above information.

Patient Signature Date

Financial Disclosure

West Functional Chiropractic provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. In the event that we are billing your insurance company and a check is mailed to you, you MUST bring the check into the office within 7 days so that we may properly credit your account. I have read and understood all the above information.



Name:

Patient Signature

Date

Approved HIPAA Contacts

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patient** or **legal guardian**.

If you would like to add additional contacts (other than the patient or legal guardian) that West Functional Chiropractic is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like West Functional Chiropractic to list as your **Emergency Contact** in the event an emergency situation was to take place at our office.

Contact Name

Relationship to Patient

Contact Phone Number

Billing Account Information

Medical Condition Information

Emergency Contact

Contact Name

Relationship to Patient

Contact Phone Number

Billing Account Information

Medical Condition Information

Emergency Contact

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

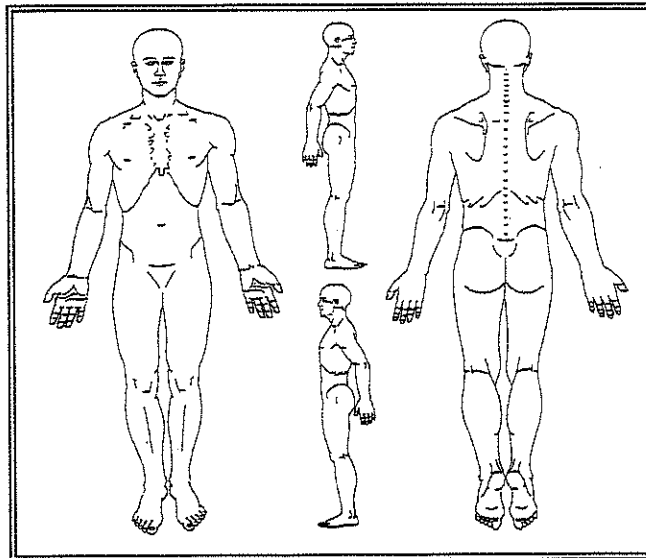
Name: _____

We appreciate you choosing our office. Is there anyone we can thank for referring you? _____

Please indicate the main reason you are seeing us today: _____

If you are seeing us for a pain related issue, USE THE SYMBOLS to show the type of pain you feel in each location.

XXXXXXXXX // // // // // // // O O O O O O O O O S S S S S - - - - -
DULL/ACHY SHARP/STABBING NUMBNESS/TINGLING STIFF/TIGHT BURNING



Using the pain scale below, CIRCLE the pain level you experience when your problem is at its very worst:

- 0 = **No Pain.** No Discomfort
- 1 = **Minimal Discomfort.** Minor stiffness or tightness.
- 2 = **Discomfort.** Stiff, tight, sore. Muscle fatigue.
- 3 = **Minimal Pain.** More than just sore. Uncomfortable.
- 4 = **Mild Pain.** Noticeable pain but tolerable.
- 5 = **Moderate Pain.** Aggravating. Still allows movement.
- 6 = **Strong Pain.** Quite aggravating. Movement slightly limited.
- 7 = **Very Strong Pain.** Very aggravating. Movement definitely limited.
- 8 = **Very, Very Strong Pain.** Extremely aggravating. Movement very limited.
- 9 = **Severe Pain.** Brings tears. Almost impossible to move.
- 10 = **Excruciating Pain.** Agony. Unbearable. Cannot move. ER.

Is there any radiating pain into the arms or legs? _____ Is there any numbness or tingling? _____

How often do you experience your problem? (Please indicate for each of the body location if applicable)

Constant (75 – 100% of the time) _____
 Frequent (50 – 75% of the time) _____
 Occasional (25 – 50% of the time) _____
 Intermittent (0 – 25% of the time) _____



Name: _____

List any MD's or Chiropractors you've already seen for this problem: _____

What tests have you already had for this problem? X-rays MRI C.T. Scan Myelogram EMG/NCV
 None Other _____

What makes your problem worse? Sitting Standing Changing Position Walking Bending Lifting Twisting
 Reaching Driving Sleeping Sneeze/Cough Computer Work Telephone Going From Sit To Stand
 Other _____

PAST MEDICAL HISTORY

Please list any significant conditions that you've been diagnosed with or been treated for over the course of your life:

Please list any surgeries you have had over the course of your life: _____

MEDICATIONS & ALLERGIES

Are you allergic to any medications? Yes No If yes, please list: _____

List any medications, herbs or supplements you are taking and the reason for their use:

FAMILY HISTORY

Mother: Living Deceased List any medical problems: _____

Father: Living Deceased List any medical problems: _____

List any problems common in your family: Cancer Diabetes Heart disease High blood pressure Stroke
 Arthritis Scoliosis Thyroid disease Osteoporosis _____

SOCIAL HISTORY

Marital status: Married Single Divorced Common Law Engaged Widowed

Do you have any children? Yes No If yes, how many? _____

Do you drink alcohol? Yes No If yes, how much & how often? _____

Do you smoke? Yes No If yes, how much, how often & how long? _____

Are you currently employed? Yes No If yes, what is your occupation? _____

Who is your current employer? _____ How long have you been at this job? _____

What do you do most of the day in your job postures, positions and repetitive movements: _____

On a scale of 0 to 10 with 0=Worst and 10=Best, rate how well you think you are doing with the following:

Exercise _____ Sleep _____ Diet _____ Stress Level _____ Water Intake _____ Energy Level _____ = _____



Name: _____

REVIEW OF SYSTEMS

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days:
 0 = Never have this symptom

- 1 = Occasionally have this symptom, effect not severe
- 2 = Occasionally have this symptom, effect is severe
- 3 = Frequently have this symptom, effect not severe
- 4 = Frequently have this symptom, effect is severe

Head: <input type="checkbox"/> Headaches <input type="checkbox"/> Faintness <input type="checkbox"/> Dizziness <input type="checkbox"/> Insomnia	Energy/Activity: <input type="checkbox"/> Fatigue/Sluggishness <input type="checkbox"/> Apathy/Lethargy <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Restlessness	Lungs: <input type="checkbox"/> Chest Congestion <input type="checkbox"/> Asthma, Bronchitis <input type="checkbox"/> Shortness Of Breath <input type="checkbox"/> Difficulty Breathing
Eyes: <input type="checkbox"/> Watery or Itchy Eyes <input type="checkbox"/> Swollen, Red or Sticky Eyelids <input type="checkbox"/> Bags or Dark Circles Under Eyes <input type="checkbox"/> Blurred or Tunnel Vision (not including near or far sightedness)	Weight: <input type="checkbox"/> Binge Eating/Drinking <input type="checkbox"/> Craving Certain Foods <input type="checkbox"/> Excessive Weight <input type="checkbox"/> Compulsive Eating <input type="checkbox"/> Water Retention <input type="checkbox"/> Underweight	Heart: <input type="checkbox"/> Irregular or Skipped Heartbeat <input type="checkbox"/> Rapid or Pounding Heartbeat <input type="checkbox"/> Chest Pain
Ears: <input type="checkbox"/> Itchy Ears <input type="checkbox"/> Earaches, Ear Infections <input type="checkbox"/> Drainage From Ear <input type="checkbox"/> Ringing in Ears, Hearing Loss	Emotions: <input type="checkbox"/> Mood Swings <input type="checkbox"/> Anxiety/Fear/Nervousness <input type="checkbox"/> Anger/Irritability/Aggressiveness <input type="checkbox"/> Depression	Digestive Tract: <input type="checkbox"/> Nausea, Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloating Feeling <input type="checkbox"/> Belching, Passing Gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Intestinal/Stomach Pain
Nose: <input type="checkbox"/> Stuffy Nose <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Hay Fever <input type="checkbox"/> Sneezing Attacks <input type="checkbox"/> Excessive Mucus Formation	Mind: <input type="checkbox"/> Poor Memory <input type="checkbox"/> Confusion, Poor Comprehension <input type="checkbox"/> Poor Concentration <input type="checkbox"/> Poor Physical Condition <input type="checkbox"/> Difficulty Making Decisions <input type="checkbox"/> Stuttering or Stammering <input type="checkbox"/> Slurred speech	Other: <input type="checkbox"/> Frequent Illness <input type="checkbox"/> Frequent or Urgent Urination <input type="checkbox"/> Genital Itch or Discharge
Mouth & Throat: <input type="checkbox"/> Chronic Coughing <input type="checkbox"/> Frequent Need to Clear Throat <input type="checkbox"/> Sore Throat, Hoarseness <input type="checkbox"/> Swollen or Discolored Tongue <input type="checkbox"/> Canker Sores		Grand Total:
Skin: <input type="checkbox"/> Acne <input type="checkbox"/> Hives, Rashes, Dry Skin <input type="checkbox"/> Hair Loss <input type="checkbox"/> Flushing, Hot Flashes <input type="checkbox"/> Excessive Sweating	Joints/Muscles: <input type="checkbox"/> Pain or Aches in Joints <input type="checkbox"/> Arthritis <input type="checkbox"/> Stiffness or Limited Movement <input type="checkbox"/> Pain or Aches in Muscles <input type="checkbox"/> Weakness or Fatigued Muscles	



Name: _____

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ Last Name: _____

Email address: _____ @ _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

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 Signature: _____ Date: _____

For office use only			
Height: _____	Weight: _____	Blood Pressure: _____ / _____	



Name:

NOTICE OF APPOINTMENT CANCELLATION/NO-SHOW POLICY

We would like to inform you of our policy regarding missed appointments and same-day cancellations effective immediately, this refers to all appointments made in the office: Chiropractic, Personal Training, Massage and Nutrition. We require a 24-hour notice of cancellations **BY PHONE** during business hours. We will **NOT** accept these cancellations thru email, voicemail or any other social media. Any patient who misses a scheduled appointment without notifying the office will be subject to a no-show fee.

Due to an increased number of no-show visits, there will be a charge to you (not your insurance company) for a missed appointment. A \$30 fee will be assessed for routine office visits, \$30 for missed therapies and trainings, and \$40 for missed massage appointments. These fees are subject to change without prior notice.

At this time, patients who provide advanced notice for missed appointments will **not** be assessed a fee. A no call/no show to your scheduled appointment **WILL** result in a 100% fee, out of which our staff is paid.

We understand extenuating circumstances may prevent you from being present at your appointment but increasing numbers of missed appointments are negatively impacting our ability to provide excellent care to our patients.

After 3 no call/no show visits, you will be dismissed from the practice.

If you have any questions regarding this policy, please do not hesitate to contact our office at 940-668-8755. It is our hope that this policy will reduce wait times and increase efficiency at our office so that we can better serve you with safe, quality healthcare.

Please sign and date below:

Signature

Date

Printed Name

DOB



Name: _____

Curis Functional Health is an Integrated Wellness Center. What does Integrated mean? It means Doctors of Chiropractic, Mental Health Professionals & Dietitians / Nutritionists all working together to provide a greater spectrum of services. This model allows you the convenience of a multi-disciplinary approach without the headache of juggling multiple doctors at multiple locations on multiple schedules. You shouldn't have to put off dealing with one problem while you deal with another. You deserve quick, concise, expert patient care for all of your needs, and you deserve all of those experts working together to know what each other are doing for you and why.

HELP US HELP YOU AND THE ONES YOU LOVE

Here is a list of some of the more common problems we can help you with at Curis.

Please check those that you or your immediate family suffer from:

X = you F= family member

- | | |
|---|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Anxiety, Stress, Worry, or Panicked |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Trouble Coping After Difficult Life Changes |
| <input type="checkbox"/> General Chronic Pain | <input type="checkbox"/> Feeling Down, Depressed, Apathetic |
| <input type="checkbox"/> Chronic Arthritis | <input type="checkbox"/> Chronic Fatigue, Difficulty Sleeping / Insomnia |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Trouble in Your Relationships or Parenting Problems |
| <input type="checkbox"/> Bulging or Herniated Disc | <input type="checkbox"/> History of Trauma, Fear, Avoidance |
| <input type="checkbox"/> Neuropathy (Arms or Legs) | <input type="checkbox"/> Negative Thinking, Difficulty Controlling Thinking |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Difficulty Managing Weight |
| <input type="checkbox"/> Knee Pain or Degeneration | <input type="checkbox"/> Emotional Eating / Overeating |
| <input type="checkbox"/> Shoulder Pain or Degeneration | <input type="checkbox"/> Diabetes / Pre-Diabetes |
| <input type="checkbox"/> Rolled Shoulders or "Humpback" | <input type="checkbox"/> Lack of Exercise, Physically Unfit |
| <input type="checkbox"/> Trigger Points (Knots or Spasms in your Muscles) | <input type="checkbox"/> Other Problems that haven't previously responded to treatment? Please List: |
| <input type="checkbox"/> Carpal Tunnel Symptoms | _____ |
| <input type="checkbox"/> Headaches | _____ |

Name: _____ Phone # _____ Email: _____

Thank You For Your Trust!

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, 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 other procedures that may be recommended during the course of 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 provided 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 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 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-inflammatory, muscle relaxants, and pain-killers, hospitalization or surgery. If one chooses to use one of the above noted "other treatment" options, one should be aware that there are 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 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. I 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 I 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