CURA Integrative
HEALTH CARE

Confidential Patient Information (Please Print)

Personal Information

Full Name_____ Date_____

Birth Date_____ Height_____ Weight_____ SSN_____

Marital Status: M S W D Occupation_____ Smoker? Y N

Mailing Address: Street: _____ City:_____ State:_____

Zip:_____Home Phone (____)_____Cell Phone (____)_____

Primary Email Address_____

Spouse/Guardian Name _____ Name/Ages of Children_____

Age_____ Pregnant?_____ EDD:_____ List and hobbies you enjoy_____

Who may we thank for referring you?_____

Emergency Contact Name/Number_____

Primary Care Physician Name/Number_____

Would you like an email reminder about your appointments? Y N

Would you like Cura to file out of network insurance claims for you? Y N

ADDRESSING WHAT BROUGHT YOU INTO THIS OFFICE:

If you have No symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General Health History" section.

I. HEALTH CONCERNS

List health concerns according to their severity.	Rate of Severity: 1-10, 10 being the worst	When did this start?	If you have had this condition before, When?	Did this problem begin with an injury, explain.	% of time the pain is present.	What have you done to relieve the pain?	What makes the pain worse?

Has anyone in your family had any of the above listed complaints? (Please explain):

_____

_____

Other Doctors Seen for above listed conditions:

1. Name/General location:_____ When:_____
   What did they say was wrong?_____
   What did they do?_____
2. Name/General location:_____ When:_____
   What did they say was wrong?_____
   What did they do?_____

Have you ever been "forced" or "felt the need" to make "positive" changes in your life due to this pain, illness, condition, etc? (i.e. eat better, less alcohol or drugs, meditate, reduce stress, less destructive sports, exercise more, etc.)
If so, explain:_____

_____

Is this condition interfering with your: work_____ sleep_____daily routine_____sports/exercise_____
other_____ explain_____

Are you unable to do certain activities that you would like to do because of this pain/condition? (i.e. sports, walk, pickup grandchildren, etc. If so, what activities?_____

_____

General Health History:

Have you ever had surgery? Please include all surgeries:

1. Type:_____When:_____Doctor:_____
2. Type:_____When:_____Doctor:_____
3. Type:_____When:_____Doctor:_____
4. Type:_____When:_____Doctor:_____

All Accidents and/or injuries: auto, work related, or other:

1. Type:_____When:_____Hospitalized: Y_____ N_____
2. Type:_____When:_____Hospitalized: Y_____ N_____
3. Type:_____When:_____Hospitalized: Y_____ N_____
4. Type:_____When:_____Hospitalized: Y_____ N_____

Have you ever had x-rays taken?_____When?_____Area of body?_____Why?_____

Do you wear orthotics or heel lifts? Y_____ N_____

Current Medications/Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription or non):

_____

_____

_____

Please list any nutritional supplements, vitamins, probiotics, homeopathic remedies you presently take and why:

_____

_____

_____

Are you interested in knowing more about how your nutrition affects your overall health and well-being?

Y_____ N_____ Maybe_____

If dietary changes are indicated, would you be willing to make changes? Y_____ N_____ Maybe_____

Diet

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D-Consume this daily W-Consume this weekly M-Consume this monthy O-Do not consume this

Alcohol_____	Eggs_____	Fasting_____	Artificial Sweetener_____
Tobacco_____	Fruit_____	Diet Food_____	Fried Foods_____
Coffee_____	Beef_____	Refined Sugar_____	Raw vegetables_____
Soda_____	Poultry_____	Fish_____	Whole grains_____
Cooked or canned Vegetables_____		Seafood_____	Dairy_____
Gluten_____	Organic foods_____		

How much water do you drink per day?_____

Past Health History

Mark the following conditions you may have, or have now(+have had, -have now, leave blank if never had)

___ Allergy ___ Diarrhea ___ Measles ___ Rheumatic Fever ___ Alcoholism ___ Eczema

___ Miscarriage ___ Stroke ___ Anemia ___ Multiple Sclerosis ___ HIV(Aids) ___ Gout

___ Neuritis ___ Mumps ___ Emphysema___ Sinus Trouble ___ Arthritis ___ Asthma

___ Nervousness ___ Ulcers ___ Cancer ___ Heart Disease ___ Depression ___ Convulsions

___ Malaria ___ Pleurisy ___ Constipation ___ High Blood Pressure ___ Pneumonia ___ Cold Sores

___ Polio ___ Neck Pain ___ Migraines ___ Gall Bladder Problem ___ Headaches ___ Back Pain

___ Ringing in Ears ___ Epilepsy ___ Low Blood Sugar ___ Menstrual Cramps ___ Arteriosclerosis

___ Thyroid Problems ___ Venereal Disease ___ Whooping Cough ___ Other(Please explain)

_____

_____

_____

Please list your top three stresses in each category:

1. Physical stress (falls, accidents, work postures, etc.)
    a. _____
    b. _____
    c. _____
2. Bio-chemical stress (smoke, unhealthy food, missed meals, low water intake, drugs/alcohol, etc.)
    a. _____
    b. _____
    c. _____
3. Psychological stress (work, relationships, finances, self-esteem, etc.)
    a. _____
    b. _____
    c. _____

How would you grade your physical health?

Excellent____ Good____ Fair____ Poor___ Getting Better____ Getting Worse____

How would you grade your emotional/mental health?

Excellent____ Good____ Fair____ Poor___ Getting Better____ Getting Worse____

Is there anything else which may help to better understand you, which has not been discussed?

_____

_____

_____

INSURANCE & PAYMENT INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in out-of-network collection from the insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. If balance becomes delinquent and suit is filed, I agree to pay all collection costs, and attorney's fees in addition to above fees. I also understand that all payments rendered are due at the time of service. All fees for professional services rendered to me are immediately due and payable.

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize the doctor and whomever she may designate as his assistant to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to the family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, worker's compensation carriers, welfare funds or the patient's employer. My signature also authorizes any insurance benefits to be paid on my behalf to the provider at Cura Integrative Health Care. I understand that the doctor is prohibited from selling any part of my medical record.

I, _____, have read and understand the above insurance and consent statements.

Patient Signature_____Date_____

NUTRITIONAL INFORMED CONSENT

I hereby attest to the following:

I fully understand that the Nutritional Consult I am seeking in this office is not a physician and I am not consulting for medical, diagnostic, or treatment procedures. The services provided are at all times restricted to helping me gain a better understanding of my degree of health, not disease, so that I may have a greater sense of awareness of my health and wellbeing.

I understand that and course of care pertains to the whole body concept of nutrition and does not relate in the context of a particular ailment of medical condition. There is no diagnosing, treating, prescribing of medicines or drugs for the treatment of disease, or any act that will constitute the practice of medicine in this state.

According to the Federal Food, Drug and Cosmetic Association, as amended, Section 201 (g) (1), the term “Drug” is defined to mean:

> “Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.”

A vitamin is not a drug. Neither is a mineral, trace element, amino acid, essential oil, herb, or homeopathic remedy.

Although a vitamin, mineral, trace element, amino acid, essential oil, herb, or homeopathic remedy may have an effect on any disease process or symptoms, this does not mean that it can me misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary guidance is not intended as a primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional Counseling, vitamin supplementations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient’s diet in order to supply good, proper nutrition that will support the physiological and bio-mechanical processes of the human body. Nutritional intake may enhance the stabilization of the eight chemical components of the vertebral subluxation complex and the energy movement in Traditional Chinese Medicine. These homeopathic, whole food supplements are not medications and do not have the shelf life of pharmaceuticals. Due to this decreased shelf life and also to sensitivity of supplements to temperature and sunlight, there will be no returns or refunds on supplements purchased.

Signed: _____ Date: _____

Print Name: _____

Cura Integrative
HEALTH CARE

Name_____ Date _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

- How would you rate your current physical health? (Please Circle.)

  Poor Unsatisfactory Satisfactory Good Very Good

  Please list any specific health problems you are currently experiencing:

  _____

  _____

- How would you rate your current sleeping habits? (Please Circle.)

  Poor Unsatisfactory Satisfactory Good Very Good

  Please list any specific sleep problems you are currently experiencing:

  _____

- How many times per week do you generally exercise? _____

  What types of exercise do you participate in? _____

  _____

- Please list any difficulties you experience with your appetite or eating patterns:

  _____

- Are you currently experiencing overwhelming sadness, grief, or depression?

  _____NO _____YES

  If yes, for approximately how long?_____

- Are you currently experiencing anxiety, panic attacks, or have any phobias?

  _____NO _____YES

  If yes, for approximately how long?_____

- Are you currently experiencing chronic pain?

  _____NO _____YES

  If yes, please describe._____

- Do you drink alcohol more than once a week? _____NO _____YES
- Are you currently in a romantic relationship?

  _____NO _____YES

  If yes, for approximately how long?_____

  On a scale of 1-10, how would you rate your relationship?_____
- What significant life changes or stressful events have you experienced recently?

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (grandmother, father, uncle, sister, etc.)

_____Alcohol/Substance Abuse
_____Anxiety
_____Bipolar Disorder
_____Depression
_____Domestic Violence
_____Eating Disorders
_____Obesity
_____Obsessive Compulsive Behavior
_____Schizophrenia
_____Suicide Attempts

ADDITIONAL INFORMATION:

Have you previously received any mental health services (psychotherapy, psychiatric services?)

_____NO _____YES Previous Therapist/Practitioner_____

Are you currently taking any prescription medication?

_____NO _____YES Please list:_____

Have you ever been prescribed anti-depressant or other psychiatric medication?

_____NO _____YES Please list and provide date:_____

Is there anything about your health or well-being that concerns you?

_____

_____