Confidential Patient Information (Please Print)

Personal Information

Full Name____ Date______________

Birth Date__________________ Height____________ Weight____________ SSN_____________________

Marital Status: M S W D Occupation____

Mailing Address: Street: ___________________________________ City:___________________ State:_______

Zip:_________________Home Phone (_____)_______________________Cell Phone (_____)__________________

Primary Email Address____

Spouse/Guardian Name____

Age__________ 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? ☐ Yes ☐ No

Would you like Cura to file out of network insurance claims for you? ☐ Yes ☐ No

Female Health History:

Do you menstruate? ☐ Yes ☐ No

If yes, Date that your last period began: ____________________

Current day of cycle:_______________________

At what age did you have your first period?_________________

My cycles are: ☐ Regular ☐ Irregular

Average number of days of cycle: _________________________

Average number of days that you have bleeding:_____________

Average Ovulation Day:______________

Please select appropriate response:

Do you pass clots with your periods?	☐ Yes	☐ No
Do you have pain with your periods?	☐ Yes	☐ No
Do you have pain during/after intercourse?	☐ Yes	☐ No
Have you ever missed school or work due to pain or excessive bleeding?	☐ Yes	☐ No
Do you have bleeding/spotting between menstrual periods?	☐ Yes	☐ No
Do you have bleeding/spotting after intercourse?	☐ Yes	☐ No
Have you ever used contraception?	☐ Yes	☐ No
Have you ever had an abnormal Pap smear?	☐ Yes	☐ No

Have you ever been diagnosed with:

- ☐ Polycystic Ovary Syndrome(PCOS)
- ☐ Endometriosis
- ☐ Uterine Fibroid(s)
- ☐ Endometrial Polp(s)
- ☐ Ovarian Cyst(s)
- ☐ Sexually Transmitted Infection
- ☐ Pelvic Inflammatory Disease (PID)

Sexual History

Is your partner: ☐ Male ☐ Female

How many months have you been trying to get pregnant? __________________

How many months have you had intercourse without contraception?__________

Have you used over the counter ovulation kits to time intercourse? ☐ Yes ☐ No

If yes, do you have a positive ovulation? ☐ Yes ☐ No

Do you use lubricants during intercourse? ☐ Yes ☐ No

Pregnancy History

Please list all previous pregnancies.

☐ I have never been pregnant

MM/YYYY	Duration of Pregnancy	If Delivered, Method of Delivery	If Miscarriage, was a procedure required?	If Live Birth, Sex, Weight	Complications

History of Fertility Therapy

Have you been treated for infertility previously? ☐ Yes ☐ No

If yes, who was your physician?____

What cause of infertility was diagnosed? If unexplained, please indicate here. ____________________

____

Please list any medications/drugs, nutritional supplements, vitamins, etc. for infertility? Please list all that apply:________

____

____

Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:

- ☐ 'Day 3' FSH, LH, Estradiol Date: _________ Results:______________________
- ☐ AMH (anti-Mullerian hormone) Date: _________ Results:______________________
- ☐ Hysterosalpingogram Date: _________ Results:______________________
- ☐ Sonohysterogram Date: _________ Results:______________________
- ☐ Laparoscopy, Hysteroscopy Date: _________ Results:______________________
- ☐ Thyroid tests Date: _________ Results:______________________
- ☐ Chromosomes Date: _________ Results:______________________
- ☐ Genetic Screening Date: _________ Results:______________________
- ☐ MTHFR Testing Date: _________ Results:______________________

Have you ever undergone Intrauterine Insemination (IUI)? ☐ Yes ☐ No

If yes, ☐ partner ☐ donor sperm _______Number of IUI Medication? ☐ Yes ☐ No

Have you ever undergone In Vitro Fertilization (IVF)? ☐ Yes ☐ No

If yes, ☐ partner ☐ donor sperm _______Number of IVF

Surgical 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:_____________________

Have you ever had x-rays taken?______________When?_______________Area of body?_________Why?________________

General Health

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?_____________________________

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

____

____

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

____

____

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?
____
____
____

Male Health History:

Number of pregnancies conceived with current partner: ____________________

Number of pregnancies conceived with previous partners:___________________

Do you or have you ever used (check all that apply):

- ☐ Alcohol
  - If yes, how many drinks per week? Wine_______ Beer________ Cocktails_____
- ☐ Cigarette Use
  - If yes, the average smoked daily in the last 3 months:__________
  - Number of years of smoking:__________
- ☐ Recreational Drugs
  - Specify:____________________________

Have your genitals ever been exposed to excessive heat (i.e. hot tub, laptop, etc)? ☐ Yes ☐ No

Have you had any serious injuries to your genitals? ☐ Yes ☐ No

Have you had any infections of your penis, testicles, or prostate gland? ☐ Yes ☐ No

Do you or have you ever had any difficulties with erection? ☐ Yes ☐ No

Do you or have you ever had any difficulties with ejaculation? ☐ Yes ☐ No

Do your hobbies include bike riding or other activities that could affect your genitals? ☐ Yes ☐ No

Have you ever had a semen analysis performed? ☐ Yes ☐ No

If yes, please provide information below.

Date:________________Results: Volume _______Count________Motility_______Morphology__________

Date:________________Results: Volume _______Count________Motility_______Morphology__________

Date:________________Results: Volume _______Count________Motility_______Morphology__________

Do you have any medical concerns unrelated to fertility? ☐ Yes ☐ No

If yes, Please describe. ____

____

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: ____

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?

____

____