Premier Health Care 8970 Watson Rd. Crestwood, MO 63119 (314) 647-1384

Cranial Facial Release (CFR) Health History Intake Form

Last Name ______________________ First Name ______________________

Address ____

City ______________________ State/Zip Code ______________________

Phone # ______________________ Alternate # ______________________

Email ______________________________ SS# ______________________

Date of Birth ______________________ Sex: Male _____ Female _____

Occupation ____

Marital Status: M D S W Spouse's Name ______________________

Primary Doctor ______________________ PCP # ______________________

How did you hear about us? ______________________________

Health/History Information

Have you had previous Chiropractic care? Yes No If so, when and for what condition?____________

____

How was your experience? ______________________________

Have you had previous CFR/NCR/BNS/Cranial Balloon Therapy before? Yes No If so, when, by whom and for what condition? ______________________________

How was your experience? ______________________________

Dental History

Braces Root Canals Extractions Current Dental Issues Dental Surgeries (Please Circle all that apply)

Are you allergic to latex? Yes No **Are you absolutely positive?** Yes No

Patient Questionnaire

What is your primary complaint and rate of severity? (1 to 10 with 10 being the worst) ____________

____

How long have you had these symptoms? Approximate onset? ______________________

Do you have any other complaints? ______________________________

Have you ever had any head, facial, jaw trauma or surgery? ______________________

Do you ever have difficulty breathing out of your nose? ______________________

Do you have any family members with similar symptoms? ______________________________

What have you done for treatment of these symptom? Please start from the beginning and include the number of doctors seen and any drugs taken. Any surgeries? ______________________________

____

Have your symptoms changed since the onset – have they gotten better or worse? Explain __________

____

____

____

To what extent have these health problems interfered with your normal life? ________________

____

How did you hear about Cranial Facial Release Technique (CFR)? ______________________

____

How are you hoping CFR will help you? What are your treatment goals? __________________

____

Other Conditions (Circle all that apply)

Headache	Depression	Dental Surgery	Difficulty breathing	Neck Pain
Braces	Memory Loss	Stiff Neck	Ringing in Ears	Substance Abuse
Anxiety	Fingers Numb	Back Pain	Toes Numb	Pins & Needles legs/Feet
Dizziness	Facial Pain	Jaw Pain	Seizures	Pins & Needles Arms/Hands
Fainting	Jaw Clicking	Sinusitis	Loss of Balance	Lightheadedness
Snoring	Loss of Smell	Fatigue	Teeth Clenching	Sensitive to Light
Sleep Apnea	Loss of taste	Chest Pain	Cold Feet	Cold Hands
Concussions	Addictions	Teeth Grinding	Tingling/Numbness in Face	

IF YOU ARE ALLERGIC TO LATEX YOU CANNOT UNDERGO THIS TREATMENT. YOUR INITIALS HERE ATTEST TO THE FACT THAT YOU ARE NOT ALLERGIC TO LATEX AND THAT YOU TAKE FULL RESPONSIBILITY FOR ANY ADVERSE REACTIONS TO LATEX. ____________ **Initials**

Signature of Patient ______________________________ Date __________

Signature of Doctor ______________________________ Date __________

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Informed Consent for Chiropractic & Cranial Facial Release (CFR)

CFR Treatment: CFR is an intra-nasal "balloon assisted" cranial adjusting technique where the doctor uses tiny balloons that are carefully inserted in the nose – specifically the naso-pharynx, which is opening between the nose and the throat. The balloon is the quickly inflated and bubbles into the throat – this is the desired result. The balloon is then quickly deflated and removed. The entire procedure lasts about 3-5 seconds. It is not particularly painful, but not exactly comfortable. You will experience and increased amount of pressure in your face – not your nose – straight back in your face that is somewhat uncomfortable. Then the balloon expands back through your nasal passageway and into your throat. The pressure is then released and the balloon is removed.

Often times you will experience audible "cracking sounds" in your skull as the balloon expands and the cranial sutures unlock – this is normal. Other possible occurrences when undergoing CFR treatment are bloody noses, excessive bleeding, congestion, infection, clogged nose, clogged ears, sore throat, trauma to the throat and soft palate, headaches, facial pain, facial paralysis, facial and/or nasal fracture, loss of hearing, visual disturbance, loss of taste, loss of smell, pain across your teeth or roof of your mouth, fatigue, malaise, anxiety, allergic reactions, emotional distress, mild shock, and in one case even death (of an infant who suffocated on the balloon).

Other occurrences that may arise are the balloon may temporarily NOT deflate causing a momentary blockage of the airway, interfering with your ability to breathe causing you to feel like you are suffocating. Occasionally the balloon may separate from the inflator device and could possibly get lost in the nasal passageway between the nose and throat. These are rare occurrences but are an inherent risk of the technique. Although these circumstance rarely occur, we have encountered them in the past and have specific protocols in place.

Cranial Facial Release treatment is safe and the majority of patients experience relief from their targeted symptoms. *There is no guarantee that this specialized treatment will work for you.* It is important to understand that **the primary objective of CFR is to mobilize the cranial bones, unlock cranial fixations, correct cranial aberrations, and optimize brain function.** *It is not directed at the treatment of any one specific symptom, disease, or disorder, but often works when other methods have failed.*

Please see "List of Conditions that Respond Favorably to CFR Treatment".

Also important to understand that it usually takes 3-4 series of CFR treatments before you experience the full benefits of this technique – the results are exponential as you go.

Chiropractic spinal adjusting and conventional cranial adjusting techniques are also part of CFR treatment, in where the doctor will use his/her hands or a mechanical devices to manipulate your spine or other targeted areas. The doctor may occasionally need to wear surgical glove and enter your mouth or oral cavity.

IF YOU ARE ALLERGIC TO LATEX, PLEASE INFORM THE DOCTOR BEFORE UNDERGOING CFR TECHNIQUE. YOU MAY NOT BE A CANDIDATE FOR THIS SPECIALIZED PROCEDURE.

When your spine or cranium is adjusted, you may feel or hear a "click" or "pop" and possibly feel movement. Your treatment might also include specific exercise, Trigger Point therapy, Cold Laser therapy, Acuscope and Myoplulse therapy, Ultra Sound, Electric Stimulation, or other forms of therapy not listed, and also braces, devices, vitamins, or analgesics the doctor deems necessary.

Occasionally, the doctor may need to have you wear a gown, shorts, or loosen your belt to be able to treat a specific area – your permission will be required first and the doctor will not proceed without your consent. Your chiropractor will recommend treatment he/she determines is most appropriate for your condition and inform you of the benefits and risks of each procedure. It is your responsibility to ask questions about any procedure you don't fully understand and voice your concern about any procedure you are unsure of or uncomfortable with.

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Possible chiropractic risks: Chiropractic treat for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain, soreness, and stiffness in the treated area, possibly due to minor muscle strain, tendon and ligament. When this occurs within the first few days of treatment, the increased pain is typically brief and improves over the next few days. Increased pain may also occur with exercise, heat, cold and electrical stimulation, or any other adjunctive therapies the doctor may use. Possible skin irritation or burns may also occur with the use of gels, patches, thermal, or electrical therapy.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic or CFR treatment. But many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer, aneurysm, occluded arteries, and other illnesses, disease or conditions. When these conditions are present, CFR and chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord, nerve injury, or cerebral vascular accident. In cases of symptoms of stroke or cerebrovascular injury following a chiropractic adjustment or CFR procedure, immediately alert the doctor and seek medical attention. Your doctor is aware of this association and when appropriate may assess for symptoms and signs of stroke.

Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.

Other options for the treatment of pain include: do nothing – Just live with it, use over-the-counter medications, massage, physical therapy, medical care, injections, or surgery.

There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic and/or CFR treatment.

IF YOU HAVE AN ANEURYSM, ARE ON BLOOD THINNERS, HAD FACIAL OR MAXILLARY SURGERY, HAVE BRAIN CANCER (EITHER BENIGN OR MALIGNANT), ARE ALLERGIC TO LATEX, OR EXPERIENCED A PREVIOUS CVA, YOU MAY NOT BE A CANDIDATE FOR THIS TREATMENT. YOUR INTIALS BELOW ATTEST TO THE FACT THAT YOU HAVE BEEN FULLY INFORMED OF THESE INHERENT RISKS AND THAT NONE OF THESE ISSUES PERTAIN TO YOU, AND THAT YOU TAKE FULL RESPONSIBILTY FOR ANY ADVERSE REACTIONS RELATING TO ANY OF THE ABOVE-MENTIONED CONDITIONS.

____________ **INITALS**

My signature below confirms that I have read the paragraphs above and that I understand what my doctor has told me about possible risks of treatment and that I have had the opportunity to ask questions and have my questions answered. I also understand that there is NO guarantee that Chiropractic or CFR treatment will work for me or help improve my condition. I understand that my condition may even get worse, and though this is usually not the case, the doctor has explained this possibility to me, I fully understand it, and I am still agreeing to proceed with the recommended treatment. I have fully disclosed to my doctor my medical history regarding the above specified complicating factors and all other conditions that have caused symptoms in the past.

______________________________ ______________________________ ____________

Patient Name **Signature** **Date**

______________________________ ______________________________

Patient Phone # **Patient email address**

______________________________ ____________

Doctor's Signature **Date**

Fax (314) 270-8113 Text (314) 649-7119 Email phcdrb@gmail.com

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _______. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

	(Date)
PATIENT SIGNATURE **X**	

(Or Patient Representative) (Indicate relationship if signing for patient)

	(Date)
OFFICE SIGNATURE **X**	

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

CHIROPRACTOR NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Guardian/Parent/Representative)

(Provide name and relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

NCC-CA

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To All Cranial Facial Release Patients:

CFR treatment is typically done in a series of 4 days of treatment, which is what we highly recommend.

The cost of the treatment is $1,500 which is for the **Initial Visit** (Exam, Chiropractic, and CFR treatment) **Only!**

The additional follow-up 3 days of treatment are offered to you at **NO CHARGE!**

To achieve maximal benefit from CFR treatment, we highly encourage you to take advantage of this generous offer and follow through with the entire 4 day series of treatment.

Please understand that there is no guarantee that this specialized treatment will improve your condition or achieve your specific treatment goals.

By the signature below I attest to the fact that I have read the above explanation of CFR treatment & CFR charges, and fully agree & accept these payment & treatment terms.

Signature ____ Date ______________________

Email phcdrb@gmail.com Text (314)649-7119 Phone (314) 647-1384 Fax (314) 2708113