CURIS FUNCTIONAL HEALTH
JERROD EDWARDS, D.C.

CURIS FUNCTIONAL HEALTH INTAKE FORM

Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Cell: ( ) _____Home: ( ) _____Work: ( ) _____
E-mail: _____
Birth Date: _____ Age: _____ Male: ____ Female: ____ Marital Status: _____
Social Security Number: _____ How were you referred? _____
Have you seen a Chiropractor before? YES NO If yes, When? _____

YOUR HEALTH HISTORY

Please **CHECK** all symptoms you have problems with, even if they do not seem related to your primary problem.

☐ Neck Pain	☐ Headaches	☐ Dizziness	☐ Indigestion
☐ Mid Back Pain	☐ Tingling into arm/hand	☐ Ringing in Ears	☐ Heart Burn
☐ Low Back Pain	☐ Tingling into leg/foot	☐ Loss of taste	☐ Diarrhea
☐ Jaw Pain	☐ Tension	☐ Loss of smell	☐ Problem urinating
☐ Hip Pain	☐ Sleeping problems	☐ Fever	☐ Constipation
☐ Shoulder Pain	☐ Cold Sweats	☐ Hot Flashes	☐ Stomach upset
☐ Foot Pain	☐ Cold hands/feet	☐ Depression	☐ Nervousness
☐ Bursitis	☐ Loss of Balance	☐ Mood Swings	☐ High blood pressure
☐ Pregnant	☐ Arthritis	☐ Low blood pressure	☐ An infectious disease
☐ Diabetes	☐ Skin Problems	☐ Epilepsy	☐ Blood clots
☐ Heart trouble	☐ Varicose veins	☐ Cancer	☐ Other_____

Do you smoke? Yes/ No If yes: How many years/ packs per day? _____
List any medications you are taking: _____
_____N/A or None.
Do you have any medically diagnosed conditions? _____ N/A or None.

Does anyone in your family have any medically diagnosed conditions (If so, whom)? _____
_____N/A or None.

MASSAGE PATIENTS ONLY

Please **CHECK** the following of which apply to you:
☐ I have contacts in my eyes I have allergies to: ☐ Lotions ☐ Fragrances ☐ Oils
I consent to massage of (mark all that apply): ☐ gluteal region ☐ face ☐ pectorals (not breast tissue)

I know and understand the following:

- Proper client draping procedures protect the modesty of each the client and therapist.
- Massage therapists are prohibited from prescribing, diagnosing or treating any medical condition. It is recommended that I see a physician for any medical problems I might have.
- I have submitted correct information regarding my state of health medical history, injuries, and/or surgeries undergone.
- I understand that Texas massage law prohibits massage or manipulation of the breast tissue of female without prior written consent.

Signed: _____ **Date**_____

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HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) CONSENT FORM

Release of Information: Your Protected Health Information (PHI) will be used by this office and/or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information: **You may request a restriction on the use or** disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent: You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I, _____ **(print)** acknowledge that I have reviewed the above information and I authorize this office to release information concerning my condition and treatment to my insurance company, attorney, insurance adjuster and/or other health care providers deemed necessary for treatment purposes, processing my claim, benefits and payment of services rendered to me as well as coordinated treatment. I do understand that if I choose to refuse release of this information, that my **PHI** will be used **within** the office for purposes of my care, to those individuals designated by the doctor.

INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of Chiropractic procedures, various forms of physio-therapy, physical examination, x-ray studies, and/or any clinical services that are deemed necessary in my case to be administered by the doctor and/or any support staff employed or contracted by this office or clinic. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and include, but are not limited to, muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fracture, disc injury, stroke, dislocations and sprains. The Journal of Alternative and Complementary Medicine, Vol. 16, No. 2, 2010 in a study entitled "**Unanticipated Benefits of CAM (Complementary/Alternative Medicine) Therapies for Back Pain: An Exploration of Patient Experiences"** concludes, "*Positive outcome themes included increased options and hope, increased ability to relax, positive changes in emotional states, increased body awareness, changes in thinking that increased the ability to cope with back pain, increased sense of well-being, improvement in physical conditions unrelated to back pain, increased energy, increased patient activation, and dramatic improvements in health or well-being. The first five of these themes were mentioned for all of the CAM treatments, while others tended to be more treatment specific. A small fraction of these effects were considered life transforming.*"

I understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also be used to alleviate other symptoms through a conservative approach with hopes to avoid more invasive procedures. I further understand that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has the right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I further understand that there are other treatment options available for my condition, and that I have the right to a second opinion should I have concerns as to the nature of my symptoms and/or treatment options. If during the course of my care my insurance company requires me to take an examination from any other doctor, I will notify this facility/physician immediately. I understand that failure to do so may jeopardize my case.

I, _____ **(print)** have read the above consent and I have had an opportunity to ask questions regarding its content. By signing below, I agree to the above-named procedures and intend this consent to cover my entire course of treatment for my present condition and for any future condition(s) for which I seek treatment with this office.

Patient or Guardian Signature: _____ Date: _____

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OFFICE POLICIES

Welcome to our family. Our goal is to serve this community with exceptionally friendly and prompt service. We want to provide the best health care available for your family. It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health.

Office Hours:

Monday	9:00am to 1:00pm	3:00pm to 6:00pm
Tuesday	3:00pm to 6:00pm	
Wednesday	9:00am to 1:00pm	3:00pm to 6:00pm
Thursday	9:00am to 1:00pm	3:00pm to 6:00pm
Friday	9:00am to 1:00pm	

Initials _____

Appointment Schedule:
For your convenience and to ensure prompt, reliable service, we request that you pre-schedule all your appointments. We have a specific course of care that requires a number of adjustments in a set amount of time. Please provide a 24 hour notice when rescheduling an appointment so that we may serve others during your appointment time. Please refrain from repeatedly rescheduling. Keeping your appointments is *your* part in the correction of *your* problem and the restoration of *your* health. Therefore, more than three consecutive missed appointments is grounds for dismissal from care. If you are more than 15 minutes late, we reserve the right to reschedule your appointment. As there are only a few massage appointments available each day, a missed hour long appointment is seriously detrimental to our schedule, not to mention to our massage therapist's pocketbooks. After your first missed massage, a charge of $20 will be assessed to your account when a 24 hour notice is not provided if we are unable to fill your reserved time.

Initials _____

Children & Family:
Once you understand how the nervous system controls and coordinates all functions in the body and that subluxations interfere with nerve flow, we would expect that you would want everyone in your family checked for subluxation. We have a cost effective family program for you. We will be happy to schedule an appointment for their check-up today. We don't know if they need care, we do know they need to be checked.

Initials_____

Interruption of Care:
In the unlikely event that it is necessary to discontinue care, for any reason, any outstanding fees become due **immediately**. If you, the patient, discontinue care at any time, all fees become payable at the retail fee. If we find the need to dismiss you from care, all fees will be payable at any discounted rate agreed upon. If the care was prepaid, you are entitled to a refund of any unused portion, after all visits are paid at the retail rate.

Initials_____

Chiropractic Excellence:
In order to continue providing the best Chiropractic Care available, our doctors and staff occasionally need to be away from the office to attend conferences and continuing education seminars. So that you may continue your recommended adjustment schedule, another highly qualified doctor may be here to care for you in their absence.

Initials_____

Remember…
Healing and correction takes time. If at any time during your care you do not feel that you are responding as well as you expected, please discuss it with us. We want you to get the most from your Chiropractic care!

Initials_____

Treatment Plans
Your treatment plan's discounted price is based off of you completing it. If you choose not to complete the treatment all the way through the refunded charges are the full charge amount not at a discounted rate. All refunds are up to Crowne Chiropractic's discretion.

Initials_____

Referrals:
The greatest honor a patient can give to us is a referral of their family and friends. We promise to give your loved ones the same quality, love and attention that you receive. We also want to tell you in advance…..***THANK YOU FOR TRUSTING US!***

I have read and understand the above policies and agree to abide by them.

Signed: _____ **Date**_____

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