

# Curis Functional Health Intake

## 1 PATIENT INFORMATION

Patient Name \_\_\_\_\_  
Last Name

Employer / School \_\_\_\_\_

Occupation \_\_\_\_\_

First Name Middle Initial

Employer / School Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

Employer / School Phone (\_\_\_\_) \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

E-mail \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Sex ☐ M ☐ F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for \_\_\_\_\_ years

Whom may we thank for referring you? \_\_\_\_\_

## 2 PATIENT CONDITION

Reason for Visit: ☐ Spinal and Nervous System Check-up

☐ Other: \_\_\_\_\_

If there is a symptom, when did your symptom appear? \_\_\_\_\_

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling:

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

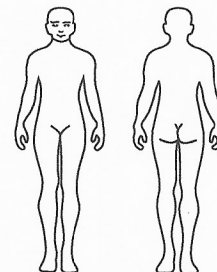
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying Down



## 3 Financial Agreement

I understand that I am personally financially responsible for services rendered at this office. Should I or the Doctor end care prior to completion of care, any credit on the account will be refunded within 48 hours of written notification and any balance due on the account will be due within 2 weeks of end date.

Signature: \_\_\_\_\_

Please print name: \_\_\_\_\_



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[www.gocuris.com](http://www.gocuris.com)



## HEALTH HISTORY

What health care have you already received for your condition?

- ☐ Chiropractic Care (Dr. \_\_\_\_\_ Date \_\_\_\_\_) ☐ Surgery (Dr. \_\_\_\_\_ Date \_\_\_\_\_)
- ☐ Medications (Dr. \_\_\_\_\_) ☐ Physical Therapy (Dr. \_\_\_\_\_ Date \_\_\_\_\_)
- ☐ Other: \_\_\_\_\_ (Dr. \_\_\_\_\_ Date \_\_\_\_\_)
- ☐ None

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |                    |  |                  |  |                     |  |                      |  |
|--------------------|--|------------------|--|---------------------|--|----------------------|--|
| AIDS/HIV           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chicken Pox      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical           |  | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other                | _____  |
| Dependency         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care    | <input type="checkbox"/> Yes <input type="checkbox"/> No |                      | _____  |

### EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

### WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

### HABITS

- ☐ Smoking
- ☐ Alcohol
- ☐ Coffee/Caffeine Drinks
- ☐ High Stress Level

Packs/Day \_\_\_\_\_

Drinks/Week \_\_\_\_\_

Cups/Day \_\_\_\_\_

Reason \_\_\_\_\_

### PREGNANCY

Are you currently pregnant? ☐ No ☐ Yes, and I am due \_\_\_\_\_

Number of past pregnancies \_\_\_\_\_

Children's Ages: Child #1 \_\_\_\_\_ Child #2 \_\_\_\_\_ Child #3 \_\_\_\_\_ Child #4 \_\_\_\_\_

Injuries/Surgeries you have had:

Description

Date

Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____



## MEDICATIONS

## ALLERGIES

## SUPPLEMENTS

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

# Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.  
I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Signature and/or Guardian \_\_\_\_\_ Date: \_\_\_\_\_

# Informed Consent Document

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

## **The nature of the chiropractic adjustment.**

The primary treatment we use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

## **Analysis/Examination / Treatment**

As a part of the analysis, examination, and treatment, you are consenting to the following:

- Spinal manipulative therapy
- Range of motion testing
- Muscle strength testing
- Radiographic studies
- Traction
- Rehabilitation
- Nutrition
- Palpation
- Orthopedic testing
- Postural analysis
- Basic neurological testing
- Pulsed Electromagnetic Field Therapy

## **The material risks inherent in chiropractic adjustment**

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, and vertebral strains and separations.

Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention; it is your responsibility to inform me.

## **The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

## **The availability and nature of other treatment options.**

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

## **The risks and dangers attendant to remaining untreated.**

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The above stated information is provided by Dr. Jerrod Wright, Dr. Wade Parkhill, and their staff and professionals under their supervision.

## **Release of Information:**

By signing this form, you are granting consent to Curis Functional Health LLP disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 817-488-4186. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

## **Medicare and Medicaid Consent to Release Information:**

I certify that the information given by me in applying for payment under Title XVI II and or Title XI of the Social Security Act is correct. I authorize and holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

I have reviewed the "Notice of Privacy Practices" of Jerrod Wright D.C. and Wade Parkhill-D.C. and have had all questions answered by this office.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

Patient's Signature and/or Guardian \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Acknowledgment receipt for consent to use and disclosure of Protected Health Information.**

**Use and disclosure of your Protected Health Information**

Your PHI (Protected Health Information) will be used by **180 Wellness** to authorize and disclose to others for purposes of treatment, obtaining payment, or health care operations of this office.

**Notice of Privacy Practices**

The undersigned acknowledges receipt of a copy of the current Notice of Privacy Practices for this health care facility. It describes your rights to the limited use of protected health information, including your demographic information.

You have the right to request a restriction or disclosure on the use of your PHI (Protected Health Information). This office may or may not agree to your request.

This office utilizes open or common areas for treatment, however, private areas are available upon request. You may refuse to sign this acknowledgement and authorization and revoke this consent to use PHI. This must be done in writing.

I authorize contact from this office to confirm my appointments, treatment, and billing information by means:

**Patient Acknowledgement Contact**

- |                                     |   |                                       |
|-------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Cell phone | <input type="checkbox"/> Home phone       | <input type="checkbox"/> Text message |
| <input type="checkbox"/> Email      | <input type="checkbox"/> All of the above |                                       |

I acknowledge receipt of a copy of the office "Notice of Patient Privacy Policy"

\_\_\_\_\_  
Patient or legal authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Patient

\_\_\_\_\_  
Sign Guardian of Patient

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

Office use only- As compliance office, attempt to obtain patients signature of this notice was not obtained because:

\_\_\_\_\_  
Signature of Privacy officer