Curis Functional Health
17202 Midland Drive, Shawnee, KS 66217

Mark A. Swickard, DC
Bret Lickteig, DC

New Patient Health Intake Form

First Name: _____ M.I. _____ Last Name: _____

Address: _____City _____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____

Sex M F Marital Status M S D W Date of Birth_____Age_____Social Security #_____

If married, Spouse's Name:_____# of Children_____

Occupation_____Employer_____

Primary Care Physician Name:_____
Address:_____ Phone _____
I give you permission to share a brief summary of my case and diagnosis with my primary care physician.
□ Yes □ No Initial: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____
Name of most recent Chiropractor: _____

Referred by: _____

1. **Reasons for seeking chiropractic care:**

Primary reason:
_____

Secondary reason:
_____

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**
_____
_____
_____

3. Past Health History:

A. **Please indicate if you have a history of any of the following:**
□ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
□ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
□ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other _____
□ None of the above

B. **Previous Injury or Trauma:**
_____

Have you ever broken any bones? Which?
_____

C. **Allergies:** _____

D. **Surgeries:**

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Date _____ Type of Surgery _____

_____

_____ _____

_____

E. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery _____ Outcome _____

_____

_____ _____

_____

F. **Prior Imaging (ie., X-rays, MRI, CT, etc):**

What Images were performed? _____ Reason they were done: _____

_____

_____

_____

_____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer	□ Strokes/TIA's	□ Headaches
□ Cardiac disease	□ Neurological diseases	□ Diabetes
□ Psychiatric disease	□ Adopted/Unknown	□ Cardiac disease below age 40
□ Other _____		□ None of the above

Deaths in immediate family: _____

Cause of parents or siblings death _____ Age at death

_____

_____

_____

_____

Social and Occupational History:

A. **Job description:**

_____

B. **Work schedule:**

_____

C. **Recreational activities:**

_____

D. **Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):**

_____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?

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□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/ problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____
□ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here?

_____
_____
_____
_____

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

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- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What movements/activities make the symptom worse?
  - Please describe:_____
- What makes the symptom better?
  - Please describe:_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Doctor's Notes:

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What movements/activities make the symptom worse?
  - Please describe:_____
- What makes the symptom better?
  - Please describe:_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Doctor's Notes:

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

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- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What movements/activities make the symptom worse?
  - Please describe:_____
- What makes the symptom better?
  - Please describe:_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Doctor's Notes:

Symptom 4 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What movements/activities make the symptom worse?
  - Please describe:_____
- What makes the symptom better?
  - Please describe:_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Doctor's Notes:

Please indicate sites of **pain** with an "X". (×××)
Does the **pain radiate (travel)**? If so, mark with an "arrow". (→→→)

Name/Initial: _____ Date: _____

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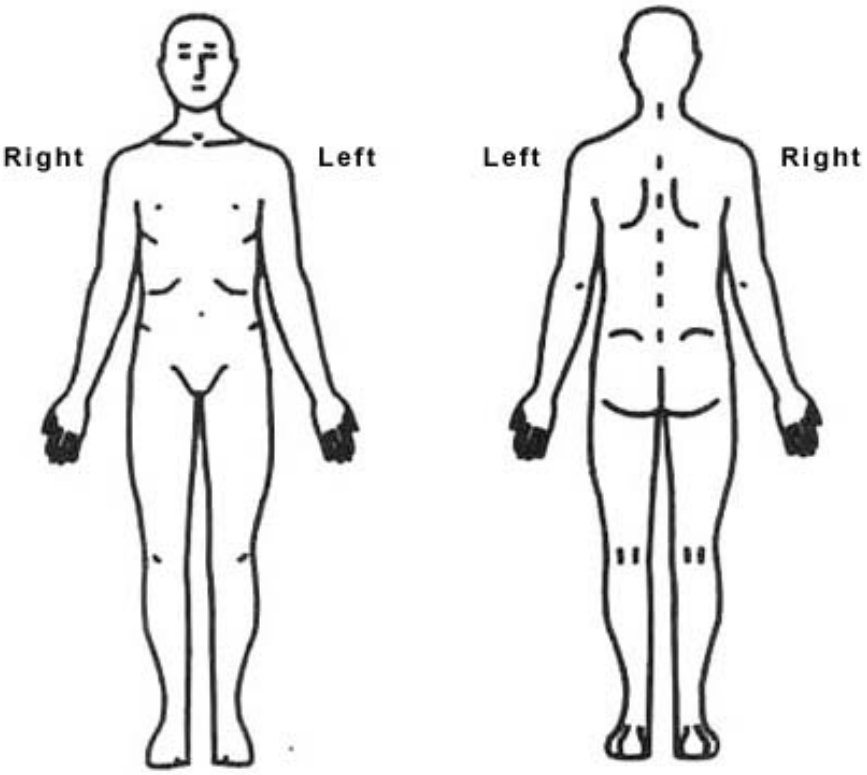
New Patient Health Intake Form



Do you have headaches?

□ Yes □ No, skip to next page.

If yes, please answer the following:

a. Mark where you get your headache(s) with an "X"

b. **On a scale from 0-10, with 10 being the worst, indicate the intensity of your headache:** 1 2 3 4 5 6 7 8 9 10

c. **What describes your headaches?** (circle all that apply)
Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other: _____

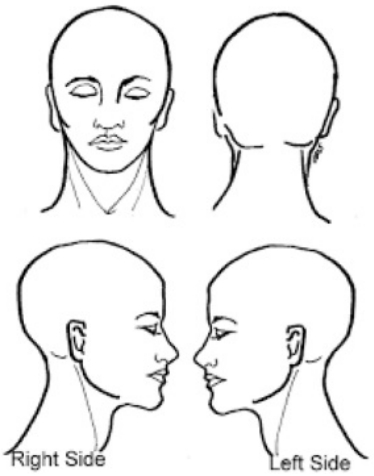
d. How often do they occur?
_____ X/week _____ X/month _____ Sporadic

e. Are your headaches worse at certain times of the day or night?
Morning Afternoon Evening Night Unaffected time of day

f. **When did your headaches begin?** _____

g. **What makes your headaches worse?** _____

h. **What makes your headaches better?** _____



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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment, and Healthcare Operations

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. Curis' Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for Curis to provide treatment to me, and also necessary for Curis to obtain payment for that treatment and to carry out it's health care operations. Curis explained that the Privacy Notice would be available to me in the future at my request. Curis has further described my right to obtain a copy of the Privacy Notice before signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. Curis reserves the right to change its privacy practices described in its Privacy Notice in accordance with applicable law.
3. Curis' "Notice of Privacy Practices" is also provided in the front lobby and on the website. I may also request a copy from this office at any time via US Mail, or email.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.
5. I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

I have read and understood the preceding notice, and all of my questions have been answered to my complete satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Parent/Guardian Date Signed

_____
Witness

PRIMARY INSURANCE:

INSURANCE COMPANY:_____

Name/Initial: _____ Date: _____

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New Patient Health Intake Form

INSURED'S NAME: _____RELATIONSHIP TO INSURED:_____

INSURED'S BIRTHDATE:_____ PHONE NUMBER:_____

ADDRESS:_____CITY:_____ STATE:_____ ZIP:_____

EMPLOYER NAME: _____

SECONDARY INSURANCE

INSURANCE COMPANY:_____

INSURED'S NAME: _____RELATIONSHIP TO INSURED:_____

INSURED'S BIRTHDATE:_____ PHONE NUMBER:_____

ADDRESS:_____CITY:_____ STATE:_____ ZIP:_____

EMPLOYER NAME: _____

RELEASE OF INFORMATION:

I _____ give permission to the staff at Swickard Chiropractic Clinic of Shawnee, P.A. to share any information related to my care, account and services to the following people:

NAME: (LAST, FIRST, MI): _____
RELATIONSHIP: _____
ADDRESS_____CITY:_____ STATE:_____ ZIP: _____
PHONE: _____

NAME: (LAST, FIRST, MI): _____
RELATIONSHIP: _____
ADDRESS_____CITY:_____ STATE:_____ ZIP: _____
PHONE: _____

NAME: (LAST, FIRST, MI): _____
RELATIONSHIP: _____
ADDRESS_____CITY:_____ STATE:_____ ZIP: _____
PHONE: _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Swickard Chiropractic Clinic of Shawnee, P.A. for services performed.

Patient or Guardian Signature _____ Date_____

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

Name/Initial: _____ Date: _____

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New Patient Health Intake Form

First Name: _____ **Last Name:** _____
Email address: _____@_____
Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail
By providing my e-mail address, I understand that authorized personnel from Swickard Chiropractic may communicate with me regarding scheduling, treatment, receipts, statements, appointment reminders, health education, and promotional information. If you do not consent to e-mail communication, please initial here. _____

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer
Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*

Medication	Dosage and Frequency (i.e. 5mg once a day, etc.)	Reason for Taking

Do you have any medication allergies?

Medication	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*
Patient Signature: _____ Date: _____

Name/Initial: _____ Date: _____

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New Patient Health Intake Form

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____

Name/Initial: _____ Date: _____

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Bret Lickteig, DC

New Patient Health Intake Form
CURIS FUNCTIONAL HEALTH
Informed Consent

Please read this entire document prior to signing. Ask questions before you sign if there is anything that is unclear.

Based on my complaints and the history I have provided, I hereby authorize Curis Functional Health ("the Practice") and its licensed doctors and assistants to undertake an examination and provide an evaluation and treatment plan that may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I understand that state law entitles me to receive information concerning my condition and proposed treatment and refuse any treatment to the extent permitted by law. With that knowledge and with my consent, I wish to rely on the Curis Functional Health doctors to make those decisions about my care, based on the facts that they believe are in my best interest.

As a part of the analysis, examination, and treatment, I am consenting to services that may include: Chiropractic adjustment, palpation, massage therapy, spinal decompression, intersegmental traction, vital signs, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, hot/cold therapy, EMS, radiographic studies and other procedures as necessary. The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments, and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

Based on current findings, I understand that the Practice doctors will discuss my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment, and the reasonable alternatives to the proposed treatment. They will also explain the cost of my proposed care (or provided me with a current fee schedule).

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those that relate to physical aberrations unknown or reasonably undetectable by the doctor. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if I have a condition that would otherwise not come to the Doctor's attention, I understand that it is my responsibility to inform the Doctor before treatment.

The availability and nature of other treatment options may include self-administered, over-the-counter analgesics and rest, medical care and drugs such as anti-inflammatory, muscle relaxants, and pain-killers, hospitalization or surgery. If one chooses to use one of the above noted "other treatment" options, one should be aware that there are risks and benefits of such options, and I understand that I may wish to discuss these with my primary medical physician.

Name/Initial: _____ Date: _____

New Patient Health Intake Form

The risks and dangers to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility, setting up a pain reaction and further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

This document is intended as a general, broad-based consent applies to any and all contemplated procedures. I have discussed all of the above risks and benefits with the Practice, and, if applicable, have made an informed decision that the potential benefits outweigh the risks in my case.

I understand and accept that:

1. I have the right to withdraw from or discontinue any treatment at any time and that the Practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve making judgments based upon the facts known to the doctor during my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent {or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment l may receive. My signature below acknowledges my consent to the Practice's examination, evaluation, and proposed course of care and treatments.

_____ _____

Witness Patient's Printed Name

_____

Patient's Signature

_____

Signature of Doctor

Name/Initial: _____ Date: _____

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1. As a service to you we verify how your insurance company supports your care in our office. If we are unable to verify prior to the end of your first visit our policy is to collect $75. Once benefits are known any credit will be refunded to you or used for future visits if you wish. Any balance will be due at your next visit.

2. We will collect your deductible, co-pay, uncovered services, and/or the percent you are responsible for at the time of each visit.

3. We will submit claims to your insurance and collect according to how they support your care. In the event insurance denies care (examples: services are not a covered benefit, insurance determines care is not medically necessary, etc.) you become responsible for the balance. You will be become a "self-pay" patient and will be responsible for the fees. Our self-pay fee for spinal manipulations is $45. Other treatments and services have additional fees.

4. SELF-PAY Patients: This includes patients with no insurance, patients who have insurance plan with which we do not participate or patients that have exhausted their benefits.

5. All effort is made by our billing office to work closely with the insurance companies. 99% of the time we are quoted the correct benefits, however, benefits are sometimes misquoted. If we are misquoted and a balance is due on your account, it becomes patient responsibility. It is highly recommended that you verify your benefits as well.

6. Personal injury, Workman's Compensation and Auto cases. A signed lien will be required allowing payments to be made directly to us. We file on your behalf. Should benefits be exhausted or denied any unpaid balance becomes patient responsibility.

7. Delinquent accounts over 90 days old will be sent to a collection agency. Any fees incurred will become patient responsibility.

_____ _____
Patient or Guardian Date

_____
Printed Name

Name/Initial: _____ Date: _____