



Initial Consent & Intake Form - Terrance McCurdy

We are delighted seeing you take the first step towards your personal healing journey. Since this will be your first therapy session with us, we need to collect some additional information from you.

The following information will be used to help plan safe and effective therapy sessions. Any information exchanged on this form is strictly confidential. It will be used for the sole purpose of providing the best health care services to you. Please review carefully and fill in your information as accurate as you can, then sign when you are ready.

Thank you!

* required

Name of Client *

Terrance McCurdy

Name of Parent/Legal Guardian (if client is under 18)

Primary Reason for seeking Juneva's services *

Low energy; enlarged prostate; muscle tension in shoulder and neck;

Other concurrent therapies - briefly list other approaches you have tried for your condition

Health Goals - pain relief, chronic issues relief, stress relief, detox, emotional issues relief, etc...

Name of Primary Care Physician

Office Phone

Primary Care Physicians Diagnosis



How are you responding in your present treatment?

☐ Better ☐ Same ☐ Worse

Date of last visit with Primary Care Physician

Reason for that last visit

Are you currently taking any medication? - If yes, please list medication and dosage per day

Are you pregnant? * ☐ Yes ☒ No

If so, how many months?

Do you have a Pace Maker? * ☐ Yes ☒ No

If so, please state for how long and if you experienced any problems

Do you have organ transplants? * ☐ Yes ☒ No

If so, please list type and for how long and if you experienced any problems

Do you use tobacco in any form? * ☐ Yes ☒ No

If so, please list type, amount and frequency of use

Do you use Alcohol in any form? * ☐ Yes ☒ No

If so, please list type, amount and frequency of use

Do you have body implants? * ☒ Yes ☐ No

If so, please list type and for how long and if you experienced any problems

Spinal fusion L1-L5



Please check all conditions listed below that apply to you

☐ ADD / ADHD ☐ Alcohol Abuse ☒ Allergies / Sensitivities ☒ Stress / Anxiety / Hyperactive ☐ Appetite Poor or Heavy
☐ Asthma ☐ Atherosclerosis ☐ Autism ☒ Back / Neck Problems ☒ Blood Conditions - Anemia / Leukemia / Clots / Hemophilia... ☐ Blood Pressure High or Low ☐ Cancer / Chemotherapy ☒ Chronic Fatigue / Sudden Energy Drop ☒ Chronic Pain / Cough ☐ Dementia / Cognitive Impairment / Alzheimer / Parkinson ☐ Dental Conditions - Grinding Teeth / Gingivitis / Periodontitis... ☐ Depression / Grieving ☐ Diabetes / Blood Sugar Regulation / Weight Problems ☐ Difficulty Breathing / Chest Pain / Bronchitis / Pneumonia / Emphysema... ☐ Digestive Disorders - Abdominal Pain / Constipation / IBS / Diarrhea / Heartburn / Ulcers... ☐ Drug Abuse ☐ Epilepsy / Seizures / Fainting Spells ☐ Eye Conditions - Poor Vision / Glaucoma / Cataracts / Macular Degeneration... ☐ Fertility Problems / Low Sex Drive ☐ Fevers or Chills ☒ Headaches / Migraines ☐ Hearing Conditions / Tinnitus ☐ Heart Conditions ☐ HIV + AIDS / Immune / Autoimmune System Disorder ☐ Joint Conditions - Arthritis / Tendonitis... ☐ Kidney Conditions ☐ Liver Conditions ☐ Lymphatic Conditions / Swollen Glands ☐ Women Health Conditions - PMS / Menopause... ☐ Mental Health Conditions / Memory Issues ☒ Musculoskeletal Conditions - Osteoporosis / Fibromyalgia / Sprains / Strains... ☒ Nausea / Vertigo / Vomiting ☒ Numbness / Tingling / Stiffness ☐ Open Sores / Wounds / Easy Bruising ☐ PTSD ☐ Radiation Therapy ☐ Recent Accident / Injury ☐ Recent Fracture / Concussion ☐ Sexually Transmitted Disease ☐ Shingles ☐ Sinus Conditions / Congestion ☒ Skin Conditions - Rash / Warts / Hives / Eczema / Itching... ☐ Sleeping Disorders / Insomnia ☒ Stroke ☐ Thyroid / Hormonal Conditions ☐ TMJ ☒ Urinary Conditions - UTI / Incontinence / Urethritis... ☐ Varicose Veins / Phlebitis / Swollen Hands or Feet ☐ Other

Please explain any condition that you have marked above

Surgeries - briefly describe any physical and/or emotional trauma you experienced

partial thyroid removal; fusion L1-L5 after spinal injury; prostate surgery 2022

Significant Exposures - briefly describe any significant chemical/radiation/environmental exposures

acid exposure during plate making

Emotional Stresses - briefly describe any personal/work/other emotional influences you may experience

Regular Exercises - briefly list any regular fitness activities you may perform (type, duration, frequency)

daily walks

Is there anything else about your health history you think your practitioner should know

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1. I fully understand that the therapy, information, and advice which I will be given pertains solely to me and will be based upon information revealed by myself.
 2. I fully understand that the attending NES certified practitioner is not an allopathic doctor ("licensed physician") and does not portray to be one but is a bioenergetic/biofeedback health and wellness



consultant.

3. I fully understand that there is a difference between the practice of allopathic medicine and bioenergetic/biofeedback health and wellness consultants.
4. I fully understand that the services provided by the attending practitioner is not allopathic, but strictly energetic or biofeedback in nature, and are therefore considered alternative or complementary to allopathic medical services licensed by the state.
5. I fully understand that the attending practitioner performs services within the parameters of natural holistic health care using biofeedback and stress reduction or other energy therapies not licensed by the state.
6. I fully understand that the attending practitioner does not offer allopathic drugs, surgery, chemical stimulants, radiation therapy or any other conventional treatments. In addition, the practitioner does not diagnose, treat, or otherwise prescribe for my disease, conditions, or illness.
7. I fully understand that my energy and stress parameters are being measured.
8. I presently seek counsel, advice, opinions related to energetic balancing, stress management or biofeedback within the scope of the attending practitioner's health and wellness practice.
9. I am fully aware and release the attending practitioner to do biofeedback and energy assessments.
10. I fully understand that the services provided by the attending practitioner are in the emerging field of bioenergetic ('information') medicine and may not be understood by all allopathic doctors.
11. I acknowledge that I am responsible to be on time for my appointments and that the attending practitioner is not under any obligation to extend my therapy session. I also agree that I am responsible to pay for the full time I have booked with the attending practitioner if I am late. I understand that my appointment time is reserved for me only. If I miss an appointment ('no show') or if I am late for more than fifteen (15) minutes for an appointment or unable to give at least twenty-four (24) hours advance notice when I need to change or cancel my appointment, I agree to pay \$75 late cancellation fee on the second occurrence, and on the third occurrence and thereafter after I pay in full for the booked appointment time.
12. I have stated all my known medical conditions on the Client Intake form. I have consulted a medical doctor or licensed medical health care practitioner regarding any checked or described conditions.
13. I fully understand that it is solely my responsibility to keep the attending practitioner updated on any changes in my physical health and I further understand that Juneva Health and the attending practitioner shall not be liable for any purpose and for any reason whatsoever, should I fail to do the needful as per this paragraph.
14. I fully understand that Juneva Health reserves the right to decline, discontinue, or restrict services based on any provided information that may indicate that the therapy would put my health or the practitioner's health at risk.
15. I fully understand that Juneva Health does not claim to cure, prevent, treat, or diagnose any medical condition. Their claims have not been evaluated by any government agency or regulatory organization. Should I be concerned about a medical condition I'll seek advice from a qualified medical professional.

I Agree *

☒ By checking this box, I acknowledge that I am at least 18 years of age, I have carefully read and fully understand all parts of this consent/waiver and I agree to the terms and conditions of it. I understand that the information given today is accurate to my knowledge and that I have the opportunity to ask any questions with regard to any services or therapies offered.



(Parent/Legal Guardian must sign if client is under 18):

X Terrance McCurdy

Signed by Terrance McCurdy
Signed on April 22, 2024



Signature Certificate

Document name: Initial Consent & Intake Form - Terrance McCurdy

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Terrance McCurdy
Party ID: f8374782-a4ff-4cc2-8dab-f3a11cd5e8a6
IP Address: 66.248.200.10
Security Level: E-mail

Digital Signature:

Terrance McCurdy

Multi-Factor

Digital Fingerprint Checksum

1e1e4e1293ae23e877a9888bd1dd7
1e0



Timestamp

April 19, 2024 2:35 pm PDT

April 19, 2024 2:35 pm PDT

April 21, 2024 8:43 am PDT

April 21, 2024 5:01 pm PDT

April 22, 2024 8:19 am PDT

April 22, 2024 8:57 am PDT

April 22, 2024 10:54 am PDT

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April 22, 2024 11:42 am PDT

April 22, 2024 11:43 am PDT

April 22, 2024 2:12 pm PDT

April 22, 2024 2:12 pm PDT

April 22, 2024 2:21 pm PDT

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