FAITH FAMILY CHIROPRACTIC, INC.

Dr. Javad Faith, D.C.
26302 La Paz Rd., Suite 215, Mission Viejo, CA 92691
Tel: (949) 430-6001 Fax: (949) 430-6002 Email: DrJ@Vitality.us

CONSENT TO CHIROPRACTIC EXAMINATION & TREATMENT

Purpose and scope. I request and consent to examination and chiropractic care by Dr. Javad Faith, D.C., and/or another appropriately licensed chiropractor practicing at Faith Family Chiropractic, Inc. Care may include chiropractic manipulation/adjustment, mobilization, manual and soft-tissue procedures, therapeutic exercise, physical-therapy modalities within scope of practice, postural/ergonomic care, and clinically indicated diagnostic procedures or X-rays.

Expected benefits. The goals of care may include reducing pain, improving mobility and function, improving tolerance for normal activity, and supporting recovery of musculoskeletal conditions. Individual responses vary, and no specific result or cure is guaranteed.

Common temporary reactions. Treatment may temporarily cause soreness, stiffness, tenderness, fatigue, headache, bruising, or a short-lived increase in symptoms.

Material risks. Chiropractic and manual procedures have potential risks. Depending on the procedure and my health, complications may include sprain/strain, aggravation of an existing condition, disc injury, fracture, or dislocation. Serious neurological or vascular complications, including stroke, have been reported in association with manipulation of the neck and may result in serious injury, permanent disability, or death. Not every possible complication can be predicted in advance.

Alternatives. Depending on my condition, reasonable alternatives may include no treatment/watchful waiting, activity modification, exercise/rehabilitation, physical therapy, medication or medical care, specialist evaluation, injections, or surgery when appropriate.

My choices. I may ask questions, decline any examination or treatment procedure, request a modification, or withdraw consent and stop care at any time. If my condition or proposed treatment materially changes, additional discussion or consent may be appropriate.

Acknowledgment. I have had the opportunity to discuss the nature and purpose of the proposed care, material risks, reasonable alternatives, and my questions with the doctor. I understand the information provided and voluntarily consent to the recommended chiropractic examination and care.

Patient / Legal Representative Signature	_____	Date	_____
Printed Name	_____	Relationship (if applicable)	_____
Doctor Signature / Initials	_____	Date	_____

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NEW PATIENT INFORMATION

Last Name		First Name	
Middle Initial		Date of Birth	
Address		City / State / ZIP	
Cell Phone		Email	
Occupation		Employer / School	

Emergency Contact

Name		Relationship	
Phone		Primary Care Physician	

Reason for Consultation

Main reason for today's visit:

☐ Not related to an accident ☐ Auto accident

☐ Work injury ☐ Home injury

☐ Sports injury ☐ Other: _____

Date of accident / injury		Reported to	
How did you hear about us?		Referral name	

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INSURANCE INFORMATION

Health Plan		Primary Insured	
Member / Subscriber ID		Group #	
Relationship to Patient		Subscriber DOB	
Secondary Insurance		Secondary ID	

Please bring or provide: your current insurance card(s), photo identification, medication list, and relevant imaging or reports if available.

Insurance Billing

Insurance billing, when provided, is a courtesy. Insurance benefits are determined by your health plan and are not a guarantee of payment.

You remain responsible for deductibles, copayments, coinsurance, non-covered services, and balances that are your responsibility under your health plan or office agreement.

Please notify Faith Family Chiropractic, Inc. promptly of any change in insurance coverage.

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CURRENT COMPLAINT & FUNCTIONAL INTAKE

Main body area / condition _____ When did it begin? _____

Pain today (0-10) _____ Worst level (0-10) _____

How did it begin?

☐ Suddenly
☐ Gradually
☐ Auto accident
☐ Work injury
☐ Exercise / sport
☐ No known cause
☐ Other: _____

Please describe your symptoms in order of importance:

1. _____

2. _____

3. _____

4. _____

What do the symptoms feel like?

☐ Aching
☐ Sharp
☐ Dull
☐ Burning
☐ Stiff
☐ Tingling
☐ Numb
☐ Shooting
☐ Electric-like
☐ Throbbing
☐ Weakness
☐ Other: _____

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SYMPTOM PATTERN & FUNCTION

How often do you experience your symptoms?

☐ Constant (76-100% of the time)
☐ Frequent (51-75% of the time)
☐ Occasional (26-50% of the time)
☐ Intermittent (1-25% of the time)

How are your symptoms changing?

☐ Getting better
☐ About the same
☐ Getting worse

Which activities are affected?

☐ Sleep
☐ Sitting
☐ Walking
☐ Lifting
☐ Household tasks
☐ Caring for family
☐ Work
☐ Standing
☐ Driving
☐ Exercise
☐ Sports / recreation
☐ Social activities

What makes your symptoms worse?

What makes your symptoms better?

What can you no longer do, or do less well, because of this problem?

What is your main goal from care?

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PREVIOUS CARE & TESTING

Who have you seen for this problem?

☐ No one
☐ Chiropractor
☐ Primary care physician
☐ Orthopedist
☐ Neurologist
☐ Physical therapist
☐ Massage therapist
☐ ER / urgent care
☐ Other: _____

Have you had any testing for this problem?

☐ X-ray
☐ MRI
☐ CT scan
☐ Ultrasound
☐ EMG / nerve study
☐ Blood tests
☐ None

Where and when were these tests performed?

_____
_____
_____

What treatment have you already tried, and did it help?

_____
_____
_____
_____

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HEALTH HISTORY

Please check Yes or No for each item.

Osteoporosis / osteopenia	☐ Yes ☐ No
Previous fracture	☐ Yes ☐ No
Cancer / tumor	☐ Yes ☐ No
Heart disease	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No
Stroke / TIA	☐ Yes ☐ No
Blood-clotting disorder	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Rheumatoid / inflammatory arthritis	☐ Yes ☐ No
Seizure disorder	☐ Yes ☐ No
Migraine / significant headaches	☐ Yes ☐ No
Dizziness / fainting	☐ Yes ☐ No

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HEALTH HISTORY - CONTINUED

Neurological disease	☐ Yes ☐ No
Kidney disease	☐ Yes ☐ No
Liver disease	☐ Yes ☐ No
Recent infection / fever	☐ Yes ☐ No
Unexplained weight loss	☐ Yes ☐ No
Recent surgery	☐ Yes ☐ No
Joint replacement	☐ Yes ☐ No
Spinal surgery	☐ Yes ☐ No
Herniated disc	☐ Yes ☐ No
Pacemaker / implanted device	☐ Yes ☐ No
Bleeding disorder	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No

Medications, Allergies & Procedures

Current prescription medications:

_____

Over-the-counter medications / supplements:

_____

Allergies:

_____

Past surgeries / major injuries:

_____

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IMPORTANT SAFETY QUESTIONS

Please tell the doctor immediately if you are currently experiencing any of the following:

☐ New or progressive weakness in an arm or leg
☐ New difficulty walking or severe balance problems
☐ Loss of bowel or bladder control
☐ Numbness around the groin, buttocks, or inner thighs
☐ Sudden severe or unusual headache
☐ New difficulty speaking or swallowing
☐ New facial weakness or numbness
☐ Double vision or sudden visual change
☐ Fainting or loss of consciousness
☐ Fever with severe neck or back pain
☐ None of the above

Additional health factors

☐ Blood thinner / anticoagulant
☐ Long-term corticosteroid
☐ Osteoporosis medication
☐ Currently pregnant
☐ Possibly pregnant
☐ Not applicable

Anything else important for the doctor to know?

_____

_____

Patient / Legal Representative Signature		Date	
Printed Name		Relationship (if applicable)	

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FINANCIAL RESPONSIBILITY, PRIVACY & OFFICE POLICIES

Financial Responsibility

Insurance billing, when provided, is a courtesy. I understand that insurance benefits are determined by my health plan and are not a guarantee of payment. I remain financially responsible for deductibles, copayments, coinsurance, non-covered services, and balances that are my responsibility under my health plan or office agreement.

Assignment of Benefits

I authorize payment of eligible insurance benefits directly to Faith Family Chiropractic, Inc. when assignment of benefits is permitted, and I authorize release of information reasonably necessary to obtain payment and determine benefits.

Privacy / Notice of Privacy Practices

I acknowledge that I have been offered access to Faith Family Chiropractic, Inc.'s Notice of Privacy Practices, which describes how health information may be used or disclosed and how I may exercise my privacy rights.

No-Show / Late Cancellation Policy

Faith Family Chiropractic, Inc. reserves the right to charge a $75 fee per 30 minutes of reserved appointment time for an appointment that is missed or cancelled with less than 24 hours' notice. The office may waive the fee when circumstances reasonably warrant. Insurance generally does not pay missed-appointment fees.

Patient / Legal Representative Signature		Date	
Printed Name		Relationship (if applicable)	