Faith Family Chiropractic
La Paz Medical & Dental Center
26302 La Paz Rd. Suite 213
Mission Viejo, CA 92691

Tel: (949) 430 6001
Fax: (949) 430 6002
Email: DrJ@Vitality.us
www.Vitality.us

Patient Information	**Insurance**
Date:	Health Insurance Company:
Last Name:	Who is the primary insured?
First Name: Middle Initial:	Relationship to Patient:
Address:	Insurance ID number:
City:	Group #:
State: Zip:	Is patient covered by additional insurance? ☐ Yes ☐ No
E-mail:	
Sex: ☐ M ☐ F	
Date of Birth:	
Occupation:	
Patient Employer/School:	**FINANCIAL RESPONSIBILITY:** I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Faith Family Chiropractic, Inc. and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Faith Family Chiropractic, Inc. of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Faith Family Chiropractic, Inc. and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financially responsibility as explained above for all payment for medical services and/or supplies received.
Employer/School Address:	
☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated Divorced ☐ Partnered for _____ years	**ASSIGNMENT OF BENEFITS:** I authorized direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Faith Family Chiropractic, Inc. for all covered medical services and supplies provided to me during all courses of treatment and care provided by Faith Family Chiropractic, Inc. and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Faith Family Chiropractic, Inc. and will constitute a continuing authorization, maintained on file with Faith Family Chiropractic, Inc. which will authorize and allow for direct payment to Faith Family Chiropractic, Inc. of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Faith Family Chiropractic, Inc.
Home Phone: ( )	
Cell Phone: ( )	
Work Phone: ( )	The Faith Family Chiropractic, Inc. may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.
Best time & place to reach you:	
In Case of Emergency	
Contact Name: Phone:( )	_____ - _____
Relationship to you?	Signature of Patient, Parent, Guardian or Personal Representative – DATE
Reason for consultation:	_____ - _____
Is your condition due to accident? ☐Yes ☐No Date: Type of accident: ☐Auto ☐Work ☐Home ☐Other To whom have you made a report of your accident? ☐Auto insurance ☐Employer ☐Work Comp. ☐Other If other, how?	Print name of Patient, Parent, Guardian or Personal Representative - DATE
How did you hear about us?	

Dr. Javad Faith, D.C.
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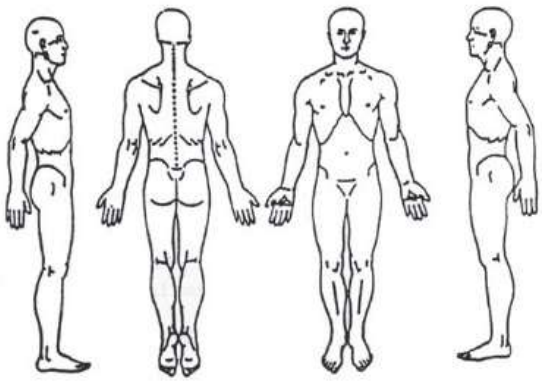
Clinical Information Intake Form

Patient Name:
Date of Birth:

1. Indicate with an X on the drawing below where you have pain/symptoms



Please list/describe your symptoms
In order of severity

1.
2.
3.
4.
5.
6.

2. How often do you experience your symptoms?
☐ Constantly (76-100% of the time)
☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time)
☐ Intermittently (1-25% of the time)

3. How would you describe the type of pain?

☐ Sharp	☐ Tingly	☐ Numb	☐ Sharp with motion
☐ Diffuse	☐ Shooting	☐ Stiff	☐ Shooting with motion
☐ Dull	☐ Achy	☐ Burning	☐ Stabbing with motion

☐ Electric like with motion ☐ Other _____

4. How are your symptoms changing with time?
☐ Getting Worse ☐ Not Changing ☐ Getting Better

5. Using a scale from 0-10 (10 being the worst,) how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (please circle)

6. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

7. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER Physician

□ Orthopedist □ Massage Therapist □ Physical Therapist □ Other/No One _____

9. How long have you had this problem? _____

10. How do you think this problem began? □ Auto Accident □ Work Injury □ Other _____

11. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

12. What aggravates your problem? _____

13. What makes your problem better? _____

14. What concerns you the most about your problem; what does it prevent you from doing? _____

_____

15. What is your: Height _____ft._____in. Weight_____lbs. Date of Bith _____

Occupation _____

16. How would you rate your overall health?

□ Excellent □ Very Good □ Good □ Fair □Poor

17. What types of exercises do you do?

□ Strenuous □ Moderate □ Light □ None

Any other information you would like to add:

Patient Name: Patient date of birth: Today's date:

1. Indicate if you have any Immediate family members with any of the following:
   - ❑ Rheumatoid Arthritis ❑ Diabetes ❑ Lupus
   - ❑ Heart Problems ❑ Cancer ❑ ALS
2. What treatment have you already received for your condition? ❑ Medications ❑ Surgery ❑ Physical Therapy
   ❑ Chiropractic Services ❑ None ❑ Other _____

   Name and address of other doctor(s) who have treated you for your condition _____

   Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
   Spinal Exam _____ Chest X-Ray _____ Urine Test _____
   Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

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

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

3. What habits do you currently do?
   - ❑ Smoking Packs/Day _____ ❑ Alcohol Drinks/Week _____
   - ❑ Coffee/Caffeine Drinks Cups/Day _____ ❑ High Stress Level Reason _____
4. Are you pregnant? ❑ Yes ❑ No Due Date _____

   List all prescription medications/supplements you are currently taking:

   _____
5. List all of the over-the-counter medications you are currently taking:

   _____
6. List all surgical procedures you have had:

   _____
7. What activities do you do at work?

❑ Sit:	❑ Most of the day	❑ Half the day	❑ A little of the day
❑ Stand:	❑ Most of the day	❑ Half the day	❑ A little of the day
❑ Computer work:	❑ Most of the day	❑ Half the day	❑ A little of the day
❑ On the phone:	❑ Most of the day	❑ Half the day	❑ A little of the day

8. What activities do you do outside of work?

   _____
9. Have you ever been hospitalized? ❑ No ❑ Yes

   If yes, why _____
10. Have you ever seen a chiropractor? ❑ No ❑ Yes

    If yes, what was your experience? _____
11. Have you had significant past trauma? ❑ No ❑ Yes
12. Anything else pertinent to your visit today? _____

Print Patient Name _____ DOB: _____

Patient Signature _____ Date: _____

Name / Signiture of Legal Guardian - Parent / Date:

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Laser Light Therapy - Patient Intake Form

Are you a candidate for laser therapy?

Laser therapy is an FDA cleared modality for the treatment of pain and inflammation and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. This form is a tool to help your clinician determine if you are a candidate for laser therapy. If you answer yes to any of these questions you will need to discuss details of your condition with your clinician.

Please check YES or NO to the questions below

YES ☐ NO ☐ Do you have a pacemaker or any other implanted devices?

YES ☐ NO ☐ Are you pregnant?

YES ☐ NO ☐ Do you have cancer?

YES ☐ NO ☐ Are you taking medications that may increase your sensitivity to light?

YES ☐ NO ☐ Have you had a steroid injection in the last 7 days?

Patient Name:

Patient Signature: Date:

Notes / questions / Concerns:

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No-Show or Late Cancellation Policy

Faith Family Chiropractic, Inc. reserves its right to charge a 'No-Show' or 'Late Cancellation Fee' of $75.00 per 30 minutes of booked session that is missed or cancelled with less than a 24 hour notice.

We require all our patients to agree with the above given terms prior to the start of their 1st session at Faith Family Chiropractic, Inc. Please sign below to agree with our no-show or late cancellation policy.

Patient or Patient's Guardian's Signature: _____

Date: _____

Patient's Name: _____

Guardian's Name (if applicable): _____