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

NEW PATIENT INFORMATION & INSURANCE

Last Name		First Name	
Middle Initial		Date of Birth	
Address		City / State / ZIP	
Cell Phone		Email	
Occupation		Employer / School	
Preferred contact		Best time to reach you	

Emergency Contact

Name		Relationship	
Phone		Primary Care Physician	

Insurance Information

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

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 (if any)	

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

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CURRENT COMPLAINT & FUNCTIONAL INTAKE

Your Main Problem

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

Pain / symptom 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: _____

How often?

[ ] Constant (76-100%) [ ] Frequent (51-75%) [ ] Occasional (26-50%) [ ] Intermittent (1-25%)

How is it changing?

[ ] Getting better [ ] About the same [ ] Getting worse

Function

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

What makes it worse? _____ What makes it better? _____

What can you not do, or do less well, because of this problem? _____ Your main goal from care _____

Previous Care for This Problem

[ ] None [ ] Chiropractor [ ] Primary care
[ ] Orthopedist [ ] Neurologist [ ] Physical therapist
[ ] Massage therapist [ ] ER / urgent care [ ] Other: _____
[ ] X-ray [ ] MRI [ ] CT
[ ] Ultrasound [ ] EMG / nerve study [ ] Blood tests

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HEALTH HISTORY & SAFETY SCREEN

Please answer carefully. This information helps determine whether chiropractic care, manual therapy, exercise, imaging, laser, or shockwave treatment is appropriate for you.

Osteoporosis / osteopenia	[ ] Yes [ ] No	Neurological disease	[ ] Yes [ ] No
Previous fracture	[ ] Yes [ ] No	Kidney disease	[ ] Yes [ ] No
Cancer / tumor	[ ] Yes [ ] No	Liver disease	[ ] Yes [ ] No
Heart disease	[ ] Yes [ ] No	Recent infection / fever	[ ] Yes [ ] No
High blood pressure	[ ] Yes [ ] No	Unexplained weight loss	[ ] Yes [ ] No
Stroke / TIA	[ ] Yes [ ] No	Recent surgery	[ ] Yes [ ] No
Blood-clotting disorder	[ ] Yes [ ] No	Joint replacement	[ ] Yes [ ] No
Diabetes	[ ] Yes [ ] No	Spinal surgery	[ ] Yes [ ] No
Rheumatoid / inflammatory arthritis	[ ] Yes [ ] No	Herniated disc	[ ] Yes [ ] No
Seizure disorder	[ ] Yes [ ] No	Pacemaker / implanted device	[ ] Yes [ ] No
Migraine / significant headaches	[ ] Yes [ ] No	Bleeding disorder	[ ] Yes [ ] No
Dizziness / fainting	[ ] Yes [ ] No	Tuberculosis	[ ] Yes [ ] No

Important Current Symptoms - tell the doctor immediately if any apply

[ ] New or progressive arm/leg weakness
[ ] Loss of bowel or bladder control
[ ] Sudden severe or unusual headache
[ ] Fainting / loss of consciousness
[ ] None of the above
[ ] New difficulty walking or severe imbalance
[ ] Numbness around groin / inner thighs
[ ] New speech, swallowing, facial, or vision change
[ ] Fever with severe neck or back pain

Medications, Allergies & Procedures

Current prescription medications _____

Over-the-counter medications / supplements _____

Allergies _____

Past surgeries / major injuries _____

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

Lifestyle & Work

[ ] Smoking / nicotine
[ ] Prolonged standing
[ ] Alcohol
[ ] Frequent lifting
[ ] High stress
[ ] Computer work
[ ] Prolonged sitting
[ ] Regular exercise

Anything else important for the doctor to know? _____

Previous chiropractic care - experience _____

Patient / Legal Representative Signature _____ Date _____

Printed Name _____ Relationship (if applicable) _____

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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	_____

Doctor documentation: The patient or legal representative was given an opportunity to ask questions and was informed verbally and in writing regarding the nature of proposed care, material risks, and reasonable alternatives.

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FINANCIAL RESPONSIBILITY, PRIVACY & OFFICE POLICIES

Financial Responsibility & Insurance

- 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.

- I agree to notify Faith Family Chiropractic, Inc. promptly of changes in insurance coverage.

- 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. This acknowledgment is not a waiver of those 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 Authorization & Acknowledgment

By signing below, I acknowledge the financial responsibility, insurance authorization, privacy acknowledgment, and no-show/late-cancellation policy stated above.

Patient / Legal Representative Signature _____ Date _____

Printed Name _____ Relationship (if applicable) _____

Office use: Notice of Privacy Practices offered/provided: [ ] Yes [ ] Declined copy Date: _____

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FOCUSED SHOCKWAVE THERAPY (fESWT) - INFORMED CONSENT | Page 1 of 2

Patient Name		Date of Birth	
Area(s) to be treated		Treating Doctor	Dr. Javad Faith, D.C.

What is Focused Shockwave Therapy?

Focused extracorporeal shockwave therapy (fESWT) is a non-invasive treatment that delivers controlled acoustic pressure waves to a targeted musculoskeletal area. It may be used for selected tendon, muscle, ligament, fascial, joint, and related soft-tissue conditions.

Aims of Treatment

[ ] Reduce pain
[ ] Improve tolerance for activity
[ ] Improve local circulation
[ ] Improve tendon / muscle / fascial function
[ ] Improve movement and function
[ ] Support tissue repair/remodeling responses
[ ] Address chronic tissue irritation
[ ] Other goal: _____

What Treatment May Feel Like

Focused shockwave treatment is often uncomfortable and may be painful, particularly over a sensitive or injured area. Treatment intensity will be adjusted using my feedback and will be kept within a level that I consider reasonably tolerable.

[ ] I may ask for the intensity to be reduced at any time.
[ ] I may ask for treatment to be paused at any time.
[ ] I may ask for treatment to be stopped completely at any time.
[ ] I do not have to tolerate excessive pain for treatment to continue.

Possible Benefits

Possible benefits may include reduced pain, improved mobility, improved function, reduced stiffness or tenderness, and improved tolerance for activity. Improvement may be gradual and may require a series of treatments. **No particular result, cure, or degree of improvement is guaranteed.**

Common Temporary Reactions

[ ] Soreness / aching
[ ] Tenderness
[ ] Temporary increase in symptoms
[ ] Redness
[ ] Mild swelling
[ ] Bruising
[ ] Increased sensitivity
[ ] Fatigue

These effects are generally temporary. I will contact the office if I develop a severe, unusual, or persistent reaction.

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FOCUSED SHOCKWAVE THERAPY (fESWT) - INFORMED CONSENT | Page 2 of 2

Less Common Risks / Complications

Potential complications may include more significant bruising or hematoma, temporary numbness or tingling, nerve irritation, swelling, skin irritation, temporary worsening of pain, aggravation of an existing condition, or injury to blood vessels or surrounding soft tissue. Rare complications involving tendon or other tissue injury may occur. Not every possible complication can be predicted.

Please Tell the Doctor Before Treatment If Any Apply

[ ] Pregnant or possibly pregnant
[ ] Known/suspected tumor or cancer in treatment area
[ ] Active infection in treatment area
[ ] Bleeding/clotting disorder
[ ] Blood thinner / anticoagulant use
[ ] Pacemaker or implanted electronic device
[ ] Severe vascular disease
[ ] Significant nerve damage in treatment area
[ ] Open wound in treatment area
[ ] Recent surgery in treatment area
[ ] Recent fracture
[ ] Growing child/adolescent near a growth plate

Some of these conditions do not automatically prevent treatment, but may require modification, medical clearance, or avoidance of a particular area. Shockwave should not be directed toward certain sensitive structures such as brain, spinal cord, lung tissue, major blood vessels, active tumor tissue, a fetus, or growth plates in skeletally immature patients.

Alternatives

Depending on my condition, alternatives may include no treatment, activity modification, exercise/rehabilitation, chiropractic or manual care, physical therapy, medication or medical care, injection therapy, specialist evaluation, or surgery when appropriate.

Consent

I have been given the opportunity to ask questions. I understand the purpose and aims of focused shockwave therapy, the likelihood of discomfort or pain during treatment, possible benefits, common temporary reactions, material risks, reasonable alternatives, and that results are not guaranteed. I understand that treatment will be adjusted using my feedback and that **I may reduce the intensity, pause treatment, or stop treatment entirely at any time.** I voluntarily consent to focused shockwave therapy.

Patient / Legal Representative Signature _____ Date _____

Printed Name _____ Relationship (if applicable) _____

Doctor Signature / Initials _____ Date _____