4132 Katella Avenue, Suite 102
Los Alamitos, CA 90720
562.596.9677
info@bodyrevivechiropractic.com

New Patient Intake Form

Today's Date: ____ / ____ / _______

Patient Information

First Name: ________________________________ Last Name: ________________________________

Preferred Name: ________________________________ Date of Birth: ____ / ____ / _______

Male ☐ Female ☐ Prefer Not to Answer ☐ Contact Phone: ________________________________

Contact Email: ________________________________

Mailing Address: ________________________________ Occupation: ________________________________

____

Preferred Method of Communication for Patient Reminders: ☐Email ☐Phone ☐Text

Insurance Information

Insurance Company: ________________________________. Subscriber Name: __________________________

Policy # ________________________________

Group# ________________________________

How did you find out about us?

☐ Yelp!
☐ Google
☐ Insurance
☐ Friend/Family

May we thank who referred you? ☐Yes ☐ No

Name: ________________________________

Health & Social History

Check box to left of any conditions listed below that apply to yourself:

☐ Alcohol Abuse
☐ Arthritis
☐ Autoimmune Disease
☐ Blood Disease
☐ Bleeding Disorder
☐ Cancer
☐ COPD
☐ Diabetes (DM2 or DM1)
☐ Drug Use
☐ Epilepsy
☐ Emphysema
☐ Gastrointestinal Issues
☐ Genetic Disease
☐ Heart Attack
☐ Hypertension
☐ Psychiatric Condition
☐ Seizure
☐ Stroke
☐ Tuberculosis

Have you been diagnosed with a condition not listed above? Yes ☐ No ☐ If yes, please describe: __________________________

____

Are you currently taking any medication (include regularly used over the counter medications)? Yes ☐ No ☐ If yes, please describe:

____

Do you smoke? Yes ☐ No ☐ If yes, check which applies: ☐Every Day ☐Occasionally ☐Former For how long? _________

Do you drink alcohol? Yes ☐ No ☐ If yes, how many drinks per day on average do you drink? _____ For how long? _________

Do you exercise? Yes ☐ No ☐ If yes, briefly describe the type of exercise and frequency performed: _________________________

Family History

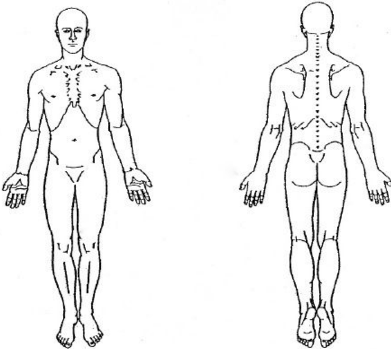
Check box to left of any conditions listed below that apply to any members of your immediate family:

☐ Autoimmune Disease
☐ Cancer
☐ Diabetes
☐ Epilepsy
☐ Gastrointestinal Condition
☐ Heart Disease
☐ Stroke
☐ Systemic Arthritide (Gout, Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Sponylitis)

Please list any conditions not listed above: ____

Reason for Today's Visit

1. Check box to the left of all that apply: ☐New Injury ☐Chronic Injury/Pain ☐Preventative/Maintenance
2. **Circle the areas of complaint on the diagram(s) below:**



1. Primary complaint: ________________________
   ☐New Injury ☐Chronic Injury/Pain
2. Secondary complaint: ____________________
   ☐New Injury ☐Chronic Injury/Pain
3. Third complaint: _________________________
   ☐New Injury ☐Chronic Injury/Pain

3. Are you currently in pain? Yes ☐ No ☐ If yes, please rate your pain on a scale of 1-10 (10 being the most intense): __________

ANSWER THE FOLLOWING IN RELATION TO YOUR PRIMARY COMPLAINT

4. Mechanism of Injury: ☐Work ☐Auto-Accident ☐Athletics ☐Daily Activities ☐Unknown ☐Other: ______________
   Brief description of the mechanism of injury: ____
   ____
   Date of injury : ____ / ____ / _______ Where were you when the injury occurred? ______________________
5. Has this injury/complaint occurred in the past? Yes ☐ No ☐
   If yes, please describe: ____
6. Have you been treated for the current complaint at an alternative location? Yes ☐ No ☐

If yes, who was the treating physician or party? ____

Specialty?: ____ Contact #: ______________________________

7. Is your condition interfering with any of the following? ☐Work ☐Sleep ☐Daily Routine ☐Other: _____________________

8. Which quality of pain/discomfort accurately describes your complaint?

☐Ache ☐Burn ☐Cramp ☐Dull ☐Numb ☐Sharp ☐Stiff ☐Tender ☐Other: _____________________

9. My pain is currently:

☐Getting Better

10.

____

11. When is your pain at its worst? ☐Morning ☐Afternoon ☐Night ☐After Activity

12. Alleviating Factors? ☐Ice ☐Rest ☐Lying Down ☐Sitting Specific Position: ______________ ☐Other: ___________

Acknowledgement

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with office personnel. If an account is not paid within 90 business days, the patient will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting past due fees.

I authorize the staff to perform any necessary services needed during the diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the aforementioned information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Printed Full Name: ________________________________ Signature: ______________________________ Date: ___ / ___ / _____

Parent/Guardian Printed Name & Signature (if applicable): ____

Acknowledgement of Services not Covered by Insurance

I, ______________________________________ a patient being treated by Dr. Reza Shahba, do hereby acknowledge that a certain portion of my care may not be covered by my insurance healthcare plan under the terms of by benefit plan. I understand and agree to be responsible to self-pay for the following services if not covered by my insurance:

Procedure	Charge
97140-59 – Manual Therapy (Myofascial Release)	$40
97110-25 – Therapeutic Exercise	$40

I acknowledge that I have been told in advance of treatment not covered by my insurance that I am responsible for, and I agree to pay for these services.

____ ______________________

(Patient/Guardian Signature) (Date)

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Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other indicated chiropractic procedures, including various modes of physiotherapy and manual therapy (e.g. myofascial release) on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Dr. Shahba, D.C.

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 which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of 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 results with respect to any course of care or treatment.
5. My 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 I have also had an opportunity to ask questions about the informed consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation, and proposed course of care and treatments by Body Revive Chiropractic & Alamitos Back Pain Center.

Affirmed,

______________________________	______________________________	____________________
(Patient/Guardian Signature)	(Patient/Guardian Print)	(Date)