33325 Santiago Rd
Acton, CA 93510

Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: _____ Date: _____

Address: _____

_____

SSN: _____ □ Male □ Female Age: ___

Date of Birth: _____

Email: _____

Phone: _____ Cell Phone: _____

Occupation:_____ Employer:_____

Do you have insurance that covers chiropractic? Yes No

Primary Insurance: PPO HMO Other _____

Patient Name:_____ DOB: _____

Subscriber Name:_____DOB: _____

Primary Insurance Blue Cross Blue Shield Aetna Cigna Other _____

Patient's Relationship to Subcriber:_____

ID Number:_____ Group #: _____

Who may we thank for referring you to our office? _____

Have you had chiropractic care before? Yes No

If so, when and who was the doctor / clinic? _____

Do you have a Family Doctor? Yes No Name of Doctor _____

Phone Number _____ City _____ Last Visit _____

Circle all that apply

1)How often do you experience symptoms? Rarely (0-26%) Occasional (26-50%) Frequent (51-75%) Constant (76-100%)

2)Describe the nature of your symptoms: Sharp/Shooting, Dull Ache, Tingling, Headache, Radiating Pain, Inflammation, Throbbing Pain on Movement, Numbness, Burning

3)Have you had similar symptoms in the past? Yes/No

4)Since your problem began, is the pain: Getting Better, Not Changing, Getting Worse

5)What makes your symptoms worse? Sitting, Standing, Walking, Bending, Lifting, Sleeping, Reaching Lying Down, Movement, Stretching/Exercise, Nothing Other_____

6)What makes your symptoms better? Sitting, Standing, Lying Down, NO movement, Movement, Heat Medication, Rest, Stretching/Exercise, Adjustments Other_____

7)How much has your pain interfered with your normal work (including housework)? Not at all, A little bit, Moderately, Quite a bit, Extremely

8)How much time has your condition interfered with your social activities? All of the time, Most of the time, Some of the time, A little of the time, None of the time

9)Who have you seen for your current symptoms? No one, Chiropractor, Medical Doctor, Physical Therapist, Other :_____

10)What tests have you had for your current symptoms? X-rays, MRI, CT Scan, Massage Therapist, Lab work (blood, urine, etc.) Other_____

Patient Intake Form

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

_____

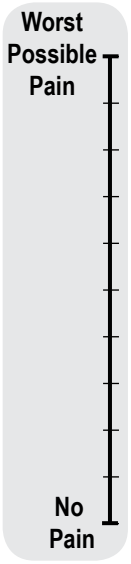
How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

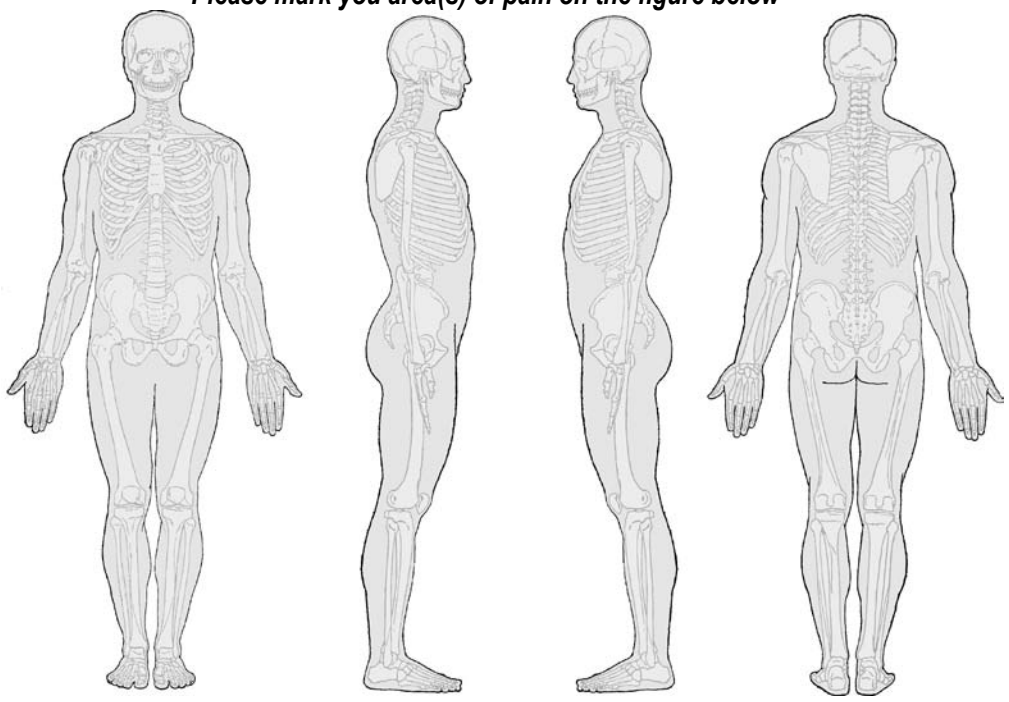
Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:





Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	□	□	_____
... had any broken bones?	□	□	_____
... had any strains/sprains?	□	□	_____
... ever used orthotics?	□	□	_____

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your mattress? _____

When was your last physical exam?_____

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Alcoholism_____	□ Cancer_____	□ High blood pressure_____
□ Anemia _____	□ Diabetes_____	□ High cholesterol_____
□ Arteriosclerosis_____	□ Emphysema_____	□ Multiple sclerosis_____
□ Arthritis_____	□ Epilepsy_____	□ Osteoporosis_____
□ Asthma_____	□ Glaucoma_____	□ Stroke_____
□ Bleed easily_____	□ Heart disease_____	□ Thyroid disease_____

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

Check ☑ and indicate the age when you had any of the following:

General

- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint

- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin

- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash

Gastrointestinal

- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary

- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Pus in urine
- ☐ Stress incontinence Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory

- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Eye, Ear, Nose & Throat

- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Check any of the conditions you have or have had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medications (including vitamins and minerals) you are currently taking, dosage and condition:

1_____ 6_____

2_____ 7_____

3_____ 8_____

4_____ 9_____

5_____ 10_____

Office Use Only:

Effective Date: _____ Is Chiropractic covered? Y / N Is Pre-certification required? Y / N

Individual Deductible: $ _____ APPLIED: $ _____ TO MEET: $ _____

Family Deductible: $ _____ APPLIED: $ _____ TO MEET: $ _____

Co-insurance: _____ % Insurance Percentage of Coverage: _____ % Co-pay: $_____

How many visits allowed: _____ Visits Used: _____

Is there a dollar amount limit per VISIT? Y / N AMOUNT$ _____ APPLIED: $ _____

Is there a dollar amount limit per YEAR? Y / N AMOUNT$ _____ APPLIED: $ _____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear

I,_____, have voluntarily requested that the doctors of chiropractic at Cordova Chiropractic, assist me in the management of my health concerns. I understand that the doctors at Cordova Chiropractic are chiropractors and that their services are not to be serve as a substitute for standard medical care. The doctor recommends that I undergo regular routine medical check-ups by my medical doctor.

Health care providers who perform manipulation are required by law to obtain your informed consent before starting treatment. I, the undersigned, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues

I understand that as a part of the analysis, examination, and treatment being performed, I may be subjected to the following procedures: spinal manipulation therapy (adjustments), palpation, range of motion testing, orthopedic testing, muscle testing, neurological screening, postural analysis, cryotherapy, thermotherapy, instrument assisted soft tissue mobilization, muscle release technique, EMS, radiographic studies, in office exercise, taping, nutritional supplementation/dietary recommendations among others.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The doctors at Cordova Chiropractic will use this procedure to treat me. The treatment may involve the use hands or a mechanical instrument upon my body in such a way as to move my joints. This may produce an audible "pop" or "click," much as I have experienced when I "crack" my knuckles. I may feel a sense of movement.

Risks of Treatment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: dizziness, soreness, muscle sprain/strain, fractures, disc injuries, dislocations, cervical myelopathy, costovertebral strains and separations, and burns. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This may lead to serious neurological impairment, and may, on rare occasion, result in paralysis or death. Stroke and /or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of a vertebral artery stroke. The other complications are also generally described as rare.

Some patients will feel some stiffness and soreness following the first few days of treatment.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history, during examination and X-ray

Alternative Treatments

Other treatment options for your condition may include:
Exercise
Self-administered, over-the-counter analgesics and rest
Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
Hospitalization
Surgery

If you chose to use one of the above noted “other treatment” options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

Treatment Refusal

Remaining untreated may allow the formation of adhesions and reduce mobility resulting in increased inflammation. This may set up a pain reaction further reducing mobility, and possible nerve damage. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Arturo Cordova and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: _____

_____
Patient’s Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

Date: _____

_____
Doctor’s Name

_____
Signature

Our office has affordable fees and comfortable payment arrangements, ensuring patients are able to receive the care they require. If you have an insurance policy which provides coverage for treatment in our office, we will provide the courtesy of billing your insurance company. Although we provide the service of billing the insurance, any payments that are not received from your insurance company within 60 days will ultimately become your responsibility. The amount of your insurance coverage and out of pocket expense will be discussed in detail. If you choose to enter into care at our office, flexible payment options are offered.

Self Pay Plan: all fees will be paid when services are rendered. The fees will be discounted for payment at the time of service.

Insurance: If your insurance is in network with our office, or you have out of network coverage, we will bill your insurance as a courtesy. Payment of deductibles, if it has not been met, as well as copayments are the responsibility of the patient. **Your co-pay is due at the time of service.** You may also be responsible for portions of your bill that exceed your insurance coverage.

Special Arrangement: Payment plans can be arranged on a case to case basis.

Please note: A quote of coverage benefits by your insurance company is **NOT A GUARANTEE OF PAYMENT.**

IF YOUR INSURANCE COMPANY REJECTS OR DENIES YOUR CLAIM YOU WILL BE RESPONSIBLE FOR FULL PAYMENT OF ALL SERVICES RENDERED. IF OUR OFFICE BILLS YOUR INSURANCE AND YOUR INSURANCE CARRIER HAS NOT PAID A CLAIM WITHIN 90 DAYS, YOU WILL BE RESPONSIBLE FOR TAKING AN ACTIVE PART IN THE RECOVERY OF THE CLAIM. AFTER 120 DAYS, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL FOR ANY OUTSTANDING BALANCE.

In the event of discontinuation of care, you will be billed for any outstanding balance and payment is expected within 60 days.

If your bill remains unpaid after 120 days and no satisfactory payment arrangements have been made towards reconciling it, then the debt on your account may be assigned to a collection agency.

I have read and understand the statements above and give the doctor permission to evaluate me. I further agree to the fee schedule set forth by Cordova Chiropractic and will ultimately be the party that is financially responsible for this account.

Date: _____

_____
Patient's Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

Date: _____

_____
Doctor's Name

_____
Signature