STRIVE
CHIROPRACTIC

NEW PATIENT INTAKE FORM

Name:_____ Today's Date:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: ( )_____ Work: ( )_____ Cell: ( )_____

Email Address: _____

Male: ____ Female: ____ Birth Date: _____ Age: _____

Occupation: _____

Employer Name and Address:_____

Single: _____ Married: _____ Spouse's Name: _____

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA)? Yes____ No_____

Have you seen a Chiropractor before? Yes No If yes, when?_____

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

YOUR HEALTH HISTORY

Please check all symptoms you currently have with **"C"** or have had in the past with **"P"**:

- ☐ Headaches
- ☐ Pins and Needles in arms
- ☐ Dizziness
- ☐ Numbness in fingers
- ☐ Fatigue
- ☐ Sleeping problems
- ☐ Cold Sweats
- ☐ Mood Swings
- ☐ Pins and Needles in legs
- ☐ Loss of smell
- ☐ Ringing in ears
- ☐ Numbness in toes
- ☐ Depression
- ☐ Neck Pain
- ☐ Constipation
- ☐ Lights bother eyes
- ☐ Menstrual Pain
- ☐ Fainting
- ☐ Back Pain
- ☐ Appetite Changes
- ☐ Loss of taste
- ☐ Irritability
- ☐ Cold hands
- ☐ Fever
- ☐ Problem urinating
- ☐ Menstrual irregularity
- ☐ Neck Stiffness
- ☐ Loss of Balance
- ☐ Nervousness
- ☐ Stomach upset
- ☐ Tension
- ☐ Cold feet
- ☐ Hot flashes
- ☐ Heartburn
- ☐ Seizures

Name of your Medical Doctor (M.D.) _____ M.D City:_____

List any medications you are taking: _____

_____N/A or None.

Do you have any medically-diagnosed conditions?:_____

_____ N/A or None.

Does anyone in your family have any medically-diagnosed conditions (If so, whom)?:_____

_____ N/A or None.

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: X

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: X Date: _____

Guardian Signature: _____ Date: _____

STRIVE CHIROPRACTIC

4299 MacArthur Blvd., Suite 106, Newport Beach, CA 92660

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Release of Information: Your Protected Health Information (PHI) will be used by this office and/or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information: You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent: You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I, _____ **(print)** acknowledge that I have reviewed the above information and I authorize this office to release information concerning my condition and treatment to my insurance company, attorney, insurance adjuster and/or other health care providers deemed necessary for treatment purposes, processing my claim, benefits and payment of services rendered to me as well as coordinated treatment. I do understand that if I choose to refuse release of this information, that my PHI will be used **within** the office for purposes of my care, to those individuals designated by the doctor.

Patient or Guardian Signature: X_____ Date: _____

Informed Consent for Treatment and Financial Agreement

I hereby request and consent to the performance of chiropractic procedures, various forms of physio-therapy, physical examination, x-ray studies, and/or any clinical services that are deemed necessary in my case to be administered by the doctor and/or any support staff employed or contracted by this office or clinic. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as “rare” and include, but are not limited to, muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fracture, disc injury, stroke, dislocations and sprains.

I understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also be used to alleviate other symptoms through a conservative approach with hopes to avoid more invasive procedures. I further understand that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has the right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I further understand that there are other treatment options available for my condition, and that I have the right to a second opinion should I have concerns as to the nature of my symptoms and/or treatment options. If during the course of my care my insurance company requires me to take an examination from any other doctor, I will notify this facility/physician immediately. I understand that failure to do so may jeopardize my case.

I, _____ **(print)** have read the above consent and I have had an opportunity to ask questions regarding its content. By signing below, I agree to the above-named procedures and intend this consent to cover my entire course of treatment for my present condition and for any future condition(s) for which I seek treatment with this office. I authorize any financial balance I have outstanding to Strive Chiropractic and Integrative Health, Gill Corporation to be charged to my credit or debit card on file for balances two weeks past last date of service.

Patient or Guardian Signature: X_____ Date: _____