Pineda Family Chiropractic
4454 Van Nuys Blvd., Suite 216
Sherman Oaks, CA 91403

Dr. Karla Pineda DC, LAc.

Welcome. Please complete the information below accurately as possible. Your answers will help determine the best course of treatment for you. If you have any questions about this form please do not hesitate to ask. Thank you!

Patient Intake Information

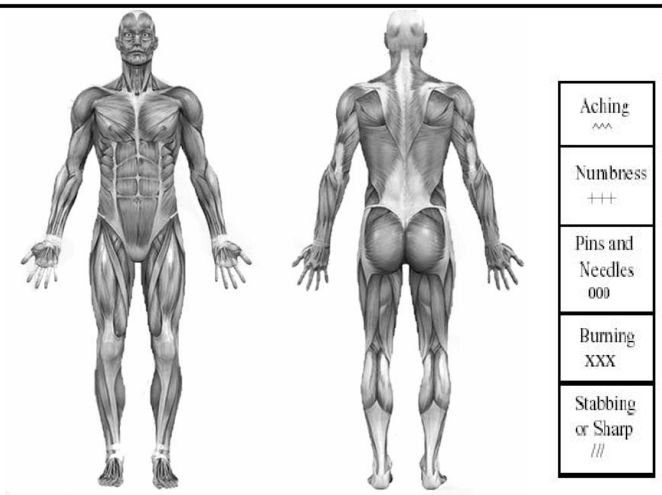
Name	DOB / /	Today's Date: / /
Address	Apt #	City
State	Zip	Email
Home #	Cell #	Work #
Height	Weight	Sex ☐M ☐F / Smoker ☐Y ☐N
Marital Status M☐S☐D☐	DL # or SS # - -	
Referred By: ☐ Friend ☐ Yelp ☐ Google ☐ Other		
Employer:	Occupation:	
Emergency Contact:	Phone #	
Primary Physician Name:	Phone #	
Last Physical Exam Date / /		

Health History / Nature of Injury

What is your Chief Complaint/Concern:

Date of Onset? / / | Has this problem occurred before? ☐Yes ☐No

Please explain your goals for this office visit:



Please mark diagram with corresponding symptoms

1) What percentage of the time do you experience this problem? < 25% 25% 50% 75% 100%

2) How many days a week do you experience this problem? 1 2 3 4 5 6 7

On the horizontal line below, draw a vertical line (|) denoting the severity of your pain:

No Pain ——————————— Excruciating Pain

3) What makes it better? _____

4) What makes it worse? _____

5) Injury due to: ☐Work ☐Car accident ☐Other

List any Imaging MRI, CT, X-Ray or Prior Surgeries:

If you have another problem area, which is the next worst?

Please make a Check Mark (☐) for current problems and CIRCLE for any prior conditions.

☐ None of the below is applicable

General
☐Allergies
☐Depression
☐Dizziness
☐Fainting
☐Fatigue
☐Fever
☐Headaches
☐Loss of sleep
☐Mental illness
☐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
☐Boils
☐Bruise easily
☐Dryness
☐Hives or allergies
☐Itching
☐Rash
☐Varicose veins

Eye, Ear, Nose & Throat
☐Colds
☐Deafness
☐Earache
☐Eye pain
☐Gum trouble
☐Hoarseness
☐Nasal obstruction
☐Nose bleeds
☐Ringing of the ears
☐Sinus infection
☐Sore throat
☐Tonsillitis
☐Vision problems

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

Genitourinary
☐Bed-wetting
☐Bladder infection
☐Blood in urine
☐Kidney infection
☐Kidney stones
☐Prostate trouble
☐Pus in urine
☐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
☐Hardening of the arteries
☐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

Women Only
☐Congested breasts
☐Hot flashes
☐Lumps in breast
☐Menopause
Are you pregnant?
☐Yes,☐no if yes, how many months?
____

Other conditions:
☐Alcoholism
☐Anemia
☐Appendicitis
☐Arteriosclerosis
☐Asthma
☐Bronchitis
☐Cancer
☐Chicken pox
☐Cold sores
☐Diabetes
☐Eczema
☐Edema
☐Emphysema
☐Epilepsy
☐Goiter ☐Gout
☐Heartburn
☐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

List any **medications** and or **supplements** that you've had and prescribing Doctor:

1._____ Dose: _____ Dr: _____
2._____ Dose: _____ Dr: _____
3._____ Dose: _____ Dr: _____

DATE: _____**SIGNATURE X:** _____

INFORMED CONSENT FOR TREATMENT AND CARE

ALL OF THE FOLLOWING AUTHORIZATIONS (PERSONAL INFORMATION, PATIENT HISTORY, AND FINANCIAL RESPONSIBILITY) MUST BE SIGNED BEFORE TREATMENT WILL BE PROVIDED

I hereby request and consent to the performance of chiropractic adjustments, therapy, including soft tissue treatment, massage therapy, acupuncture, chiropractic adjustments and other therapy procedures such as ice, heat, and therapeutic exercise on me (or the patient/minor named below, for whom I am legally responsible) by Dr. Karla Pineda D.C., L.Ac., and or any other associate/intern affiliated with Pineda Family Chiropractic.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, bruising, muscle soreness, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the Doctor(s) to be able to anticipate and explain all risks and complications. I wish to rely on the Doctor(s) to exercise judgment during the course of treatment, which the doctor feels at the time, based on the facts then known, and is in my best interests.

I have had an opportunity to discuss with the doctor of chiropractic named above the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I have read, or have had read to me, the above consent.

By signing below I agree to the above and allow the Doctor, mentioned above to perform as such. I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I certify to the best of my knowledge, the personal and patient history information I have provided is complete and accurate. I understand that I am responsible for all charges for services rendered and I agree to notify the doctor immediately whenever I have changes in my health condition or personal information in the future.

_____

Print Name

X_____ _____

Patient Signature or
(Parent/ Guardian of a Minor's) Signature

Date

For Office Use Only. Please Do Not Write Below Dashed Line

The patient has been notified of the possible risks, alternatives and complications to our treatment approaches. All questions were answered.

Doctor initials: _____ **Date**: _____

OFFICE POLICIES AND PROCEEDURES

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. As a courtesy, if you wish our office to submit insurance claims on your behalf, additional required forms will need to be completed. I understand by signing this form I am accepting financial responsibility as explained by the doctor for all procedures rendered that day and any subsequent office visits.

_____ Initial here

Release of Medical Information

I understand some cases require that our office may need to contact other doctors, physician or health care providers if my condition needs to be co-managed. Also, your insurance company may request medical reports or records to document your treatment or progress. Your signature below authorizes this office to release the medical information requested by providers or your insurance company.

_____ Initial here

Authorized Communication

I acknowledge that my doctor or office staff may need to contact me with appointment reminders, or other health related information. If this contact is made by phone and I am not at home, a message will be left on my answering machine. This contact may also be made through email, postal mail, or text messaging. Please indicate which form of communication is most convenient for you.

_____ Initial here

Cancellation Policy

I understand this clinic provides care for many individuals and missed visits result in time lost to provide care for others. Therefore we will assess a **$25.00** cancellation fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits thereafter.

_____ Initial here

I have read and agree to the above.

X_____ _____

Signature **Date**

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence-giving rise to any claim. This agreement is intended to bind the patient and health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the health care provider to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the health care provider, any fee dispute, whether or not subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty (30) days and the arbitrators appointed parties within thirty (30) days thereafter shall select a third arbitrator (neutral arbitrator). The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such parties pro rata share of all expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such parties own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the invention and jointer in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and jointer any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one (1) proceeding. A claim shall be waived and forever barred if 1: on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or 2: the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within thirty (30) days of signature and if not revoked will govern all professional services received by the patient.

Article 6: Retroactive Effect: If a patient intends this agreement to cover services rendered before the date it is signed (for example: emergency treatment) patient should initial here, _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR A COURT TRIAL. (SEE ARTICLE 1 OF THIS CONTRACT.)

PLEASE READ AND SIGN BELOW

PATIENT SIGNATURE: (Date)

(Or patient representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE: (Date)