Casalino Chiropractic ***PI PATIENT INTAKE FORM*** Date: _____

1000 E. Camelback Rd. Phx AZ 85014 602.279.7376

Name Nickname

Address Apt# City

State Zip Occupation

DOB Age M / F Social Security #

Cell # Home # Work #

E-mail:

Circle one: Single Married Partnered Divorced Widowed # of children

Name of Spouse / Partner

Contact Name in Case of Emergency Relation

Emergency Person Contact Phone

How did you learn about our office

Did you retain an attorney Y / N if so, who Phone

***Nature of This Accident***

Date of this accident _____ Time of Day _____ State: _____

Were you: ( ) Driver ( ) Passenger ( ) Front seat ( ) Back seat ( ) Motorcycle ( ) Pedestrian

Were you using your Seat Belt Y / N How many people were in your car _____

Were you struck from: ( ) Behind ( ) Front ( ) Drivers side ( ) Passenger side

Did you hit anything ***IN*** your car: ( ) Dashboard ( ) Windshield ( ) Center Console ( ) Other _____

Do you Remember the Moment of Impact Y / N How long did you not remember? ( ) A few seconds ( ) More

Were you knocked unconscious Y / N Do you know for how long _____

Were the Police notified Y / N Who was at fault _____

In your own words describe the accident _____

***Please Describe How You Felt…***

IMMEDEATELY AFTER the accident _____

LATER that day _____

The NEXT day _____

What do you feel like NOW _____

Have you noticed any limited activities or restrictions in your daily life as a result of this accident? Examples:

Were you taken to the hospital Y / N If so, Where _____

Were you given medication Y / N What _____

Were you X-rayed Y / N If so, Where _____

Have you seen another Doctor Y / N If so, who _____

Have you seen Physical Therapy or other treatment Y / N If so, who _____

Have you lost any time from work Y / N If so, how long _____

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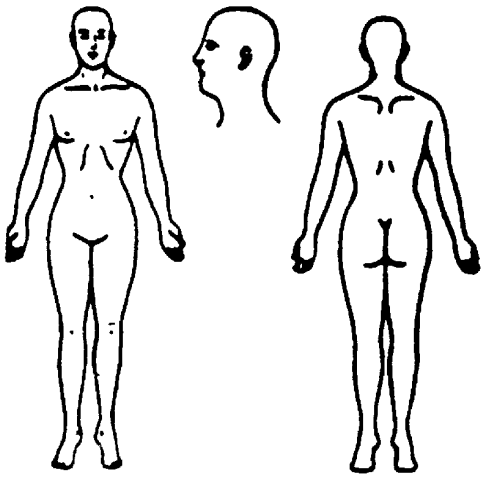
***Please mark all areas of discomfort or pain on the figures below***
***Using the symbols that best describe your pain or sensation from this accident***

**T** – Tight  **D** – Dull  **A** – Achy  **B** – Burning  **S** – Spasm
**N** – Numb  **O** - Pins & Needles  **X** - Stabbing

*For any other sensations please describe off to the side of the picture*
***don't forget to mark any symptoms that radiate into your head, arms or legs***



******It's very important for you to List & Score Your Symptoms from This Accident in the area below:***

| List where Your Pain or Symptoms are located in the area below: | Circle How Severe Your Pain or Symptoms are using the scale in which "0" is no pain or symptoms and "10" is severe pain or symptoms(s):  | Please check the box below that best represents how often or What Percent of the Day you feel your pain or symptoms: |
|---|---|---|
| 1 | 0 1 2 3 4 5 6 7 8 9 10 | ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% |
| 2 | 0 1 2 3 4 5 6 7 8 9 10 | ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% |
| 3 | 0 1 2 3 4 5 6 7 8 9 10 | ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% |
| 4 | 0 1 2 3 4 5 6 7 8 9 10 | ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% |
| 5 | 0 1 2 3 4 5 6 7 8 9 10 | ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% |
| 6 | 0 1 2 3 4 5 6 7 8 9 10 | ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% |

***Have you felt any of the following symptoms Since the Accident***

| | | |
|---|---|---|
| ___ *Headache* | ___ *Nervousness* | ___ *Ringing / Buzz in Ears* |
| ___ *Dizziness* | ___ *Blurred Vision* | ___ *Paralysis* |
| ___ *Loss of Concentration* | ___ *Depression* | ___ *Fainting* |
| ___ *Forgetfulness* | ___ *Difficulty Sleeping* | ___ *Palpitations* |
| ___ *Confusion* | ___ *Loss of Energy* | ___ *Convulsions* |

**Did** you have any physical complaints BEFORE this Accident? Y N If so, please describe in detail

_____

_____

_____

LIST MEDICATIONS OR DRUGS YOU ARE TAKING **AND** FOR WHAT OR WHY?

□ I AM NOT TAKING ANY MEDICATION OR DRUGS AT THIS TIME

| | |
|---|---|
| | |
| | |
| | |
| | |

*Check any of the following conditions that YOU have had*

__ Heart Disease
__ High Blood Pressure
__ Stroke / Aneurysm
__ Diabetes
__ Kidney Disease
__ Lupus
__ Gout
__ Seizures
__ Polio
__ HIV / AIDS
__ Valley Fever

**D**izzy or **L**ight **H**eaded when
__ Moving your neck,
__ Changing positions
__ or Laying down

__ Osteoarthritis
__ Degenerative Disc Disease
__ Disc Injuries
__ Herniated / Slipped Disc
__ Spinal Block Injections
__ Lumbar / low back
__ Neck
__ Scoliosis
__ Osteoporosis/Osteopenia
__ Rheumatoid Arthritis
__ Unexplained weight loss

Abdominal Waist Size
__ Over 35 inches (female)
__ Over 40 inches (male)

Broken Bones – Location & When
_____
_____
_____

Surgeries - Location & When
_____
_____
_____

History of Cancer - Type
_____
_____
_____

Other
_____
_____

## FAMILY HEALTH HISTORY

| *Mother's Side* | *Father's Side* |
|---|---|
| __ Cardio Vascular Disease | __ Cardio Vascular Disease |
| __ High Blood Pressure | __ High Blood Pressure |
| __ Diabetes | __ Diabetes |
| __ Arthritis | __ Arthritis |
| __ Autoimmune Disease | __ Autoimmune Disease |
| __ Kidney Disease | __ Kidney Disease |
| __ Cancer - type | __ Cancer - type |

_____ _____

*I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Casalino Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Casalino Chiropractic will be credited to my account upon receipt. However, I clearly understand that all services rendered to me are charged directly to me and that I AM PERSONALLY responsible for payment. I also understand that if I suspend or terminate my care and treatment, ANY fees for professional services rendered to me will be immediately due and payable. I also understand and agree to give Casalino Chiropractic Office, P.C. the POWER OF ATTORNEY to sign any insurance check mailed to the doctor with my name on the check for any services rendered at Casalino Chiropractic Offices, P.C. I authorize payment of medical benefits to Casalino Chiropractic Office, P.C. for any and all services rendered. I also authorize the release of any information pertinent to my case to any insurance, adjuster, or attorney involved in this case.*

***NAME OF PERSON RESPONSIBLE FOR PAYMENT_____***

***PATIENT SIGNATURE_____ DATE _____***

***PARENT OR GUARDIAN SIGNATURE_____ DATE _____***