CASALINO CHIROPRACTIC

1000 E. Camelback Rd Phoenix AZ 85014 602.279.7376

PERSONAL HISTORY

DATE_____

NAME _____ NICKNAME_____

ADDRESS _____ APT# _____ CITY _____

STATE _____ ZIP_____ OCCUPATION_____

BIRTH DATE_____ AGE _____ ☐ MALE ☐ FEMALE

CELL PHONE _____

HOME PHONE _____

E-mail Address _____

CHECK ONE: ☐ MARRIED ☐ SINGLE ☐ PARTNERED ☐ DIVORCED ☐ WIDOWED # OF CHILDREN _____

NAME OF SPOUSE / PARTNER _____

HOW DID YOU LEARN ABOUT OUR OFFICE _____

NAME IN CASE OF EMERGENCY _ _____PHONE _____

HEALTH INFORMATION: RELATION:_____

DESCRIBE YOUR CURRENT COMPLAINT_____

WHEN DID THIS START? _____ DID IT DEVELOP OVER TIME YES____

HOW DID IT START? __ *TRAUMA* __ *AUTO ACCIDENT* __ *ON THE JOB* __ *POST-SURGICAL* __ *REPETITIVE*

* *PLEASE DESCRIBE* _____

IS IT GETTING WORSE YES_____ NO_____ DOES IT COME & GO YES____ NO____

HOW MUCH HAS THIS INTERFERED WITH YOUR DAILY LIFE? __*A LITTLE* __*MODERATELY* __*QUITE A BIT* __*EXTREMELY*

HAVE YOU SEEN OTHER *DOCTORS OR PHYSICAL THERAPIST* FOR THIS CONDITION Yes____ No____

IF SO, WHO DID YOU SEE? _____

PREVIOUS CHIROPRACTIC CARE YES____ NO____ IF SO, FOR WHAT CONDITION _____

DATE OF LAST VISIT_____ DRS. NAME _____

HOW WOULD YOU DESCRIBE YOUR OVERALL HEALTH? __*EXCELLENT* __ *VERY GOOD* __ *GOOD* __ *FAIR* __ *POOR*

PRIMARY CARE PHYSICIAN NAME & PHONE _____

WHEN WAS YOUR LAST PHYSICAL? _____ PHONE _____

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.

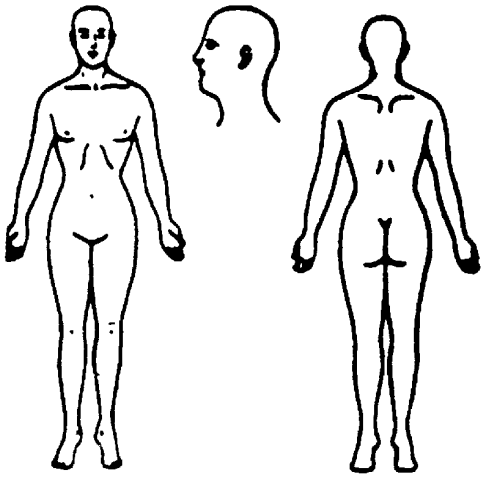
NAME OF PERSON RESPONSIBLE FOR PAYMENT _____

PATIENTS SIGNATURE _____DATE _____

PARENT OR GUARDIAN SIGNATURE_____DATE _____

Please mark all the areas of discomfort or pain on the pictures below using the corresponding symbols that best describe what you are feeling.

Numb – n *Pins & Needles – o* *Burning – b* *Stabbing - x*
Dull ache – d *Tightness – t* *Spasm – s* *Other: describe off to the side*



Complete the table below for each of the symptoms that you are experiencing.

Please **list** *where your Pain or Symptoms are located in the area below:*	*Circle* **how severe your pain or symptoms are** *using the scale below "0" is no pain or discomfort & "10" is severe pain or discomfort*	*Please check the box below that best represents* **what percent of the day** *you feel your pain or symptoms:*	**Date you first noticed** *this symptom?*
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%	

Please check the box that best describes whether your pain or symptom(s) limit normal activities.

Activity	**Normal**	**Somewhat limited**	**Very limited**	**Activity**	**Normal**	**Somewhat limited**	**Very limited**
Lifting	☐	☐	☐	Running	☐	☐	☐
Bending	☐	☐	☐	Sleeping	☐	☐	☐
Standing	☐	☐	☐	Intercourse	☐	☐	☐
Walking	☐	☐	☐	Work	☐	☐	☐
Computer work/typing	☐	☐	☐	Household activities	☐	☐	☐
Sitting	☐	☐	☐	Recreational Activities	☐	☐	☐
Climbing Stairs	☐	☐	☐	Other (list below)			
				_____	☐	☐	☐

How would you rate the following categories in your daily living?

Your Exercise Routine
- ☐ None to light
- ☐ Moderate
- ☐ Heavy

_____ # of days per week

Primary Work position or Activity
- ☐ Sitting
- ☐ Standing / Bending
- ☐ Light Labor
- ☐ Heavy Labor

Social Habits
- ☐ Smoking ____ Packs/day ___NA
- ☐ Alcohol ____ Drinks/day ___NA
- ☐ Caffeine ____ Drinks/day ___NA
- ☐ High Stress

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NAME _____

LIST ANY MEDICATIONS YOU ARE TAKING & FOR WHAT CONDITION YOU ARE TAKING THEM FOR:

☐ **NONE** – *I am NOT currently taking any medications.*

LIST THE MEDICATIONS YOU ARE TAKING	**FOR WHAT CONDITION**

CHECK ANY OF THE FOLLOWING CONDITIONS THAT APPLIES TO YOU:

__ Heart Disease
__ High Blood Pressure
__ Stroke / Aneurysm
__ Diabetes
__ Kidney Disease
__ Connective Tissue disease
___Ehlers Danlos Syndrome
___Marphan syndrome
__ Rheumatoid Arthritis
__ Lupus
__ Gout
__ Osteoporosis/Osteopenia
__ Seizures
__ Dizziness or light headed

Lumbar Spine / Low Back
__ Osteoarthritis
__ Degenerative Disc
__ Herniated /Slipped Disc
__ Spinal Block / RFA

Cervical Spine / Neck
__ Osteoarthritis
__ Degenerative Disc
__ Herniated/Slipped Disc
__ Spinal Block / RFA

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

__ Unexplained weight loss

History of Cancer: Type & When
_____
_____
_____

Broken Bones: Location & When
_____
_____
_____

Surgeries: Location & When
_____
_____
_____

Is there any other health condition that has not been listed?

_____

FAMILY HEALTH HISTORY

Mother's Side

__ Cardio Vascular Disease
__ High Blood Pressure
__ Diabetes
__ Arthritis
__ Autoimmune Disease
__ Kidney Disease
__ Cancer – *What type?*

_____
_____

Father's Side

__ Cardio Vascular Disease
__ High Blood Pressure
__ Diabetes
__ Arthritis
__ Autoimmune Disease
__ Kidney Disease
__ Cancer – *What type?*

_____
_____