Casalino Chiropractic

1000 E. Camelback Rd.
602.279.7376

PATIENT INTAKE FORM

Name Date File #

Address City

State Zip Occupation

Mobile # Carrier Name Home#

Email Address Work #

DOB Age M/F Social Security #

Name of Spouse Single Divorced Widowed # of children

Name & Phone in Case of Emergency

Relation to you

How did you learn about our office

Nature of This Accident

Date of this accident _____ Time of Day _____

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

Approximate speed of your car _____ The other car _____

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

Were you knocked unconscious Y / N If so, for how long _____

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

Did you have any physical complaints before the accident Y / N If so please describe in detail _____

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 activity restrictions as a result of this accident _____

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

Were you X-rayed Y / N Were you given medication Y / N What _____

Have you seen another Dr. or Physical Therapist Y / N If so, who _____

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

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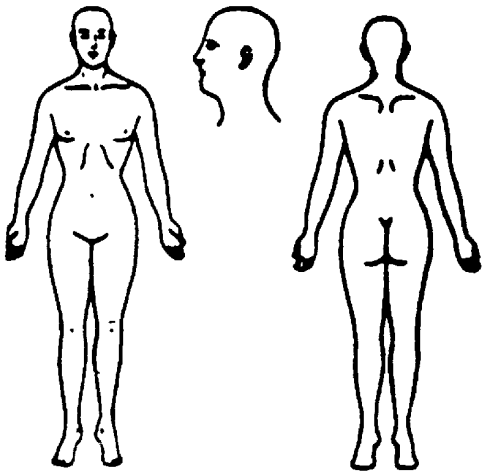
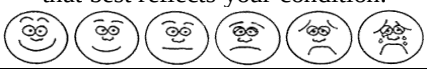
Please mark all areas of discomfort or pain on the figures below
Using the symbols that best describe your pain or sensation

T – Tight D – Dull A – Achy B – Burning S – Spasm
N – Numb O - Pins & Needles X - Stabbing
Any other sensations please describe off to the side of the picture
don't forget to mark any symptoms that radiate into your arms or legs



******Please mark the scales below to show the amount of pain that you are in and what percentage of the day that you have that pain.***

Please list your reason(s) for this visit or your condition(s) in order of importance:	Using a scale in which "0" is none (no pain or symptoms) and "10" is severe pain or symptoms(s), **circle** the number that best reflects your condition: 	Please check the box below that best represents how much of the time you feel pain or your symptom(s) for the listed reason:
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 since the accident

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

LIST MEDICATIONS OR DRUGS YOU ARE TAKING	**AND** FOR WHAT:
NONE *(PLEASE CIRCLE IF THIS IS ACCURATE)*	

Check any of the following conditions that you have had

__ Heart Disease	__ Osteoarthritis	
__ High Blood Pressure	__ Degenerative Disc Disease	History of Cancer - Type
__ Stroke / Aneurysm	__ Disc Injuries	_____
__ Diabetes	__ Herniated Disc	_____
__ Elevated Cholesterol	__ Slipped Disc	_____
__ Elevated Triglycerides	__ Spinal Block Injections	_____
__ Osteoporosis/Osteopenia	__ Rheumatoid Arthritis	
__ Kidney Disease	__ Seizures	Broken Bones - Where
__ Food Allergies	__ Gout	_____
__ Abdominal Waist Size	__ Lupus	_____
__ Over 35 inches (female)	__ Polio	_____
__ Over 40 inches (male)	__ HIV / AIDS	_____
__ Unexplained weight loss	__ Valley Fever	_____

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 _____