CASALINO CHIROPRACTIC

1000 E. Camelback Rd Phoenix AZ 85014
602.279.7376

PATIENT NO._____

PERSONAL HISTORY

NAME _____ DATE _____

ADDRESS _____ CITY _____

STATE_____ ZIP_____ OCCUPATION_____

BIRTH DATE_____ AGE _____ ☐ MALE ☐ FEMALE

HOME PHONE _____ SOCIAL SECURITY # _____

CELL PHONE _____ WORK PHONE _____

CELL CARRIER NAME _____ E-MAIL ADDRESS _____

CIRCLE ONE: MARRIED SINGLE WIDOWED DIVORCED # OF CHILDREN _____

NAME OF SPOUSE _____

HOW DID YOU LEARN ABOUT OUR OFFICE _____

NAME AND PHONE IN CASE OF EMERGENCY _____RELATION_____

HEALTH INFORMATION:

DESCRIBE YOUR CURRENT COMPLAINT_____

WHEN DID THIS START _____ DID IT DEVELOP OVER TIME YES____

HOW DID IT START _____

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

IS THIS CONDITION DUE TO AN AUTO ACCIDENT YES____ NO____ IS THIS JOB RELATED YES____ NO____

OTHERS DOCTORS SEEN FOR THIS CONDITION _____

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

DATE OF LAST VISIT_____ DRS. NAME _____

PRIMARY CARE PHYSICIAN & PHONE_____

DATE OR YOUR LAST PHYSICAL _____

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.

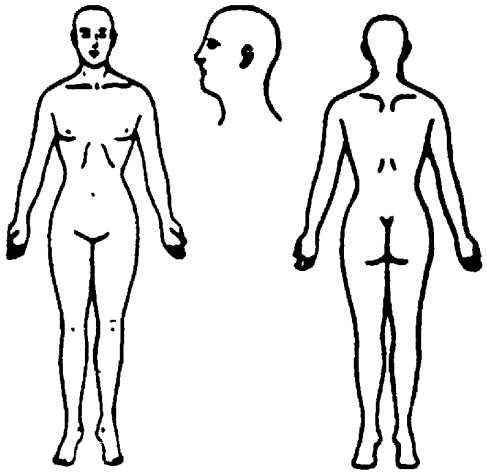
NAME OF PERSON RESPONSIBLE FOR PAYMENT _____

PATIENTS SIGNATURE _____DATE _____

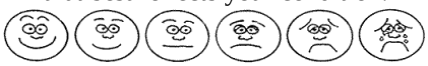
PARENT OR GUARDIAN SIGNATURE_____DATE _____

Please mark all the areas of discomfort or pain
on the figures using the right symbols that best describe the feeling:

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



Please mark the table below to show the ***location***, ***severity*** of symptom and what ***percentage*** of the day that you have that pain.

Please list the location of your pain or symptom in order of severity or importance	Using a scale in which "0" is <u>none</u> (no pain or symptoms) and "10" is <u>severe</u> 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:	***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
☐ Moderate
☐ Heavy
_____ Days per Week

Your Work Activity

☐ Sitting
☐ Standing / Bending
☐ Light Labor
☐ Heavy Labor

Your Habits

☐ Smoking ____ Packs/day
☐ Alcohol ____ Drinks/day
☐ Caffeine ____ Drinks/day
☐ High Stress

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NAME _____

File #_____

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

☐ NONE

LIST MEDICATIONS OR DRUGS YOU ARE TAKING	**AND** FOR WHAT:

CHECK ANY OF THE FOLLOWING CONDITIONS THAT APPLIES TO YOU:

__ Heart Disease
__ High Blood Pressure
__ Stroke / Aneurysm
__ Diabetes
__ Elevated Cholesterol
__ Elevated Triglycerides
__ Osteoporosis/Osteopenia
__ Kidney Disease
__ Food Allergies
__ Abdominal Waist Size
__ Over 35 inches (female)
__ Over 40 inches (male)
__ Unexplained weight loss

__ Osteoarthritis
__ Degenerative Disc Disease
__ Disc Injuries
__ Herniated Disc
__ Slipped Disc
__ Spinal Block Injections
__ Rheumatoid Arthritis
__ Seizures
__ Gout
__ Lupus
__ Polio
__ HIV / AIDS
__ Valley Fever

History of Cancer - Type
_____
_____
_____
_____
_____

Broken Bones - Where
_____
_____
_____
_____
_____

__ Blurred vision, dizziness, or light headed when changing positions, laying down or moving your neck

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?*

_____
_____
_____