Patient Name _____Date_____Age _____

- Are you seeking Chiropractic care for ___ injury ___ condition ___ wellness care?

- Please list any current health complaints or concerns:

_____
_____
_____
_____

- List any health professionals seen for the issues listed above:

_____
_____
_____
_____

- List all surgeries and procedures:

_____
_____
_____
_____

- List medications and/or supplements you take:

_____
_____
_____
_____

- Have you had an automobile accident, worker's comp or other injury:

_____
_____
_____
_____

- Is there any health information you would like us to know about you:

_____
_____
_____
_____

Name: _____ **Date:** _____

SYMPTOM SURVEY: * Please check ALL that apply

Head:

Headache Severity: ( )Mild ( )Moderate ( )Severe
Frequency: ___ times per day( ) wk( ) mo( )
Characteristics: ( )Sharp ( )Dull ( )Constant ( )Intermittent
Located: _____
Other: _____

Neck:
Pain Severity: ( )Mild ( )Moderate ( )Severe
Location: ( )Right ( )Left ( )Both
Pain with movement: ( )Forward ( )Backward ( )Turn ( )Bend
Characteristics: ( )Stiffness ( )Spasm ( )Grinding

Shoulder:

Pain in joint	( )Left ( )Right ( )Both
Pain across shoulder	( )Left ( )Right ( )Both
Movement restricted	( )Left ( )Right ( )Both
Tension	( )Left ( )Right ( )Both

Arms:

Pain in upper arm	( )Left ( )Right ( )Both
Pain in elbow	( )Left ( )Right ( )Both
Pain in Forearm	( )Left ( )Right ( )Both
Tingling/Numbness	( )Left ( )Right ( )Both

Hands:

Pain in wrist	( )Left ( )Right ( )Both
Pain in Hand	( )Left ( )Right ( )Both
Tingling/Numbness	( )Left ( )Right ( )Both

Mid back:
Pain Severity: ( )Mild ( )Moderate ( )Severe
Location: ( )Left ( )Right ( )Both
Pain with movement: ( )Forward ( )Backward ( )Turn ( )Bend
Characteristics: ( )Sharp ( )Dull ( )Constant ( )Intermittent

Chest:

Pain in deep chest	( )Left ( )Right ( )Both
Pain in ribs	( )Left ( )Right ( )Both
Pain Severity	( )Mild ( )Moderate ( )Severe

Abdomen:
Pain Severity: ( )Mild ( )Moderate ( )Severe
Location: ( )Left ( )Right ( )Both
Characteristics: ( )Nausea ( )Gas ( )Constipation ( )Diarrhea

Low back:
Pain Severity: : ( )Mild ( )Moderate ( )Severe
Location: ( )Left ( )Right ( )Both
Pain with movement: ( )Forward ( )Backward ( )Turn ( )Bend
Characteristics: ( )Sharp ( )Dull ( )Constant ( )Intermittent

Hips and Legs:

Pain in buttocks	( )Left ( )Right ( )Both
Severity	( )Mild ( )Moderate ( )Severe
Pain in hip	( )Left ( )Right ( )Both
Severity	( )Mild ( )Moderate ( )Severe
Pain down leg	( )Left ( )Right ( )Both
Severity	( )Mild ( )Moderate ( )Severe
Numbness leg	( )Left ( )Right ( )Both
Severity	( )Mild ( )Moderate ( )Severe
Knee pain	( )Left ( )Right ( )Both
Severity	( )Mild ( )Moderate ( )Severe
Leg Cramps	( )Left ( )Right ( )Both
Severity	( )Mild ( )Moderate ( )Severe

Feet:

Ankle Pain	( )Left ( )Right ( )Both
Swollen Ankle	( )Left ( )Right ( )Both
Foot Pain	( )Left ( )Right ( )Both
Numbness	( )Left ( )Right ( )Both
Swollen Feet	( )Left ( )Right ( )Both
Cramps	( )Left ( )Right ( )Both

Notes: _____
_____
_____
_____
_____

System Review Form

Eyes:
- ( ) Blurring of vision
- ( ) Double Vision
- ( ) Eye Fatigue easily
- ( ) Excessive tearing
- ( ) Light bothers eyes
- ( ) Excessive itching
- ( ) Pain in eyeball

Ears:
- ( ) Loss of hearing
- ( ) Pain in ears
- ( ) Discharge from ears
- ( ) Vertigo
- ( ) Ringing in ears

Nose/Sinus:
- ( ) Unusual nasal discharge
- ( ) Nose bleeds
- ( ) Pressure over eyes
- ( ) Pressure under eyes
- ( ) Obstruction of nose
- ( ) Frequent colds
- ( ) Sinusitis
- ( ) Nasal allergies
- ( ) Loss of smell
- ( ) Nasal trauma

Mouth/Throat:
- ( ) Pain in mouth
- ( ) Pain in throat
- ( ) Bleeding gums
- ( ) Cavities
- ( ) Abscessed teeth
- ( ) Dentures
- ( ) Difficulty swallowing
- ( ) Changes in voice

Respiratory:
- ( ) Shortness of breath
- ( ) Cannot breathe while lying
- ( ) Cannot sleep while lying
- ( ) Dry cough
- ( ) Productive cough
- ( ) Coughing up blood
- ( ) Wheezing

Gastrointestinal:
- ( ) Poor appetite
- ( ) Constant nibbling
- ( ) Difficult swallowing
- ( ) Indigestion
- ( ) Some foods bother
- ( ) Nausea, vomiting
- ( ) Jaundice
- ( ) Abdominal pain
- ( ) Change in bowel
- ( ) Diarrhea
- ( ) Constipation
- ( ) Hemorrhoids

Genitourinary:
- Urination:
  - ( ) Frequent
  - ( ) Normal
  - ( ) Infrequent
- Urine Amount:
  - ( ) High
  - ( ) Normal
  - ( ) Low
- ( ) Need to get up at night to urinate
- ( ) Abnormal intense desire to urinate
- ( ) Difficulty starting urination
- ( ) Decreased output
- ( ) Pain on urination
- ( ) Dribbling
- ( ) Blood in urine
- ( ) Cloudy urine
- ( ) Lack of bladder control
- ( ) Abdominal pain

Skin/Hair/Nails:
- ( ) Eczema
- ( ) Itchy skin
- ( ) Dry scalp
- ( ) Oily scalp
- ( ) Rough, scaly skin
- ( ) Dry/oily skin
- ( ) Psoriasis
- ( ) Yellow skin
- ( ) Bruise easily
- ( ) Paper thin nails
- ( ) Nail biting

Venereal Disease:
- ( ) AIDS
- ( ) Syphilis
- ( ) Gonorrhea
- ( ) Other _____

Social History:
- ( ) Smoking
- ( ) Tobacco, other
- ( ) Alcohol use
- ( ) Drink coffee, tea
- ( ) Nervousness
- ( ) Irritability
- ( ) Fatigue
- ( ) Depression
- ( ) Generally run-down
- ( ) Crave sweets
- ( ) Crave salt

Diet:
- ( ) Balanced
- ( ) Not balanced

Rest:
- ( ) Sufficient
- ( ) Not sufficient

Recreation:
- ( ) Sufficient
- ( ) Not sufficient

Stress Levels:
- Family:
  - ( ) Severe
  - ( ) Moderate
  - ( ) Minimal
  - ( ) None
- Job:
  - ( ) Severe
  - ( ) Moderate
  - ( ) Minimal
  - ( ) None

Work:
- ( ) I like it very much
- ( ) It's okay
- ( ) I hate it

For Women:
- ( ) Painful period
- ( ) Spotting
- ( ) PMS
- ( ) Irregular periods
- ( ) Lumps in breasts

Family History:
- Cancer: ____Yes ____No
  Relationship: _____
- Diabetes ____Yes ____No
  Relationship: _____
- Heart: ____Yes ____No
  Relationship: _____
- Kidney: ____Yes ____No
  Relationship: _____
- Lung: ____Yes ____No
  Relationship: _____
- Osteoporosis: ____Yes ____No
  Relationship: _____
- Scoliosis: ____Yes ____No
  Relationship: _____

...About You

Last: _____ First: _____ MI: ____

Address: _____City, St, ZIP _____

Email: _____Cell #: _____

Employer: _____ Occupation: _____ Work #:_____

Birth Date: _____ Age: _____

Emergency Contact: _____ Phone _____

...Account Information

Person Financially Responsible for Account: _____

Address: _____

Relationship: _____

Phone: _____ DOB: _____

I authorize Dr. Mascali and to perform examination and treatment, and to diagnose and administer whatever chiropractic care is deemed necessary. I am NOT pregnant.

I authorize assignment of my insurance benefits or sums from any settlement, judgment, or verdict directly to Edward J. Mascali, D.C. for the services he provides. I authorize the release of my records to insurance companies, other medical professionals, or attorneys' offices.

I agree to pay Dr. Mascali for his services, as the charges are incurred, unless other arrangements have been made prior to treatment. I understand that my insurance plan is a contract between my company and me and that I am fully responsible for payment of all fees.

Signature: _____ Date _____

Name of Guardian, if Applicable _____

Informed Consent for Chiropractic Services

Patient Information:

Name: _____ **Date of Birth:** _____

Address: _____ **Phone Number:** _____

Purpose of Chiropractic Care:

The purpose of chiropractic care is to help improve overall health and alleviate pain through spinal and extra-spinal adjustments, as well as the use of modalities for the care of the musculoskeletal system.

Some Potential Benefits:

Relief from pain and discomfort, improved mobility and function, enhanced overall wellness and prevention of future injuries.

Risks and Considerations:

While chiropractic care is generally safe, it is important to be aware of the following potential risks, such as, temporary soreness or discomfort in the treated area, headaches or fatigue, and very rare but serious complications, such as herniated discs or nerve damage

I understand that no treatment is without risk, and I have the right to ask questions about any aspect of my care.

I understand and am informed that, in the practice of chiropractic, there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Patient Responsibilities:

I agree to provide accurate and complete information regarding my health history, including medications, past treatments, and current health conditions. I also agree to communicate openly with my chiropractor about my health and any changes I may experience during treatment.

Consent for Treatment:

By signing this form, I consent to receive chiropractic care from Edward J. Mascali, D.C. and associates. I understand that I can withdraw my consent at any time and that I am free to ask questions regarding the treatment and procedures recommended.

Acknowledgment:

I have read and understood the information provided above. I acknowledge that I have had the opportunity to ask questions and that all my questions have been answered to my satisfaction.

Signature of Patient: _____ **Date:** _____