

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 _____