Welcome to Dr. Mascali's Office!

We appreciate and value the privilege of serving you
and your family through Chiropractic Care!

We offer detailed examinations, specific and gentle Chiropractic adjustments and varied therapies to partner with you in maintaining or regaining your health.

Appointments

We make very attempt to stay on schedule and it is helpful if you are on time for your appointments. ***We do not double book*** – therefore, the time scheduled is reserved specifically for you. We encourage you to schedule in advance so that you can book the time slots you prefer.

We understand that unforeseen events may require you to reschedule or cancel an appointment. In that case, please give us the courtesy of a 24-hour notice. This enables us to reschedule you for the time you would prefer, while filling the appointment with another patient that may need it – as we frequently have a waiting list for cancellations.

In the event a patient misses a scheduled appointment without calling to reschedule or cancel, we must charge a $50 fee.

Payment

We are currently out-of-network with all major medical insurance companies; however, your policy may have a provision which covers part of your care in our office. In these cases, patients pay in full at the time service is rendered and we provide a receipt for your reimbursement.

In most cases of automobile accident or worker's comp injury, we are able to bill directly to the appropriate insurance company. Your unique policy and circumstance will determine our ability to do so. Please understand, since our relationship is with you, our patient, and not an insurance company, ultimately we must hold you responsible for all fees for services rendered.

For our self-pay patients, we offer a pay-as-you-go option, as well as a pre-paid plan. We are glad to share the details of these options with you.

I have read and agree to the above office policy.

_____

Signature Date

Medical Payment information

In order to file your Med-Pay Claim our office must have the following information prior to treatment:

Name of Patient: _____

Today's Date: _____ Date of Accident: _____

The Insurance Company insuring the vehicle you were in at the time of the accident.

Name: _____

Claims Address: _____

_____

Adjuster's Name: _____

Phone Number: _____

CLAIM NUMBER: _____

I, hereby, authorize and direct my insurance company, attorney or insurance adjuster to promptly pay Edward J. Mascali, DC any monies due and owed him for fees incurred for chiropractic services rendered and to withhold such sums from any settlement, judgement or verdict as may be necessary to fully compensate said doctor.

I understand that I am fully and directly responsible to Dr. Mascali for all fees incurred in his office and for care rendered to me. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

_____

Signature Today's Date

Name _____ Age _____ Date _____

...Please list ALL your current health complaints, including the reason that brought you to our office:

...List any other doctors seen for current problems and list treatment received and results:

...List all surgeries you have had and list dates:

...List medications you are now taking:

...Have you ever been in an automobile accident? Date and information:

...Have you ever had an industrial/work related injury or any other serious injury, which required treatment:

Name: _____ Date: _____

SYMPTOM SURVEY: Please Circle ALL that Apply

Head:
Headache Severity: Mild / Moderate / Severe
Frequency: 1 2 3 4 5 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
Other: _____

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: Right / Left / Both
Pain with movement: Forward / Backward / Turn / Bend
Characteristics: Sharp / Dull / Constant / Intermittent
Other: _____

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: Right / Left / Both
Characteristics: Nausea / Gas / Constipation / Diarrhea

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

Hips and Legs:

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

Feet:

Ankle Pain	Right / Left / Both
Swollen Ankle	Right / Left / Both
Foot Pain	Right / Left / Both
Numbness	Right / Left / Both
Swollen Feet	Right / Left / Both
Cramps	Right / Left / Both

Notes: _____

System Review

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 is: ( ) frequent
( ) normal
( ) infreq
amount is: ( ) 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
( ) Lake 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
( ) Baldness

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	*Job*
( ) severe	( ) severe
( ) mod	( ) mod
( ) min	( ) min
( ) none	( ) none

Work:
( ) I like it very much?
( ) It' ok
( ) I hate it

For Women:
( ) Painful period
( ) Spotting
( ) Vaginal discharge
( ) PMS
( ) Irregular periods
( ) Lumps in breast
pregnancies _____
deliveries _____

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 ___ SS#_____

Address _____ Home #_____

_____ Email _____

Employer _____Occupation _____ Work # _____

Birth Date _____ Age _____ SMWD Cell # _____

Emergency Contact_____ # _____

...Account information

Person Financially Responsible for Account _____

Address _____ Relationship _____

_____

SS # _____ Phone _____ DOB _____

...Insurance Information

Insurance Co. _____

Address for Claims _____

_____

Name of Primary Insured _____ DOB _____

Pt. ID# _____ Group# _____

Customer Service Phone _____

I authorize Dr. Mascali and his agents to perform examination and treatment, including x-ray exam 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 also authorize Dr. Mascali to release my x-rays to a radiologist if a second opinion is necessary. I understand there is a fee for this service and I will be responsible for the fee.

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.

X_____

signature

Informed consent to Chiropractic Treatment with Edward J. Mascali, D.C.

Please read this consent form, feel free to ask any questions you may have and then sign where indicated at the bottom.

Clinicians who use spinal manual/instrument therapy techniques, such as for example joint adjustment or manipulation or mobilization, are required to inform patients that there are or may be some risks associated with such treatment.

While rare, some patients have experienced muscle and ligament sprains or strains, or rib fractures following spinal manual therapy. There have been reported cases of injury to a vertebral artery following neck adjustment, manipulation and mobilization. Such vertebral artery injuries may on rare occasion cause stroke, which may result in serious neurological injury and/or physical impairment. This form of complication is an extremely rare event, occurring about 1 time per 1 million treatments.

There have been reported cases of disc injuries following spinal manual therapy, although no scientific study has ever demonstrated that such injuries are caused, or may be caused, by adjustment or manipulative techniques and such cases are also very rare.

Treatments provided in my office, including spinal adjustment, manipulation and /or mobilization, have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders/arms/legs, headaches and other similar symptoms. The risk of injury or complication from manual treatment is substantially lower than the risk associated with many medications, other treatments and procedures frequently given as alternative treatments for the same forms of musculoskeletal pain and other associated syndromes.

Additionally, we primarily use the Activator Method in our practice. The Activator Method is one of the most widely-researched chiropractic techniques and the only instrument adjusting technique with 23 clinical trials to support its efficacy. Activator Methods has published hundreds of clinical and scientific peer-reviewed papers, worked with major academic research institutions, and received grants from recognized entities like the National Institutes of Health. - activator.com/research

Acknowledgement: I acknowledge I have discussed, or have been given the opportunity to discuss, with my Dr. the nature of chiropractic treatment in general and my treatment in particular as well as the contents of this consent.

Consent: I consent to the chiropractic treatment(s) offered or recommended to me by my clinician, including joint adjustment or manipulation or mobilization to the joints of my spine (neck and back), pelvis and extremities (shoulder, upper limbs and lower limbs). This consent applies to all my present and future treatments with Dr. Mascali.

X _____ ***Patient / Guardian Signature***

_____ ***Date***

AUTO ACCIDENT FORM

Patient Information

Last_____ First_____
Middle_____ Birthdate___/___/_____
Address_____
City_____ State_____ Zip_____
Phone Numbers (cell)_____(other)_____
Today's Date ___/___/_____ Email_____
Occupation_____ Employer_____
Contact Name_____
Contact Phone Number_____

Accident Information

Date of accident____ /_____ /_____ Time of accident_____ am / pm
Road conditions at the time of accident _____
Describe the accident in your own words _____

_____

Where were you seated in the vehicle?_____
Did you lose consciousness upon impact? **Yes No** Did any part of your body contact the inside of the vehicle? **Yes No**
If so, please describe here _____

_____

Were you wearing a seatbelt? **Yes No**
If yes, did you receive any injury or bruising from the seatbelt? **Yes No**
At the time of the accident or just after did you become or experience any of the following? ☐ Disoriented ☐ Confused ☐ Dizzy ☐ Nauseated ☐ Blurred Vision ☐ Loss of Balance ☐ Lightheaded ☐ Ringing/Buzzing in Ears
Do you still have any of these symptoms? **Yes No**

Do you still have any of these symptoms? **Yes No**
Did you go to the hospital? **Yes No** If yes, when? _____
Name of hospital? _____
What did the hospital do for your injuries? (collars, splints, x-rays, medication, surgery, etc.) _____
What was their diagnosis? _____
What did they recommend for follow-up care?

_____

Was any other doctor consulted after your accident? **Yes No**
If yes, please complete information below:

Dr. _____ Specialty:_____
Date first seen:_____ /_____ /_____
Type of treatment:_____
Are you still receiving treatment? _____

Auto Accident Insurance Information:

Name of YOUR Auto Insurance Company:_____

Address for Claims: _____

_____

Med-Pay Claim # : _____

Name and Phone of Adjuster : _____

Was this accident on the job? **Yes No** Is there a police report? **Yes No**

Lost time at work? **Yes No** Amount: _____

Workman's Comp Insurance Information:

Name of Company: _____

Address for Claims: _____

_____

Claim # : _____

Name and Phone Number of Adjuster: _____

DATE: _____

NECK DISABILITY INDEX

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Section 1 -- Pain Intensity
- A I have no pain at the moment.
- B The pain is very mild at the moment.
- C The pain is moderate at the moment.
- D The pain is fairly severe at the moment.
- E The pain is very severe at the moment.
- F The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)
- A I can look after myself normally without causing extra pain.
- B I can look after myself normally, but it causes extra pain.
- C It is painful to look after myself and I am slow and careful.
- D I need some help, but manage most of my personal care.
- E I need help every day in most aspects of self care.
- F I do not get dressed, I wash with difficulty and stay in bed.

Section 3 -- Lifting
- A I can lift heavy weights without extra pain.
- B I can lift heavy weights, but it gives extra pain.
- C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniety positioned.
- E I can lift very light weights.
- F I cannot lift or carry anything at all.

Section 4 -- Reading
- A I can read as much as I want to with no pain in my neck.
- B I can read as much as I want to with slight pain in my neck.
- C I can read as much as I want with moderate pain in my neck.
- D I cannot read as much as I want because of moderate pain in my neck.
- E I cannot read at all.

Section 5 -- Headaches
- A I have no headaches at all.
- B I have slight headaches which come infrequently.
- C I have moderate headaches which come infrequently.
- D I have moderate headaches which come frequently.
- E I have severe headaches which come frequently.
- F I have headaches almost all the time.

After Vernon & Mior, 1991
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Revised 10/16/91

Section 6 -- Concentration
- A I can concentrate fully when I want to with no difficulty.
- B I can concentrate fully when I want to with slight difficulty.
- C I have a fair degree of difficulty in concentrating when I want to.
- D I have a lot of difficulty in concentrating when I want to.
- E I have a great deal of difficulty in concentrating when I want to.
- F I cannot concentrate at all.

Section 7 -- Work
- A I can do as much work as I want to.
- B I can only do my usual work, but no more.
- C I can do most of my usual work, but no more.
- D I cannot do my usual work.
- E I can hardly do any work at all.
- F I cannot do any work at all.

Section 8 -- Driving
- A I can drive my car without any neck pain.
- B I can drive my car as long as I want with slight pain in my neck.
- C I can drive my car as long as I want with moderate pain in my neck.
- D I cannot drive my car as long as I want because of moderate pain in my neck.
- E I can hardly drive at all because of severe pain in my neck.
- F I cannot drive my car at all.

Section 9 -- Sleeping
- A I have no trouble sleeping.
- B My sleep is slightly disturbed (less than 1 hour sleepless).
- C My sleep is mildly disturbed (1-2 hours sleepless).
- D My sleep is moderately disturbed (2-3 hours sleepless).
- E My sleep is greatly disturbed (3-5 hours sleepless).
- F My sleep is completely disturbed (5-7 hours sleepless).

Section 10 -- Recreation
- A I am able to engage in all of my recreational activities, with no neck pain at all.
- B I am able to engage in all of my recreational activities, with some pain in my neck.
- C I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- D I am able to engage in a few of my usual recreational activities because of pain in my neck.
- E I can hardly do any recreational activities because of pain in my neck.
- F I cannot do any recreational activities at all.

Comments: _____

ACTIVATOR METHODS, INC., P.O.Box 80317, Phoenix, AZ 85060-0317
(602) 224-0220 Fax: (602) 224-0230

NECK DISABILITY INDEX

NAME:_____

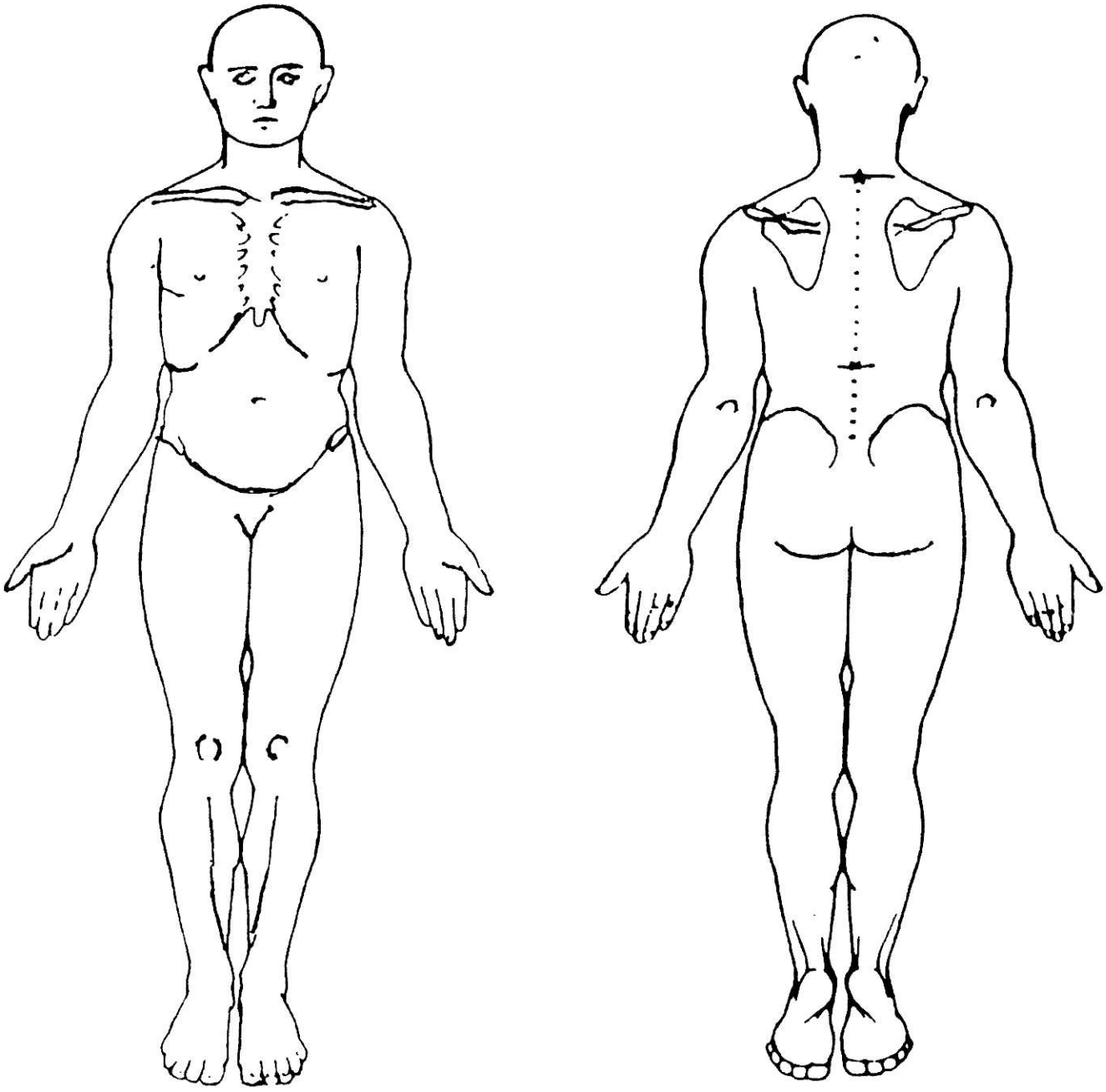
AGE:_____ DATE OF BIRTH:_____

OCCUPATION:_____

HOW LONG HAVE YOU HAD NECK PAIN? ____YEARS ____MONTHS ____WEEKS

IS THIS YOUR FIRST EPISODE OF NECK PAIN? ____YES ____NO

ON THE DIAGRAMS BELOW, **PLEASE MARK WHERE YOU ARE EXPERIENCING PAIN, RIGHT NOW.** (Please remember to complete both sides of this form.)



REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1 -- Pain Intensity

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2 -- Personal Care

A I would not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing and dressing without help.
F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 -- Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights, at the most.

SECTION 4 -- Walking

A Pain does not prevent me from walking any distance.
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than 1/2 mile.
D Pain prevents me from walking more than 1/4 mile.
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and have to crawl to the toilet.

SECTION 5 -- Sitting

A I can sit in any chair as long as I like without pain.
B I can only sit in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than ten minutes.
F Pain prevents me from sitting at all.

From: N. Hudson, K. Tome-Nicholson, A. Breen; 1989

REVISED 9/11/92

SECTION 6 -- Standing

A I can stand as long as I want without pain.
B I have some pain while standing, but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than ten minutes without increasing pain.
F I avoid standing, because it increases the pain straight away.

SECTION 7 -- Sleeping

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal night's sleep is reduced by less than one-quarter.
D Because of pain, my normal night's sleep is reduced by less than one-half.
E Because of pain, my normal night's sleep is reduced by less than three-quarters.
F Pain prevents me from sleeping at all.

SECTION 8 -- Social Life

A My social life is normal and gives me no pain.
B My social life is normal, but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D Pain has restricted my social life and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9 -- Traveling

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10 -- Changing Degree of Pain

A My pain is rapidly getting better.
B My pain fluctuates, but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

Comments: _____

Patient Signature: _____ Date: _____

ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317
(602) 224-0220 Fax: (602) 224-0230

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print): _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

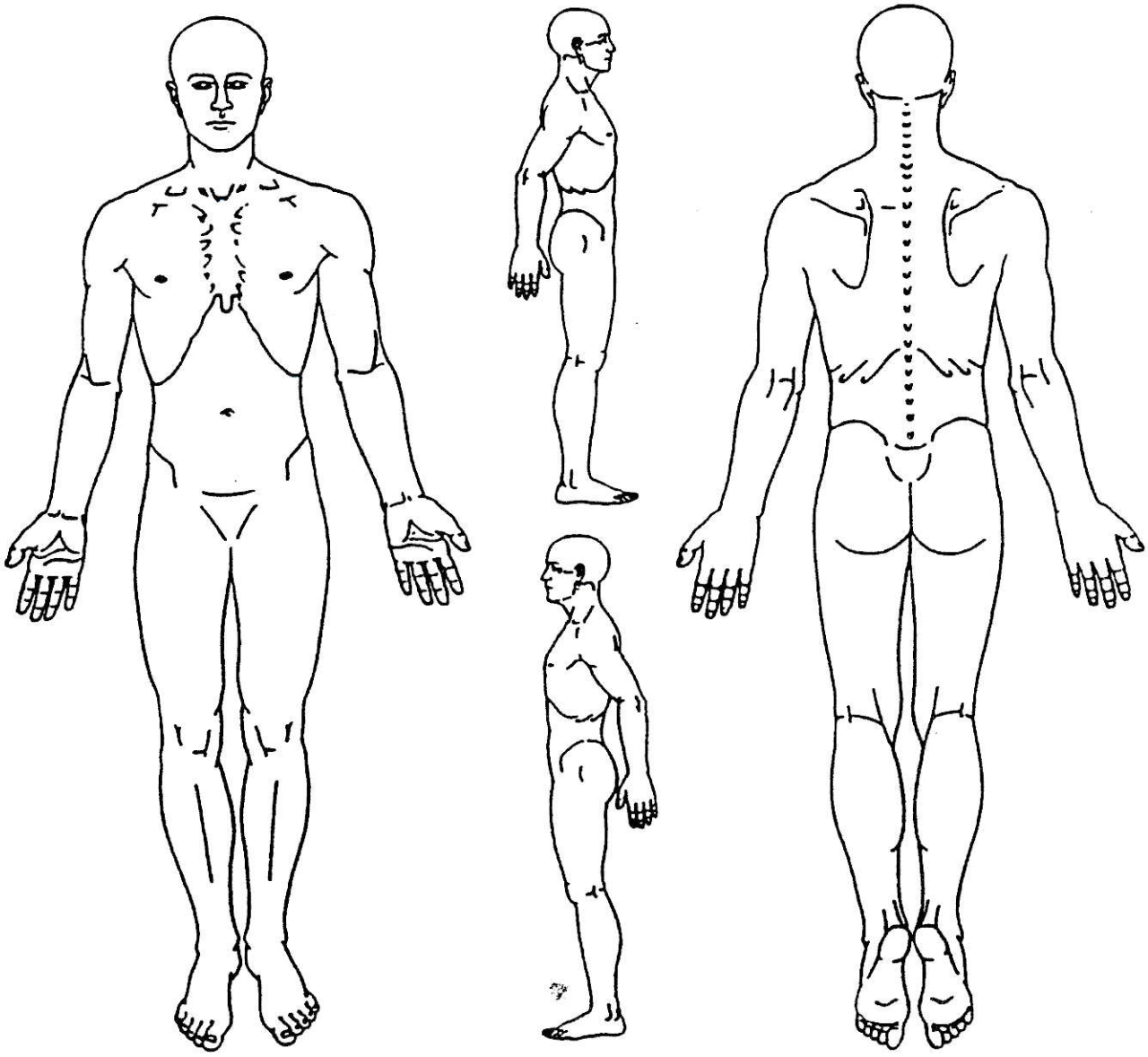
HOW LONG HAVE YOU HAD LOW BACK PAIN? ___YEARS ___MONTHS ___WEEKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? ___YES ___NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY: **A**=ACHE **B**=BURNING **N**=NUMBNESS
P=PINS & NEEDLES **S**=STABBING **O**=OTHER



OVER PLEASE