Welcome to Dr. Mascali's Office

We appreciate and value the privilege of serving you and your family through Chiropractic Care. We will do our very best to honor your health goals, respect your time, protect your privacy and answer your questions.

We offer detailed examinations, specific and gentle Chiropractic adjustments and varied therapies. Our hope is that we can assist you in maintaining or regaining your health.

Appointments

We make every 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 have the time slots you prefer.

We hope you can keep your scheduled appointments, however, we understand that unforeseen events may make that impossible. In that case, please give us the courtesy of a 24-hour notice. This enables us to reschedule you for the time you would like, 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 Options

We offer several options for payment. We are out–of-network with all insurance companies; however, your policy may have a provision which covers part of your care in our office. In that case, we ask that you pay, in full, at the time of service and we will be glad to file your claims for you. If there is reimbursement we will ask your company to send it directly to you. Additionally, please understand, since our relationship is with each patient and not the insurance company, we must hold you ultimately responsible for your bill.

We understand that many of our patient's do not have applicable insurance and will pay us out-of-pocket. We extend a 20% bookkeeping discount, in those cases. If you prefer to purchase a package for your care, we offer a ten-visit program at a greater discount. Please see the details to determine if this offer applies to your care.

In any case, it is preferred payments are made as services and supplies are rendered. We accept cash, checks and major credit cards.

I have read, understand and agree to the above policies.

X____

Signature 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***

ACCIDENTAL INJURY REPORT

Name____ Today's Date________ ____________________

AUTO/TRAFFIC ACCIDENT

Was the accident reported to Police Department? ______Yes ______ No Number of people in your car?_________

Were traffic citations issued to? You______ Driver of your car______ Driver of other car_______ None_________

Were you a ______Driver ______Passenger _______Pedestrian?

What kind of vehicle were you in? _______________Truck _______________ Car ________ Motorcycle __________Other

If passenger, were you sitting in _________Front _________ Right Rear __________ Left Rear

Did your vehicle hit other vehicle(s)? Yes____ No_____ Estimated speed of your vehicle at impact?_________MPH

Was your vehicle hit by other vehicle(s)? Yes____ No_____ Estimated speed of other vehicle at impact? _____MPH

What kind of vehicle hit your's? _______________Truck _______________Car _________Motorcycle __________Other

Was the impact from _____ front? _____ from the right side? _____ from the left side? _____ from the rear?

Were you wearing seat belts? ____Yes _____ No Did you strike anything in vehicle at time of impact? yes/no

If yes, specify: ____steering wheel ____ dashboard ___ windshield ___ side door ___ arm rests ___ side window

Please state part of body: ___chest ____chin ___knee ___shoulder ___hand ___head other____________________

VIHICLE YOU WERE IN:

Driver____

Insured____

Address____

Phone____

Auto Insurance Co____

Ins. Co Address____

Adjustor____

Phone____

Policy #____

Claim #____

OTHER VEHICLE:

Driver____

Insured____

Address____

Phone____

Auto Insurance Co____

Ins Co Address____

Adjustor____

Phone____

Policy #____

Claim #____

Have you been contacted by a representative of the Insurance Compamy ? Yes________ No________

Date Contacted__________________ By:______________________________ Insurance Company____________________

Your Insurance Agent's Name/phone #:____

Have you contacted your insurane Company? ____

WORK/ON JOB ACCIDENT

List any equipment, machinery and/or object related to the accident:____________________

Was accident reported to supervisor or employer? ___Yes ___No If so, to whom ____________________

Has a Worker's Compensation claim been filed? ___Yes ___No Insurance Carrier____________________

Name and Office Phone # of your immediate supervisor/foreman:____________________

Type of work being done at time of injury:____

Length of time you have worked there prior to accident:__________ Have you been injured before? Yes____ No____

Job Title/Activity:____

In a typical 8-hour workday, I (Circle # of hours/activity)

Sit: 1 2 3 4 5 6 7 8 hours; Stand: 1 2 3 4 5 6 7 8 hours Walk: 1 2 3 4 5 6 7 8 hours

On the job I perform:	Not at all	Occasionally	Frequently	Continuously
Bend/stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above head	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Push/Pull	( )	( )	( )	( )
I lift up to:				
10 lbs	( )	( )	( )	( )
25 lbs	( )	( )	( )	( )
50 lbs	( )	( )	( )	( )

Patient's Signature:____ Date____________________

ACCIDENTAL INJURY REPORT

Name_ ______________________________ Today's Date ____________________

Date of Accident ____________________ Time of Accident ____________________ AM PM

Location of Accident ____

Type of Accident: _______Auto/Traffic ________Work/On Job __________ At Home Other____________

Describe how the accident happened in your own words:____________________________

____

____

____

Immediately following the accident, how did you feel?____________________________

How did you feel next day? ____

Were you unconscious? ___Yes ___No In a daze? ___Yes ___No Did you go to the hospital? ___Yes ___No

If you went to hospital, when? At time of accident ___Yes ___No Next Day ___ Yes ___No Other__________

How did you get to hospital? Ambulance ___Yes ___No Private transportation ___Yes ___No

Did the ambulance attendants place you in: Neck collar ___Yes ___No Splints ___Yes ___No Brace ___Yes ___No

Name of Hospital:______________________________Attended by Dr.____________________

Were you x-rayed at hospital? ___Yes ___No If so, what was the diagnosis?____________________

______________________________Were you admitted to the hospital? ___Yes ___No

How long did you stay?____________________What treatment was rendered?____________________

What recommendations were made?____

List any other doctors you have seen as a result of this accident:____________________

____

Have you lost any time from work because of this accident? ___Yes ___No If yes, give dates of disability:

Totally disabled from________________ to ________________ Partially disabled from____________ to____________

Have you returned to works since the accident? No.________ Yes______ Please complete the following:

Date	Employer	Occupation	Light duty/Reg. Duty	Full Time/Part-Time

Since this accident occurred, are your symptoms: Improving__________ Getting Worse___________ Same__________

Do you notice any activity restrictions as a result of this injury? Yes_____ No______ Please describe:_____

____

____

Have you been contacted by an insurance adjuster or company representative about this accident? ___Yes ___No

If so, name, phone # of person contacting you:____________________________________

Have you retained an attorney? Yes_____ No______ Date attorney retained or to be retained:______________

Attorney's name:______________________________Phone ____________________

Address:____

City:______________________________State____________________ Zip____________

Were there any witnesses? Yes_____ No_____ Name(s)____________________________________

Other pertinent information:____

____

____

X______________________________ ______________________________

Patient's Signaure Date

Please complete the questions on the next page in the category of accident you had.

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 conveniently 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
Reprinted by permission of the Journal of Manipulative and Physiological Therapeutics

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:____

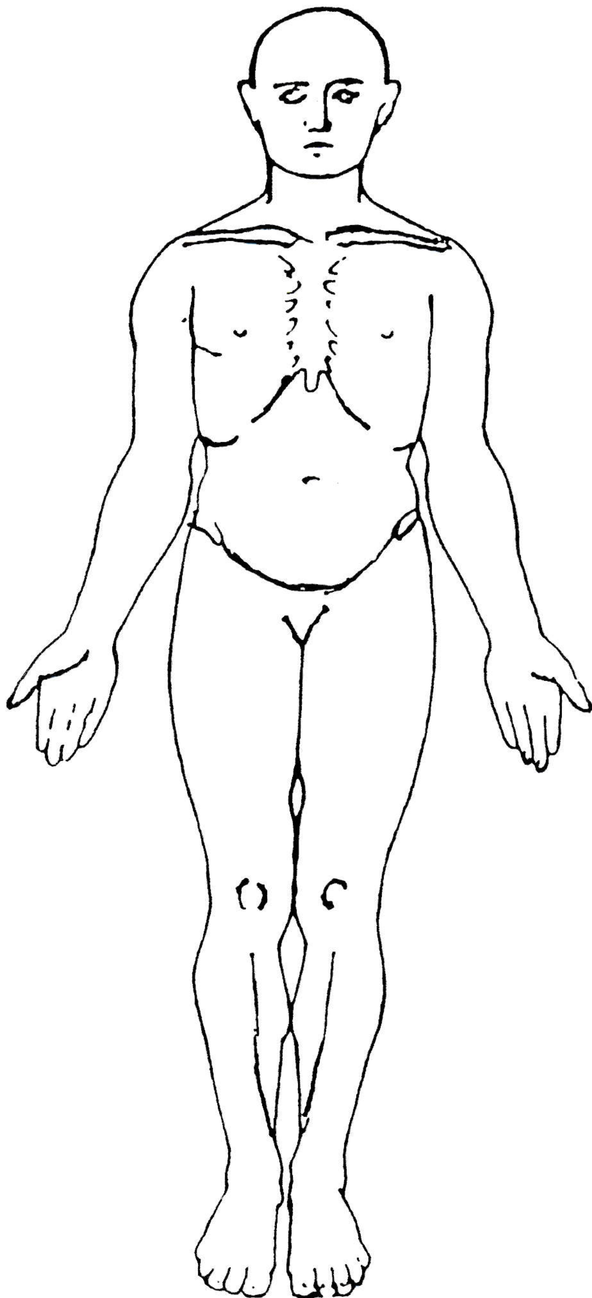
AGE:______________ DATE OF BIRTH:______________________________

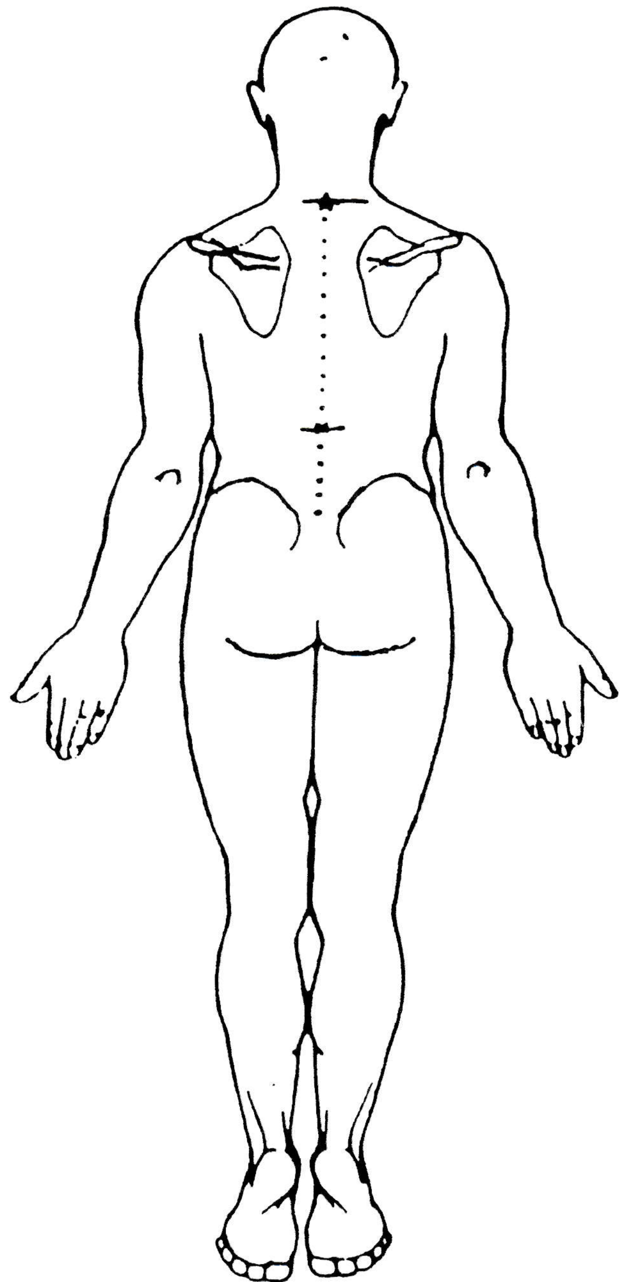
OCCUPATION:____

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: ______________________

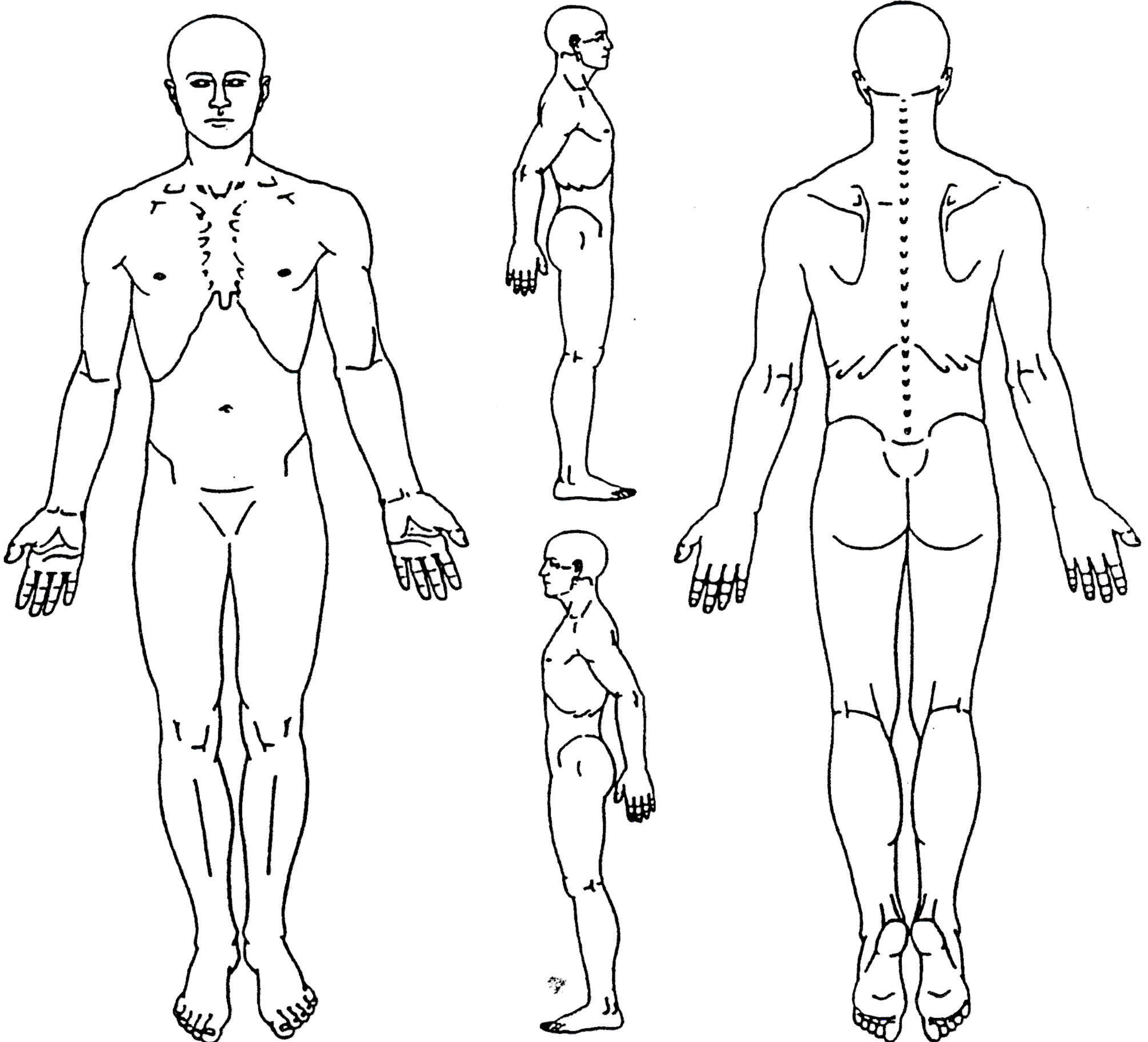
HOW LONG HAVE YOU HAD LOW BACK PAIN? ___YEARS ___MONTHS ___WEEKS

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

Edward J. Mascali, D.C.
140 Vann Street, Suite 400
Marietta, GA 30060
770.427.8877

In order to be able to file your auto accident billing our office must have the following information prior to treatment:

Patient's name ______________________________

Date ____________ Date of accident ____________________

The insurance company of the car you were in at the time of the accident:

Name ______________________________

Address to send claims ______________________________

____

Adjustor's name ______________________________

Adjustor's phone ______________________________

Med-Pay Claim Number ______________________________

- I hereby authorize and direct my insurance company, attorney or liability insurance adjustor to promptly pay Edward J. Mascali, D.C. any monies due and owed him for fees incurred for chiropractic treatment rendered and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor.

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

X____

Signed Date