Casalino Chiropractic ***PI PATIENT INTAKE FORM*** Date: _____
1000 E. Camelback Rd. Phx AZ 85014 602.279.7376

Name Nickname

Address Apt# City

State Zip Occupation

DOB Age M / F Social Security #

Cell # Home # Work #

E-mail:

Circle one: Single Married Partnered Divorced Widowed # of children

Name of Spouse / Partner

Contact Name in Case of Emergency Relation

Emergency Person Contact Phone

How did you learn about our office

Did you retain an attorney Y / N if so, who Phone

Nature of This Accident

Date of this accident _____ Time of Day _____ State: _____

Were you: ( ) Driver ( ) Passenger ( ) Front seat ( ) Back seat ( ) Motorcycle ( ) Pedestrian

Were you using your Seat Belt Y / N How many people were in your car _____

Were you struck from: ( ) Behind ( ) Front ( ) Drivers side ( ) Passenger side

Did you hit anything ***IN*** your car: ( ) Dashboard ( ) Windshield ( ) Center Console ( ) Other _____

Do you Remember the Moment of Impact Y / N How long did you not remember? ( ) A few seconds ( ) More

Were you knocked unconscious Y / N Do you know for how long _____

Were the Police notified Y / N Who was at fault _____

In your own words describe the accident _____

Please Describe How You Felt…

IMMEDEATELY AFTER the accident _____

LATER that day _____

The NEXT day _____

What do you feel like NOW _____

Have you noticed any limited activities or restrictions in your daily life as a result of this accident? Examples:

Were you taken to the hospital Y / N If so, Where _____

Were you given medication Y / N What _____

Were you X-rayed Y / N If so, Where _____

Have you seen another Doctor Y / N If so, who _____

Have you seen Physical Therapy or other treatment Y / N If so, who _____

Have you lost any time from work Y / N If so, how long _____

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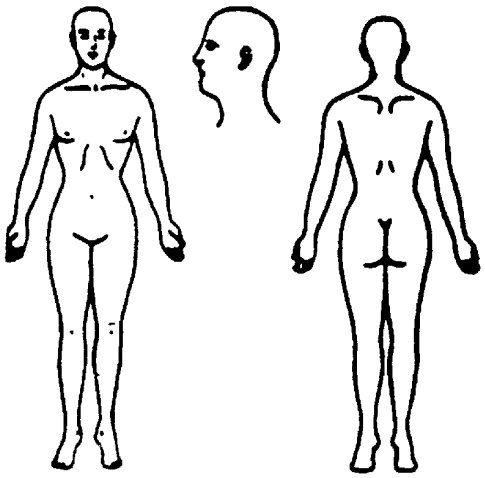
-Write the letter(s) that match your pain, from the accident, on the image below

T – Tight **D** – Dull **A** – Achy **B** – Burning **S** – Spasm
N – Numb **O** - Pins & Needles **X** - Stabbing



List all pain locations	Circle pain level 	How often pain occurs
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%

Have you felt any of the following symptoms since the accident?

___ Headache
___ Dizziness
___ Loss of Concentration
___ Forgetfulness
___ Confusion
___ Nervousness
___ Blurred Vision
___ Depression
___ Difficulty Sleeping
___ Loss of Energy
___ Ringing / Buzz in Ears
___ Paralysis
___ Fainting
___ Palpitations
___ Convulsions

Did you have any physical complaints <u>BEFORE this Accident</u>? Y N If yes, please describe in detail

LIST MEDICATIONS OR DRUGS YOU ARE TAKING **AND** FOR WHAT OR WHY?

□ I AM NOT TAKING ANY MEDICATION OR DRUGS AT THIS TIME

Check any of the following conditions that YOU have had

__ Heart Disease
__ High Blood Pressure
__ Stroke / Aneurysm
__ Diabetes
__ Kidney Disease
__ Lupus
__ Gout
__ Seizures
__ Polio
__ HIV / AIDS
__ Valley Fever

Dizzy or **L**ight **H**eaded when
__ Moving your neck,
__ Changing positions
__ or Laying down

__ Osteoarthritis
__ Degenerative Disc Disease
__ Disc Injuries
__ Herniated / Slipped Disc
__ Spinal Block Injections
__ Lumbar / low back
__ Neck
__ Scoliosis
__ Osteoporosis/Osteopenia
__ Rheumatoid Arthritis
__ Unexplained weight loss

Abdominal Waist Size
__ Over 35 inches (female)
__ Over 40 inches (male)

Broken Bones – Location & When
_____
_____
_____

Surgeries - Location & When
_____
_____
_____

History of Cancer - Type
_____
_____
_____

Other
_____
_____

FAMILY HEALTH HISTORY

Mother's Side	*Father's Side*
__ Cardio Vascular Disease	__ Cardio Vascular Disease
__ High Blood Pressure	__ High Blood Pressure
__ Diabetes	__ Diabetes
__ Arthritis	__ Arthritis
__ Autoimmune Disease	__ Autoimmune Disease
__ Kidney Disease	__ Kidney Disease
__ Cancer - type	__ Cancer - type

_____ _____

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_____

PATIENT SIGNATURE_____ DATE _____

PARENT OR GUARDIAN SIGNATURE_____ DATE _____