

PATIENT APPLICATION//INTAKE FORM

Date: \_\_\_\_\_

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Social Security #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Marital Status: S M D W Right Handed / Left Handed (Circle one that applies) Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

List any complaints currently bothering you and rate your pain level for each 0 = no pain and 10 = unbearable.

1.) _____	0	1	2	3	4	5	6	7	8	9	10
2.) _____	0	1	2	3	4	5	6	7	8	9	10
3.) _____	0	1	2	3	4	5	6	7	8	9	10
4.) _____	0	1	2	3	4	5	6	7	8	9	10
5.) _____	0	1	2	3	4	5	6	7	8	9	10

When did this condition begin? \_\_\_\_\_ What do you think caused this condition? \_\_\_\_\_

How would you describe your symptoms?

\_\_\_ Burning \_\_\_ Stabbing \_\_\_ Aching \_\_\_ Sharp \_\_\_ Tingling \_\_\_ Numb \_\_\_ Other: \_\_\_\_\_

Do you have numbness, tingling, or pain in your hands, feet, arms, or legs? Y / N If Yes, Where? \_\_\_\_\_

Do you experience pain when you go from sitting to standing? Y / N **Do you have a pacemaker? Y / N**

What makes your pain WORSE? (Check all that apply) Women Only: Is there any chance that you are expecting? Y / N

\_\_\_ Coughing \_\_\_ Lifting \_\_\_ Pulling \_\_\_ Walking \_\_\_ Twisting \_\_\_ Swallowing

\_\_\_ Sneezing \_\_\_ Bending \_\_\_ Driving \_\_\_ Running \_\_\_ Laughing \_\_\_ Other: \_\_\_\_\_

\_\_\_ Pushing \_\_\_ Sitting \_\_\_ Standing \_\_\_ Laying down \_\_\_ Bowel Movements \_\_\_\_\_

What helps for pain RELIEF? (Check all that apply)

\_\_\_ Ice \_\_\_ Heat \_\_\_ Massage/Rubbing \_\_\_ Rest \_\_\_ Exercise/Activity \_\_\_ Other : \_\_\_\_\_

Have you seen a chiropractor before? Yes / No Who? \_\_\_\_\_ When? \_\_\_\_\_

Reason for visits: \_\_\_\_\_

Does anyone in your immediate family have a history of scoliosis, heart disease, strokes, Parkinson's, or diabetes? Y / N

Are you presently taking any prescribed medications? Y / N If yes, please list them:

1.) \_\_\_\_\_ 4.) \_\_\_\_\_

2.) \_\_\_\_\_ 5.) \_\_\_\_\_

Previous Surgeries / Broken Bones (all types): Approximate Date:

1.) \_\_\_\_\_ \_\_\_\_\_

2.) \_\_\_\_\_ \_\_\_\_\_

Previous accidents/injuries:

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Treated: \_\_\_\_\_

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Treated: \_\_\_\_\_

Name of Primary Physician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

RICHARD CASABONA Jr. D.C. 7562 N. LA CHOLLA BLVD. TUCSON, AZ 85741



HIPAA Compliant Patient Authorizations and Releases

This authorization is required in order to meet Federal and State privacy guidelines. This information is being requested so that we can better meet your health care needs. However, should you decline to authorize any of the items listed it will not affect the treatment that we provide you. You may also put certain limitations on the use of your information. This must be done in writing.

*Please refer to our "Privacy Manual" in our waiting room for details on the extensive measures we have taken to protect your personal information. If you feel that we are not meeting those policies nor have any suggestions on how we need to amend those policies, please share your feelings with one of our staff.*

**Notification and Acknowledgment of Notice of Privacy Practices Regarding Protected Health Information:**

Accept  Decline  I hereby acknowledge that I have read and received this notification and the HIPAA privacy practices by signing below and returning it to us.

**Consent for Treatment:**

Accept  Decline  I hereby authorize Dr. Richard Casabona, D.C. and whomever he may designate as his assistant (s) to perform diagnostic tests, including but not limited to radiographs, photographs, videos, and to administer treatment as necessary in the open gym/rehab setting.

**Release of Medical Information:**

Accept  Decline  I hereby authorize Dr. Richard Casabona, D.C. to release any medical information pertinent to my treatment plan to my family physician, employer, attorney, or insurance company if necessary.

**Consent for Treatment of a Minor:**

Accept  Decline  I hereby authorize Dr. Richard Casabona, D.C. and whomever he may designate as his assistant (s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he deems necessary to my (relation to child) \_\_\_\_\_, (child's name) \_\_\_\_\_.

**Payment of Benefits to Provider:**

Accept  Decline  I hereby authorize the \_\_\_\_\_ insurance company/insurance administrator to pay by check, and for it to be mailed directly to: Dr. Richard Casabona, D.C., 7562 N. La Cholla Blvd., Tucson, AZ 85741 the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

**X-Ray/Records Release:**

Accept  Decline  (patient's name) \_\_\_\_\_ (Location of records) \_\_\_\_\_  
I hereby request and authorize you and your employees to furnish all copies of records and reports, including copies of x-rays and photo copies, of all records and any other information concerning any condition that I may have had in the past. Please forward to: Dr. Richard Casabona, D.C., 7562 N. La Cholla Blvd., Tucson, AZ 85741.

**Personal Injury/Worker's Compensation:**

\_\_\_\_\_ I understand that it is office protocol for Casabona Chiropractic to file a County Lien against myself, my insurance company (if any), and my attorney (if any) in order to ensure payment for services after the case has been settled, at which point, the lien (s) will be released.

Accept  Decline  I give permission to call me at home

Accept  Decline  I give permission to call me at work

Accept  Decline  I give permission to send mail to my home regarding treatment

I authorize the staff and doctor (s) at Casabona Chiropractic to use my personal and health information as outlined above and in their Privacy Manual.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_



# REVIEW OF SYSTEMS

Patient Name: \_\_\_\_\_ Patient File #: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**INSTRUCTIONS:** Please fill out all of the sections. If none of the conditions apply, select "None."

**Constitutional:**

- None
- Chills
- Daytime Drowsiness
- Fatigue
- Fever
- Night Sweats
- Weight Gain
- Weight Loss

**Eyes/Vision:**

- None
- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Double Vision
- Eye Pain
- Field Cuts
- Glaucoma
- Itching (around the eyes)
- Photophobia
- Tearing
- Wears Glasses or Contacts

**Ears, Nose and Throat:**

- None
- Bleeding
- Dental Implants
- Dentures
- Difficulty Swallowing
- Discharge
- Dizziness
- Ear Drainage
- Ear Infection(s)
- Ear Pain
- Fainting
- Headaches
- Head Injury (history of)
- Hearing Loss
- Hoarseness
- Loss of Smell
- Nasal Congestion
- Nose Bleeds
- Post Nasal Drip
- Rhinorrhea (runny nose)
- Sinus Infections
- Snoring
- Sore Throats
- Tinnitus (ringing in the ears)
- TMJ Disorder

**Cardiovascular:**

- None
- Angina (chest pain or discomfort)
- Chest Pain
- Claudication (leg pain or achiness)
- Heart Murmur
- Heart Problems
- Orthopnea (difficulty breathing while lying)
- Palpitations (irregular or forceful heart beat)
- Paroxysmal Nocturnal Dyspnea (shortness of breath at night)
- Shortness of Breath
- Swelling of Leg(s)
- Ulcers
- Varicose Veins

**Gastrointestinal:**

- None
- Abdominal Pain
- Belching
- Black, Tarry Stools
- Constipation
- Diarrhea
- Difficulty Swallowing
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice (yellowing of the skin)
- Nausea
- Rectal Bleeding
- Abnormal Stool Caliber (quality)
- Abnormal Stool Color
- Abnormal Stool Consistency
- Vomiting
- Vomiting Blood

**Respiration:**

- None
- Asthma
- Coughing up blood
- Shortness of Breath
- Sputum Production
- Wheezing

**Endocrine:**

- None
- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Frequent Urination
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

**Skin:**

- None
- Changes in Nail Texture
- Changes in Skin Color
- Hair Growth
- Hair Loss
- Hives
- Itching
- Paresthesia (numbness, prickling, or tingling)
- Rash
- History of Skin Disorders
- Skin Lesions or Ulcers
- Varicosities

**Nervous System:**

- None
- Dizziness
- Facial Weakness
- Headaches
- Limb Weakness
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors
- Unsteadiness of Gait

**Allergy:**

- None
- Anaphylaxis (history of)
- Food Intolerance
- Itching
- Nasal Congestion
- Sneezing

**Hematology:**

- None
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusion(s)
- Bruises easily
- Fatigue
- Lymph Node Swelling

**Psychological:**

- None
- Anhedonia (inability to experience joy or enjoy life)
- Anxiety
- Appetite Changes
- Behavioral Change(s)
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Insomnia
- Memory Loss
- Mood Change(s)

**Female:**

- None
- Birth Control Therapy
- Breast Lumps / Pain
- Burning Urination
- Cramps
- Frequent Urination
- Hormone Therapy
- Irregular Menstruation
- Urine Retention
- Vaginal Bleeding
- Vaginal Discharge

**Male:**

- None
- Burning Urination
- Erectile Dysfunction
- Frequent Urination
- Hesitancy or Dribbling
- Prostate Problems
- Urine Retention

Patient Signature: \_\_\_\_\_

**FOR OFFICE USE ONLY:**

I have reviewed the above ROS with the above named patient:

R. Casabona D.C.  
Doctor Signature

\_\_\_\_\_  
Date



# Functional Rating Index

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

<p><b>1. Pain Intensity</b></p> <p>0   1   2   3   4</p> <p>No pain   Mild pain   Moderate pain   Severe pain   Worst possible pain</p>	<p><b>6. Recreation</b></p> <p>0   1   2   3   4</p> <p>Can do all activities   Can do most activities   Can do some activities   Can do a few activities   Cannot do any activities</p>
<p><b>2. Sleeping</b></p> <p>0   1   2   3   4</p> <p>Perfect sleep   Mildly disturbed sleep   Moderately disturbed sleep   Greatly disturbed sleep   Totally disturbed sleep</p>	<p><b>7. Frequency of pain</b></p> <p>0   1   2   3   4</p> <p>No pain   Occasional pain; 25% of the day   Intermittent pain; 50% of the day   Frequent pain; 75% of the day   Constant pain; 100% of the day</p>
<p><b>3. Personal Care (washing, dressing, etc.)</b></p> <p>0   1   2   3   4</p> <p>No pain; no restrictions   Mild pain; no restrictions   Moderate pain; need to go slowly   Moderate pain; need some assistance   Severe pain; need 100% assistance</p>	<p><b>8. Lifting</b></p> <p>0   1   2   3   4</p> <p>No pain with heavy weight   Increased pain with heavy weight   Increased pain with moderate weight   Increased pain with light weight   Increased pain with any weight</p>
<p><b>4. Travel (driving, etc.)</b></p> <p>0   1   2   3   4</p> <p>No pain on long trips   Mild pain on long trips   Moderate pain on long trips   Moderate pain on short trips   Severe pain on short trips</p>	<p><b>9. Walking</b></p> <p>0   1   2   3   4</p> <p>No pain; any distance   Increased pain after 1 mile   Increased pain after 1/2 mile   Increased pain after 1/4 mile   Increased pain with all walking</p>
<p><b>5. Work</b></p> <p>0   1   2   3   4</p> <p>Can do usual work plus unlimited extra work   Can do usual work; no extra work   Can do 50% of usual work   Can do 25% of usual work   Cannot work</p>	<p><b>10. Standing</b></p> <p>0   1   2   3   4</p> <p>No pain after several hours   Increased pain after several hours   Increased pain after 1 hour   Increased pain after 1/2 hour   Increased pain with any standing</p>

Name \_\_\_\_\_ **PRINTED** \_\_\_\_\_ Total Score \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_





# Informed Consent Form

To determine the cause of a patient's presentation and need for and extent of care, the chiropractic doctor will obtain details about the current complaint[s] as well as one's past health history, subsequently perform a physical examination, and in particular cases acquire diagnostic images (such as x-rays or MRI) or laboratory tests.

Chiropractic doctors employ various manually-applied treatment procedures when caring for patients, the most common being an *adjustment*. A chiropractic adjustment involves the application of a quick, precise and usually painless force directed over a very short distance to a specific body part. Adjustments can be performed by hand, by hand-guided instruments, and with the use of specially designed equipment. In addition to adjustments, chiropractors may use other treatment procedures to care for a patient, such as mobilization procedures, physiotherapy modalities (heat, ice, ultrasound, electrical muscle stimulation), soft-tissue manipulation, nutritional recommendations, and supervised exercise and other rehabilitation measures. Neck and back pain are known to generally improve in time, however, recurrence is common. It is also known that keeping a positive attitude and remaining physically active improves one's chances for recovery.

The beneficial effects associated with chiropractic treatment procedures include decreased pain, improved mobility and function, and reduced muscle spasm. There are some conditions for which chiropractic care is contraindicated; other conditions may not respond to chiropractic treatment or perhaps worsen with chiropractic treatment. In these cases, referral to another healthcare provider may be necessary or suggested by the chiropractor.

The body of evidence suggests that chiropractic care is generally safe; however, as with any form of treatment, some risk may be involved. Listed below are summaries of both common and rare side-effects/complications reported to be associated with chiropractic care:

## Common <sup>1,2</sup>

- Reactions most commonly reported are local soreness/discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, the vast majority of which resolve within 48 hours

## Rare <sup>3,4</sup>

- Fractures or joint injuries in isolated cases with underlying physical defects, deformities or pathologies
- Burns due to some physiotherapy procedures
- Disc herniation
- Cauda equina Syndrome (1 case per 100 million adjustments)
- Vertebrobasilar artery stroke (1 case per 400,000 to 1 million cervical spine adjustments [manipulations]). A similar level of association to stroke is found for patients under the age of 45 when consulting with a medical doctor; for those older than age 45, the level of association to stroke is higher when seeing a medical doctor than a chiropractic doctor. ***Please indicate to your doctor if you have a headache or neck pain that is the worst you have every felt. These symptoms may indicate a dissection in progress.***

Alternative forms of treatment that a patient may want to consider before undergoing chiropractic care include *prescription and over-the-counter medications, surgical intervention, and non-treatment*. Listed below are summaries of concerns with these alternative procedures:

- Long-term use or overuse of certain medications carry some risk of dependency; with other medications, long-term use or overuse increases the risk of gastrointestinal bleeding
- Surgical risks may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery<sup>5</sup>
- Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition<sup>6</sup>

1. Thiel HW, Bolton JE, Docherty S, Portlock JC. Safety of chiropractic manipulation of the cervical spine: a prospective national survey. *Spine*. Oct 1 2007;32(21):2375-2378; discussion 2379.
2. Rubinstein SM, Leboeuf-Yde C, Knol DL, de Koekkoek TE, Pfeifle CE, van Tulder MW. The benefits outweigh the risks for patients undergoing chiropractic care for neck pain: a prospective, multicenter, cohort study. *J Manipulative Physiol Ther*. Jul-Aug 2007;30(6):408-418.
3. Cassidy JD, Boyle E, Cote P, et al. Risk of vertebrobasilar stroke and chiropractic care: results of a population-based case-control and case-crossover study. *Spine*. Feb 15 2008;33(4 Suppl):S176-183.
4. Boyle E, Cote P, Grier AR, Cassidy JD. Examining vertebrobasilar artery stroke in two Canadian provinces. *Spine*. Feb 15 2008;33(4 Suppl):S170-175.
5. Carragee EJ, Hurwitz EL, Cheng I, et al. Treatment of neck pain: injections and surgical interventions: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine*. Feb 15 2008;33(4 Suppl):S153-169.
6. Carroll LJ, Hogg-Johnson S, van der Velde G, et al. Course and prognostic factors for neck pain in the general population: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine*. Feb 15 2008;33(4 Suppl):S75-82.

## Informed Consent Form

Please answer the following questions to help us determine possible risk factors:

DOCTOR COMMENTS

YES NO

QUESTION

GENERAL

Have you ever had an adverse (i.e. bad) reaction to or

following chiropractic care?

**BONE WEAKNESS**

Have you been diagnosed with osteoporosis?

Do you take corticosteroids (e.g. prednisone)?

Have you been diagnosed with a compression fracture(s)

of the spine?

Have you ever been diagnosed with cancer?

Do you have any metal implants?

**VASCULAR WEAKNESS**

Do you take aspirin or other pain medication on a

regular basis?

If yes, about how much do you take daily?

Do you take warfarin (coumadin), heparin, or other

similar "blood thinners"?

Have you ever been diagnosed with any of the following

disorders/diseases?

• Rheumatoid arthritis

• Reiter's syndrome, ankylosing spondylitis, or

psoriatic arthritis

• Giant cell arteritis (temporal arteritis)

• Osteogenesis imperfecta

• Ligament hypermobility such as with Marfan's

disease, Ehlers-Danlos syndrome

• Medial cystic necrosis (cystic mucoid

degeneration)

• Bechter's disease

• Fibromuscular dysplasia

Have you ever become dizzy or lost consciousness when

turning your head?

**SPINAL COMPROMISE OR INSTABILITY**

Have you had spinal surgery?

If yes, when?

Have you been diagnosed with spinal stenosis?

Have you been diagnosed with spondylolithesis?

Have you had any of the following problems?

• Sudden weakness in the arms or legs?

• Numbness in the genital area?

• Recent inability to urinate or lack of control

when urinating?

I have read the previous information regarding risks of chiropractic care and my doctor has explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
 PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
 DOCTOR SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_