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: ______________________

Do you have a Health Savings Account (HSA)? Y / N

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.**

	0	1	2	3	4	5	6	7	8	9	10
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:** __________

Casabona Chiropractic P.C. 7562 N. La Cholla Blvd. Tucson, AZ 85741 520-498-9984

HIPAA Compliant Patient Authorizations and Releases

This authorization is required 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.

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 send mail to my home regarding treatment

Accept ____ Decline ____ I give permission to contact me via e-mail:____

CHOICE OF PAYMENT OPTIONS: We are happy to provide the following payment options. If you are choosing to use your insurance, you will need to pick a second payment option for any service not covered by your insurance.

1. Insurance Coverage: Coverage varies with individual plans; generally, only a portion of the recommended care plan will be covered.
2. Cash/Credit per visit: Includes money orders, personal checks, credit, and debit cards; generally, a 20% discount applies
3. Payment Plans: Monthly or yearly payment plans are available with an approximate savings of 25-30%.
4. Care Credit Card/HealthCare Solutions: A zero-or-low interest healthcare credit card which you may apply for and use here in our office upon request.

Please circle your TWO choices above and initial here: ______

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: ________________________

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.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
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

5. Work

0	1	2	3	4
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

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
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

8. Lifting

0	1	2	3	4
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

9. Walking

0	1	2	3	4
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

10. Standing

0	1	2	3	4
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

Name ______________________
PRINTED

Total Score________

____
Signature

____
Date

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Casabona Chiropractic P.C. 7562 N. La Cholla Blvd. Tucson, AZ 85741 520-498-9984

Richard Casabona Jr D.C.

Casabona Chiropractic 7562 N. La Cholla Blvd., Tucson, AZ 85741 P: 520-498-9984 F: 520-498-1607

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

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 [1,2]

- 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 [3,4]

- 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[5]
- Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition[6]

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:

QUESTION	YES	NO	DOCTOR COMMENTS
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)	☐	☐	
• Bechet'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 spondyliolithesis?	☐	☐	
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 ____________