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.

_____

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 see for current problems and list treatment received and results:

_____
_____
_____
_____

…List all surgeries you have had and dates:

_____
_____
_____
_____

…List medications you are 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? Date and information:

_____
_____
_____
_____

…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

Insurance Co. _____

Address for Claims _____

_____

Name of Insured _____ DOB _____

Pt. ID # _____ Group # _____

Customer Service Phone _____

I authorize Dr. Mascali and his agents to perform examination and treatment 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 and attorneys' offices. I authorize Dr. Mascali to release my scans or 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 service as the charges are rendered, unless other arrangements have been made prior to treatment. I understand that my insurance plan is a contract between my company and me and I am fully responsible for payment of all fees.

_____

Signature Date

Informed Consent to Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;

b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.
I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____.

_____ _____

Patient Signature (or Legal Guardian) Signature of Witness

Patient Name: _____ Witness Name: _____

(please print)
Prior Chiropractic Treatment Information

Name of Chiropractor:_____ Location (city):_____
When was your last treatment?_____ Have you had x-rays? _____

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
( ) Lack 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's 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 _____
_____