Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address *(if different from patient)* _____ City _____

State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Reason for Visit

Have you ever seen a chiropractor? ☐ Yes ☐ No If yes, when and why? _____

Your reason for *this* visit: _____

Please describe your pain and its location: _____

When did symptoms begin (date)? _____ Have you had similar conditions in the past? _____

Is pain getting: ☐ Worse ☐ Better ☐ Same ☐ Comes and goes How often do you have this pain? _____

Have you been treated by a medical physician for this condition? _____

If so, when and where? _____

Activities or movements that are difficult/painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Lifting

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness ☐ Cramping
☐ Stiffness ☐ Swelling ☐ Other _____

Is pain interfering with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Please complete both sides.

Health History

Please list any medication (including pain killers) you are taking: _____

_____

Please list any serious injuries you have had in the last 10 years:

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Other Serious Injuries		

Women: Are you pregnant? ☐ Y ☐ N If so, how far along? _____ Nursing ☐ Y ☐ N

Medical Conditions

Check (✓) yes or no whether you have had or currently have any of the following medical conditions?

☐ Y ☐ N Heart Attack/Stroke
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Alcohol/Drug Abuse
☐ Y ☐ N Fainting/ Seizures/Epilepsy
☐ Y ☐ N Shingles
☐ Y ☐ N Psychiatric Problems
☐ Y ☐ N Difficulty Breathing
☐ Y ☐ N Hepatitis
☐ Y ☐ N Anemia

☐ Y ☐ N Arthritis
☐ Y ☐ N Frequent Neck Pain
☐ Y ☐ N Jaw Pain
☐ Y ☐ N Wrist Pain
☐ Y ☐ N Shoulder Pain
☐ Y ☐ N Arm Pain
☐ Y ☐ N Leg Pain
☐ Y ☐ N Lower Back Problems
☐ Y ☐ N Severe/ Frequent Earaches

☐ Y ☐ N Ringing in Ears
☐ Y ☐ N Severe/ Frequent Headaches
☐ Y ☐ N Diabetes/Tuberculosis
☐ Y ☐ N Dizziness
☐ Y ☐ N Emphysema/Glaucoma
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Artificial Bones/Joints
☐ Y ☐ N Cancer
☐ Y ☐ N HIV Positive/AIDS

☐ Y ☐ N Ulcer/Colitis
☐ Y ☐ N Gout
☐ Y ☐ N Numbness, where? _____
☐ Y ☐ N Tingling, where? _____
☐ Y ☐ N Muscle Spasms, where? _____

Personal Habits

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Live Life Well Adjusted
Casto Chiropractic, Inc.
Nichole Casto, D.C. & Jason Casto, D.C.
1156 Bldg C Emerald Bay Road
South Lake Tahoe, CA 96150
530.543.1201

PATIENT NAME:_____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contradictions to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. Everyone's body responds differently to treatment. You need to disclose all prior medical conditions and treatment even if you think they are not relevant or related to the subject of your current visit. They may affect what course of treatment I provide.

The probability of those risks.

Fractures are rare occurrences and generally result from underlying weakness of the bone which I check for during the taking of history and during examination and X-ray, if warranted. Not all patients will appear to require an X-ray. And, even if an X-ray is done it may not reveal all of your underlying medical issues. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million

and one in five million cervical adjustments. The other complications are also generally described as rare, but they can occur.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Nichole Casto and/or Dr. Jason Casto and have had many questions answered to my satisfaction. I have fully disclosed all of my prior and current medical problems, procedures and complaints. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____ **Dated:**_____

Patient's Name:_____ **Doctor's Name:**_____

Signature:_____ **Signature:**_____

Signature of Parent or Guardian (if a minor):_____