TUCSON CHIROPRACTIC CENTER

PATIENT HEALTH RECORD

ABOUT THE PATIENT:

Date _____ File #: _____

Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____

Mobile Phone _____ Mobile Phone Provider _____

Birth Date _____ Age _____ Gender: □ M □ F Number of Children _____

Employer _____ Work Phone _____

Social Security # _____ Email Address _____

ABOUT THE SPOUSE OR PARENT:

Name _____ Relationship _____

Employer _____ Work Phone _____

INSURANCE INFORMATION:

Please provide Tucson Chiropractic Center your Insurance Information for better assistance.

REASON FOR THIS VISIT:

Please describe to the doctor or assistant the reason for this visit.

If auto collision related, have you made a report of your accident? □ Yes □ No □ N/A

Date your condition began? _____

If job related, have you made a report of your accident to your employer? □ Yes □ No □ N/A

Date your condition began? _____

Have you seen other doctors for this condition? □ Yes □ No

Doctor's Name(s): _____

SOCIAL HISTORY AND HEALTH HABITS:

	No	Yes	
Do you smoke?	□	□	____ packs/day
Do you drink alcohol?	□	□	____ drinks/day
Do you exercise regularly?	□	□	□ Mild □ Moderate □ Intense
Do you wear heel lifts?	□	□	
Do you wear Orthotics?	□	□	

SURGERY: □ No □ Yes

Type	Date

MEDICATIONS I NOW TAKE: □ I am not taking prescription or over the counter medication at this time.

□ Nerve Pills □ Pain Killers □ Muscle Relaxant □ Blood Pressure Medication □ Stimulants □ Blood Thinners

□ Tranquilizers □ Insulin □ Others _____

FAMILY HISTORY:

	Diabetes	Heart	Kidney	Cancer	Back	Other
Mother	□	□	□	□	□	_____
Father	□	□	□	□	□	_____
Brother	□	□	□	□	□	_____
Sister	□	□	□	□	□	_____

For Office Use Only

Patient Name _____ **Date:** _____

REVIEW OF SYSTEMS:

Please indicate with a **(C) for CONDITIONS** you have **CURRENTLY**. Indicate with a **(P) for PAST CONDITIONS** in the last ***12 MONTHS***. Leave blank if the condition does not relate to you.

General Symptoms
___ Allergies
___ Night sweats
___ Fainting
___ Dizziness
___ Loss of balance
___ Unsteady on feet
___ Loss of sleep
___ Fatigue
___ Nervousness
___ Anxiety
___ Irritability
___ Loss of weight
___ Pain on sneezing, coughing, at stool
___ Loss of memory
___ Concentration problems

Skin or Allergies
___ Skin eruptions
___ Bruise easily
___ Eczema

Genito-Urinary
___ Urination problem
___ Blood in urine
___ Kidney infection
___ Prostate trouble

Musculoskeletal
___ Neck pain
___ Neck stiffness
___ Headaches
___ Back pain
___ Back stiffness
___ Chest pain
___ R L Shoulder pain
___ R L Elbow pain
___ R L Wrist pain
___ R L Hand pain
___ R L Finger pain
___ R L Hip pain
___ R L Knee pain
___ R L Ankle pain
___ R L Foot pain
___ R L Toe pain
___ R L Jaw pain
___ Radiating pain
___ Sciatica
___ Numbness & Tingling
___ Pins & Needles
___ Cold hands/feet
___ Weakness
___ Swollen joints
___ Arthritis
___ Scoliosis

Gastro-Intestinal
___ Diabetes
___ Hernia
___ Nausea
___ Vomiting
___ Liver problems
___ Gall bladder
___ Tonsillitis
___ Pain over stomach

Cardio-Vascular
___ Heart disease
___ High blood pressure
___ Low blood pressure
___ Rapid beat
___ Slow beat
___ Chest pain
___ Stroke
___ Heart attack
___ Heart surgery
___ Swollen ankles
___ Poor circulation
___ Pacemaker
___ Heart murmur
___ Congenital heart defect
___ Heart stint(s)

Eye Ear Nose Throat
___ Vision Problems
___ Deafness
___ Earache
___ Ears ringing
___ Loss of smell
___ Sinus problems
___ Loss of taste
___ Thyroid problems

Respiratory
___ Asthma
___ Spitting blood
___ Difficulty breathing

For Women Only
___ Pregnant
___ Nursing
___ Birth control
___ Painful periods
___ Irregular cycles
___ Excessive flow
___ Hot flashes
___ Cramps
___ Miscarriage
___ Vaginal discharge
___ Breast Implants
___ Last PAP _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES? PLEASE CIRCLE:

Tuberculosis	Stomach/Ulcer	Hepatitis	Paralysis	HIV positive
Lung Disease	Seizures	Gout	Polio	AIDS
Kidney Disease	Cancer	Transfusion	Multiple Sclerosis	
Colon Disease	Anemia	Bleeding	Drug Dependence _____	

For Office Use Only
Patient Name _____ **Date:** _____

RADIOGRAPHIC CONFIRMATION:
Arizona State Law mandates that radiographs are the property of the doctor, clinic, hospital, or facility where they are performed. It is understood and agreed that the payments made to Tucson Chiropractic Center are for the performance and interpretation of the radiographs. The radiographs are saved in a file as part of the patient record and can be burned on a CD per patient request.

Males and Females must read and sign:
This is to confirm that the doctor has advised me that radiographs can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and consent to radiographic exposure.

_____ _____ _____
Patient/Parent Signature Date Last menstrual period

INFORMED CONSENT:
I hereby request and consent to the performance of chiropractic manipulative treatment, physical medicine modalities, and radiographs on me (or the patient named below, for whom I am legally responsible) by Wayne L. Rudnick, D.C., or any covering doctor of chiropractic in this office.

I have had the opportunity to discuss with the doctor of chiropractic and/or with other office personnel the nature and purpose of chiropractic manipulative treatment, physical medicine modalities, and radiographs that will be performed on today and on regular office visits. I also have been notified by reading this Informed Consent that the benefits and risks of treatment have been posted on the wall in each treatment room. Upon request, I will receive a copy of all the benefits and risks of treatment options in this office.

I understand and I am informed that, as in the practice of medicine and in the practice of chiropractic, there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is in my best interest.

I have read, and/or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name: _____

Patient/Parent Signature: _____ Date: _____

For Office Use Only
Patient Name _____ **Date:** _____

PATIENT MESSAGING CONSENT:
By supplying my home phone number, mobile phone number, work number, email address, and any other personal contact information, I authorize Tucson Chiropractic Center to use my personal information, the name of my care provider, the time and date of my scheduled appointment(s) and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue exam, balances due, or any and all other communications in regard to services provided to me.

I also authorize Tucson Chiropractic Center to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events.

_____ I agree to the above statements. (Initials)

_____ I disagree to the above statements. (Initials)

Patient/Parent Signature: _____ Date: _____

TUCSON CHIROPRACTIC CENTER HIPAA COMPLIANCE:
Tucson Chiropractic Center is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. My signature below acknowledges that I have read the posted Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient/Parent Signature: _____ Date: _____

Witness: _____ Date: _____