

# 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		SURGERY: <input type="checkbox"/> No <input type="checkbox"/> Yes	
				Type	Date
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____ packs/day	_____	_____
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____ drinks/day	_____	_____
Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Intense	_____	_____
Do you wear heel lifts?	<input type="checkbox"/>	<input type="checkbox"/>		_____	_____
Do you wear Orthotics?	<input type="checkbox"/>	<input type="checkbox"/>		_____	_____

**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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Tucson Chiropractic Center  
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Wayne L. Rudnick, D.C.  
 David D. Heaton, D.C.

Dr. Initials \_\_\_\_\_

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:**

- |   |  |                                      |  |                                       |
|---|--|--------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Stomach/Ulcer | <input type="checkbox"/> Hepatitis   | <input type="checkbox"/> Paralysis             | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> Lung Disease   | <input type="checkbox"/> Seizures      | <input type="checkbox"/> Gout        | <input type="checkbox"/> Polio                 | <input type="checkbox"/> AIDS         |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Transfusion | <input type="checkbox"/> Multiple Sclerosis    |                                       |
| <input type="checkbox"/> Colon Disease  | <input type="checkbox"/> Anemia        | <input type="checkbox"/> Bleeding    | <input type="checkbox"/> Drug Dependence _____ |                                       |



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

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