

AUSTIN ALLEN GENTRY, D.C., P.T.
899 N. Wilmot Road, Suite A-3
Tucson, AZ 85711

CONFIDENTIAL PATIENT CASE HISTORY

Name _____ SS# _____

Address _____ APT# _____ Home Phone _____

City _____ State _____ Zip _____

Age _____ Birthdate _____ Marital Status: M S W D

Employer _____ Occupation _____

Address _____ Phone _____

Spouse's Name _____ Occupation _____

Address _____ Phone _____

In case of emergency notify _____ Phone _____

What is your MAJOR complaint? _____

When did pain initially start? _____

Most recent occurrence? _____ Is it constant? _____

If pain travels, where? _____

What time of day is it worse? _____

What makes the pain better? _____ What makes it worse? _____

Describe the kind of pain (e.g. sharp dull) _____

What caused the pain to begin? _____ Getting worse? _____

Have you been treated for this type of pain before? _____

If yes, what facility? _____

Name of Family Physician _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance and payment by the insurance company will be credited to my account on receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian or

Responsible Party Signature _____ Date _____

NAME _____ BIRTH DATE _____ Date _____

HEIGHT _____ WEIGHT _____ SEX _____ Case No. _____

CHILDREN (list ages & sex) _____

Describe major complaints & symptoms (indicate areas of pain on reverse side of this form) .

Date you first noticed symptoms _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

OCCASIONAL FREQUENT	GENERAL	GASTRO-INTESTINAL	RESPIRATORY
	<input type="checkbox"/> Allergy (list below)*	<input type="checkbox"/> Colon trouble	<input type="checkbox"/> Chest pain
	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Constipation	<input type="checkbox"/> Chronic cough
	<input type="checkbox"/> Dizziness or Fainting	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Difficult breathing
	<input type="checkbox"/> Headache	<input type="checkbox"/> Difficult digestion	<input type="checkbox"/> Spitting up blood
	<input type="checkbox"/> Neuralgia	<input type="checkbox"/> Distension of abdomen	<input type="checkbox"/> Spitting up phlegm
	<input type="checkbox"/> Numbness	<input type="checkbox"/> Gall bladder trouble	<input type="checkbox"/> Wheezing
	MUSCLE & JOINT	<input type="checkbox"/> Hemorrhoids	SKIN
	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Liver trouble	<input type="checkbox"/> Bruise easily
	<input type="checkbox"/> Bursitis	<input type="checkbox"/> Pain over stomach	<input type="checkbox"/> Dryness
<input type="checkbox"/> Foot trouble	EYES, EARS, NOSE & THROAT	<input type="checkbox"/> Skin eruptions (rash)	
<input type="checkbox"/> Low back pain	<input type="checkbox"/> Asthma	<input type="checkbox"/> Varicose veins	
<input type="checkbox"/> Neck pain or stiffness	<input type="checkbox"/> Colds	GENITO-URINARY	
<input type="checkbox"/> Pain between shoulders	<input type="checkbox"/> Deafness	<input type="checkbox"/> Bed-wetting	
<input type="checkbox"/> Sciatica	<input type="checkbox"/> Earache	<input type="checkbox"/> Blood in urine	
<input type="checkbox"/> Swollen joints	<input type="checkbox"/> Ear discharge	<input type="checkbox"/> Frequent urination	
<input type="checkbox"/> Pain, numbness or Cramps	<input type="checkbox"/> Ear noises	<input type="checkbox"/> Inability to control kidneys	
<input type="checkbox"/> Shoulders	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Kidney infection or stones	
<input type="checkbox"/> Arms	<input type="checkbox"/> Nasal obstruction	<input type="checkbox"/> Painful urination	
<input type="checkbox"/> Elbows	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Prostate trouble	
<input type="checkbox"/> Hands	<input type="checkbox"/> Sinus infection	<input type="checkbox"/> Pus in urine	
<input type="checkbox"/> Hips	CARDIO-VASCULAR	FOR WOMEN ONLY	
<input type="checkbox"/> Legs	<input type="checkbox"/> Hardening of arteries	<input type="checkbox"/> Congested breasts	
<input type="checkbox"/> Knees	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Cramps or backache	
<input type="checkbox"/> Feet	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Excessive menstrual flow	
DATE OF LAST: (Approx.)	HABITS:	HAVE YOU EVER:	<input type="checkbox"/> Hot flashes
_____ Physical examination	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Been knocked unconscious?	<input type="checkbox"/> Irregular cycle
_____ Blood test	<input type="checkbox"/> Coffee	<input type="checkbox"/> Used a crutch, or other support?	<input type="checkbox"/> Lumps in breast
_____ Chest x-ray	<input type="checkbox"/> Tobacco	<input type="checkbox"/> Been treated for a spine or nerve disorder?	<input type="checkbox"/> Menopausal symptoms
_____ Spinal x-ray	<input type="checkbox"/> Drugs	<input type="checkbox"/> Had a fractured bone?	<input type="checkbox"/> Painful menstruation
_____ Dental x-ray	<input type="checkbox"/> _____	<input type="checkbox"/> Been hospitalized for other than surgery?	<input type="checkbox"/> Vaginal discharge
_____ Urine test		<input type="checkbox"/> Ever had surgery? (list below)	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No
			Date of last period _____
			Previous miscarriages <input type="checkbox"/> Yes <input type="checkbox"/> No

*Please list any drugs now taken, allergies and past surgeries — _____

HAVE HAD	CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:				
	CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS				
	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Stroke
	<input type="checkbox"/> Anemia	<input type="checkbox"/> Eczema	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Polio	<input type="checkbox"/> Tuberculosis
	<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Goiter			<input type="checkbox"/> Foot Problem	

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Sign Your Name _____ Date _____

FEEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE

CASE HISTORY

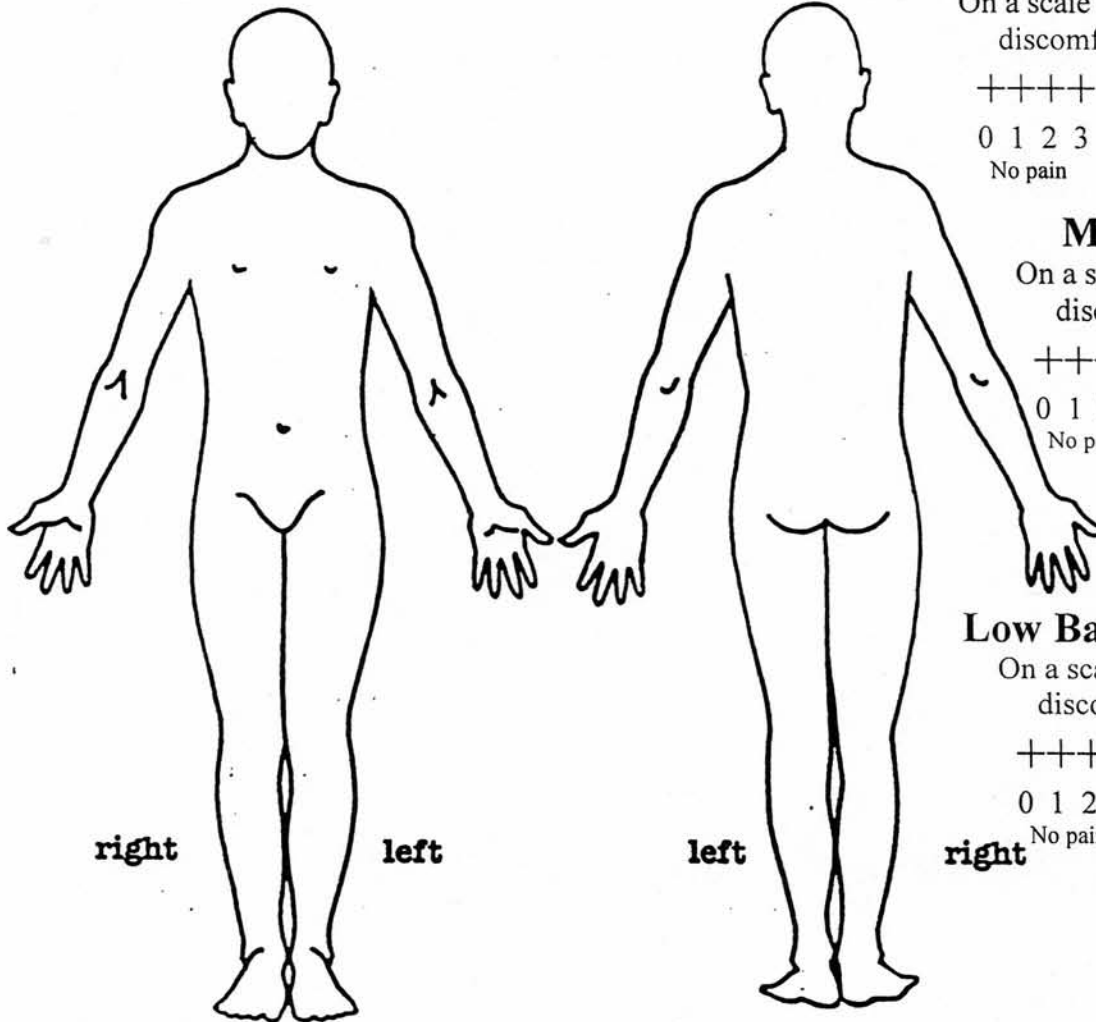
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.
 Use the appropriate symbols.
 Mark areas of radiation.
 Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	00000	XXXXXX	*****	/////
-----	00000	XXXXXX	*****	/////
-----	00000	XXXXXX	*****	/////

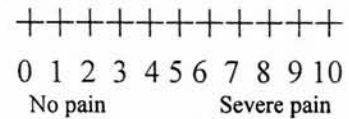
Please mark on the pain scale from zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.

Pain Chart



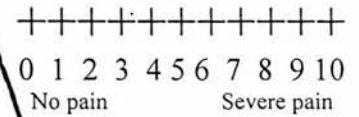
Neck-Shoulder-Arm Pain

On a scale of 0-10, I rate my discomfort as follows:



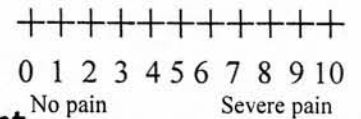
Mid Back Pain

On a scale of 0-10, I rate my discomfort as follows:



Low Back and Leg Pain

On a scale of 0-10, I rate my discomfort as follows:



Date: _____

Signature _____

Protocol for Preservation of Patient Records

Pursuant to ARS 32-3210 and the requirements of the State of Arizona for the preservation of patient records, this document is intended to inform all patients of Dr. Gentry of their rights and obligations.

Patients or their representatives may request copies of their records, in writing. Dr. Gentry agrees to comply with Arizona law for the production of these records and will timely respond to any reasonable requests.

Dr. Gentry will maintain your records for a period of seven (7) years following your last date of service. After 7 years from the last date of service, Dr. Gentry reserves the right to destroy your records. Should Dr. Gentry exercise that right, Dr. Gentry will first attempt to contact you and inform you of your right to obtain a copy of these records. Dr. Gentry will attempt to contact you by regular mail, at your last known address, and will give you thirty (30) business days to request that your records not be destroyed. If you do not respond to this notice, you will be waiving your rights to have your records preserved.

Should Dr. Gentry retire, cease to practice, or sell his practice to another health care professional, Dr. Gentry will notify all eligible patients, by regular mail, concerning the location of their records and how they may request copies of those records. The required notice will be sent to each eligible patient's last known address.

Patient's Signature
I acknowledge receipt of this document

Acknowledgement and Agreement: Patient's Protocol for Records Preservation

I, _____, patient of Dr. Gentry, do hereby acknowledge I have read and understand the doctor's protocol for the preservation of patient records. I agree to inform Dr. Gentry's office of any address changes and acknowledge that all requests for records, either by me or by my representatives, must be in writing. I agree that the doctor's office may comply with all statutory notification requirements to me by regular mail to my indicated address.

Patient's Signature

Date

Address

AUSTIN ALLEN GENTRY, D.C., P.T.

Notices of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **PLEASE READ IT CAREFULLY.**

We provide this notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you.

We Protect Your Information.

We maintain protocols to ensure the security and confidentiality of your personal information. We have passwords to protect databases and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs.

How We May Use and Disclose Medical Information About You

Medical Treatment. We may disclose medical information about you to individuals and businesses outside our practice that may be involved in your medical care. Our Business associates must promise that they will respect the confidentiality of your health information.

Communication with Family. We may disclose to a family member or close personal friend (or any other person you identify) health information relevant to that person's involvement in your care or payment related to your care.

Payment. We may use and disclose medical information about you to bill for our services and to collect payment

from you or your insurance company. We may also inform your payer of treatment you are going to receive in order to obtain prior approval or to determine whether the service is covered.

Health Care Operations. We may use and disclose information about you for the general operation of business. For example, we may use and disclose information about you for internal or external utilization review and/or quality assurance, for purposes of helping us to comply with our legal requirements, or to auditors or billing companies to aid us in this process.

Appointment and Patient Recall Reminders. We may ask that you sign a "Sign In" log on the day of your appointment. We may use and disclose medical information to contact you as a reminder that you have an appointment or that you are due to receive periodic care from the Practice.

Emergency Situations. We may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that you family can be notified about your condition, status and location.

Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

Worker's Compensation. We may disclose health information to the extent authorized by law to workers' compensation programs for work-related injuries or illness.

Investigation and Government Activities. We may disclose medical information about you to a local, state or federal agency for activities authorized by law.

Lawsuits and Disputes. We may disclose medical information about you in response to a subpoena, or a court or administrative order. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information if you so desire. We may use such information to defend ourselves or any member of our Practice in any legal or threatened action.

Law Enforcement. We may release information if asked to do so by a law enforcement official.

We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide such permission, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose personal information about you for the reasons covered by our written authorization, except to the extent we have already relied on your original permission.

Changes To This Notice

We reserve the right to make changes to this notice at any time.

For More Information or to Report a Problem

If you have questions or complaints concerning our Privacy Practice, you may contact:

A. Allen Gentry, D.C., P.T.
Privacy Officer
899 N. Wilmot, Suite A-3
Tucson, AZ 85711

If you believe your privacy rights have been violated, you can either file a complaint with Retina Associates Privacy Officer or with the Office for Civil Rights, U.S. Dept of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our Privacy Officer or the OCR. The addresses for the OCR is as follows:

Office for Civil Rights
U.S. Dept of Health & Human Services
200 Independence Ave., S.W.
Room 509F, HHH Bldg.
Washington, DC 20201

PATIENT RIGHTS

Right to Inspect and Copy. You have the right to inspect and copy medical, billing, and other records used to make decisions about your care. Upon proof of an appropriate legal relationship, records of others related to you or under your care may also be disclosed.

You must submit your request in writing to our Privacy Officer. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Amend. If you feel that the medical information we have in your record is incorrect or incomplete you have the right to request an amendment.

You must make your request in writing, along with your intended amendment and a reason that supports your request. The amendment must be dated and signed by you and notarized.

Right to an Accounting of Disclosures. You have the right to request a list of the disclosures we made of medical information about you to others.

Submit your request in writing. Your request may not include dates before April 14, 2003 (or the actual implementation date of HIPAA Regulations). We will notify you of the cost and you may choose to withdraw before any costs are incurred.

Right to Request Restrictions. You have the right to request that we limit disclosure about your care to someone who is involved in your care or the payment for your care. For example, you may ask that we not use or disclose information about a particular treatment you received.

You must make your request in writing. *We are not required to agree to your request.*

Right to Request Confidential Communications. You have the right to request that we communicate with you in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail, that we not leave voice mail or e-mail.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice at any time.

A. Allen Gentry, D.C., P.T.
899 N. Wilmot Rd.
Suite A-3
Tucson, AZ 85711
(520) 745-0545

Austin Allen Gentry, DC, PT

The doctors' choice for effective pain relief

A. Allen Gentry,
DC, PT

Over 28 years of experience

DC: Los Angeles College of
Chiropractic *magna cum laude*,
Los Angeles, CA

BS: Physical Therapy,
University of Oklahoma,
Norman, OK

Member: American Physical
Therapy Association, Arizona
Physical Therapy Association,
American Chiropractic
Association, Arizona

Association of Chiropractic
(Board of Delegates Member),
CareAdvantage (Board
Member)

Comprehensive care for:

- Acute or chronic back pain
- Acute or chronic neck pain
- Work injuries
- Headaches
- Arthritis
- Leg & arm pain
- Postsurgical rehabilitation
- Auto injuries
- Sports injuries

Conveniences that matter:

- Modern facility
- Advanced technology
- Convenient location
- Walk-ins & same-day
emergencies welcome
- Affordable rates
- Insurance accepted & filed
- Detailed & timely paperwork
for PCPs
- Open five days a week

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

Patient Name (Print)

Date

Parent or Authorized Representative (if applicable)

Signature

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ The pain is moderate and does not vary much.
- Ⓟ The pain comes and goes and is very severe.
- Ⓠ The pain is very severe and does not vary much.

Sleeping

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓜ Because of pain my normal sleep is reduced by less than 25%.
- Ⓨ Because of pain my normal sleep is reduced by less than 50%.
- Ⓟ Because of pain my normal sleep is reduced by less than 75%.
- Ⓠ Pain prevents me from sleeping at all.

Sitting

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit in my favorite chair as long as I like.
- Ⓜ Pain prevents me from sitting more than 1 hour.
- Ⓨ Pain prevents me from sitting more than 1/2 hour.
- Ⓟ Pain prevents me from sitting more than 10 minutes.
- Ⓠ I avoid sitting because it increases pain immediately.

Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓜ I cannot stand for longer than 1 hour without increasing pain.
- Ⓨ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓟ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓠ I avoid standing because it increases pain immediately.

Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓨ I cannot walk more than 1/2 mile without increasing pain.
- Ⓟ I cannot walk more than 1/4 mile without increasing pain.
- Ⓠ I cannot walk at all without increasing pain.

Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓨ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓟ Because of the pain I am unable to do some washing and dressing without help.
- Ⓠ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor.
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓟ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓠ I can only lift very light weights.

Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓟ Pain restricts all forms of travel except that done while lying down.
- Ⓠ Pain restricts all forms of travel.

Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓜ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓨ Pain has restricted my social life and I do not go out very often.
- Ⓟ Pain has restricted my social life to my home.
- Ⓠ I have hardly any social life because of the pain.

Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓜ My pain seems to be getting better but improvement is slow.
- Ⓨ My pain is neither getting better or worse.
- Ⓟ My pain is gradually worsening.
- Ⓠ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back
Index
Score