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 occurance?__________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 ______ (last) ______ (first) ______ (middle) ______ 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
- ☐ ☐ Allergy (list below)*
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness or Fainting
- ☐ ☐ Headache
- ☐ ☐ Neuralgia
- ☐ ☐ Numbness

MUSCLE & JOINT
- ☐ ☐ Arthritis
- ☐ ☐ Bursitis
- ☐ ☐ Foot trouble
- ☐ ☐ Low back pain
- ☐ ☐ Neck pain or stiffness
- ☐ ☐ Pain between shoulders
- ☐ ☐ Sciatica
- ☐ ☐ Swollen joints

Pain, numbness or Cramps
- ☐ ☐ Shoulders
- ☐ ☐ Arms
- ☐ ☐ Elbows
- ☐ ☐ Hands
- ☐ ☐ Hips
- ☐ ☐ Legs
- ☐ ☐ Knees
- ☐ ☐ Feet

GASTRO-INTESTINAL
- ☐ ☐ Colon trouble
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Difficult digestion
- ☐ ☐ Distension of abdomen
- ☐ ☐ Gall bladder trouble
- ☐ ☐ Hemorrhoids
- ☐ ☐ Liver trouble
- ☐ ☐ Pain over stomach

EYES, EARS, NOSE & THROAT
- ☐ ☐ Asthma
- ☐ ☐ Colds
- ☐ ☐ Deafness
- ☐ ☐ Earache
- ☐ ☐ Ear discharge
- ☐ ☐ Ear noises
- ☐ ☐ Eye pain
- ☐ ☐ Nasal obstruction
- ☐ ☐ Nosebleeds
- ☐ ☐ Sinus infection

CARDIO-VASCULAR
- ☐ ☐ Hardening of arteries
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Pain over heart
- ☐ ☐ Poor circulation
- ☐ ☐ Rapid heart beat
- ☐ ☐ Slow heart beat
- ☐ ☐ Swelling of ankles

RESPIRATORY
- ☐ ☐ Chest pain
- ☐ ☐ Chronic cough
- ☐ ☐ Difficult breathing
- ☐ ☐ Spitting up blood
- ☐ ☐ Spitting up phlegm
- ☐ ☐ Wheezing

SKIN
- ☐ ☐ Bruise easily
- ☐ ☐ Dryness
- ☐ ☐ Skin eruptions (rash)
- ☐ ☐ Varicose veins

GENITO-URINARY
- ☐ ☐ Bed-wetting
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Inability to control kidneys
- ☐ ☐ Kidney infection or stones
- ☐ ☐ Painful urination
- ☐ ☐ Prostate trouble
- ☐ ☐ Pus in urine

FOR WOMEN ONLY
- ☐ ☐ Congested breasts
- ☐ ☐ Cramps or backache
- ☐ ☐ Excessive menstrual flow
- ☐ ☐ Hot flashes
- ☐ ☐ Irregular cycle
- ☐ ☐ Lumps in breast
- ☐ ☐ Menopausal symptoms
- ☐ ☐ Painful menstruation
- ☐ ☐ Vaginal discharge

Pregnant ☐ Yes ☐ No

Date of last period ______

Previous miscarriages ☐ Yes ☐ No

DATE OF LAST: (Approx.)
- ______ Physical examination
- ______ Blood test
- ______ Chest x-ray
- ______ Spinal x-ray
- ______ Dental x-ray
- ______ Urine test

HABITS:
- ☐ Alcohol
- ☐ Coffee
- ☐ Tobacco
- ☐ Drugs
- ☐ ______

HAVE YOU EVER:
- ☐ Been knocked unconscious?
- ☐ Used a crutch, or other support?
- ☐ Been treated for a spine or nerve disorder?
- ☐ Had a fractured bone?
- ☐ Been hospitalized for other than surgery?
- ☐ Ever had surgery? (list below)

*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

- ☐ ☐ Alcoholism
- ☐ ☐ Anemia
- ☐ ☐ Appendicitis
- ☐ ☐ Cancer
- ☐ ☐ Diabetes
- ☐ ☐ Eczema
- ☐ ☐ Emphysema
- ☐ ☐ Goiter
- ☐ ☐ Gout
- ☐ ☐ Heart Disease
- ☐ ☐ Miscarriage
- ☐ ☐ Multiple sclerosis
- ☐ ☐ Polio
- ☐ ☐ Rheumatic fever
- ☐ ☐ Stroke
- ☐ ☐ Tuberculosis
- ☐ ☐ Ulcers
- ☐ ☐ 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 ______

FEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE

CASE HISTORY

Reorder - RETRIEVAL BUSINESS SYSTEMS P.O. Box 1001, Milan, IL 61264 309 787-1024
FORM-C 106 A

Name______________________________ Date_______________

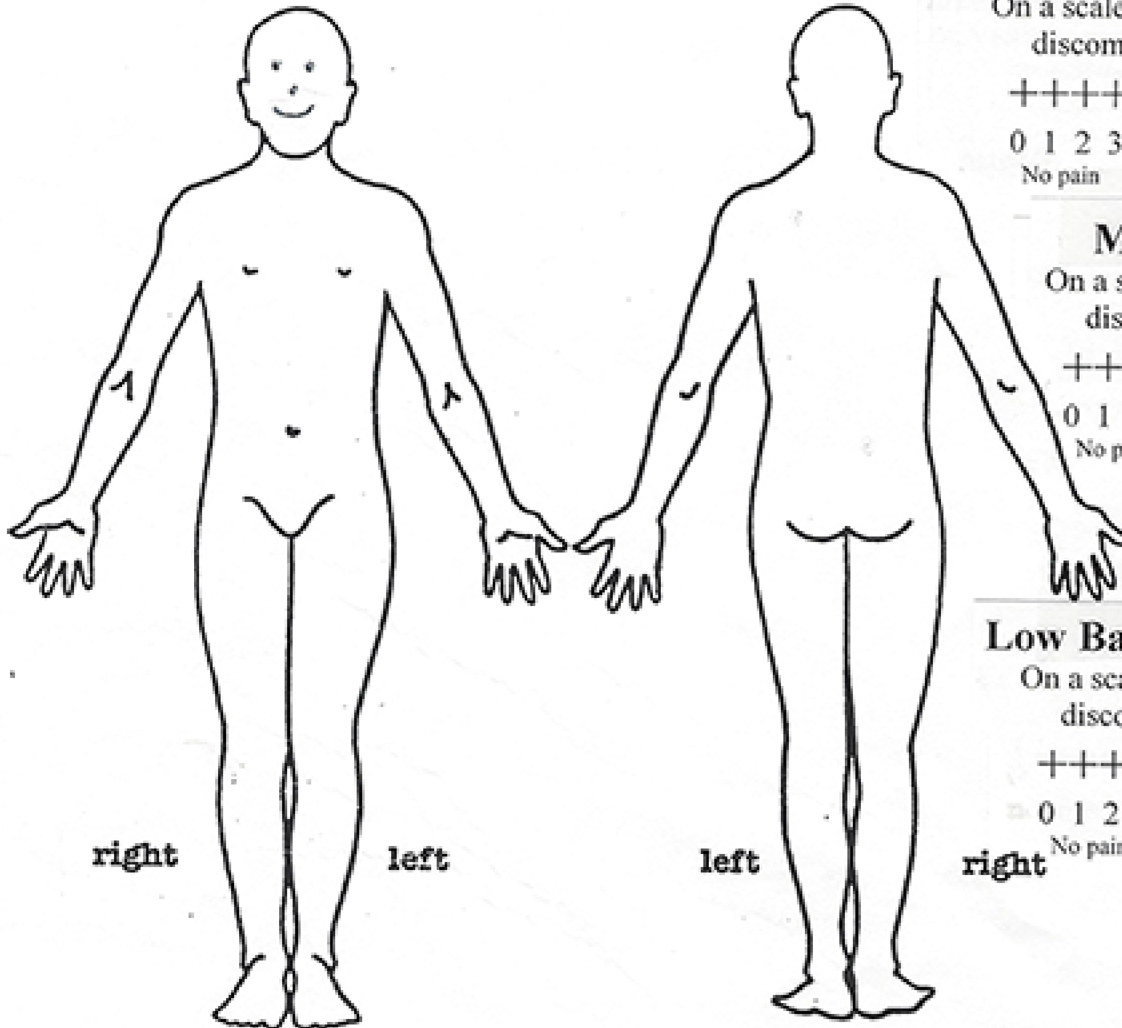
Austin Allen Gentry, DC, PT

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	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////

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.



Neck-Shoulder-Arm Pain

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

+++++++++++

0 1 2 3 4 5 6 7 8 9 10

No pain Severe pain

Mid Back Pain

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

+++++++++++

0 1 2 3 4 5 6 7 8 9 10

No pain Severe pain

Low Back and Leg Pain

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

+++++++++++

0 1 2 3 4 5 6 7 8 9 10

No pain Severe pain

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 documents 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 periods 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 Compenstation. We may disclose health information to the extent authorized by law to workers' compensation programs for work-related injures 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

____

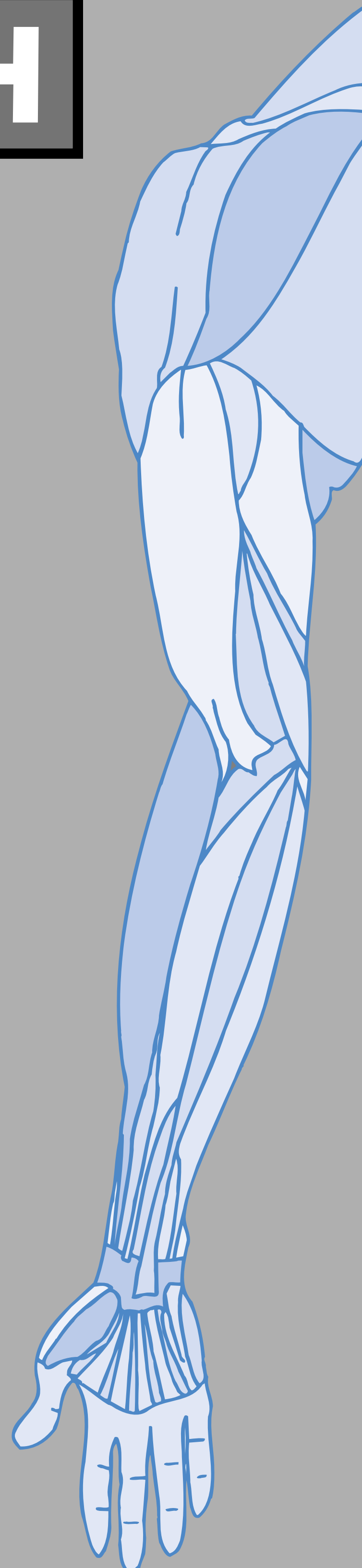
Parent or Authorized Representative (if applicable)

____

Signature

899 N. Wilmot, Suite A-3 • Tucson, AZ 85711
Phone (520) 745-0545 • Fax (520) 745-0505

THE DASH



INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

DISABILITIES OF THE ARM, SHOULDER AND HAND

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

DISABILITIES OF THE ARM, SHOULDER AND HAND

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = ____ ([(sum of n responses / n) - 1] x 25, where n is the number of completed responses.)

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.

DISABILITIES OF THE ARM, SHOULDER AND HAND

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is:______________________________

❒ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*.
If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

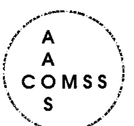
Please indicate the sport or instrument which is most important to you:______________________________

❏ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may not be calculated if there are any missing items.



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