TUSKEN CHIROPRACTIC AND ACUPUNCTURE REGISTRATION AND HISTORY

Date_____

Patient Name_____Nickname_____

Address_____
Street/PO Box Apt# City State Zip

Birthdate_____Age_____ M F Marital Status M W D S

Home#_____Cell#_____Can we leave a message? _____(c) _____ (h)

Best time and place to reach you_____Email_____

Would you like appointment reminders? Text ☐ Name of Cell Carrier_____ or Email ☐

Are you a student?_____Full Time_____ Part Time_____

Employer_____Occupation_____Work Phone_____

Spouse or Parent's Name_____ Birthdate_____

Emergency Contact_____Relationship_____Phone #_____

Whom may we thank for referring you?_____

Who is responsible for this account?_____Relationship_____

Insurance Company_____ **Please present insurance card to the front desk.**

General Consent Form: The undersigned hereby consents to evaluation and treatment rendered by Dr. Rhett Tusken and /or Dr. Christopher Tusken, massage therapists and their assistants according to the applicable standards of care. It is understood that any/all treatments have risks and benefits. Some risks include but are not limited to, fractures, disc injuries, strokes, sprains, and bruising. I do not expect the doctor to be able to anticipate or explain all risks or complications. I choose to rely on the doctor to exercise judgment during the course of the procedure, based on the facts I have provided, and to do what is in my best interest. If the risks and benefits of proposed treatment are not clear to me, it is my responsibility to ask any questions that I have regarding treatment. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment. I understand that I have a responsibility to communicate honestly with the doctors and to notify them of any changes to my health status.

Financial Awareness and Consent: I understand that I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. I hereby assign my insurance benefits, if applicable, to Tusken Chiropractic and Acupuncture. I authorize the use of my signature on all insurance submissions.

Release of Records: I authorize Tusken Chiropractic and Acupuncture to release all health records necessary for my treatment including any protected health information required to secure payment.

HIPAA: I have been provided an opportunity to review the Notice of Privacy Practices and agree to their terms.

Cancellation Policy: We respectfully ask for a 2 hour notice on all canceled appointments, but prefer 24 hours. A minimum fee of $50 may be assessed for missed appointments.

I GIVE CONSENT TO TREAT THE MINOR LISTED ABOVE

GUARDIAN'S SIGNATURE_____**DATE**_____

PATIENT SIGNUATRE _____**DATE**_____

COMPLAINTS

Main problem you would like our help with:_____

_____

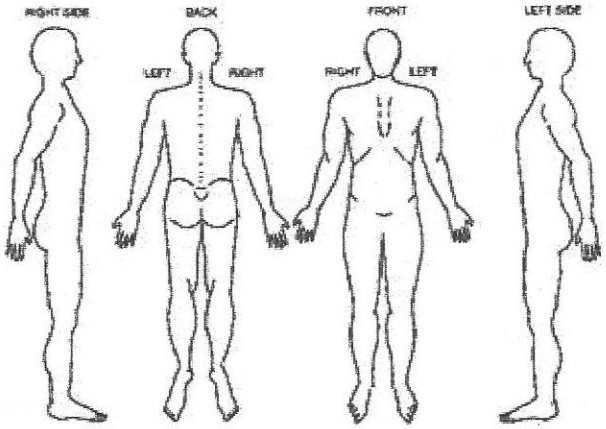
How long ago did this problem begin?_____

Has anything helped? Y N If yes, please explain:_____

Are there any other problems that you would like us to address?:_____

_____

Please indicate where you have pain or other symptoms:



Type of pain:

( ) Sharp ( ) Dull ( ) Throbbing

( ) Aching ( ) Shooting ( ) Numbness

( ) Burning ( ) Tingling ( ) Cramps

( ) Stiffness ( ) Swelling ( ) Other

Pain Level: 1(least) - 10(most) _____

LIFESTYLE - because, YES, it makes a difference!

Do you follow any type of special diet? If yes, what type of diet and how long?_____

HABITS

( ) Smoking Packs/Day_____ ( ) Coffee/Cups per day _____ Pop/Cans per day ____

( ) Alcohol Drinks/Week_____ ( ) Artificial Sweeteners ( ) Sugar

( ) Water (8oz) Cups/Day_____ ( ) Work Hours a week _____

( ) Exercise Hours a week_____ ( ) Sitting ( ) Standing ( ) Light Labor ( ) Heavy Labor

Type(s) of Exercise_____ Stress Level ( ) High ( ) Moderate ( ) Low

How do you manage your stress (ie meditation, yoga, tai chi, etc) _____

PERSONAL MEDICAL HISTORY

Height: _____ Current Weight: _____ Weight history: _____

Please list hospitalizations and surgeries with approximate dates: _____

_____

Cancer/Tumors:_____

Vaccinations/Recent Injections (please list):_____

Communicable/Contagious conditions: (If yes, please list):_____

Please list any significant trauma (accidents, falls, loss, etc): _____

Name:_____

Please list all allergies (food, drugs, environmental, etc.):_____

_____

Please list all medicines, vitamins, herbal remedies, supplements, etc., taken within the last 2 months:

NAME & BRAND/PRESCRIPTIONS	DOSAGE	REASON FOR TAKING
NON-PRESCRIPTIONS		

Do you take them regularly? Of course_____ Not so much_____Only when I think I need them_____

Please place an "x" next to all that relate to your health.

Body Temperature:

( ) Feel warm all the time ( ) Chills ( ) Spontaneous sweats
( ) Feel cold all the time ( ) Cold hands/feet ( ) Fever/Night Sweats

Sleep:

( ) Trouble falling asleep ( ) Vivid/Troublesome dreams ( ) Sleep Apnea ( ) Grinding teeth
( ) Trouble staying awake ( ) Insomnia ( ) Crave naps ( ) Hours per night:
( ) Waking un-rested ( ) Snoring ( ) Take naps _____

Energy Level:

( ) Always feel tired ( ) Energy is consistently good ( ) Tired, but I keep going ( ) Can't sit still
( ) Sudden drops in energy, if so when:_____

Skin and Hair:

( ) Rashes ( ) Psoriasis ( ) Itching ( ) Eczema ( ) Acne ( ) Hives ( ) Dry Skin
( ) Dermatitis ( ) Dandruff ( ) Hair Loss ( ) Premature Graying ( ) Plantar Warts

Head, Eyes, Ears, Nose and Throat:

( ) Headaches ( ) Migraines ( ) Eye pain/strain ( ) Spots/floaters
( ) Cataracts ( ) Poor/Blurry Vision ( ) Night blindness ( ) Frequent sore throat
( ) Difficulty hearing ( ) Earaches ( ) Canker Sores ( ) Difficulty Swallowing
( ) Dizziness ( ) Vertigo ( ) Sinus pain ( ) Nosebleeds
( ) Jaw Pain/TMJ ( ) Memory Loss ( ) Trouble concentrating
( ) Seizures ( ) Tremors ( ) Loss of Balance
( ) Muscle Weakness/paralysis ( ) Neurological Diagnosis (MS, Alzheimer's, Parkinson's) _____

Endocrine

( ) Diabetes ( ) Thyroid Trouble ( ) Liver/Gall Bladder Trouble

Cardiovascular:

( ) High blood pressure ( ) Spider/varicose veins ( ) Chest pains
( ) Low blood pressure ( ) Swelling of extremities ( ) Palpitations ( ) Irregular heart beat
( ) Blood clots ( ) Fainting ( ) Anemia ( ) High Cholesterol
( ) Stroke ( ) Heart Disease of History of Heart Attack

Respiratory:

( ) Asthma ( ) Recurrent bronchitis ( ) Shortness of breath ( ) Phlegm produced:
( ) Chronic cough ( ) Pneumonia ( ) Pain with deep breath Color_____
( ) Coughing blood ( ) Chest tightness ( ) Phlegm stuck in chest ( ) Difficulty Breathing

Gastro-Intestinal:

( ) Nausea ( ) Bad breath ( ) Constipation ( ) Excessive appetite
( ) Vomiting ( ) Bleeding gums ( ) Hemorrhoids ( ) Poor appetite
( ) Indigestion/Belching ( ) Bloating ( ) IBS ( ) Hernia
( ) Acid Reflux ( ) Gas ( ) Abdominal pain ( ) Colitis
( ) Diarrhea ( ) Laxative use ( ) Crohn's Disease ( ) Ulcers

Genitourinary:

( ) Frequent Urination ( ) Pain upon urination ( ) Kidney stones ( ) Blood in urine
( ) Recurrent UTI ( ) Kidney/Bladder infections ( ) Waking up to urinate-times per night _____

Female Reproductive and Gynecological:

Are you pregnant? Y N What trimester are you in? _____ # of previous pregnancies _____
( ) Menstrual clots ( ) Irregular periods ( ) Endometriosis ( ) Pre-menstrual cramps
( ) PCOS ( ) Breast soreness/cysts ( ) Ovulation pain ( ) Uterine fibroids

Psychological and Emotional and Mental Health:

( ) Anxiety ( ) Sadness ( ) Fearful ( ) Excessive worry
( ) Depression ( ) Bad temper ( ) Grief ( ) Panic attacks
( ) Easily stressed ( ) Other _____

Musculoskeletal:

( ) Muscle tightness ( ) Sprain/strain ( ) Carpal tunnel ( ) Osteoporosis
( ) Muscle soreness ( ) Tendonitis ( ) Restricted mobility ( ) Numbness
( ) Muscle spasm ( ) Bursitis ( ) Sciatica ( ) Fibromyalgia
( ) Osteoarthritis ( ) Rheumatoid Arthritis ( ) Neuropathy

Comments: Please use this section to describe anything else that hasn't already been addressed on this form.

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