Dr. Armando R. Babcock, D.C 316-612-0600 TRINITY Chiropractic **3300 N Rock Road, Suite A2 Wichita, KS 67226**

New Patient Form

Today's Date: ___________________________

Full Name: ____

Address: __________________________________ **Sex**: ○ M ○ F

City: ___________________ **State**: _______ **Zip**: ____________

Date of Birth: _________________ **SSN**: __________________

Status: ○ Single ○ Married ○ Divorced ○ Other_______________

E-mail: ____

Do we have permission to send you periodic emails? ○Yes ○No

H. Phone: ________________ **C. Phone**: ___________________

Preferred contact method: ○ Home Phone ○ Cell Phone ○ Email

Emergency contact: ___________________________________

Number: ___________________ **Relation:** _________________

How did you hear about us: ○ Internet ○ Ad ○ Friend ○ Family ○ Event ○ Existing patient: _____________________________

Occupation: ________________ **Employer**: _________________

Type of work: ○ sitting ○ standing ; ○ Full time ○ Part time

Do you have a primary care physician? ○ Yes ○ No

If yes, Name: ______________________ Phone #: ________________

Address: ____

May we send updates to your provider regarding your care? ○ Yes ○ No

Are you seeing any other doctors for this condition? ○ Yes ○ No

If yes, Name: ______________________ Phone #: ________________

Have you received previous chiropractic care? ○Yes ○ No

If yes, when/where? ____

Are you taking any medications? ○ Yes ○ No

Please list: (Include medications, supplements, vitamins)

____

____

Do you have any medication allergies? ○ Yes ○ No

If yes, please list: (Please include reactions)

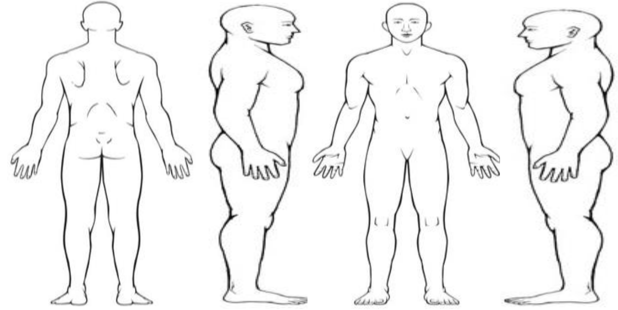
____

____

(For women only) Are you pregnant? ○ Yes ○ No

What is your primary complaint? __________________________

Please circle/mark the areas bothering you on the illustrations below.



Is this related to ○ an auto accident ○ a work injury ○ neither

If yes, when was the accident/injury? ___________________________

Have you ever been injured in an auto accident? ○ Yes ○ No

If yes, when? ____

Have you been diagnosed with a nerve disorder? ○ Yes ○ No

If yes, what/when____

Had any X-Rays or MRIs taken for this condition? ○ Yes ○ No

If yes, what/when____

Have you ever had a fractured/broken bone? ○ **Yes** ○ **No**

If yes, what/when____

Surgeries/Hospitalizations:

____________________________________ Date_______________

____________________________________ Date_______________

____________________________________ Date_______________

____________________________________ Date_______________

What is your goal for your care? ○ Pain Relief ○ Comprehensive

What is your Race? ○ Caucasian ○ American Indian ○ Asian ○ African American ○ Hispanic/Latino ○ Other _______________

Alcohol intake: ○ Daily ○ Moderate ○ Socially ○ Never

Caffeine intake: ○ Never ○ Occasionally ○ Daily (Cups per day___)

Recreational drug use: ○ Never ○ Socially ○ Moderate ○ Daily

Smoking Status: ○ Daily ○ Occasional ○ Former ○ Never

Eating Habits: ○ One to two meals/day ○ Two to three meals/day

Exercise Habits: ○ Daily ○ Few times/week ○ Once/weekly ○ None

Family History: Please mark below

○ Alcoholism ○ Alzheimer's ○ Anemia ○ Arthritis ○ Asthma ○ Cancer ○ Dementia ○ Depression ○ Diabetes ○ Epilepsy ○ Heart Disease ○ High Blood Pressure ○ High Cholesterol ○ Kidney Disease ○ Liver Disease ○ Lung Disease ○ Osteoporosis ○ Stroke ○ Ulcers ○ Other: _______________________________

Please mark any health conditions that you currently have or have had in the past.

○ **NO MEDICAL PROBLEMS** (Please mark here if you have no prior history of any significant medical problems)

Do you have any: ○ implants ○ pins ○ screws ‖ If yes, where? ____

Musculoskeletal: ○ Gout ○ Lupus ○ Osteoarthritis ○ Rheumatoid arthritis ○ Scoliosis ○ TMJ issues ○ Other_____________________________________

Neurological: ○ Anxiety ○ Cerebral Palsy ○ Depression ○ smell/vision/hearing loss ○ MS ○ Parkinson's ○ Polio ○ Stroke ○ Other_________________________

Head/ENT: ○ Earaches ○ Headaches ○ Hearing loss ○ Sinus trouble ○ Tinnitus ○ Other________________________________

Cardiovascular: ○ Chest pain ○ Heart attack ○ Heart murmur ○ High/Low blood pressure ○ High cholesterol ○ Irregular beat ○ Other________________________

Respiratory: ○ Asthma ○ COPD ○ Cystic Fibrosis ○ Emphysema ○ Pneumonia ○ Pulmonary Embolism ○ Tuberculosis ○ Other_________________________

Gastrointestinal: ○ Acid reflux ○ Diverticulitis ○ GI bleed ○ Irritable bowel ○ Inflammatory bowel disease ○ Peptic/stomach ulcer ○ Other________________

Genitourinary: ○ Bladder issues ○ Dialysis ○ Kidney problems ○ Kidney stones ○ Urinary tract infections ○ Other_______________________________________

Endocrine: ○ Diabetes ○ Hashimoto's Thyroiditis ○ Hypo/Hyperglycemia ○ Hyper/Hypothyroidism ○ Osteoporosis ○ Thyroid cancer ○ Other_____________

Dermatological/Hematopoietic: ○ Acne ○ Easy bruising ○ Eczema ○ Psoriasis ○ Skin cancer ○ Other_______________________________________

Any medical problems NOT listed:

____

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Please read and write your initial on the lines to the left of each statement your agreement with the terms below.

— I grant permission to be called to confirm or reschedule an appointment or called for any missed appointments and to be sent occasional cards, letters, emails, or health information as an extension of my care in this office.

— I am responsible for all services rendered to me and/or my dependents. I also understand that if I suspend or terminate care for myself and/or my dependents, any fees for services rendered will still be my responsibility.

— Trinity Chiropractic will file/verify my health insurance if provided. Verification of my insurance benefits does not guarantee payment. In the event of non-payment from my health insurance or limitations, I am responsible.

— I assign and transfer all medical benefits to which I am entitled. I authorize and direct payments of insurance and/or Medicare benefits be issued to Trinity Chiropractic for medical services rendered to myself and/or my dependents. If these payments are made out to me directly, I grant Trinity Chiropractic the authority in my name to endorse any and all checks.

— I authorize Trinity Chiropractic to disclose past, present, and future health care information to insurance carriers, attorneys, or adjusters regarding my treatment and allow a photocopy of my signature to be used to process insurance claims. I understand that the information used or disclosed under this Authorization may be subject to re-disclosure by the person(s) or facility receiving it and that it would then no longer be protected by federal privacy regulations. I have the right to refuse to sign this Authorization. If signed, I have the right to revoke this authorization in writing. I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions. I acknowledge that I have the right to review the Notice of Privacy Policies and can be provided a copy of it if at my request.

____ _______________________

Patient (or Guardian's) Signature **Date**

____

Date of Birth

(CONSENT TO TREATMENT OF MINOR)

I, _________________________________, being the parent and/or legal guardian of ___________________________ do hereby request and authorize Dr. Babcock to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter. This authorization also extends to all office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

____ _______________________

Parent (or Guardian's) Signature **Date**

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Please read and initial to the left of each section of this document before signing. It is important you understand the following information. Please ask questions if anything is unclear.

— **THE NATURE OF THE CHIROPRACTIC ADJUSTMENT**
The primary treatment used by doctors of chiropractic is a chiropractic adjustment. A chiropractic adjustment is designed to reduce vertebral subluxations. Subluxations are spinal vertebrae that are out of position and can cause loss of function. Dr. Babcock will use chiropractic adjustments to treat you. He may use his hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible pop or click much as you have experienced when you crack your knuckles. You may also feel a sense of movement.

— **ANALYZE / EXAMINATION / TREATMENT**
As part of the analysis, examination, and treatment, you are consenting to any the following procedures as recommended by Dr. Babcock: Chiropractic Adjustment, Palpation, Vital Signs, Range of Motion Testing, Orthopedic Testing, Basic Neurological Testing, Muscle Strength Testing, Postural Analysis Testing, X-Ray, Ultrasound, Traction, Laser, Hot/Cold Therapy, Electrical Muscle Stim, Other:________________________________

— **THE RISKS INHERENT IN CHIROPRACTIC**
As with any healthcare procedure, there are certain complications which may arise during a chiropractic adjustment and therapy. Complications include but are not limited to fractures, disc injuries, dislocations, muscle strains, cervical myelopathy, costovertebral strains/separations, and burns. Some types of adjustments of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel stiffness and soreness following the first few days of treatment. Dr. Babcock will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to Dr. Babcock's attention, it is your responsibility to inform him.

— **THE PROBABILITY OF THOSE RISKS OCURRING**
Fractures are rare occurrences and generally result from an underlying weakness of the bone which we check for during the taking of your history and during examination and X-Ray. Stroke and/or arterial dissection caused by chiropractic adjustment of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a casual relationship at all, it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

— **THE AVAILABILITY AND NATURE OF OTHER TREATMENT OPTIONS**
Other treatment options for your condition may include self-administered, over-the-counter analgesics and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain-killers, hospitalization, and surgery. If you choose to use one of the other treatment options, there are risks and benefits of such options and you can discuss these with your primary care physician.

— **THE RISKS AND DANGERS ATTENDANT TO REMAINING UNTREATED**
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Babcock and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

______________________________	______________________________
Patient's Name	**Doctor's Name**
______________________________	______________________________
Patient (or Guardian's) Signature	**Doctor's Signature**