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: _____ Sex ○ M ○ F

Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Race: ○ Caucasian ○ American Indian ○ Asian ○ Hispanic/Latino ○ African American ○ Other _____

Status: ○ Single ○ Married ○ Divorced ○ Other_____

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

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

Occupation: _____ Employer: _____
Type of work: ○ sitting ○ standing ; ○ Full time ○ Part time

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

If yes, Name: _____ Phone #: _____
May we send periodic medical updates to your provider? ○ Yes ○ No

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

If yes, Name: _____ Phone #: _____

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)

_____

_____

Surgeries/Hospitalizations:

_____ **Date_____**

_____ **Date_____**

_____ **Date_____**

Goal for your care: ○ Pain Relief ○ Comprehensive (long term)

Alcohol intake: ○ Never ○ Socially ○ Weekly ○ Daily

Caffeine intake: ○ Never ○ Occasionally ○ Daily (Cups daily ___)

Recreational drugs: ○ Never ○ Occasionally ○ Weekly ○ Daily

Smoking Status: ○ Never ○ Former ○ Occasionally ○ Daily

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

Exercise Habits: ○ Daily ○ Few times/week ○ 1xWeekly ○ None

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

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.

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

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

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

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

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

Cardiovascular: ○ Chest pain ○ Heart attack ○ Heart murmur ○ High BP ○ Low BP ○ High cholesterol ○ Irregular heart beat ○ Other_____

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

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

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

Endocrine: ○ Diabetes ○ Thyroid cancer ○ Hypoglycemia ○ Hyperglycemia ○ Hypothyroidism ○ Hyperthyroidism ○ Osteoporosis ○ Hashimoto's Thyroiditis ○ Other_____

Dermatological (Skin): ○ Acne ○ Eczema ○ Easy bruising ○ Psoriasis ○ Skin cancer ○ Other_____

Any medical problems NOT listed:

_____

Drs Initials _____

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

Name: _____

What is your primary complaint? _____

When did your symptoms begin/what happened?

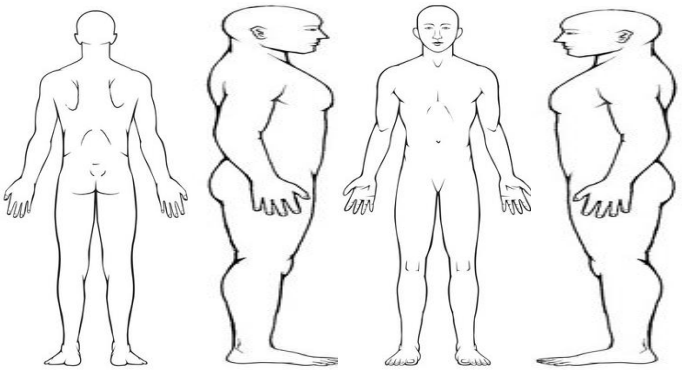
_____

Is this related to ○ an auto accident ○ a work injury ○ neither
If yes, when was the accident/injury? _____

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_____

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



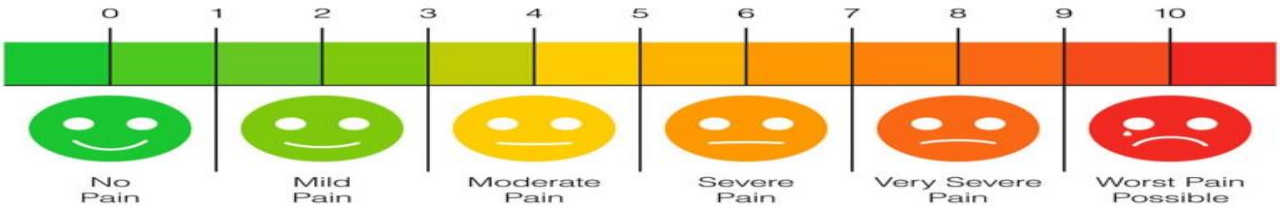
Do you have pain in any of the following? Check all that apply. Use the image below as a guide.

○ **Neck** - ○ achy ○ sharp ○ stiff ○ throbbing ‖ **Pain level** – **<u>At its worst</u>** (low 0-10 high): _____
How often: ○ Random ○ Occasional (some of the time) ○ Frequent (most of the time) ○ Constant (all of the time)

○ **Upper back** - ○ achy ○ sharp ○ stiff ○ throbbing ‖ **Pain level** - **<u>At its worst</u>** (low 0-10 high): _____
How often: ○ Random ○ Occasional (some of the time) ○ Frequent (most of the time) ○ Constant (all of the time)

○ **Mid back** - ○ achy ○ sharp ○ stiff ○ throbbing ‖ **Pain level** - **<u>At its worst</u>** (low 0-10 high): _____
How often: ○ Random ○ Occasional (some of the time) ○ Frequent (most of the time) ○ Constant (all of the time)

○ **Low back** - ○ achy ○ sharp ○ stiff ○ throbbing ‖ **Pain level** - **<u>At its worst</u>** (low 0-10 high): _____
How often: ○ Random ○ Occasional (some of the time) ○ Frequent (most of the time) ○ Constant (all of the time)



Do you have any of the following? Check all that apply

○ Numbness ○ tingling ○ weakness that radiates down **<u>shoulder</u>** - ○ right ○ left ○ both

○ Numbness ○ tingling ○ weakness that radiates down **<u>arm</u>** - ○ right ○ left ○ both

○ Numbness ○ tingling ○ weakness that radiates down **<u>hand</u>** - ○ right ○ left ○ both

○ Numbness ○ tingling ○ weakness that radiates down **<u>buttock</u>** - ○ right ○ left ○ both

○ Numbness ○ tingling ○ weakness that radiates down **<u>leg</u>** - ○ right ○ left ○ both

○ Numbness ○ tingling ○ weakness that radiates down to **<u>foot</u>** - ○ right ○ left ○ both

Do you have any other symptoms not listed? ○ Yes ○ No - If yes, please explain: _____

Does your current condition interfere with any of the following? (Check all that apply)
○ Sitting ○ standing ○ walking ○ lying down ○ bending ○ lifting ○ working ○ recreational activities ○ household duties

Have you done any of the following to relieve the symptoms? (Check all that apply)
○ Rest ○ Ice ○ Heat ○ Exercise ○ Chiropractic ○ Physical Therapy ○ Massage Therapy ○ Surgery
○ OTC medication ○ Prescription Medication ○ other_____

Drs Initials _____

Name: _____

***Please read and initial to the left of each statement 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.

_____ I authorize this office to 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 authorize direct payments of medical benefits and/or Medicare benefits to Trinity Chiropractic for medical services rendered to myself and/or my dependents and allow a photocopy of my signature to be used to release medical information necessary to process my insurance claims.

*I understand the information used/disclosed may be subject to re-disclosure by the person(s)/facility receiving it and that it would 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 have the right to review the Notice of Privacy Policies and can be provided a copy of it if at my request.

The following person(s) have my permission to receive my personal health information:

Name: _____ Relation _____

Name: _____ Relation _____

Name: _____ Relation _____

_____ _____

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

_____

Date of Birth

CONSENT TO TREATMENT OF MINOR

(Fill this out if the patient is under 18 years of age)

I, _____, being the parent and/or legal guardian of _____ 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.

_____ _____

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

Drs Initials _____

***Please initial to the left of each statement. Read 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, one or more of the following procedures will be performed 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:_____
***These procedures will be discussed prior to performing them.**

_____ THE RISKS INHERENT IN CHIROPRACTIC

As with any healthcare procedure, there are 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 underlying weakness of the bone which we check during the taking of your history and examination and X-Ray (if necessary). 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. 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 information above. I have had my questions answered to my satisfaction. By signing below, I have weighed the risks involved and hereby give my consent to treatment.

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

Drs Initials _____