REFLECTION RIDGE CHIROPRACTIC

WELCOME! Our goal is to help you achieve the best health possible. Please provide the following information as completely as you can. The better we communicate, the better we can care for your needs.

Patient Registration

Patient Name	How do you wish to be addressed?	Date of Birth

Address	City	State	Zip

Home Phone #	Cell Phone #	Social Security #

Email Address	Patient Status	School Status
	☐ Single ☐ Married ☐Other	☐ Full-time ☐ Part-time ☐N/A

Account Information

☐ Patient's Name ☐ Guardian's Name	Employer	Work Phone #

☐ Spouse's Name ☐ Guardian's Name	Employer	Work Phone #

If the patient is a child, who is responsible for this account?

Is the condition we are treating related to a: ☐ auto accident ☐ work accident ☐other accident ☐N/A

PLEASE FILL OUT YOUR <u>HEALTH</u> INSURANCE INFORMATION BELOW. IF YOUR VISIT IS RELATED TO AN ACCIDENT, PLEASE PUT YOUR ACCIDENT INSURANCE INFORMATION ON THE ACCIDENTAL INJURY FORM.

Primary Health Insurance Information

Primary Insurance Company	Identification #	Name of Policyholder

Policyholder's Social Security **#**	Policy/Group #	Policyholder's Date of Birth	Insurance Phone #

Secondary Health Insurance Information

Secondary Insurance Company	Identification #	Name of Policyholder

Policyholder's Social Security **#**	Policy/Group #	Policyholder's Date of Birth	Insurance Phone #

How did you learn about our office? (If from a friend or relative, his/her name.)	Someone not living with you to contact in case of emergency (name and phone #).

Other family members in this practice:

Family Medical Doctor:	When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐ Yes ☐ No

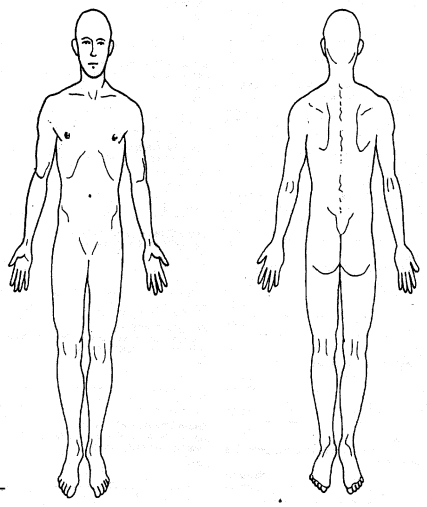
Reflection Ridge Chiropractic
2290 N. Tyler Rd, Ste. 100 Wichita, KS 67205 ♦ (316) 721-3003

Patient Name:_____ Date:_____

Height_____ Weight_____

MEDICAL HISTORY

CHIEF COMPLAINT
What is your major symptom?_____
_____



Please circle your area(s) of discomfort on the figures to the right.

PLEASE DESCRIBE YOUR PAIN OR CONDITIONS
Is your pain: ☐Sharp ☐Dull ☐Numbness ☐Tingling ☐Aching
☐Burning ☐Stabbing ☐Other_____
Has your pain: ☐Become worse recently ☐Stayed the same
☐Getting better ☐Gradually Worse
How frequent is your condition? ☐Constant ☐Daily ☐Intermittent
☐Night only ☐Morning only
How long does it last? ☐All day ☐A few hours ☐Minutes
Are there any other conditions or symptoms that may be related to your major symptom?_____
_____
What makes the problem worse? ☐Standing ☐Sitting ☐Lying ☐Bending
☐Lifting ☐Twisting ☐Other_____
What makes the problem better?_____
Does icing help? ☐ Yes ☐ No Does heat help? ☐ Yes ☐ No Do you wear a heel lift? ☐ Yes ☐ No
Does the pain interfere with your sleep? ☐ Yes ☐ No Does the pain get worse at night? ☐ Yes ☐ No

Symptoms developed from: ☐ Auto Accident ☐ Work related injury ☐Other
When did they begin:_____ How did it occur?_____
_____
Does your pain interfere with work or living habits? ☐ Yes ☐ No If yes, how?_____
_____

HEADACHES		NECK		LOW BACK	
Do you experience:		**Do you experience:**		**Do you experience:**	
Nausea or vomiting	☐ Yes ☐ No	Difficulty turning your head	☐ Yes ☐ No	Numbness/tingling in feet/legs	☐ Yes ☐ No
Visual Disturbances	☐ Yes ☐ No	Pain or pressure behind eyes	☐ Yes ☐ No	Pain down your legs	☐ Yes ☐ No
Pain or cracking in jaw	☐ Yes ☐ No	Numbness of hands/fingers	☐ Yes ☐ No	Changes in bowel or bladder function	☐ Yes ☐ No
Abnormal blood pressure	☐ Yes ☐ No				

Are you currently suffering from any condition other than that for which you are consulting us? If yes, what?_____
_____

PAST MEDICAL HISTORY
Have you ever seen a chiropractor before? ☐ Yes ☐ No If yes, what condition?_____
When did you have this condition?_____
Have you previously seen a doctor for the condition you are consulting us? ☐ Yes ☐ No When?_____
Where treated?_____ By whom? _____
Diagnosis they gave you?_____ Results?_____

Patient or guardian signature:_____ Date:_____
Doctor signature: _____ Date:_____

Have you ever been in an automobile accident? ☐ Yes ☐ No If yes, explain:_____
_____

Have you ever had any major illnesses, injuries or falls? ☐ Yes ☐ No If yes, explain: _____
_____

Have you ever had any surgeries? ☐ Yes ☐ No If yes, explain:_____
_____

Are you currently or have you been taking any over the counter medications/vitamins/or prescription drugs on a regular basis? ☐ Yes ☐ No If yes, please list:_____
_____

SOCIAL HEALTH HISTORY

Do you smoke? ☐ Yes ☐ No Packs per day_____
Do you consume caffeine? ☐ Yes ☐ No Daily amount_____
Do you consume alcohol? ☐ Yes ☐ No Glasses per week?_____
Do you exercise? ☐ Yes ☐ No Hours per week? _____

FAMILY HEALTH HISTORY – health status (if deceased please state the cause.)

Mother: _____ Father: _____
Sisters: _____ Brothers: _____
Children: _____

MARK ANY OF THE FOLLOWING DISEASES YOU HAVE/HAD:

☐ Pneumonia ☐ Mumps ☐ Influenza ☐ Anemia ☐ Rheumatic Fever ☐ Small Pox ☐ Heart disease
☐ Pleurisy ☐ Polio ☐ Lumbago ☐ Diabetes ☐ Whooping Cough ☐ Measles ☐ Tuberculosis
☐ Eczema ☐ Arthritis ☐ Cancer ☐ Epilepsy ☐ Mental disorders ☐ HIV ☐ Chicken Pox
☐ Thyroid disorders

MARK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

Musculoskeletal	**Nervous System**	**Gastrointestinal**	**General**
☐ Low back pain	☐ Nervousness	☐ Poor/excessive appetite	☐ Fatigue
☐ Pain between shoulders	☐ Paralysis	☐ Excessive thirst	☐ Allergies
☐ Arm pain	☐ Dizziness	☐ Frequent nausea	☐ Loss of sleep
☐ Neck pain	☐ Forgetfulness	☐ Vomiting	☐ Fever
☐ Joint pain/stiffness	☐ Confusion/depression	☐ Diarrhea	☐ Headaches
☐ Walking problems	☐ Fainting	☐ Constipation	**Male/Female Systems**
☐ Difficulty chewing/jaw clicking	☐ Convulsions	☐ Hemorrhoids	☐ Menstrual irregularity
C-V-R	☐ Cold/tingling limbs	☐ Liver problems	☐ Menstrual cramps
☐ Chest pain	☐ Stress	☐ Gall bladder problems	☐ Vaginal pain/infection
☐ Short breath	☐ Numbness	☐ Weight trouble	☐ Breast pain/lumps
☐ Blood pressure problems	**EENT**	☐ Abdominal cramps	☐ Prostate problems
☐ Irregular heartbeat	☐ Vision problems	☐Gas/bloating after meals	☐ Sexual dysfunction
☐ Heart problems	☐ Dental problems	☐Heartburn	**Females Only**
☐ Lung Problems	☐ Sore throat	☐Black/bloody stool	When was your last period?_____
☐ Congestion	☐ Ear aches	☐Colitis	Are you pregnant?
☐ Varicose Veins	☐ Hearing difficulty	**Genito-urinary**	☐Yes ☐No ☐Not sure
☐ Ankle Swelling	☐ Stuffed nose	☐ Bladder trouble	
☐ Stroke		☐ Painful urination	
		☐Excessive urination	
		☐Discolored urine	

Doctor's Notes:_____
_____
_____

Patient or guardian signature:_____Date:_____
Doctor signature: _____ Date:_____

REFLECTION RIDGE CHIROPRACTIC DATE: _____
2290 N. TYLER RD STE 100
WICHITA, KS 67205 NAME: _____

INFORMED CONSENT TO TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic who now or in the future work at the clinic or office listed on this page.

I have/or will have the opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of Chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and I am now informed that, as in the practice of medicine, in the practice of Chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I understand I have the opportunity to ask questions about this consent and its content prior to treatment and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT'S SIGNATURE _____

DATE _____

Patient's Written Acknowledgment of Doctor's Notice of Privacy Practices:

I_____, acknowledge that I have received a copy of Reflection Ridge Chiropractic's Notice of Privacy Practices.

_____ _____

Patient's Signature Date

X-RAY CONSENT

I hereby consent to allow x-rays to be taken of any affected areas designated by the doctor. I hereby, release Kabler Chiropractic from any liability resulting from this x-ray. I give my permission for any x-ray films to be reviewed by any member of this clinic with regard to my condition and for the purpose of treatment of my condition. I agree that my films may be released to another physician for review should the doctor feel this is in my best interest, but not to be released without my knowledge and consent.

SIGNATURE_____

DATE_____

FEMALE PATIENTS*:* x-rays can cause damage to an unborn fetus. I hereby certify that I am not pregnant at this time and I give my permission for x-rays to be taken. If at a later date I find that I was pregnant without my knowledge, I will not hold Kabler Chiropractic liable.

SIGNATURE_____

DATE_____

IF PATIENT IS A MINOR

I certify that I am the parent or legal guardian of this minor child (any child under the age of 18). I hereby give my permission for x-rays to be performed on this child. I also certify that this child, if female, is not pregnant to my knowledge and that if I find the child is pregnant without my knowledge, I will not hold Kabler Chiropractic liable for possible damage to the unborn fetus.

SIGNATURE_____

DATE_____