Tri Modern Health
1000 Grand Canyon Parkway
Hoffman Estates, IL 60169 Suite 104
P: 847-884-8488

New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Date Today:

First Name | Last Name | Email*

* Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

Mailing address

Address | Apartment #: | City

State | Zip Code | Cellphone

Age | Birth Date | Height | Weight

Emergency Contact | Phone | Referred By

Pediatrician Doctor Name and Phone Number

Primary Care Doctor Name and Phone Number

Current Complaints

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other

Please describe:

Date of Injury | Date symptoms appeared

Have you ever had same condition? ◯ No ◯ Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care? ◯ No ◯ Yes

If yes, please describe

Insurance Information

Insurance Company name: | Insurance ID #:

(Please submit a copy of your insurance ID to the front desk.) | Group Number:

*** If an auto accident, please provide:**

Name of party responsible for payment | Phone:

Contact Person: | Claim #:

Signatures

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

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Medical History

Have you been treated for any conditions in the last year? ◯ No ◯ Yes

If yes, please describe

Date of last physical exam | Is there a chance that you are pregnant? ◯ No ◯ Yes

Have you had X-rays taken? ◯ No ◯ Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)I

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	◯	◯	
Been hospitalized?	◯	◯	
Been in an auto accident?	◯	◯	
Had Sprains/Strains?	◯	◯	
Been struck unconscious?	◯	◯	
Had surgery?	◯	◯	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	◯ No	◯ Yes
Do your symptoms interfere with daily life?	◯ No	◯ Yes
Does pain wake you up at night?	◯ No	◯ Yes
Are your symptoms worse during certain times of the day?	◯ No	◯ Yes
Do changes in weather affect your symptoms?	◯ No	◯ Yes
Do you wear orthotics?	◯ No	◯ Yes
Do you take vitamin supplements?	◯ No	◯ Yes

What activities aggravate your symptoms?

Is there anybody that you know that could benefit from our services? We will be glad to help.

Name:_____ Contact number: _____

Relationship:_____ Health concern/problem:_____

Pediatric Patient Questionnaire

CURRENT HEALTH CONDITIONS

What health condition(s) bring your child to be evaluated by a chiropractor?

When did the condition first begin?

How did the problem start? ◯ Suddenly ◯ Gradually ◯ Post-Injury

Has your child ever received care for this condition before? ◯ Yes ◯ No

- If yes, please explain:

Is this condition: ◯ Getting worse ◯ Improving ◯ Intermittent ◯ Constant ◯ Unsure

What makes the problem better?

What makes the problem worse?

HEALTH GOALS FOR YOUR CHILD

What are your top three health goals for your child:

1. _____
2. _____
3. _____

What would you like to gain from chiropractic care?

◯ Resolve existing condition
◯ Overall wellness
◯ Both

Have you ever visited a chiropractor? ◯ Yes ◯ No If yes, what is their name?

What is their specialty? ◯ Pain Relief ◯ Physical Therapy & Rehab ◯ Nutritional ◯ Subluxation-based ◯ Other:

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy

Any fertility issues? ◯ Yes ◯ No If yes, please explain: _____

Did mother smoke? ◯ Yes ◯ No If yes, how many per week? _____

Did mother drink? ◯ Yes ◯ No If yes, how many per week? _____

Did mother exercise? ◯ Yes ◯ No If yes, please explain: _____

Was mother ill? ◯ Yes ◯ No If yes, please explain: _____

Any ultrasounds? ◯ Yes ◯ No If yes, please explain: _____

Please explain any notable episodes of mental or physical stress during your pregnancy:

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

LABOR & DELIVERY HISTORY

Child's birth was: ◯ Natural vaginal birth ◯ Scheduled C-section ◯ Emergency C-section At how many week's was your child born?

Child's birth was: ◯ At home ◯ At a birthing center ◯ At a hospital ◯ Other: Doctor/Obstetrician's Name:

Please check any applicable interventions or complications:

◯ Breech ◯ Induction ◯ Pain meds ◯ Epidural ◯ Episiotomy ◯ Vacuum extraction ◯ Forceps ◯ Other

Please describe any other concerns or notable remarks about your child's labor and/or delivery.

Child's birth weight: lbs. oz. Child's birth height: in. APGAR score at birth: APGAR score after 5 minutes:

GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? ◯ Yes ◯ No If yes, how long? Difficulty with breastfeeding? ◯ Yes ◯ No

Did they ever use formula? ◯ Yes ◯ No If yes, at what age? If yes, what type?

Did/does your child ever suffer from colic, reflux, or constipation as an infant? ◯ Yes ◯ No
- If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ◯ Yes ◯ No
- If yes, please explain:

At what age did the child: Respond to sound: _____ Follow an object: _____ Hold their head up: _____ Vocalize: _____ Teethe: _____
Sit alone: _____ Crawl: _____ Walk: _____ Begin cow's milk: _____ Begin solid foods: _____

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history, including the year:

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

Have you chosen to vaccinate your child? ◯ No ◯ Yes, on a delayed or selective schedule ◯ Yes, on schedule
- If yes, please list any vaccination reactions:

Has your child received any antibiotics? ◯ Yes ◯ No
- If yes, how many times and list reason:

Night terrors or difficulty sleeping? ◯ Yes ◯ No If yes, please explain:

Behavioral, social or emotional issues? ◯ Yes ◯ No If yes, please explain:

How many hours per day does your child typically spend watching a TV, computer, tablet or phone?

How would you describe your child's diet? ◯ Mostly whole, organic foods ◯ Pretty average ◯ High amount of processed foods

ACKNOWLEDGEMENT & CONSENT

Patient Signature: _____ Date: / /

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Health History & Assessment

Patient Name_____ **Date:** _____

Do you take: blood thinners (heparin, coumadin, warfarin), birth control pills, steroids _____
Do you have any **family** history of: rheumatoid arthritis, gout, ankylosing spondylitis, lupus, stroke _____

Please indicate if you have experienced any of the following conditions or symptoms:

General

- ❑ Cancer
- ❑ Diabetes
- ❑ Thyroid disease
- ❑ AIDS or HIV
- ❑ Fatigue
- ❑ Depression
- ❑ Ringing in the ears
- ❑ Recent unexplained weight loss,
- ❑ Decreased energy
- ❑ Loss of appetite
- ❑ Night sweats
- ❑ Fever or chills
- ❑ Hot Flashes
- ❑ Recurrent infections
- ❑ Fluoroquinolone antibiotic use
- ❑ Skin ulcers or rashes
- ❑ Excessive thirst
- ❑ Anxiety
- ❑ Sleep Problems or Insomnia

Neuromusculoskeletal

- ❑ Stroke
- ❑ Paralysis
- ❑ Seizures
- ❑ Mental disorders
- ❑ Fractures
- ❑ Dislocations
- ❑ Orthopedic problems
- ❑ Arthritis
- ❑ Sciatica
- ❑ Rheumatoid arthritis
- ❑ Gout
- ❑ Lupus
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Change in vision, smell, hearing or taste
- ❑ Light headedness
- ❑ Dizziness/vertigo
- ❑ Concussion
- ❑ Loss of consciousness
- ❑ Difficulty speaking or swallowing
- ❑ Headaches
- ❑ Numbness or tingling
- ❑ Difficulty walking
- ❑ Change in mood or behavior
- ❑ Neck Pain or Stiffness
- ❑ Back Pain

Cardiovascular

- ❑ Pacemaker
- ❑ Defibrillator
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Irregular heart beat
- ❑ Heart attack
- ❑ Congestive heart failure
- ❑ TIA
- ❑ Peripheral vascular disease
- ❑ Blood clotting or bleeding disorder
- ❑ Anemia
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Nose bleeds
- ❑ Swollen ankles
- ❑ Redness or swelling of a limb,
- ❑ Unusual bruising
- ❑ Bleeding gums
- ❑ Swollen lymph nodes

Respiratory

- ❑ Asthma
- ❑ Emphysema
- ❑ Tuberculosis
- ❑ COPD
- ❑ Cough or change in cough
- ❑ Blood in sputum
- ❑ Wheezing
- ❑ Difficulty breathing

Digestive

- ❑ Liver disease
- ❑ Hepatitis
- ❑ Ulcers
- ❑ Gall stones
- ❑ Appendicitis
- ❑ Pancreatitis
- ❑ Reflux disease
- ❑ Stomach pain
- ❑ Pain or difficulty swallowing,
- ❑ Indigestion
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Bloating
- ❑ Excessive gas or belching
- ❑ Blood in stool
- ❑ Black stools

Genitourinary

- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Prostate enlargement
- ❑ Burning with urination
- ❑ Blood in urine
- ❑ Increased frequency of urination
- ❑ Difficulty with urination
- ❑ Loss of bladder or bowel control
- ❑ Change in menstrual bleeding

____ Initial here if none of the listed symptoms or conditions apply to you.
I have personally read and completed this form. Signature _____

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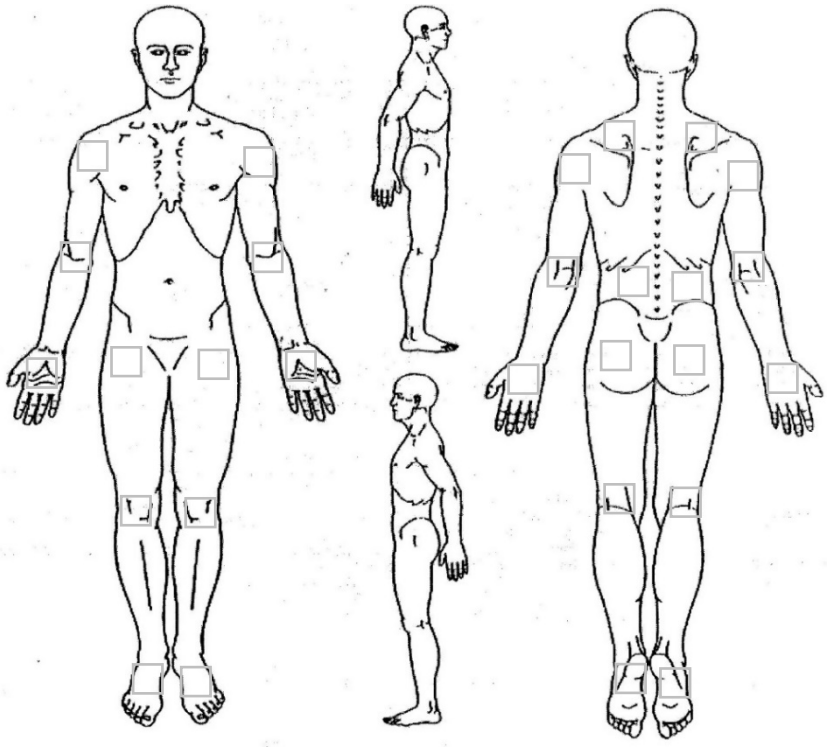
Mark your pain and/or symptoms below:

Patient: _____ **Date:** _____

Please point out where your pain or discomfort is located in the images below. Use the letters to represent the type (s) and LOCATION of sympotms. Mark the areas where it your pain radiates/travels including ALL affected áreas

❑ **A** = Ache ❑ **B** = Burning ❑ **N** = Numbness
❑ **P** = Pins and Needles ❑ **S** = Stabbing ❑ **0** = Other

Please use the space below to type/write more if needed



Please use the following scale to describe the intensity of your pain from a pain scale of 0-10

Pain Scale: 0 - 10 No Pain = 0 Severe Pain = 10

1. Pain level now:	❑ 0	❑ 1	❑ 2	❑ 3	❑4	❑ 5	❑6	❑ 7	❑ 8	❑ 9	❑ 10
2. Average Pain Level:	❑ 0	❑ 1	❑ 2	❑ 3	❑4	❑ 5	❑6	❑ 7	❑ 8	❑ 9	❑ 10
3. Pain level on your BEST day:	❑ 0	❑ 1	❑ 2	❑ 3	❑4	❑ 5	❑6	❑ 7	❑ 8	❑ 9	❑ 10
4. How high does your pain get:	❑ 0	❑ 1	❑ 2	❑ 3	❑4	❑ 5	❑6	❑ 7	❑ 8	❑ 9	❑ 10

Please type/write below if you need additional space to describe your pain/symptoms

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Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.
Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

Dr. Hector Martinez
Tri Modern Health
1000 Grand Canyon Parkway
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Insurance and Assignment of Benefits:

I understand and agree that health/accident insurance policies are an arrangement between and insurance carrier and myself. I understand that I am ultimately responsible for all charges associated with my healthcare. For my convenience Tri Modern Health have been given a quote of benefits from my insurance company, which is not binding. The exact services provided each visit will reflect my clinical needs that day. I understand that I am personally responsible for any service specified as non-covered or bundled (e.g. exam codes such as 99202-99204, 99212-99214 or Therapy codes such as 97140, 97035, 97032, Acupuncture) by my insurance company and agree to pay for the services rendered. By signing this I am giving permission for Tri Modern Health to submit claims on my behalf. After the explanation of benefits is received from my insurance company, I will be billed for the remaining balance or will receive a refund, if applicable.

Notice of Privacy Practices Pursuant to HIPAA and Consent for use of Health Information:

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

.I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Patient Name (Please Print): _____

Signed: _____ Date: _____

Guardian's Signature: _____ Date: _____