



# 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**.

<b>Patient Data</b>			Date Today: <input type="text"/>
First Name <input type="text"/>	Last Name <input type="text"/>	Email* <input type="text"/>	
* Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.			

<b>Mailing address</b>			
Address <input type="text"/>	City <input type="text"/>	State <input type="text"/>	Zip <input type="text"/>
Telephone (Work) <input type="text"/>	(home) <input type="text"/>	Referred By <input type="text"/>	
Age <input type="text"/>	Birth Date <input type="text"/>	Number of Children <input type="text"/>	Occupation <input type="text"/>
Employer <input type="text"/>	Marital Status <input type="text"/>		
Spouse's Name <input type="text"/>			
Phone <input type="text"/>	Emergency Contact <input type="text"/>		
Primary Care Doctor Name and Phone Number <input type="text"/>			

<b>Current Complaints</b>	
Nature of Injury: <input type="checkbox"/> Automobile* <input type="checkbox"/> Work <input type="checkbox"/> Other	
Please describe: <input type="text"/>	
Date of Injury <input type="text"/>	Date symptoms appeared <input type="text"/>
Have you ever had same condition? <input type="radio"/> No <input type="radio"/> Yes If yes, when? <input type="text"/>	
List of other practitioners seen for this injury/condition <input type="text"/>	
Have you ever been under chiropractic care? <input type="radio"/> No <input type="radio"/> Yes	
If yes, please describe <input type="text"/>	

<b>Insurance Information</b>	
Name of party responsible for payment <input type="text"/>	Phone <input type="text"/>
Do you have health insurance? <input type="radio"/> No <input type="radio"/> Yes Name of company <input type="text"/>	
<b>* If an auto accident, please provide:</b>	
Insurance Company Name <input type="text"/>	Insurance Company ID <input type="text"/>
Contact Person <input type="text"/>	Phone: <input type="text"/>
Claim # <input type="text"/>	

<b>Signatures</b>	
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 _____

**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)|

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?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had Sprains/Strains?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had surgery?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>

**Family History**

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

Do you experience pain every day?	<input type="radio"/> No	<input type="radio"/> Yes
Do your symptoms interfere with daily life?	<input type="radio"/> No	<input type="radio"/> Yes
Does pain wake you up at night?	<input type="radio"/> No	<input type="radio"/> Yes
Are your symptoms worse during certain times of the day?	<input type="radio"/> No	<input type="radio"/> Yes
Do changes in weather affect your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes
Do you wear orthotics?	<input type="radio"/> No	<input type="radio"/> Yes
Do you take vitamin supplements?	<input type="radio"/> No	<input type="radio"/> Yes
What activities aggravate your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes
<input type="text"/>		



## Health History & Assessment

**Patient Name** \_\_\_\_\_ **Date:** \_\_\_\_\_

How many days/per week do you exercise \_\_\_\_\_ how long each time you exercise \_\_\_\_\_ minutes/hours

Type \_\_\_\_\_

What position do you sleep in: Side Stomach Back Other \_\_\_\_\_

How old is your mattress: \_\_\_\_\_ yrs What type: coil spring foam water air \_\_\_\_\_

What type of pillow do you sleep on: foam memory foam fiberfill feather Other \_\_\_\_\_

Do you wear: arch supports orthotics heel lifts \_\_\_\_\_

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

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

### Neuromusculoskeletal

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

### Cardiovascular

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

### Respiratory

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> COPD                     | <input type="checkbox"/> Wheezing             |
| <input type="checkbox"/> Emphysema    | <input type="checkbox"/> Cough or change in cough | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Blood in sputum          |   |

### Digestive

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Reflux disease                 | <input type="checkbox"/> Diarrhea                  |
| <input type="checkbox"/> Hepatitis     | <input type="checkbox"/> Stomach pain                   | <input type="checkbox"/> Constipation              |
| <input type="checkbox"/> Ulcers        | <input type="checkbox"/> Pain or difficulty swallowing, | <input type="checkbox"/> Bloating                  |
| <input type="checkbox"/> Gall stones   | <input type="checkbox"/> Indigestion                    | <input type="checkbox"/> Excessive gas or belching |
| <input type="checkbox"/> Appendicitis  | <input type="checkbox"/> Nausea                         | <input type="checkbox"/> Blood in stool            |
| <input type="checkbox"/> Pancreatitis  | <input type="checkbox"/> Vomiting                       | <input type="checkbox"/> Black stools              |

### Genitourinary

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Kidney disease       | <input type="checkbox"/> Burning with urination           | <input type="checkbox"/> Difficulty with urination        |
| <input type="checkbox"/> Kidney stones        | <input type="checkbox"/> Blood in urine                   | <input type="checkbox"/> Loss of bladder or bowel control |
| <input type="checkbox"/> Prostate enlargement | <input type="checkbox"/> Increased frequency of urination | <input type="checkbox"/> 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 \_\_\_\_\_

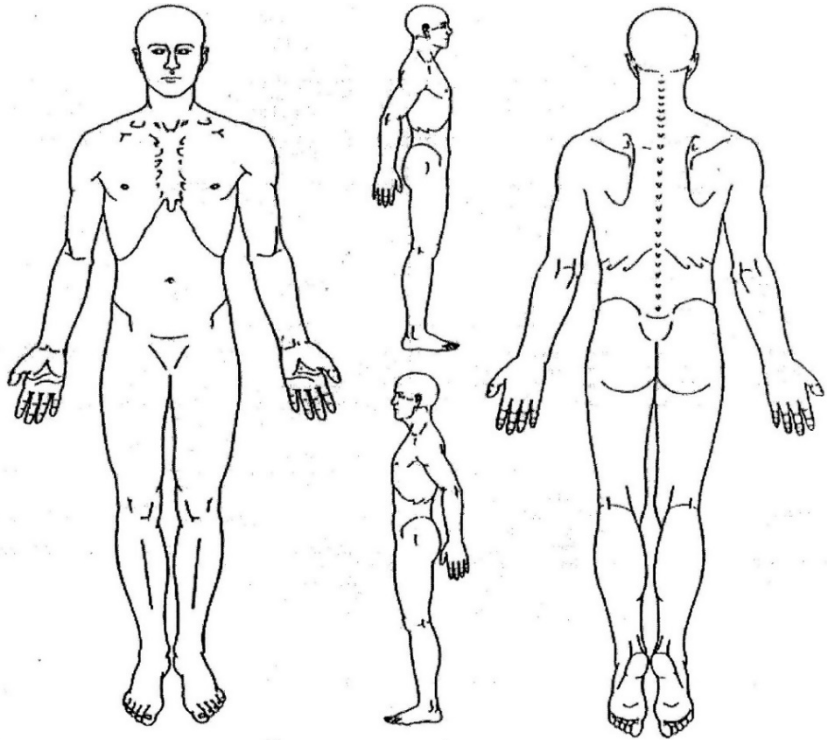
Mark your pain and/or symptoms below:

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 symptoms. Mark the areas where it your pain radiates/travels including ALL affected areas

- A** = Ache                       **B** = Burning                       **N** = Numbness  
 **P** = Pins and Needles                       **S** = Stabbing                       **O** = 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\***



### 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: \_\_\_\_\_



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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 HIPPA 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 its 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: \_\_\_\_\_