Tri Modern Health
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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 Information

Date: _____ **Referred By:** _____

First Name: _____ **Last Name** _____ **Date of Birth:** _____

Age: _____ **Gender:** ☐ Male ☐ Female **Address:** _____

City: _____ **State:** _____ **Zip Code:**_____

Cell Phone: _____(*We use text messaging for appointment reminders)*

Email: _____(*Your email will NOT be shared with any 3rd parties)*

Occupation: _____ **Employer:** _____

Marital Status: _____ **Number of Children:** _____

Emergency Contact Person:_____ **Relationship to Patient**: _____

Phone: _____ **Primary Care Doctor:** _____ **Phone:** _____

Current Complaints:

Nature of Injury/Condition: ☐ Automobile ☐ Work ☐ Other.

Please explain your current condition.:

_____

_____

_____

Date of Injury: _____ **Date symptoms first appeared:** _____ **Have you had this condition before?** ☐ Yes ☐ No **If yes, when?** _____

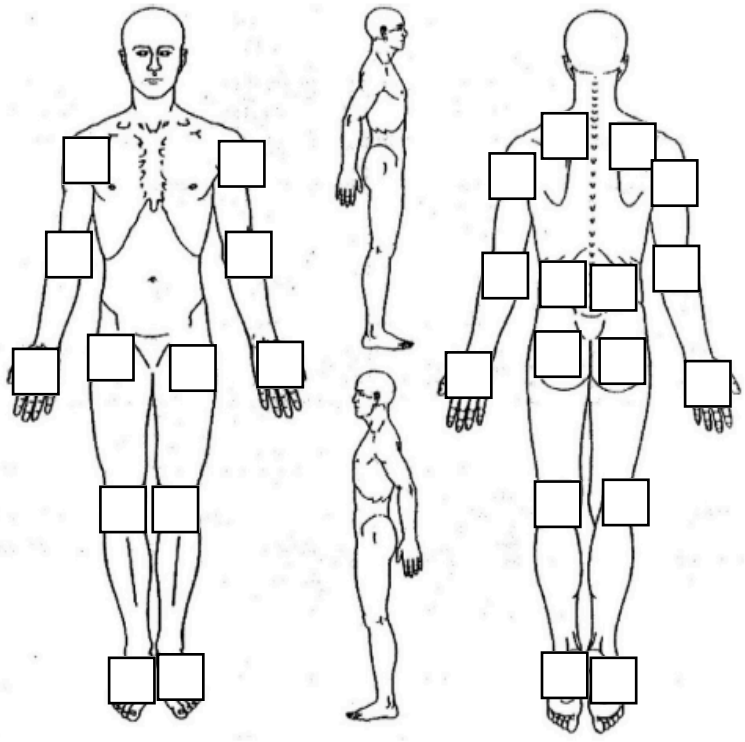
List other practitioners seen for this condition:_____

Have you seen a Chiropractor before? ☐ Yes ☐ No **If yes, when?** _____

Pain Assessment

Current Pain Level (0-10 scale): ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Average Pain Level: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Best Day Pain Level: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Worst Pain Level: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Mark your pain/symptoms on the diagram below using these letters:
- A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing



Additional pain description:

_____

_____

Insurance Information

Insurance Company: _____ **ID #:** _____

Group Number: _____ **Name of Insured:** _____

If auto accident, responsible party:_____

Contact Person:_____ **Phone:**_____ **Claim #:**_____

Health History

Current Medications (include dosage): _____

☐ **Blood Thinners (Warfarin, Eliquis, Xarelto, etc.)** ☐ **Steroids (Prednisone, etc.)** ☐ **Birth Control**

Vitamins/Supplements: _____

Date of last physical exam: _____**Any chance you're pregnant?** ☐ Yes ☐ No

Recent X-rays? ☐ Yes ☐ No **Where?** _____

Have you ever had...	**No**	**Yes**	**If yes, briefly explain**
Broken bones?	☐	☐	_____
Been hospitalized?	☐	☐	_____
Been in an auto accident?	☐	☐	_____
Sprains or strains?	☐	☐	_____
Been struck unconscious?	☐	☐	_____
Surgery of any kind?	☐	☐	_____

Check any conditions or symptoms you currently experience:

Musculoskeletal: ☐ Neck Pain/Stiffness ☐ Back Pain ☐ Headaches ☐ Joint Pain ☐ Arthritis ☐ Fractures ☐ Numbness/Tingling ☐ Osteoporosis

Neurological: ☐ Dizziness ☐ Fainting ☐ Loss of Balance ☐ Pins & Needles ☐ Memory Problems ☐Mood Swings ☐ Difficulty Speaking or swallowing ☐ Loss of Bladder or Bowel Control

General Health: ☐ Fatigue ☐ Depression ☐ Anxiety ☐ Sleep Problems ☐ Fever ☐ Weight Loss ☐ Night Sweats

Cardiovascular: ☐ High Blood Pressure ☐ Heart Disease ☐ Chest Pain ☐ Shortness of Breath ☐ Swollen Ankles ☐ Pacemaker ☐ Defibrillator (ICD) ☐ History of Stroke ☐ History of Transient Ischemic Attack

Digestive: ☐ Stomach Pain ☐ Heartburn ☐ Nausea ☐ Constipation ☐ Diarrhea ☐ Bloating

Other Conditions: ☐ Diabetes ☐ Thyroid Disease ☐ Cancer ☐ Asthma ☐ Allergies ☐ Kidney Disease

Please explain any checked items: _____

Family History of major health conditions: _____

_____

Functional Rating Index

For each item below, circle the choice that most closely describes your condition right now.

1. **Pain Intensity** No pain ☐ Mild pain ☐ Moderate pain ☐ Severe pain ☐ Worst possible pain ☐
2. **Sleeping** Perfect sleep ☐ Mildly disturbed ☐ Moderately disturbed ☐ Greatly disturbed ☐ Totally disturbed ☐
3. **Personal Care (washing, dressing)** No restrictions ☐ Need to go slowly ☐ Need some assistance ☐ Need 100% assistance ☐ Cannot do ☐

4. **Travel (driving, etc.)** No pain long trips ☐ Mild pain long trips ☐ Moderate pain long trips ☐ Moderate pain short trips ☐ Severe pain short trips ☐
5. **Work** Can do usual work plus unlimited extra work ☐ Can do usual work, no extra work ☐ Can do 50% of usual work ☐ Can do 25% of usual work ☐ Cannot work ☐
6. **Recreation** No pain ☐ Mild pain ☐ Moderate pain ☐ Severe pain ☐ Worst possible pain ☐
7. **Frequency of Pain** No pain ☐ Occasional pain (25% of day) ☐ Intermittent pain (50% of day) ☐ Frequent pain (75% of day) ☐ Constant pain (100% of day) ☐
8. **Lifting** No pain with any weight ☐ Increased pain with heavy weight ☐ Increased pain with moderate weight ☐ Increased pain with light weight ☐ Cannot lift any weight ☐
9. **Walking** No pain any distance ☐ Increased pain after 1 mile ☐ Increased pain after 1/2 mile ☐ Increased pain after 1/4 mile ☐ Increased pain with all walking ☐
10. **Standing** No pain ☐ Increased pain after several hours ☐ Increased pain after 1 hour ☐ Increased pain after 1/2 hour ☐ Increased pain with any standing ☐

Consent for Treatment & Legal Agreements

Informed Consent to Chiropractic Care

I understand that chiropractic treatment may include manual therapies such as spinal adjustments, soft tissue techniques, and other supportive procedures intended to restore normal joint function, relieve pain, and improve neurological and overall health.
I understand and acknowledge the following:

- Potential Benefits: Pain relief, improved joint mobility, reduced inflammation, enhanced neurological function, and improved overall well-being.
- Potential Risks: Temporary soreness, muscle tension, symptom aggravation, and in rare cases, estimated at 1 in 1 to 2 million cervical spine adjustments, serious complications such as fractures, disc injuries, dislocations, or arterial dissection that could lead to stroke.
- Alternative Treatment Options: Rest, self-care, over-the-counter or prescription medication, physical therapy, medical intervention, injections, and surgery.
- No Guarantees: I understand that no specific outcome is promised or guaranteed. I have the right to seek a second opinion and to refuse or discontinue treatment at any time.

I have had the opportunity to ask questions, and I consent to the chiropractic examination and treatment deemed appropriate by the providers at Tri Modern Health.

HIPAA Privacy Notice & Consent

I acknowledge that I have received and/or been offered a copy of Tri Modern Health's Notice of Privacy Practices, which explains how my protected health information (PHI) may be used and disclosed in accordance with federal law.

I authorize Tri Modern Health to:

- Use and disclose my PHI for treatment, billing, and healthcare operations.
- Contact me via phone, text, voicemail, or mail regarding appointments and clinical matters, using the contact details I have provided.
- Release health information as necessary for insurance billing, personal injury cases, and coordination of care with other healthcare providers.

I understand that I may revoke this consent in writing at any time, except to the extent that actions have already been taken based on it. I understand that refusal to sign this consent may result in denial of treatment.

Financial Responsibility & Insurance Assignment

I, the undersigned patient (or authorized representative), understand and agree to the following:

1. Financial Responsibility

I am personally responsible for all services provided by Tri Modern Health, regardless of insurance coverage, third-party claims, or attorney involvement. This includes, but is not limited to, deductibles, co-pays, denied or non-covered services, and any remaining balance after insurance or third-party payments.

2. Third-Party / MVA / Workers' Compensation Claims

If my care relates to a motor vehicle accident, Workers' Compensation Claims, or other third-party liability claim:

- I remain responsible for all charges if insurance coverage is denied, inactive, or closed.
- If my attorney withdraws or stops representing me, my responsibility for payment remains in full.
- If I am not listed or covered on any insurance policy involved, I remain responsible.
- I agree to notify Tri Modern Health promptly of changes in attorney representation, insurance coverage, or claim status.

3. Insurance Authorization

I authorize Tri Modern Health to:

- Submit claims on my behalf
- Release necessary medical information for billing
- Receive payments directly from insurance carriers

4. Payment Terms

You are responsible for any portion of your bill not covered by insurance, including deductibles, co-pays, co-insurance, or non-covered services, as indicated on your Explanation of Benefits (EOB).

If a balance remains unpaid after insurance processes the claim, and you do not communicate with the office, Tri Modern Health may refer the account to a collections agency. We are available to discuss payment plans or financial assistance if needed.

Signatures:

Patient Name (Print): _____

Patient Signature:_____Date: _____

Authorization for Minor Treatment (if applicable): I authorize chiropractic treatment for my minor child:

Name of Minor: _____

Parent/Guardian Signature: _____Date: _____*(if patient is under 18)*

Witness Name:_____ Date: _____