



TRI MODERN HEALTH
1000 Grand Canyon Parkway, Suite 104
Hoffman Estates, IL 60169
Phone: (847) 884-8488

PEDIATRIC NEW PATIENT FORM

Please complete this form thoroughly to help us provide the best possible care for your child. All information is strictly confidential and protected under HIPAA regulations.

Patient Information

Child's Full Name: _____ **Date of Birth:** _____ **Age:** _____

Gender: Male Female **Parent/Guardian Name:** _____

Relationship to Child: Mother Father Legal Guardian Other: _____

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) **Emergency Contact Person:** _____ **Phone:** _____

Primary Care Physician: _____ **Referred By:** _____

Insurance Information

Primary Insurance: _____ **Policy Holder:** _____

(Please submit a copy of your insurance ID to the front desk.)

Relationship to Patient: _____ **Insurance ID #:** _____ **Group #:** _____

Secondary Insurance: None Yes: _____

If an auto-accident, please provide: Name of party responsible for payment: _____

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

Chief Complaint and Current Condition Primary reason for today's visit:

When did this condition begin? Recently Weeks ago Months ago Years ago

How did it start? Suddenly Gradually After injury Unknown

Current status: Getting better Getting worse Staying the same Variable

If applicable, pain level (0-10 scale): Current: _____ Average: _____ Worst: _____

What makes it better? _____

What makes it worse? _____

Previous treatment for this condition? None Yes: _____

Previous chiropractic care? Yes No **If yes, where?** _____

Current Symptoms

Check all symptoms the patient is currently experiences:

Physical Symptoms:

- Headaches Neck pain Back pain Joint pain Muscle stiffness
 Numbness/tingling Dizziness Poor posture Frequent injuries

Developmental/Behavioral:

- Sleep difficulties Concentration problems Behavioral issues
 Hyperactivity Learning difficulties Mood changes

General Health: Frequent colds Digestive issues Allergies Fatigue Growth concerns

Other symptoms: _____

Birth and Early Development:

Prenatal History:

Pregnancy complications: None Yes: _____

During pregnancy, did mother:

- **Smoke?** No Yes, _____ per day
- **Drink alcohol?** No Yes, _____ per week
- **Exercise regularly?** No Yes, type: _____
- **Experience illness?** No Yes: _____

Medications taken during pregnancy: _____

Ultrasounds performed? Yes No **Any concerns noted?** No Yes: _____

Mental/physical stress during pregnancy: Minimal Moderate Significant **If significant, please explain:**

Birth Information: Weeks at birth: _____ Birth weight: _____ lbs _____ oz

Type of delivery: Natural vaginal Scheduled C-section Emergency C-section

Birth location: Hospital Birthing center Home Other: _____

Birth complications: None Breech Forceps Vacuum Prolonged labor Induction Epidural Other: _____

Early Development:

Breastfed? Yes, for _____ months No **Infant issues:** None Colic Reflux Constipation
 Sleep problems Frequent crying Head banging/arching

Developmental milestones (age in months):

- Held head up: _____ - Sat alone: _____ - Crawled: _____ - Walked: _____

Any developmental concerns? No Yes: _____

Medical History

Current Health:

Current medications: _____

Vitamins/supplements: _____

Allergies (food, drug, environmental): _____

Past Medical History:

Hospitalizations: None Yes: _____

Surgeries: None Yes: _____

Significant injuries/accidents: None Yes: _____

Head injuries/concussions? None Yes, _____ times

Immunizations: Up to date Delayed/selective None **Any vaccine reactions?** No Yes:

Antibiotic use in past year: None 1-2 times 3+ times

Family History:

Check if any family members have: Scoliosis Arthritis Diabetes Heart disease Cancer Stroke Migraines Mental health conditions Learning disabilities ADHD

Current Lifestyle:

Sleep: _____ hours per night **Sleep quality:** Good Fair Poor

Screen time: _____ hours per day **Physical activity:** High Moderate Low

Diet: Mostly whole foods Balanced Mostly processed foods

School performance: Excellent Good Average Below average N/A

Behavioral concerns: None Attention problems Aggression Withdrawal

Other: _____

Treatment Goals

Your top three goals for your child's care:

1. _____
2. _____
3. _____

Primary objective: Resolve current condition Preventive/wellness care Both

Additional concerns: _____

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 understand and agree to the following:

- I am financially responsible for all services rendered, regardless of insurance coverage.
- I authorize Tri Modern Health to:
 - Submit insurance claims on my behalf
 - Release relevant medical information for billing purposes

- Receive payments directly from my insurance provider
- I agree to pay any deductibles, co-pays, denied or non-covered services, and remaining balances. I will promptly communicate with the office if financial hardship or payment arrangements are required.

I authorize chiropractic treatment for my minor child:

Name of Minor: _____

Signatures:

Patient Name (Print): _____

Patient Signature: _____ **Date:** _____

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

Witness Name: _____ **Date:** _____

© Tri Modern Health - All information is strictly confidential.