Welcome to Cohn Health Institute

A division of Cohn Chiropractic Group, Inc.

Please fill out this confidential health history form as completely as you can. The more information you provide us, the better we will be able to help you. If you have any questions or need any assistance in filling out these forms, do not hesitate to ask one of our qualified chiropractic assistants for help.

Today's Date: ___/____/_____ Whom may we thank for referring you to our office? _____

PERSONAL HISTORY

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: (___) _____ - _____ Cell phone: (___) _____ - _____Email: _____

Birth Date: _____/_____/_____ Age: _____ Gender: ❑Female ❑ Male

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Drivers License Number: _____ Social Security Number: _____ - _____- _____

Employer: _____ Type of Work: _____

Address: _____City: _____ State: _____

Zip Code: _____ Work Phone: (____) _____ - _____

Spouse's Name: _____ Work Place: _____ Phone: (_____) _____ - _____

Name & Ages of Children (if applicable): _____

In an emergency, whom do we contact? _____ Phone: (_____) _____ - _____

CURRENT HEALTH CONDITIONS

Primary health complaint(s): _____

How long have you suffered with this problem? _____

How often does this problem currently bother you? _____

Does anyone else in your family have the same or similar problem? ❑ Yes ❑ No

If yes, who? _____

Before you began to suffer with this problem, was there an earlier accident, injury, or other condition that could have brought this about or be related to it? ❑ Yes ❑ No

If yes, was it: ❑ Job related ❑ Auto Accident ❑ Other: _____

If work related, has the accident been reported to your employer? ❑ Yes ❑ No

If auto related, what is the date and time of accident? _____

What other health practitioners have you consulted for this/these complaints? _____

_____

Have you become discouraged that this problem has not been resolved? ❑ Yes ❑ No

When this problem is at its worst, how does it make you feel? _____

When this problem is at its worst, how does it interfere with your:

Work? _____ Family Life? _____

Recreation/Hobbies? _____

What effect is this problem having on other people in your life? _____

What effect is this problem having on your level of stress? _____

What daily habits do you have that could make this worse? _____

On a scale of 1-10 (ten highest) rate your commitment to getting rid of this problem: _____

Is getting rid of this problem, and what caused it, a top priority for you? _____

PAST HEALTH HISTORY

Surgeries/Operations: Appendix _____ Tonsils ____ Hernia _____Spinal____ Cosmetic _____ Other: _____

Major accidents or falls since birth: _____

Hospitalizations (other than above): _____

Please list all medications you presently take: (please include all medications, including over the counter and vitamins):

_____

Are you currently under the care of a physician? ❑ Yes ❑ No If yes, please indicate for what condition:

_____

Please list the physician's name, phone number, and approximate date of last treatment:

_____

Have you had previous chiropractic care? ❑ Yes ❑ No Please list doctor's name and approx. date of last visit:

_____

Are you presently under the care of any other healthcare practitioners?

❑ Acupuncturist ❑ Massage Therapist ❑ Nutritionist ❑ Other: _____

Is there anything else that you would like the doctor to know about your health? _____

_____

Please check any of the following conditions that you have had in the past:

❑ Pneumonia
❑ Mumps
❑ Arthritis
❑ Heart Disease
❑ Measles
❑ Pleurisy
❑ Tuberculosis
❑ Thyroid Disorder
❑ Influenza
❑ Polio
❑ Cancer
❑ Anemia
❑ Rheumatic Fever
❑ Small Pox
❑ Eczema/Psoriasis
❑ Whooping Cough

COHN HEALTH INSTITUTE

Please check any of the following that you have had in the past six months:

Musculoskeletal
- ❑ Low back pain
- ❑ Pain b/w the shoulders
- ❑ Neck pain
- ❑ Shoulder/arm/wrist pain
- ❑ Hip/knee/ankle pain
- ❑ Joint pain or stiffness
- ❑ Difficulty walking
- ❑ Jaw/head pain

Nervous System
- ❑ Cold/tingling extremeties
- ❑ Numbness/loss of sensation
- ❑ Dizziness
- ❑ Seizures
- ❑ Paralysis
- ❑ Nervousness/Stress

Cardiovascular
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Stroke
- ❑ Lung congestion
- ❑ Varicose veins
- ❑ Ankle swelling
- ❑ Lung symptoms

General
- ❑ Allergies
- ❑ Fatigue
- ❑ Loss of sleep
- ❑ Unexplained fevers
- ❑ Headaches

Gastrointestinal
- ❑ Poor Appetite/Underweight
- ❑ Excessive Thirst
- ❑ Frequent nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Liver problems
- ❑ Colitis/Crohn's/IBS
- ❑ Gall bladder problems
- ❑ Abdominal Cramps
- ❑ Gas/bloating after meals
- ❑ Heartburn
- ❑ Blood in stool

Male Only
- ❑ Prostate dysfunction
- ❑ Loss of libido
- ❑ Sexual dysfunction

Women Only
- ❑ Menstrual cramps
- ❑ Irregular/absent periods
- ❑ Vaginal pain/infection
- ❑ PMS
- ❑ Loss of libido
- ❑ Menopausal symptoms
- ❑ Breast pain
- ❑ Uterine/ovarian fibroids
- ❑ Date of last period?

_____/_____/_____

Are you pregnant?

❑ Yes ❑ No ❑ Not sure

Genitourinary
- ❑ Painful/excessive urination
- ❑ Discolored urine
- ❑ Bladder infections
- ❑ Urinary leakage

EENT
- ❑ Vision problems
- ❑ Dental problems
- ❑ Earache/infection
- ❑ Difficult hearing
- ❑ Ringing in Ears
- ❑ Cold/Flu
- ❑ Sinus problems
- ❑ Sore throat

Other Health Issues

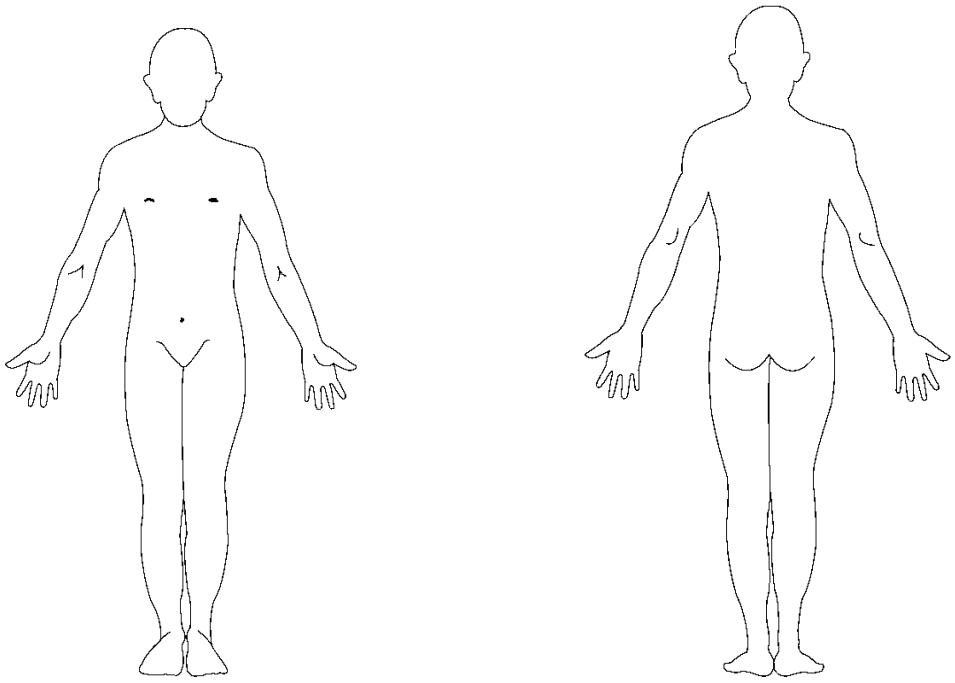
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Pain Chart

Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
----------	000000000000000	XXXXXXXXX	**********	//////////////

Please mark on the pain scale from 1-10 the pain you feel with this condition, 10 being the worst pain you have felt with this condition.



DIET/NUTRITIONAL HEALTH HISTORY

What you eat and what you supplement your diet with has a direct effect on your health. Please help us help you by providing us with the following information:

What do you commonly eat for breakfast? _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you regularly take nutritional supplements? ❑ Yes ❑ No If yes, please list them:

_____

Do you have allergies? ❑ Yes ❑ No If yes, what kind? _____

Do you smoke cigarettes, cigars, or chew tobacco? ❑ Yes ❑ No If yes, how much? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much? _____

Do you drink coffee? ❑ Yes ❑ No If yes, how much? _____

Do you drink soda/soft drinks? ❑ Yes ❑ No If yes, how much? _____

Do you eat fried foods? ❑ Yes ❑ No If yes, how much? _____

Do you use white sugar/artificial sweeteners? ❑ Yes ❑ No If yes, how much? _____

Your doctor will be making specific dietary recommendations and prescribing an individual supplementation program just for you. Please rate, on a scale of 1-10 (with 10 being the highest), your willingness to follow the recommended dietary and nutritional supplementation program. _____

ERGONOMIC HEALTH HISTORY

How you treat and support your body on a daily basis has a direct impact on your health. Please help us help you by providing us with the following information:

Exercise Habits

Do you currently exercise? _____

Do you wear orthotics/foot inserts? _____

Your doctor may recommend a cardiovascular, strength training, and/or stretching program. Please rate, on a scale of 1-10 (with 10 being the highest), your willingness to incorporate the prescribed exercise into your health care program.

1 2 3 4 5 6 8 9 10

Sleep Habits

What is your most common sleep position? ❑ Back ❑ Side ❑ Stomach

Do you use a pillow? ❑ Yes ❑ No What type? ❑ Regular ❑ Cervical (neck)

What type of mattress do you sleep on and how old is it? _____

How many hours of sleep do you average per night? _____

Work Habits

How many hours per day are you:

Sitting: _____ Standing: _____ Crouching or bending over: _____

Lifting: _____ Walking: _____ Working at a computer: _____

Electronic Radiation Exposure

Do you use any of the following daily? Check all that apply.

❑ Blow dryer/curling iron ❑ Microwave ❑ Sleep within 3 feet of an electrical outlet

❑ Cell phone/cordless phone ❑ Electric razor/toothbrush ❑ Spend more than 1 hour/day in the car

Scientific studies are now showing that repeated exposure to the above items can be extremely hazardous to your health. Your doctor will discuss with you ways to reduce your exposure to these harmful elements.

MENTAL/EMOTIONAL HEALTH HISTORY

Scientific studies are now showing that emotional stress has a great deal to do with an individual's health. Please answer the following questions as accurately and completely as possible:

Please rate the following areas of potential stress on a scale of 1-10, with 10 being the highest stress you could imagine and 1 being relatively no stress.

Please circle the appropriate number:	Low									High
Financial/Money matters	1	2	3	4	5	6	7	8	9	10
Relationship/Family	1	2	3	4	5	6	7	8	9	10
Job/Career/Education	1	2	3	4	5	6	7	8	9	10
Current level of health	1	2	3	4	5	6	7	8	9	10
Spiritual/Religious/Ethical	1	2	3	4	5	6	7	8	9	10
Overall level of life stress	1	2	3	4	5	6	7	8	9	10

Please check all of the following life events that you currently (or previously) experience stress with:

- ❑ Birth of siblings
- ❑ Toilet training
- ❑ Babysitters
- ❑ Death of a pet
- ❑ First year of school
- ❑ Teachers
- ❑ Peer relationships
- ❑ Onset of puberty
- ❑ Fights
- ❑ Romance/dating
- ❑ Illness/operations
- ❑ Parental conflict/separation
- ❑ Divorce
- ❑ Prom
- ❑ College
- ❑ Abortion/miscarriages
- ❑ Any betrayal
- ❑ Marriage
- ❑ Moving
- ❑ Accidents
- ❑ Loss of job/layoff
- ❑ Financial disruptions
- ❑ Illness of a loved one
- ❑ Diagnosis of a fatal condition
- ❑ Death of a loved one
- ❑ Other: _____

The doctors of Cohn Health Institute are specialists in NET (Neuro-emotional technique). They are able to determine through this method if stress is affecting your present condition and overall health. They will discuss this with you in your consultation. If your doctor can show you how your health can improve and your level of stress can be dramatically reduced, would you be interested in learning more about this technique? ❑ Yes ❑ No

COHN
HEALTH INSTITUTE

SENSITIVE HEALTH INFORMATION

The following items have been listed as sensitive health information and, therefore, will never be copied or released. Even though they are sensitive, they are still vital to the effective management of your case. Please complete as accurately as possible.

1) History of alcohol use/abuse: ❑ Yes ❑ No If yes, how much, what kind, and for how long have you consumed these? _____

2) History of recreational drug use/abuse: ❑ Yes ❑ No If yes, what kind, how much, and how long? _____

_____

3) Have you been diagnosed with a mental illness? ❑ Yes ❑ No Diagnosis? _____ When? _____

Treatment? _____

4) Have you ever been tested for the HIV virus? ❑ Yes ❑ No Results? _____

5) Have you ever been diagnosed with HIV or an HIV related illness? ❑ Yes ❑ No If yes, what type of treatment are you under?

_____

THIS PAGE IS NOT AUTHORIZED TO BE COPIED UNDER ANY CIRCUMSTANCES

GOALS FOR YOUR CARE

We would like to thank you for choosing our office for your chiropractic and healthcare needs. It is our primary goal to provide the highest level of health care available. At Cohn Health Institute, we know that people see chiropractors for a variety of reasons. Some go just for pain relief; some go further by wanting to correct the CAUSE of their pain/symptoms as well; and others go even further by choosing complete health and wellness by correcting all means of dysfunction going on in their bodies even before any symptoms are present.

Please check the type of care desired so that we can best serve your health needs.

❑ Relief Care: Pain/Symptom relief only

❑ Corrective Care: Correction of the CAUSE of the pain/symptoms as well as relief of pain/symptoms.

❑ Comprehensive Care: Bring all areas of the body that are malfunctioning to the highest state of health possible, while correcting the cause and providing pain/symptom relief to the areas of complaint.

❑ I want the doctor to select the type of care appropriate for my health and condition.

COHN
HEALTH INSTITUTE

OUR OFFICE POLICIES

Payment Policy

Our office is not affiliated with HMO's, PPO's, or Health/Medical insurance companies. Patients who carry any form of medical or health insurance should know that all services rendered by this office are charged directly to the patient. Payment in full is due and payable at time of service. This office does not carry balances. If payment is not received, the office uses outside sources to collect balances due.
Initials _____

Health Medical Insurance

If you have insurance that offers chiropractic benefits and you intend to submit bills, please let us know as we will print you out a statement at the time of checkout that you can submit to your health insurance provider. A charge of $25.00 will be applied for statements that need to be reissued. Should a check be mistakenly issued to Cohn Health Institute from your insurance company, the check will be voided and sent to you (the patient). It will be your responsibility to contact your insurance company for reissuance.
Initials _____

Nutritional Supplements/Health Supplies

Nutritional supplements and other health supplies must be paid for at time of service.
Initials _____

Returned Checks

There will be a $20.00 charge on all returned checks. If multiple checks are returned during the course of your care, check privileges will be revoked. Future payment of your account will only be accepted in cash, credit card, or care credit.
Initials _____

Missed Appointments

Unless the office is given a **24 hour** notice of cancellation for an appointment, you will be charged the following for each appointment:
A regular office visit: $25.00
Extended office visits: Half of the visit price (e.g. 20 min appointment at $150, charge is $75.00)
Acupuncture, esthetician, and massage appointments: $45.00 each
Initials _____

Any questions you have regarding our policies are welcome at any time.

COHN
HEALTH INSTITUTE

I hereby authorize the doctor to provide me with a consultation and examination in order to determine if my case can be helped by chiropractic and the care provided here at Cohn Health Institute. I also understand that other exams and tests such as X-rays, lab tests, etc. may be necessary to gain more information regarding my health. I understand that if I am accepted as a patient here at Cohn Health Institute, the doctor will discuss with me which course of care would be best for my case.

Patient Signature	Patient Name
Parent/Guardian Signature	Date
Witness	Date

COHN
HEALTH INSTITUTE

CONFIDENTIALITY AGREEMENT

To Our Valued Patients:

We at Cohn Health Institute have always made your privacy one of our top priorities. We would like to inform you of the measures our office has taken to ensure your rights of patient privacy (in accordance with HIPPA).

The following have been incorporated to secure your private patient information:
1. Locks on the office doors where your patient records are stored with the only keys belonging to the doctors and the office manager.
2. Locks on all file cabinets where overflow files are kept for inactive patients.
3. All employees in the office have signed a strict confidentiality agreement that requires them to keep all patient information in the office, both written and verbal.
4. All areas where mail and/or patient correspondence may be found is restricted to employees only. Each area is clearly designated as "Employee Only."
5. All computers with patient data are locked in a secure location. Access to the computers is restricted to management employees and requires a security log in, with a password, each time the computer is accessed.
6. Patients are NOT allowed behind the front desk at any time. The front desk area will be designated with a tapeline, and at no time will any person unauthorized be allowed past the line for any reason.
7. We have a cover sheet on the "Sign In Sheet." After you have signed in, the cover will be pulled down.

We communicate with our patients through mail, e-mail, and by phone. Below is a list of how we correspond with you.

Please indicate any items that you do NOT wish to receive:

Mailers

- ❑ Birthday greetings
- ❑ Healthcare maintenance reminders
- ❑ Holiday cards
- ❑ Thank you cards for your referrals
- ❑ Health newsletters

Phone Calls

- ❑ Healthcare maintenance reminders
- ❑ Missed appointment rescheduling

In Office (Board)

- ❑ "Thank you for referring" board

In the event that we are unable to speak with you directly, please indicate ALL the ways that are acceptable for us to leave a courtesy message for you:
❑ On your home/cell phone answering machine or with your family
❑ Office voicemail or with the receptionist.

We will do our best to honor your requests when communicating with you.

Yours in Health,
The doctors and staff at Cohn Health Institute

Patient Signature	Date	Witness	Date

ARBITRATION AGREEMENT

Article 1 Agreement to Arbitrate: It Is understood that any dispute as to medical malpractice that 1s as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered 'Mil be determined by submission to arbitration as provided by California and federal law and not by a lawsuit or resort to court process except as late and federal law provides for Judicial review of arbitration proceedings Both parties to this contract, by entering into, are giving up their constitutional right lo have any such dispute decided In a court of law before a Jury and instead are accepting the use of arbitration.

Article 2. All Claims Must be Arbitrated It 1s also understood that any dispute that does not relate to medical malpractice judge disputes as to whether or not a dispute Is subject to arbitration will also be determined by submission to binding arbitration It 1s the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all damages including loss cf consortium This agreement 1s also intended to bind any children of the patient whether born or unborn at the home of the occurrence giving rise to any claim This agreement Is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatures to this form or not.

All claims monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider’s associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator or (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that' provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic

payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. ___ . Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

PATIENT SIGNATURE (OR PATIENT'S REPRESENTATIVE)
Indicate relationship if signing for patient

X_____DATE_____

OFFICE SIGNATURE

X_____DATE_____

CHIROPRACTIC INFORMED CONSENT TO TREAT

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, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and /or other licensed doctors of chiropractic and support staff who now or in thee future treat me while employed by working or associated with or serving as back-up for thee doctor of chiropractic named bell, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an 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 procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed and there 1s no promise of cure. I further understand and am informed that, as in the practice of medicine. 1n 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 on the doctor to exercise judgment during the course of the procedure, which the doctor feels a1 the time, based upon the facts then known. is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment opt.Jons include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti inflammatories, muscle relaxants and painkillers; physical therapy; steroid inJections: bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. i have also had an opportunity to ask questions about its content, 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 conditions and for any future condition(s) for which I seek treatment.

CHIROPRACTOR NAME: _____

PATIENT SIGNATURE **X**_____
(OR PATIENT GUARDIAN/PARENT/REPRESENTATIVE). DATE

PROVIDE NAME AND RELATIONSHIP IF SIGNING FOR PATIENT