COHN HEALTH INSTITUTE
CREATING OUR HEALTH NOW
3151 Airway Ave, Suite U3
Costa Mesa, CA 92626
714-754-8008
www.cohnhealhtinstitute.com

PEDIATRIC PATIENT QUESTIONNAIRE

Patient Information

Child's Name _____ Parent(s)/Guardian(s) Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Is it okay to contact you at work? ❑ Yes ❑ No

E-mail _____ Child's Social Security # _____ Birthdate _____ Age _____

Have you or your child ever had chiropractic care before? You: ❑ Yes ❑ No Your child: ❑ Yes ❑ No

If yes, please tell us the doctor's name _____

Were you pleased with your care? ❑ Yes ❑ No

How did you find out about our office? _____

Is this appointment related to an auto accident? ❑ Yes ❑ No

If this injury is related to an auto accident, please fill out the Auto Accident Questionnaire.

Is your child receiving care from other health care professionals? ❑ Yes ❑ No

If yes, please name them and their specialty _____

Who is your family's primary care physician? _____

Please list any drugs or medications your child is taking _____

_____

Please list any vitamins/herbs/homeopathics/other your child is taking _____

_____

Please list any allergies your child has _____

_____

Current Health

What health condition brings your child to our office? _____

_____

When did the symptoms first begin? _____

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

Is this condition ❑ Getting worse ❑ Improving ❑ Intermittent ❑ Constant ❑ Not Sure

What makes the problem better? _____

What makes the problem worse? _____

Has your child ever had a similar condition? ❑ Yes ❑ No

Please explain _____

Has your child been treated for this problem before? ❑ Yes ❑ No

Please explain _____

Does your child eat well? ❑ Yes ❑ No

What does your child commonly eat for breakfast? _____

Lunch: _____

Dinner: _____

Snacks: _____

Does your child have regular bowel/bladder movements? ❑ Yes ❑ No

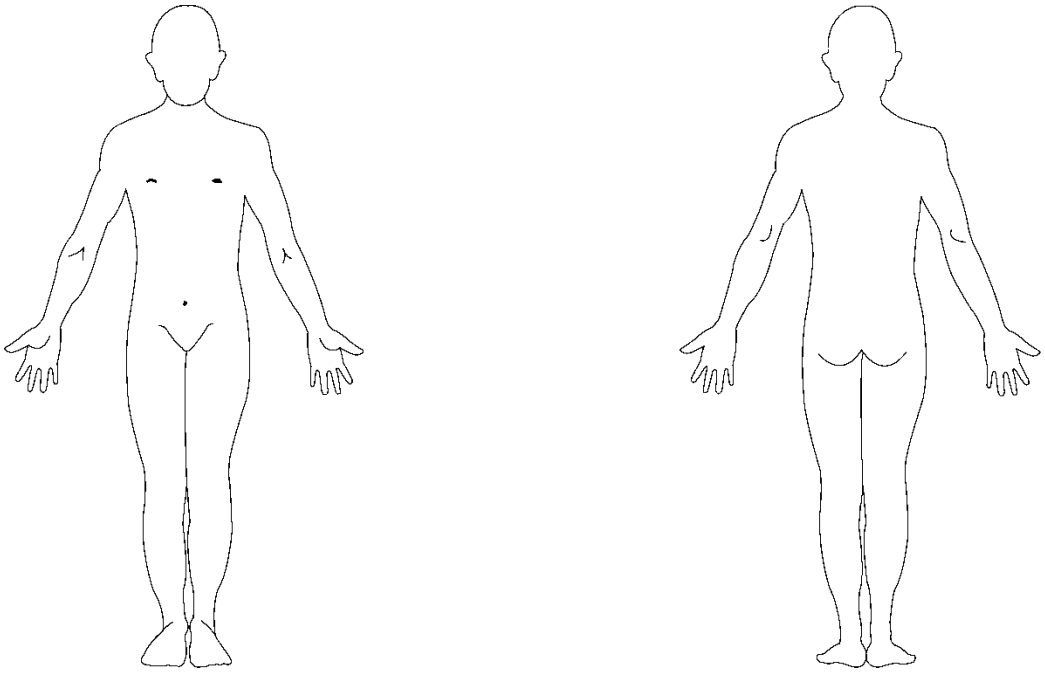
Has your child ever been checked for vertebral subluxations? ❑ Yes ❑ No ❑ Don't Know

Pain Chart

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

Numbness	**Pins & Needles**	**Burning**	**Aching**	**Stabbing**
----------	00000000000000000000	XXXXXXXXXXXXX	********** *****	//////////////////

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.



Health History

Child's birth was ❑ At Home ❑ At A Birthing Center ❑ At A Hospital

My obstetrician/midwife/family physician was _____

Child's birth was ❑ Natural vaginal (no medications/interventions)

❑ Vaginal with interventions

❑ Induction ❑ Pain Medication ❑ Epidural ❑ Episiotomy ❑ Vacuum Extraction ❑ Forceps

❑ Other _____

❑ C-section

❑ Scheduled ❑ Emergency

Please list reasons for any interventions/complications _____

_____

Child's birth weight _____Child's birth height _____ Current weight _____Current height _____

APGAR score at birth _____ APGAR score after 5 minutes _____ Not sure/can't recall ❑

Was the child vaccinated or receive inoculations before leaving the hospital at birth? ❑ Yes ❑ No

Growth & Development

Was your child alert and responsive within 12 hours of delivery? ❑ Yes ❑ No

If no, please explain _____

At what age did the child:

Respond to sound _____ Follow an object _____ Hold head up _____Vocalize _____

Sit alone _____ Teethe _____ Crawl _____ Walk _____

Patient/Hospitalization/Surgical history (please list below all surgeries and hospitalizations, including the year)

_____

_____

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

_____

_____

Is/was your child breastfed? ❑ Yes ❑ No If yes, how long? _____

Formula introduced at age _____ What type? _____

Introduction of cow's milk at age _____ Began solid foods at age _____

Please list any foods/juice intolerance _____

Did mother smoke during pregnancy? ❑ Yes ❑ No Did mother drink alcohol during pregnancy? ❑ Yes ❑ No

Did mother drink (or eat) diet sodas or artificial sweeteners during pregnancy? ❑ Yes ❑ No

Any illness of mother during pregnancy? ❑ Yes ❑ No

If yes, please explain including treatment/medications/supplements _____

_____

List any drugs/medications (including over the counter) taken during pregnancy _____

_____

List any supplements taken during pregnancy _____

Any exposures to ultrasound? ❑ Yes ❑ No If so, how many and what was the medical reason? _____

_____

Any pets at home? ❑ Yes ❑ No Any smokers at home? ❑ Yes ❑ No

Has child received any vaccinations? ❑ Yes ❑ No If yes, which ones, at what age, and list any reactions _____

_____

Has child received any antibiotics? ❑ Yes ❑ No If yes, how many times and list reason _____

_____

Any difficulty breastfeeding? ❑ Yes ❑ No If yes, please explain _____

_____

Any difficulty with bonding? ❑ Yes ❑ No If yes, please explain _____

_____

Any behavioral problems? ❑ Yes ❑ No If yes, please explain _____

_____

Any night terrors, sleepwalking or difficulty sleeping? ❑ Yes ❑ No If yes, please explain _____

_____

Age child began daycare _____ Average number of hours of TV/Digital media (iPod, iTouch, iPad, video games, etc.) per week _____

Was there any point at which you said, "that doesn't seem normal/right" since your child was born? ❑ Yes ❑ No

If yes, please explain _____

Does your child seem normal for his/her age? ❑ Yes ❑ No If no, please explain _____

_____

Family History Review

Check those involving immediate family and add identification: M=Mother; F=Father; S=Siblings; G=Grandparents

❑ Cancer, type _____ ❑ M ❑ F ❑ S ❑ G	❑ Depression ❑ M ❑ F ❑ S ❑ G	❑ Diabetes ❑ M ❑ F ❑ S ❑ G	❑ Back Problems ❑ M ❑ F ❑ S ❑ G
❑ Heart Disease ❑ M ❑ F ❑ S ❑ G	❑ Liver Disease ❑ M ❑ F ❑ S ❑ G	❑ High Blood Pressure ❑ M ❑ F ❑ S ❑ G	❑ High Cholesterol ❑ M ❑ F ❑ S ❑ G
❑ Lung Problems ❑ M ❑ F ❑ S ❑ G	❑ Scoliosis ❑ M ❑ F ❑ S ❑ G	❑ Neck Problems ❑ M ❑ F ❑ S ❑ G	❑ Osteoporosis ❑ M ❑ F ❑ S ❑ G
❑ Seizures ❑ M ❑ F ❑ S ❑ G	❑ Osteoarthritis ❑ M ❑ F ❑ S ❑ G	❑ Rheumatoid Arthritis ❑ M ❑ F ❑ S ❑ G	

❑ Other _____

_____

Do you know about Chiropractic?

Do you know what a subluxation is? ❑ Yes ❑ No

Do any of your friends or relatives see a chiropractor? ❑ Yes ❑ No

If yes, do they use chiropractic for ❑ Health maintenance/optimization ❑ Health Problems ❑ Both

Are you seeking chiropractic for ❑ Health maintenance/optimization ❑ Health Problems ❑ Both

What would you like to gain from chiropractic care? _____

_____

Are there other health concerns or anything else you'd like us to know about your child? _____

_____

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.

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.

Parent /Guardian Name	Patient Name
Parent/Guardian Signature	Date
Witness	Date

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

Parent 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