COHN
HEALTH INSTITUTE
Creating Our Health Now

ACUPUNCTURE MEDICAL HISTORY

Patient Information

Name: ____
Date: ____
Address: ____
City, State, Zip: _______________________________________
Sex: ________ Height: ________ Weight: ________
Marital Status: __________________ Children: _________
Occupation: ____
Primary Physician: ______________________________________
Physician Phone: _______________________________________
Have you received acupuncture before? ____________________

Contact Information

Home Phone: ____
Work Phone: ____
Cell Phone: ____
Email: ____

Emergency Contact
Name: ____
Relationship: ____
Phone: ____

How did you hear about us? _______________________________

Health History

Please indicate any significant illness you or a blood relative (grandparent, parent, sibling) have had:

	You	Relative	Approx. Date
Hepatitis	☐	☐	__________
High Blood Pressure	☐	☐	__________
Heart Disease	☐	☐	__________
Seizures	☐	☐	__________
Cancer	☐	☐	__________
Rheumatic Fever	☐	☐	__________
Infectious Disease	☐	☐	__________
Diabetes	☐	☐	__________
Emotional Disorders	☐	☐	__________
Tuberculosis	☐	☐	__________

List any medications and supplements you are currently taking:
Medicine, Dosage, Reason, How Long

____
____
____
____

List any accidents, surgeries, hospitalizations, or serious illness (with date):

____
____
____

Check the box if any of the following are true:

☐ I have a Pacemaker
☐ I am taking Lithium (Eskalith, Lithobid, Lithotabs)
☐ I am taking Coumadin/Warfarin

What are the health conditions that you are seeking treatment for today?

____
____
____
____

List any other health problems you now have:

____
____
____

List any allergies, food sensitivities, or cravings:

____
____
____

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad
Partner	☐	☐	☐	☐	☐
Family	☐	☐	☐	☐	☐
Diet	☐	☐	☐	☐	☐
Sex	☐	☐	☐	☐	☐
Self	☐	☐	☐	☐	☐
Work	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐
Spirituality	☐	☐	☐	☐	☐

Other information you would like to report relevant to your medical history:

____
____
____

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For Women

Age of 1st period (menarche): ________________________

Age of last period (menopause): _____________________

Number of days between periods: ___________________

Number of days of flow: ____________________________

Color of flow: ______________________________________

Clots: ☐ Yes ☐ No Color: _______________________

Are you pregnant? ☐ Yes ☐ No # of pregnancies: __________________

# of live births: ______ of live abortions: ______ of live miscarriages: ______

Date of last gynecologic exam: ___________ Pap smear date: ___________

Mammogram: _______________ Bone Density Scan: __________________

Results: ____

____

Average number of pads you use per day: 1st day ___________ 2nd ___________ 3rd ___________ 4th ____________ + days _____________

Have you been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID ☐ Other ___________

Location of Pain: ☐ Lower Abdomen ☐ Lower Back ☐ Thighs ☐ Other ____

Nature of Pain (please indicate before, during, or after menses)

Cramping _____________________ Stabbing _____________________

Burning _____________________ Aching _____________________

Dull _____________________ Bloating _____________________

Consistent ____________________ Intermittent___________________

Bearing Down Sensation ______________________

Other symptoms related to menses

☐ Discharge ☐ Vaginal Dryness ☐ Headaches

☐ Ravenous Hunger ☐ Constipation ☐ Diarrhea

☐ Swollen Breasts ☐ Mood Swings ☐ Hot Flashes

☐ Increased Libido ☐ Night Sweats ☐ Insomnia

☐ Decreased Libido ☐ Poor Appetite ☐ Nausea

For Men

Date of last prostate check up: _________________ PSA results: ________________ Manual prostate exam results: ___________________

Lab results: ____

Frequency of Urination: daytime ____________ night time ____________ color of urine: ☐ clear ☐murky odor: _________________

Symptoms related to prostate health

☐ Prostate Problems ☐ Delayed Stream ☐ Post Void Dribbling ☐ Incontinence ☐ Retention of Urine

☐ Erectile Dysfunction (ED) ☐ Increased Libido ☐ Decreased Libido ☐ Premature Ejaculation ☐ Impotence

☐ Back Pain ☐ Groin Pain ☐ Testicular Pain ☐ Decreased Force of Stream ☐ BPH or Enlarged Prostate

☐ Other: ____

For Everyone

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
No mark = never experience, check mark ( ) = sometimes experience, plus sign (+) = frequently experience

______ Lack of appetite
______ Excessive appetite
______ Loose stool/diarrhea
______ Digestive problems, indigestion
______ Vomiting
______ Belching, burping
______ Heartburn/reflux
______ Feeling the retention of food in the stomach
______ Tendency to become obsessive in work, relationships….
______ Insomnia, difficulty sleeping
______ Heart palpitations
______ Cold hands and feet
______ Nightmares
______ Mentally restless
______ Laughing for no apparent reason

______ Abdominal pain
______ Chest pain
______ Sciatic pain
______ Headaches
______ Pain/coldness in the genital area
______ Cough
______ Shortness of breath
______ Decreased sense of smell
______ Nasal problems
______ Skin problems
______ Feeling of claustrophobia
______ Bronchitis
______ Colitis or diverticulitis
______ Constipation
______ Hemorrhoids
______ Recent use of antbiotics

______ Eye problems
______ Jaundice (yellowish eyes or skin)
______ Difficulty digesting oily foods
______ Gall stones
______ Light colored stool
______ Soft or brittle nails
______ Easily angered or agitated
______ Difficulty in making plans or decisions
______ Spasms or twitching of muscles
______ Low back pain
______ Knee problems
______ Hearing impairment
______ Ear ringing
______ Kidney stones
______ Decreased sex drive
______ Hair loss

______ Fatigue
______ Edema
______ Blood in stool
______ Black tarry stool
______ Easily bruised
______ Difficult to stop bleeding
______ Asthma
______ Tendency to catch colds easily
______ Intolerance to weather changes
______ Allergies
______ Hay fever
______ Dizziness
______ Tendency to faint easily
______ High cholesterol levels
______ Sudden weight loss

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 and/or acupuncture 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 send 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 the 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 minute 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.

ARBITRATION AGREEMENT

Article 1: Agreement to arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether an medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompletely rendered, will 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 state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract. By entering into it, are giving up their constitutional right to 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 is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is 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 claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time 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 with 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 signatories to this form or not.

All claims for 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 (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 the 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: 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

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRAISL – SEE ARTICLE 1 OF THIS CONTRACT.

______________________________	______________	______________
Patient Signature	Date	Relationship to patient
______________________________	______________	
Office Signature	Date	