A Wellness Center by Dr. Patricia Cohen

PERSONAL HISTORY

Name_____E-mail_____Date_____

Address _____ City _____State _____ Zip _____

Phone (H)_____(W)_____(Cell)_____

Birthdate_____Age_____Sex_____Height_____Weight_____ Married Single Divorced Widowed Separated

Occupation_____

Main complaint(s) that brought you to this office _____

List other doctors seen for this condition _____

When did this condition begin _____ Due to accident: Yes _____ No _____

List medication/vitamins now taking and why:

1. _____
2. _____
3. _____

List any injuries, operations, or pertinent history:

1. _____Date_____
2. _____Date_____
3. _____Date_____

Who referred you to our office: _____ N.Side News _____ Brightside _____ Phonebook _____ Insurance

Who is responsible for your bill besides yourself: (check one) _____ Insurance _____ Work Comp _____ Parents _____ Other

Name, address and phone of responsible party checked above: _____

_____

_____ Name of person on insurance policy

_____ Supervisor who authorized Workman's Comp.

Instructions: Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, there are many conditions that respond favorably when treatment is given that increases your body's ability to function correctly. This office specializes in such treatment and if you wish, an individualized program will be suggested. **Please check the symptoms you have experienced in either (or both) of the chronic (recurrent symptoms) or acute (symptoms you have now).**

Gastro-intestinal

Acute	Chronic	
_____	_____	Digestive complaints
_____	_____	Stomach pain
_____	_____	Ulcers
_____	_____	Frequent heartburn
_____	_____	Nausea
_____	_____	Frequent diarrhea
_____	_____	Irritable bowel
_____	_____	Hemorrhoids
_____	_____	Frequent vomiting
_____	_____	Colitis/diverticulitis
_____	_____	Black or bloody stool
_____	_____	Gallbladder trouble
_____	_____	Frequent burping/belching

Immune Response

Acute	Chronic	
_____	_____	Frequently sick
_____	_____	Frequent swollen glands/sore throats
_____	_____	Depression and/or anxiety
_____	_____	Achy joints/muscle pain
_____	_____	Headaches/migraines
_____	_____	Recurrent digestive complaints
_____	_____	Chronic fatigue
_____	_____	Food allergies
_____	_____	Eczema or hives
_____	_____	Allergies (mild / moderate / severe)

Structural/Neurological

Acute	Chronic	
_____	_____	Headaches
_____	_____	Muscle cramps/muscle spasms
_____	_____	Neck pain
_____	_____	Jaw pain
_____	_____	Dizziness
_____	_____	Back pain
_____	_____	Shoulder / elbow / wrist pain
_____	_____	Numbness/Tingling
_____	_____	Tremors in hands or feet
_____	_____	Knee pain / Hip pain
_____	_____	Joint pain or loss of function
_____	_____	Osteoporosis/Osteomalacia
_____	_____	Current bone fracture or injury
_____	_____	Tendonitis/Bursitis

Cardiovascular

Acute	Chronic	
_____	_____	Irregular heartbeat
_____	_____	Heart murmur/palpitations
_____	_____	High or low blood pressure
_____	_____	Chest pain
_____	_____	Previous heart trouble
_____	_____	Poor circulation
_____	_____	Previous heart surgery
_____	_____	Varicose or spider veins
_____	_____	Hands and feet cold all the time

Name: **A Wellness Center by Dr. Patricia Cohen**

Respiratory

Acute	Chronic	
_____	_____	Chronic cough
_____	_____	Asthma
_____	_____	Emphysema
_____	_____	Recurrent head colds
_____	_____	Recurrent sinus infections
_____	_____	Recurrent bronchitis
_____	_____	Smoker

Genito-Urinary

Acute	Chronic	
_____	_____	Too frequent urination
_____	_____	Discolored or foul-smelling urine
_____	_____	Blood in urine
_____	_____	Recurrent kidney or bladder infections
_____	_____	Kidney stones
_____	_____	Bedwetting
_____	_____	Inability to control bladder

Eyes/Ears

Acute	Chronic	
_____	_____	Recurrent ear infections
_____	_____	Eye infections
_____	_____	Slowly losing vision
_____	_____	Floaters in eyes
_____	_____	Glaucoma
_____	_____	Macular degeneration
_____	_____	Cataracts
_____	_____	Diabetic retinopathy

Miscellaneous

Past	Present	
_____	_____	Difficulty sleeping
_____	_____	Restless, uneasy sleep
_____	_____	Edema
_____	_____	Unusual swelling in arms or legs
_____	_____	Tobacco _____packs/day
_____	_____	Alcohol _____ drinks/day / week / month
_____	_____	Drug or Alcohol Dependence
_____	_____	Coffee/Tea/Caffeinated Soft drinks: cups/cans per day _____

Have you or your family had:

Self	Family	
_____	_____	Cancer
_____	_____	Epilepsy
_____	_____	Chronic Back Problems
_____	_____	Chronic Headaches
_____	_____	High Blood Pressure

Endocrine (Glandular)

Acute	Chronic	
_____	_____	Cold hands and feet
_____	_____	Low blood pressure
_____	_____	Weight problems (over or under)
_____	_____	Thyroid problems
_____	_____	Diabetes
_____	_____	Irritable if meals are missed
_____	_____	Anxiety/nervousness/irritability
_____	_____	Dizzy upon standing too quickly
_____	_____	Weak and shaky
_____	_____	Hyperactive behavior
_____	_____	Depression
_____	_____	Very susceptible to infections
_____	_____	Frequent headaches
_____	_____	Digestive complaints

For Women Only

Acute	Chronic	
_____	_____	Recurrent urinary tract infections
_____	_____	Yeast infections
_____	_____	Vaginal discharge
_____	_____	Menstrual irregularity
_____	_____	Cramping
_____	_____	Mood swings/depression
_____	_____	Pre-menstrual syndrome
_____	_____	Infertility
_____	_____	Frequent miscarriages
_____	_____	Hot flashes
_____	_____	Currently taking hormone medication
_____	_____	Currently taking birth control pills
_____	_____	Lumps in breast
_____	_____	Uterine cysts/ovarian cysts
_____	_____	Bladder leaks too easily
_____	_____	Endometriosis
		Pregnancy, # of Births _____
Y	N	Birth Control Pills, Type _____

For Men Only

Acute	Chronic	
_____	_____	Prostate trouble
_____	_____	Urination problems
_____	_____	Reproductive problems

Self	Family	
_____	_____	Rheumatoid Arthritis
_____	_____	Diabetes
_____	_____	Heart Problems
_____	_____	Lung Problems
_____	_____	Lupus

Please read below and sign. Thank You!

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Cohen's office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to Dr. Cohen will be credited to my account on receipt. I further authorize Dr. Cohen to accept assignment of insurance benefits. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. A 1% monthly service charge will be applied to any balance that extends beyond 90 days.

Patient's Signature _____ Date _____

Guardian or Spouse's
Signature Authorizing Care _____ Date _____

HABITS: **A Wellness Center by Dr. Patricia Cohen**

Name: _____ Date:_____

To help us better understand your overall health picture and to see how much your lifestyle is influencing this picture, please answer the following:

What is your occupation? _____ Do you enjoy your work? _____
On your average day *(either at home or work)* how much time do you spend?
Sitting _____ Standing _____ Lifting _____ Bending _____
Do you eat Red Meat? Y N How often - _____ day / week / month?
Do you eat in fast food restaurants? Y N How often - _____ day / week / month?

LIQUID CONSUMPTION	Y/N	TYPE	AMOUNT	FREQUENCY
Water?				
Alcohol?				
Soda?				
Coffee?				
Tea?				
Fresh Juice?				
Canned/Bottle Juice?				
Milk?				

Frequency Of: Urination Day _____ Night_____ Any Problems? _____
Bowel Movement _____ [ ] Loose [ ] Hard Any Problems? _____
Are you a vegetarian? Y N Type? _____ For How Long? _____
Are you dieting? Y N How? _____ What supplements/vitamins do you take?
_____
_____
What sports have your played *(past)* seriously? _____
Are you in training for a particular sport? Y N Which?
_____
Which sports/recreation activities do you enjoy doing now? _____
Do you exercise [ ] Never [ ] Sometimes [ ] Often Type? [ ] Stretching [ ] Cardio-vascular [ ] Strength
Do you use Tobacco? Y N What? _____ How much? _____ How long? _____
Do you have sufficient energy for your normal activities? Y N If not, explain
_____
Do you wear glasses or contact lens? Y N Has your vision changed lately? Y N
How? _____
Time you go to bed? _____ Average # of hours/night? _____ Quality? _____
Age and type of mattress you sleep on? _____
Do you wear heel lifts or other foot supports? Y N Explain? _____
Do you use magnets on any part of your body? Y N Where? _____
Do you use an air purifier at home or office? Y N Type? _____
Do you utilize any type of stress reduction? Y N Explain? _____

Name: Date:

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a purification program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0 1 2 3 4
b. Diarrhea	0 1 2 3 4
c. Constipation	0 1 2 3 4
d. Bloated feeling	0 1 2 3 4
e. Belching and/or passing gas	0 1 2 3 4
f. Heartburn	0 1 2 3 4

Total: ____

2. EARS

a. Itchy ears	0 1 2 3 4
b. Earaches or ear infections	0 1 2 3 4
c. Drainage from ear	0 1 2 3 4
d. Ringing in ears or hearing loss	0 1 2 3 4

Total: ____

3. EMOTIONS

a. Mood swings	0 1 2 3 4
b. Anxiety, fear, or nervousness	0 1 2 3 4
c. Anger, irritability	0 1 2 3 4
d. Depression	0 1 2 3 4
e. Sense of despair	0 1 2 3 4
f. Uncaring or disinterested	0 1 2 3 4

Total: ____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0 1 2 3 4
b. Hyperactivity	0 1 2 3 4
c. Restlessness	0 1 2 3 4
d. Insomnia	0 1 2 3 4
e. Startled awake at night	0 1 2 3 4

Total: ____

5. EYES

a. Watery or itchy eyes	0 1 2 3 4
b. Swollen, reddened, or sticky eyelids	0 1 2 3 4
c. Dark circles under eyes	0 1 2 3 4
d. Blurred or tunnel vision	0 1 2 3 4

Total: ____

6. HEAD

a. Headaches	0 1 2 3 4
b. Faintness	0 1 2 3 4
c. Dizziness	0 1 2 3 4
d. Pressure	0 1 2 3 4

Total: ____

7. LUNGS

a. Chest congestion	0 1 2 3 4
b. Asthma or bronchitis	0 1 2 3 4
c. Shortness of breath	0 1 2 3 4
d. Difficulty breathing	0 1 2 3 4

Total: ____

8. MIND

a. Poor memory	0 1 2 3 4
b. Confusion	0 1 2 3 4
c. Poor concentration	0 1 2 3 4
d. Poor coordination	0 1 2 3 4
e. Difficulty making decisions	0 1 2 3 4
f. Stuttering, stammering	0 1 2 3 4
g. Slurred speech	0 1 2 3 4
h. Learning disabilities	0 1 2 3 4

Total: ____

9. MOUTH/THROAT

a. Chronic coughing	0 1 2 3 4
b. Gagging or frequent need to clear throat	0 1 2 3 4
c. Swollen or discolored tongue, gums, lips	0 1 2 3 4
d. Canker sores	0 1 2 3 4

Total: ____

10. NOSE

a. Stuffy nose	0 1 2 3 4
b. Sinus problems	0 1 2 3 4
c. Hay fever	0 1 2 3 4
d. Sneezing attacks	0 1 2 3 4
e. Excessive mucous	0 1 2 3 4

Total: ____

11. SKIN

a. Acne	0 1 2 3 4
b. Hives, rashes, or dry skin	0 1 2 3 4
c. Hair loss	0 1 2 3 4
d. Flushing	0 1 2 3 4
e. Excessive sweating	0 1 2 3 4

Total: ____

12. HEART

a. Skipped heartbeats	0 1 2 3 4
b. Rapid heartbeats	0 1 2 3 4
c. Chest pain	0 1 2 3 4

Total: ____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0 1 2 3 4
b. Rheumatoid arthritis	0 1 2 3 4
c. Osteoarthritis	0 1 2 3 4
d. Stiffness or limited movement	0 1 2 3 4
e. Pain or aches in muscles	0 1 2 3 4
f. Recurrent back aches	0 1 2 3 4
g. Feeling of weakness or tiredness	0 1 2 3 4

Total: ____

14. WEIGHT

a. Binge eating or drinking	0 1 2 3 4
b. Craving certain foods	0 1 2 3 4
c. Excessive weight	0 1 2 3 4
d. Compulsive eating	0 1 2 3 4
e. Water retention	0 1 2 3 4
f. Underweight	0 1 2 3 4

Total: ____

15. OTHER:

a. Frequent illness	0 1 2 3 4
b. Frequent or urgent urination	0 1 2 3 4
c. Leaky bladder	0 1 2 3 4
d. Genital itch, discharge	0 1 2 3 4

Total: ____

Section I Total: ____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16. Circle the corresponding number for questions 16a-16f below.

0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily

a. How often are strong chemicals used in your home?
(disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.) 0 1 2 3 4

b. How often are pesticides used in your home? 0 1 2 3 4

c. How often do you have your home treated for insects? 0 1 2 3 4

d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office? 0 1 2 3 4

e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics? 0 1 2 3 4

f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes? 0 1 2 3 4

Total: _____

17. Circle the corresponding number for questions 17a-17b below.

0	No	1	Mild Change	2	Moderate Change	3	Drastic Change

a. Have you noticed any negative change in your health since you moved into your home or apartment? 0 1 2 3

b. Have you noticed any change in your health since you started your new job? 0 1 2 3

Total: _____

18. Answer yes or no and circle the corresponding number for questions 18a-18d below.

	No	Yes
a. Do you have a water purification system in your home?	2	0
b. Do you have any indoor pets?	0	2
c. Do you have an air purification system in your home?	2	0
d. Are you a dentist, painter, farm worker, or construction worker?	0	2

Total: _____

Section II Total: _____

Grand Total (Section I & Section II) _____

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a purification program.

Adapted with permission from the author of *Clinical Purification™: A Complete Treatment and Reference Manual*, Dr. Gina L. Nick.

A Wellness Center by Dr. Patricia Cohen

_____ (Initial) **Appointment Policy:**

At A Wellness Center and Spa, we care about your health. One of the ways we can meet your healthcare needs is to provide appointments with our facility in a timely manner, in many cases the same day of your request.

We reserve your appointment exclusively for you. All appointments are scheduled in 15 minute increments. All walk-ins are scheduled into the next available appointment on the schedule. Same day sick appointments are almost always available. Please be on time. If you are late, you may be rescheduled.

Appointments are taken back in the order of the appointment time not the arrival time, to avoid delaying other patients unnecessarily.

We make every effort to maintain our schedule and minimize any inconvenience to you however, emergencies do occur. If a significant delay occurs we will reschedule your appointment if you would prefer not to wait.

_____ (Initial) **Cancellations and No Shows:**

Please call if you cannot keep your appointment. A missed appointment leaves an empty slot that could have been used by another patient in need of care.

Not canceling an appointment in a timely fashion is unfair to other patients. Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you.

We therefore request that patients who are unable to keep their schedule appointments notify us at least 24 hours in advance. We reserve the right to charge a $25 fee for appointments that are cancelled without a 24-hour notice, or if a patient does not show up for a scheduled appointment.

Your signature below is required and is proof that you acknowledge the Appointment Cancellation Policy set in place by A Wellness Center and Spa, and acknowledge that you will be responsible for payment of a cancelled or missed appointment.

Signature:_____ Date:_____

A Wellness Center by Dr. Patricia Cohen
5655 Lake Acworth Dr., Acworth, GA 30101
770-966-8000

Financial Payment Policy

Our facility accepts most commercial insurance plans, i.e., PPO's, HMO's and other provider networks. Please appreciate the complexity of insurance coverage today. It is impossible to obtain payment for services without having the full cooperation of the patient. We are experts in Chiropractic care, not insurance. **We will help you if we can with this process however it is ultimately your responsibility to know your insurance policy coverage and in-network/out-of-network responsibilities.**

If you are on a managed care plan in which we participate, then **you are responsible for paying your co-payment, co-insurance, or portion of your medical deductible at the time of service.** As a courtesy, before a procedure is performed, we will give you an estimate.

If you are not on a managed care plan in which we participate, then **you are responsible for paying the difference between our charges and what your insurance company paid, in addition to paying your co-payment, percentage, or portion of your medical deductible at the time of service.**

Our fees are generally considered to fall within the acceptable range by most insurance companies and are therefore covered as maximum allowable, as determined by each carrier. Some insurance companies utilize an arbitrary schedule of what they consider to be "UCR" (usual, customary and reasonable). Please understand that we have an agreement with you and your insurance company. We routinely make an effort to appeal any charges not covered; however, **any charges not covered, denied, or deemed to be not medically necessary by your insurance company will be your responsibility.** This excludes our contracted fee arrangements with managed care companies, including HMO's, PPO's, Workers' Compensation, and Medicare.

- I hereby understand that I am responsible for giving Dr. Patricia Cohen's office the correct insurance information.
- I understand that I am also responsible for obtaining the proper referral from another physician, if applicable.
- I agree to pay for services for which I failed to obtain a referral.
- I agree to pay for non-covered, denied, or other non-paid services under my insurance plan.
- I agree to pay for any collection costs associated to collecting balances unpaid for more than 180 days after the date of service.

_____ _____

Patient's Name Patient's Signature

Date: _____