

Welcome to Health Dynamics

(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.

Personal History

Today's Date: _____
Whom may we thank for referring you to our office? _____
Last Name: _____ First Name: _____
MI: _____
Address: _____ City: _____ State: _____
Zip Code: _____ Home Phone: _____ Cell Phone: _____
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 approx. 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:

<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Measles	<input type="checkbox"/> Influenza	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Mumps	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Polio	<input type="checkbox"/> Small Pox
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Eczema/Psoriasis
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Thyroid Dis.	<input type="checkbox"/> Anemia	<input type="checkbox"/> Whooping Cough

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 extremities
 Numbness/loss of sensation
 Dizziness
 Fainting
 Forgetfulness
 Depression
 Seizures
 Paralysis
 Nervousness/Stress

Gastrointestinal

Poor App/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

Genitourinary

Painful/excessive urination
 Discolored urine
 Bladder infections
 Urinary leakage

EENT

Vision problems
 Dental problems
 Earache/Infection
 Difficulty hearing
 Ringing in ears
 Cold/Flu
 Sinus problems
 Sore throat

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

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 ___

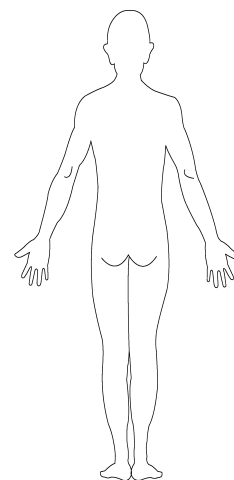
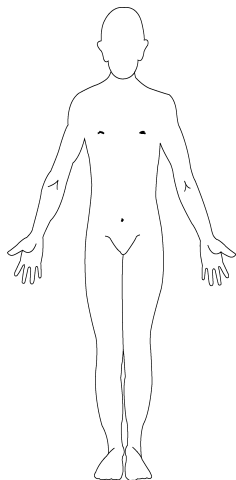
Other Health Issues

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

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	00000	xxxxx	*****	/////
-----	00000	xxxxx	*****	/////
-----	00000	xxxxx	*****	/////

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

Pain Chart



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 7 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: _____

Working at a computer: _____

Standing: _____

Walking: _____

Crouching or bending over: _____

Lifting: _____

Electronic Radiation Exposure

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

Blow dryer/curling iron

Cell phone/cordless phone

Microwave

Electric razor/toothbrush

Sleep within 3 feet of an electrical outlet

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 highest stress you could imagine and 1 being relatively no stress.

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

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

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

The doctors of Health Dynamics 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_____

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?_____

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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 Health Dynamics, 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 areas 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 the 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.

Our Office Policies

Payment Policy:

Our office is not affiliated with any 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 re-issued. Should a check be mistakenly issued to Health Dynamics 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 re-issuance.

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 \$25.00 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

Acupuncture, esthetician, and massage appointments: \$45.00 each

Initials_____

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

Confidentiality Agreement

To Our Valued Patients:

We at Health Dynamics 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

1. ___ Birthday greetings
2. ___ Healthcare maintenance reminders
3. ___ Holiday cards
4. ___ Thank you cards for your referrals
5. ___ Health newsletters

PHONE CALLS

1. ___ Healthcare maintenance reminders
2. ___ Missed appointment rescheduling

IN OFFICE (WHITE BOARD)

1. ___ "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 Health Dynamics

Patient Signature

Date

Witness

Date

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 Health Dynamics. 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 Health Dynamics, the doctor will discuss with me which course of care would be best for my case.

Patient Name

Patient Signature

Parent/Guardian Signature

Date

Witness

Date