COHEN CHIROPRACTIC CENTER

238 South Arroyo Parkway, Unit #140, Pasadena, California 91105
Phone: (626) 449-9000 – Fax: (626) 449-9939 – Email: cohenchiro@gmail.com

PATIENT NUMBER (Office Use): ________

HEALTH QUESTIONNAIRE

Date of Birth: ___/___/___

Last name: ____________ First name: ____________ Age: ______

Sex: Male ☐ Female ☐ Title (circle one): Mr. Mrs. Ms. Miss Dr. Other: ________

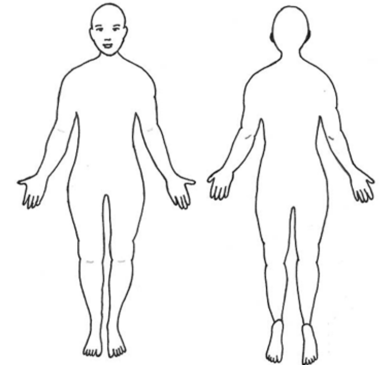
Address: ____________ Apt.# ______ Primary Language: ________

City: ____________ State: ______ Zip: ______ Phone: (   ) ________

Occupation: ____________ Employer: ____________ Work Phone: (   ) ________

DESCRIBE YOUR CURRENT CONDITION:

MARK AN X ON THE PICTURE BELOW YOU HAVE PAIN OR SYMPTOMS



Date symptoms began (MM/DD/YYYY): ______________________

Area of complaint: Neck_____ Mid-Back_____ Low Back_____ Other: ______________

Describe your condition and how it began: ________________________________

____

Is this condition: Work Related? ____ Auto Related? ____ Other? _____

Current complaint (how you feel today):

0	1	2	3	4	5	6	7	8	9	10

No Pain — Unbearable Pain

How often are your symptoms present?

(Intermittent) __ 0-25% __ 26-50% __ 51-75% __ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

0	1	2	3	4	5	6	7	8	9	10

No Interference — Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT: ____ NO ____ YES

Date(s) taken: _________________ What areas were taken? ___________________________________

PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY:

- ☐ Low back problems
- ☐ Pain between shoulders
- ☐ Neck problems
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Ruptures
- ☐ Broken bones
- ☐ Morning Pain/Stiffness
- ☐ Awakened from sleep by pain
- ☐ Numbness/Tingling
- ☐ Headaches
- ☐ Dizziness/Fainting
- ☐ Recent Fever
- ☐ Recent Cold/Flu/Infection
- ☐ Recent Coughing
- ☐ Chest Pain
- ☐ Constipation
- ☐ Urinary problems
- ☐ Female reproductive problems
- ☐ Medications (provide details below)
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Stroke (If yes, date:_______________)
- ☐ Cancer/tumor (provide details below)
- ☐ Epilepsy/seizures
- ☐ Prostate problems
- ☐ Menstrual problems
- ☐ Currently pregnant?
- ☐ If pregnant, number of weeks: ______
- ☐ Visual disturbances
- ☐ Surgeries (provide details below)

ADDITIONAL DETAILS: ____

____

Family History: Please indicate if you have a family history of any of the following conditions:

- ☐ Cancer
- ☐ Heart Problems/Stroke
- ☐ Diabetes
- ☐ Rheumatoid Arthritis
- ☐ High Blood Pressure
- ☐ Scoliosis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. ASH Health Plan patients: I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Signature: ____ Date: ________________