

Metrowellness

William J. Cohl, D.C.

WELCOME!

Thank you for choosing Metrowellness to assist you in determining the source of your personal health issues. We pledge to you a caring, professional and sharing environment dedicated to getting you back on the right track in as natural a manner as possible. Your wellness is our goal!

Your visit to our office will involve a thorough review of your history in order for us to evaluate proper treatment. This questionnaire will help Dr. Cohl determine the appropriate standing orders for testing to assess for the root cause(s) of your condition.

When you arrive at the office Dr. Cohl will obtain a more detailed history. After this, Dr. Cohl will be able to adequately assess your specific condition. Nothing will be performed without first having been explained to you.

At any time in the process, if you desire to speak with us regarding costs, payments, or your insurance coverage, we will be pleased to consult with you. It is our desire that you will be very comfortable with all of our procedures. We want you to feel at ease and confident with us at Metrowellness.

If you have any other questions, please feel free to ask.

Patient/Authorized Person Signature

Date

Witness

Date

Out of Network Insurance Provisions

In the course of diagnosis and treatment, patients at Metrowellness may undergo comprehensive testing and detailed evaluations. In network managed care programs, Medicare/ Medicaid, and HMO's, however, prefer a more simplified approach to testing and evaluations. As a result, Metrowellness is not a member of any In Network Managed Care, Medicare/ Medicaid, or HMO programs.

To avoid any inconvenience for our patients, Metrowellness has developed procedures for creative payment arrangements when necessary. The mission and purpose of Metrowellness is to work in harmony with our patients on all levels to address their health concerns and move toward a healthier state in life.

I, the undersigned, do hereby acknowledge and understand that Metrowellness is an out of network providers for my insurance carrier.

Patient/Authorized Person Signature

Date

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Notice to Patients

William J. Cohl, D.C.

This notice is provided to you pursuant of law. The above practitioner is a Doctor of Chiropractic, and under the scope of practice for Chiropractic, he is not practicing as licensed medical doctor and therefore does not practice "the application of scientific principles to prevent, diagnose and treat physical and mental diseases, disorders, and conditions and to safeguard the life and health of any person." A person registered to practice Chiropractic under the law may counsel individuals and treat human conditions through the use of "naturally occurring substances."

The underlying causes of disease can be improper diet, unhealthy habits, mental stress, and environmental factors that cause biological imbalance. A Chiropractor/Applied Kinesiologist specializes in wellness; the teaching of natural lifestyle approaches to facilitate the body's healing and health building potential.

I fully understand that the above named individual is not a medical doctor. This individual may counsel me on nutrition, supplements, and better health practices, but will not diagnose or prescribe remedies for disease.

Patient/Authorized Person Signature

Date

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Date

Assignment of Benefits Authorization / Release Form

Email Address: _____ Referred by: _____

Name: _____ Date of Birth: _____ Age: _____ Male: ___ Female: ___

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work: (____) _____ Mobile: (____) _____ Marital Status: M/ S/ D

SSN: _____ Employer: _____ Position: _____

Spouse's Name: _____ Spouse's Work Number: (____) _____

Spouse's mobile: (____) _____ Spouse's SSN: _____ Spouse's Date of Birth: _____

Spouse's Employer: _____ City: _____ State: _____ Zip: _____

Name of Nearest Relative: _____ Relationship: _____

Phone Number: (____) _____ Address: _____

Primary Care Dr: _____ Phone Number: _____ Date Last Seen: _____

ALL FEES PAYABLE AT TIME OF SERVICE UNLESS SPECIAL ARRANGEMENTS ARE MADE.

RELEASE OF MEDICAL RECORDS/LAB/IMAGING: I authorize the release of any and all information/records/x-rays, etc. needed to evaluate my condition. I further request that this and any other pertinent information be forwarded to Metrowellness, Inc. at 4652 Lawrenceville Hwy NW Suite 102, Lilburn, Georgia 30047.

REQUEST FOR CARE: I voluntarily consent to examination, treatment and the rendering of care, including treatments and performance of diagnostic procedures. I grant my consent for treatment of myself, my spouse or my minor children/dependent listed above.

DIRECT PAYMENT AUTHORIZATION WITHOUT ASSIGNMENT OF BENEFITS: By way of original or a copy hereof, I, the undersigned patient hereby direct my insurance carrier to make payment directly to Metrowellness, Inc. and William J. Cohl, D.C... This assignment includes, but is not limited to, all rights to collect benefits directly from my insurance company for services and treatment that I receive from Metrowellness, Inc. and William J. Cohl, D.C. and all rights to proceed against my insurance company in any action, including legal suit, if for any reason, my insurance company fails to make payment which I am due. I fully agree, understand, that I am responsible for any/all charges not paid by my insurance company. Furthermore, this direct payment authorization with assignment of benefits transfers no right, title or interest in said contract other than the right to receive direct payments and as specified hereinabove. I also authorize Metrowellness, Inc. and William J. Cohl, D.C. to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I further agree that should I directly receive any insurance checks for services rendered by Metrowellness, Inc. and William J. Cohl, D.C., I shall immediately endorse and forward these checks to Metrowellness, Inc., as I have no claim to these checks.

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PRIMARY COMPLAINT: _____

Date of onset: _____ **Did it begin as:** Gradual Sudden Progressive over time

Symptom and Ailments Questionnaire #1
Please check the appropriate box for each question.

Symptoms	Frequently	Occasionally	Rarely	Never
Cold hands, feet, low body temperature				
Fatigue/ tiredness				
Inability to lose weight despite dieting				
Poor memory				
Mucus in your stool				
Poor concentration				
Constipation				
Diarrhea				
Hair loss				
Depression				
Anxiety/ nervousness				
Irregular heart beats				
Trouble sleeping				
Muscle weakness				
Muscle aches				
Joint pain				
Headaches				
Early morning stiffness				
Easy fatigue from exercising				
Sleepiness in the afternoon				
Excessive thirst				
Sugar cravings				
Dizzy/ lightheaded				
Shaky or irritable when hungry				
Easily full when eating				
Belching/ burping				
Rectal itching/ nasal itching				
Toe fungus, jock itch, or athlete's foot				
High sensitivity to smells				
Chronic or long term hives				
Excessive body or foot odor				
Bad breath				
Sinus problems				
Sore throat				
Loss of voice / hoarseness				
Burning or tearing of the eyes				
Easy bruising				
Slow wound healing				
Average bowel movements per day?	(1)	(2)	(3)	(4+)

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Symptom and Ailments Questionnaire #2

Please check the appropriate box for each question.

Symptoms	Frequently	Occasionally	Rarely	Never
Bloating, belching or intestinal gas				
Vaginal burning, itching or discharge				
Prostatitis or prostate cancer				
Mood swings				
Endometriosis or infertility				
Cramps or menstrual irregularities				
Attacks of anxiety or crying				
Thyroid disease				
Shaking or irritability when hungry				
Bladder / kidney infections				
Drowsiness				
Irritability				
Poor concentration				
Trouble sleeping				
Sinus or breathing problems				
Tendency to bruise easily				
Eczema or psoriasis				
Itchy skin or eyes				
Chronic hives (urticaria)				
Indigestion or heartburn				
Decreased body hair				
Sensitivity to milk, wheat or foods				
Decreased sex drive				
Dry mouth or throat				
Bad breath				
White tongue				
Excessive foot, hair or body odor				
PMS pre-menstrual syndrome				
Frequent sore throats				
Laryngitis, loss of voice				
Recurring bronchitis				
Pain or tightness in the chest				
Shortness of breath				
Spots in front of eyes				
Burning or tearing eyes				
Recurring infections in eyes				
Ear pain or ringing				

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Symptom and Ailments Questionnaire #3

Please check the appropriate box for each question.

Symptoms and Ailments	YES	NO
Have you taken multiple courses of a broad-spectrum antibiotic drug—even in a single dose?		
Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis or other problems affecting		
Are you bothered by memory or concentration problems e.g. do you sometimes feel 'spaced out'?		
Do you feel 'sick all over' yet, in spite of visits to many different physicians, no cause has been found?		
Have you been pregnant?		
Have you taken birth control pills longer than 2 years?		
Have you taken steroids orally, by injection or inhalation?		
Does exposure to perfumes, insecticides, fabric shop odors and other chemicals provoke symptoms?		
Does tobacco smoke <i>really</i> bother you?		
Are your symptoms worse on damp, muggy days or in moldy places?		
Have you had athlete's foot, ring worm, 'jock itch' or other chronic fungus infections of the skin or nails?		
Do you crave sugar?		
Do you have high blood pressure?		
Have you ever had angina or a heart attack?		
Have you ever had a stroke?		
Do you have diabetes?		
Do you have swelling that is not known to be the result of another health issue?		
Do you smoke?		
Do you have high cholesterol?		
Have you ever had coronary bypass surgery?		
Is there history of heart disease in your family?		
Are you using any prescription medications or supplements? Please list below:		
Medications:	Supplements:	

What did you have for breakfast: _____

Lunch (yesterday or today): _____

Dinner (yesterday): _____

Snacks (past 24 hours): _____

Beverages (past 24 hours): _____

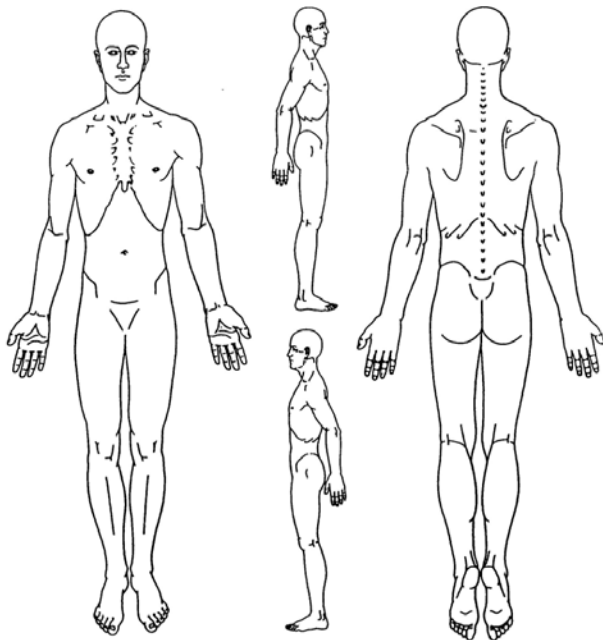
 Patient/Authorized Person Signature Date Witness Date

Pain Symptoms Questionnaire

Please check the appropriate box for each question.

Using the diagram below, indicate any areas you are feeling pain by marking a:

PPP = Pain **NNN**= Numbness **TTT** = Tingling **BBB** = Burning **CCC**= Cramping **XXX** = Other



On a scale of 1-10, with 10 being the worst possible pain, what is your level of pain?

1 2 3 4 5 6 7 8 9 10

Please indicate any other symptoms that you have experienced:

- Dizziness Memory Loss Numb Feet/Toes
- Irritability Ears Ringing Back Pain
- Difficulty Sleeping Fatigue Jaw Problems
- Chest Pain Arm/ Shoulder Pain Leg Pain
- Back Stiffness Blurred Vision Numb Hand/ Fingers
- Tension Low Back Pain Neck Stiffness
- Shortness of Breath Nausea Buzzing in Ear
- Neck Pain Upset Stomach

Other: _____

Check Quality of Pain:

- Stabbing Shooting Dull Constant Intermittent Better /Worse with heat Better/Worse with ice
- Better/Worse with movement Better/Worse sitting Better/Worse standing Better/Worse lying down

How many days a week do you exercise? _____ How long? _____

What type of exercise (s)? _____

Have you ever seen a pain management specialist? NO__ YES__

If yes, what treatments are you currently receiving on a regular basis? (adjustments, physical therapy, medication...) _____

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Environmental Profile

According to the World Health Organization as much as 65% of all illnesses can be caused or made worse by the indoor environment. Numerous chronic diseases, which were once rare, are becoming commonplace as the levels of toxins present in our environment continue to escalate. Many times treatments are rendered ineffective if the environment in which a patient lives is not conducive to the healing process. During the course of your treatment the Dr. Cohl obtains a complete profile of your living environment. This will enable Metrowellness, Inc. to determine if your illness is caused or worsened by your living or working environment and to specifically individualize a treatment program for optimal results.

Please answer the following questions by checking YES or NO:

Question	Yes	No
Are pesticides in your home or office?		
Do you use natural cleaning and laundry products?		
Is the construction of your house less than 15 years old?		
Have you had plumbing leakage, wet carpets or other water damage anywhere in your home?		
Do you have animals live indoors?		
Do you or your neighbors use lawn chemicals?		
Do you have moldy odors, mildew or visible molds anywhere in your home?		
When turning on your heating or air conditioning system(s) do you smell foul or moldy odors?		
Does the dust in your home reappear shortly after dusting?		
Do you have "blown-in" insulation in your attic?		
Are you, or is anyone in your home, experiencing any chronic ailments such as asthma, allergies, sinus infections, respiratory problems, or frequent cold or flu-like symptoms?		
Have you ever had bird, rat, mouse or any rodent infestation in your home?		
Do you have a "crawl-space" or an unfinished basement in your home?		
Do you feel better after you leave your home or office for an extended period of time?		
Do you use only natural products for your skin?		
Do you have moldy odors or visible molds in your workplace?		
Has there ever been water stains on the ceiling tiles, chemical odors, dirty air vents or excessive dust intrusion in your home or workplace?		
Do you frequently feel tired or run-down at the end of a workday?		
Do your family members and co-workers frequently complain of headaches, colds or flu-like symptoms?		
Is smoking permitted in your workplace or home?		
Do you have carpeting in your home or office?		
Do you use a filter for all drinking, cooking and shower/bath water?		
Do you have an air filter in your home or work place?		

What is your current occupation? _____
 If less than one year, what was your prior occupation? _____

 Patient/Authorized Person Signature

 Date

 Witness

 Date