Hogan Health & Chiropractic

11310 Huron St., Ste. 240
Northglenn, CO 80234
303-909-3209
Dr. Jeff Hogan, D.C.

Date:_____

Personal Information

Name:_____ Sex: M F Date of Birth:_____

Address:_____ City:_____

State:_____ Zip: _____ Email:_____

Phone:_____ Soc. Security(for insurance purposes):_____-_____-_____

Height:_____ Weight:_____(lbs)

Have you been to a Chiropractor before? YES NO If YES, WHY and WHEN?_____

How did you hear about us? _____

Occupation: _____ How many hours per week do you work? _____

Most common position at work? SIT STAND KNEEL OVERHEAD WORK OTHER:_____

What Brings You In?

What is your problem/ chief complaint? _____
_____

How did this happen?_____

When did it start?_____

What makes it better?_____

What makes it worse?_____

What type of pain? (circle all that apply): SHARP DULL THROBBING ACHE BURN STABBING STIFF
NUMBNESS SPASM PINS & NEEDLES SHOOTING

Is there a time of day pain is worse?_____

Since it began, it is: UNCHANGED GETTING BETTER GETTING WORSE VARIABLE

Does it interfere with: WORK SLEEP EXERCISE WALKING SITTING HOBBIES

Rate your pain at its best (0-10): _____ Rate your pain at its worst (0-10): _____

How important is your health to you? 0 1 2 3 4 5 6 7 8 9 10

Past Health History

Previous Doctors and Treatments (please list)

DATE	DOCTOR	TREATMENT

Medications and other Conditions (please list)

CONDITION	MEDICATION	START DATE

Any traumas or surgeries? (please list)

DATE	TYPE OF TRAUMA/ SURGERY

Females: Date of beginning of last menstrual period? _____

Is there a possibility you could be pregnant? YES NO

Additional notes/ information:

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Please check all that apply:

	Allergies		Colon trouble		Acne
	Convulsions		Diarrhea		Dry skin
	Dizziness		Digestive issues		Rash
	Depression		Gall Bladder trouble		Varicose veins
	Fainting		Heartburn		Bruise easily
	Fatigue		Hemorrhoids		
	Headaches/ Migraines		Liver trouble		Chest pain
	Decreased energy		Ulcers		Chronic cough
	Sleep problems				Shortness of breath
	Stress		Asthma		Wheezing
	Recreational drug use		Sinus issues		Trouble breathing
			Sore throat		
	Arthritis		Deafness		Bed wetting
	Bursitis		Ringing in ears		Blood in urine
	Foot pain		Earache		Frequent urination
	TMJ/ jaw pain		Eye pain		Inability to control bladder
	Low Back pain		Nasal obstruction		Kidney infection/ stones
	Neck pain		Nosebleeds		Prostate trouble
	Swollen joints				
	Hand pain		High blood pressure		**WOMEN ONLY**
	Numbness/ tingling		Low blood pressure		Irregular cycles
			Rapid heartbeat		Hot flashes
			Swelling in ankles		Cramps/ backache
			Night sweats		Lumps in breast
			High cholesterol		Painful menstruation
					Vaginal discharge

Please check all that apply:

	MEN ONLY		**Alcohol intake:**		**General wellness:**
	Erectile dysfunction		0 drinks per week		Take vitamins & supplements
	Frequent urination		1-3 drinks per week		Get a massage
	Pain while urinating		4-7 drinks per week		Meditate
	Penile discharge		8-12 drinks per week		Partake in Yoga
			12 + drinks per week		See a Chiropractor
	Diet consists of:				Have a pet
	Fruits		**Caffeine intake:**		Have children
	Vegetables		0 drinks per week		Exercise
	Whole grains		1-3 drinks per week		Enjoy nature
	Meat		4-7 drinks per week		
	Seafood		8-12 drinks per week		
	Fast food		12+ drinks per week		
	Sugars and snacks				
			Smoking:		
	Sleep consists of:		0 cigarettes per week		
	3-5 hours per night		1-7 cigarettes per week		
	6-8 hours per night		8-16 cigarettes per week		
	9-12 hours per night		16+ cigarettes per week		

I consent this personal information to be disclosed *only* to Hogan Health & Chiropractic unless written permission is granted to share with other healthcare providers.

Signature:_____ Date:_____

Dr. Jeff Hogan, D.C._____ Date:_____

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Consent to Examination and Treatment

I hereby request and consent to Chiropractic examinations, adjustments, trigger point soft tissue therapy, Graston technique, Dry Needling, Kinesiotaping and other procedures on me (or the patient named below for whom I am legally responsible) by Dr. Jeff Hogan, D.C. at Hogan Health & Chiropractic. I understand in the practice of Chiropractic there are some risks to examination and treatment including, but not limited to, soreness, bruising, fractures, disc injuries, strokes, dislocations, increased symptoms or no improvement. I understand Dr. Jeff Hogan, D.C is unable to anticipate and explain all risks and complications, and I wish to rely on Dr. Jeff Hogan, D.C. judgement based upon clinical findings throughout the examination. I agree this consent form will cover the entire course of treatment of my present condition and any further conditions for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

Signature: _____ Date:_____

Privacy Policy

I hereby give Hogan Health & Chiropractic permission to access and obtain any medical records deemed necessary pertaining to my conditions. I understand that my medical information will not be shared with any persons outside the office without my written consent. I hereby give Hogan Health & Chiropractic permission to forward my medical records to referring physicians, specialists, or therapists who are also involved in my healthcare.

Signature:_____ Date: _____

Transfer of Financial Benefits

I hereby acknowledge and understand it is likely that my insurance carrier will send me insurance checks accompanied by explanation of benefits (EOB) statements for services rendered by Hogan Health & Chiropractic. If the event above occurs, I agree to sign over all of the above mentioned documents to Hogan Health & Chiropractic for compensation of services rendered.

Signature:_____ Date:_____

Dr. Jeff Hogan, D.C._____ Date:_____