



# Hogan Health & Chiropractic

6363 W. 120<sup>th</sup> Ave, Ste. 325  
Broomfield CO 80020  
303-909-3209

Dr. Jeff Hogan, D.C. | Dr. Amanda Simone, 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)

<u>DATE</u>	<u>DOCTOR</u>	<u>TREATMENT</u>

Medications and other Conditions (please list)

<u>CONDITION</u>	<u>MEDICATION</u>	<u>START DATE</u>

Any traumas or surgeries? (please list)

<u>DATE</u>	<u>TYPE OF TRAUMA/ SURGERY</u>

Females:      Date of beginning of last menstrual period? \_\_\_\_\_

Is there a possibility you could be pregnant?      YES      NO

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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	<b>WOMEN ONLY</b>
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:

<b>MEN ONLY</b>	<b>Alcohol intake:</b>	<b>General wellness:</b>
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
<b>Diet consists of:</b>		Have a pet
Fruits	<b>Caffeine intake:</b>	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		
	<b>Smoking:</b>	
<b>Sleep consists of:</b>	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, Dry Needling, Graston technique, Kinesiotaping and other procedures on me (or the patient named below for whom I am legally responsible) by Dr. Jeff Hogan, D.C. and/ or Dr. Amanda Simone, 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 and/ or Dr. Amanda Simone, D.C is unable to anticipate and explain all risks and complications, and I wish to rely on Dr. Jeff Hogan, D.C. and/ or Dr. Amanda Simone, 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: \_\_\_\_\_

Provider: . \_\_\_\_\_

Date: \_\_\_\_\_