CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

This information is needed so we can serve you better. Please fill in as much information as possible, even if it does not apply to your current medical complaints. If you need any help filling this form out, we would be happy to assist you.

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone # _____ Cell / Home Alternate Phone _____

Email: _____

Date of Birth _____/_____/_____ Age: _____ Marital Status: ☐M ☐S ☐D ☐W

Employer: _____ Occupation: _____

Emergency Contact: _____ Their Primary Phone#: _____

Who referred you to this office/how did you hear about us? _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Identification #: _____ Group #: _____

Policy Holder Name: _____

*This office will be happy to file your claim to your Primary Carrier but we do not file to Secondary Carriers (Except on Medicare Primary Claims).

Is this visit due to an Auto or Work related injury? Yes / No

We are happy to offer a consultation at no charge. Examinations and Treatments are charged services. Please inform us if you wish to receive a consultation only.

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred be me in this office are my sole responsibility, despite any insurance plan, legal involvement or settlement.

Patient Signature: _____ Date: _____

Parent or Guardian: _____

Parent or Guardian Signature: _____ Date: _____

Current Primary Complaint

Please provide as much information as possible

1. What primary complaint are you here for? _____
2. When did it begin? _____
3. Did it start suddenly, gradually or develop over time? _____
4. What caused it? _____
5. Describe the quality of the pain. (ie. Sharp, dull, aching, throbbing, etc.) _____
6. Is it constant, frequent, intermittent or occasional? _____
7. What makes it worse? (ie. Bending, lifting, standing, etc) _____

   _____
8. What makes it feel better? _____
9. Try to rate your pain between 0 and 10. Average __ / 10; At Best __ / 10; At Worst __ /10
10. Does the pain radiate? If yes, where? _____
11. Do you experience any numbness or tingling? If yes, where? _____
12. Does it change throughout the day? _____
13. Does it interrupt your sleep? If yes, how often per night? _____
14. Have you taken any over-the-counter meds for it? What? _____
15. Have you seen any other doctors or therapists for this complaint? Who? _____

    _____
16. What have you tried that has not helped your complaint? _____
17. Do you have any secondary complaints? _____

Medical History

Please circle anything you have had in the past.

Anemia	Arrhythmia	Arthritis	Asthma
Back Pain	Sciatica	Broken Bones	Cancer
Depression/Anxiety	Diabetes	Eating Disorder	Emphysema
Epilepsy	Gall Bladder Problem	Glaucoma	Gout
Headaches	Heart Disease	Heart Murmur	Heel Spurs
High Blood Pressure	Kidney Stones	Liver Disease	Lung Disease
Mental Disorder	Neuropathy	Osteopenia	Osteoporosis
Paralysis	Pneumonia	Tendonitis	Dislocations
Prostate Problems	Reflux/Ulcers	Rheumatic Fever	Rheumatoid Arthritis
Seizures/Epilepsy	Sickle Cell	Stroke	Thyroid Disease
Tuberculosis	Concussions	GI Problems	Numbness
Sinus Trouble	Allergies	Weakness	Bleeding Disorder

Surgical History

Please list any surgeries and their approximate dates.

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

Social History

Do you: Smoke Y / N Amount per day? _____
Alcohol Y / N Drinks per week on average? _____
Caffeine Y / N Coffee / Soda / Tea Drinks per day _____
Exercise Y / N How often per week? _____
Work at Desk/Computer Y / N Hours per day? _____
Work Standing Y / N Hours per day? _____
Perform Heavy Labor Y / N

Supplementation

Do you currently take any vitamins or supplements? List any and Brand (if known).

_____
_____

Medication Information

Are you currently taking any medications? Please list them all and the condition they treat.

_____
_____

Do you have any allergies to medication or anything else? List: _____

Does anyone in your family suffer from any significant health conditions, such as cancers, heart problems, diabetes, arthritis? _____
_____

Height____'____" Weight_____lbs

Do you have a history of High Blood Pressure? Yes / No

Patient Signature _____ Date: _____

INFORMED CONSENT TO CHIROPRACTIC CARE

Hogan Family Chiropractic
8700 Main St., Suite 130
Frisco, TX 75034
469-633-0123

Please discuss any questions or concerns with the Doctor before signing this consent.

I hereby request and consent to the performance of an Examination, Chiropractic adjustments and other Chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below for whom I am legally responsible) by the doctor of chiropractic named in this document.

I have had the opportunity to discuss with the doctor and/or any other office or clinic personnel the purpose and benefits of the Chiropractic adjustments and other treatments listed below. Any alternatives to treatment have been review.

Though Chiropractic adjustments and treatments are usually beneficial and seldom any problem. I understand and am informed that there may be some risks to treatment. Risks include, but are not limited to, fractures, strokes, dislocations, sprains, strains, muscle and/or joint tenderness. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. I understand that chiropractic is not an exact science, and that by being treated in this clinic that it does not guarantee results.

I understand that I may be receiving any of the following treatments:

- Chiropractic Adjustments (hands-on or with low force instruments)
- Radiograph Diagnostic X-rays.
- Tractioning of the Spine.
- Electrical Stimulation or Therapeutic Ultrasound
- Ice and/or Heat.
- Rehabilitation Strengthening and Stretching Exercises.

X-RAY CONSENT FORM

The doctor has explained that the purpose of the x-rays about to be taken is to analyze the spine for vertebral Subluxations and to determine the appropriateness of Chiropractic spinal adjustments. If the doctor discovers a non-Chiropractic "unusual finding" when reviewing this x-ray, I will be informed. I then must determine if I should seek the services of an additional health care provider for advice, diagnosis, or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the Subluxation corrective care provided by this office. **Please Note:** Your X-rays are a document of your file and the property of this office.

FEMALES: If you think that you may be pregnant, notify the doctor, as x-rays cannot be taken at this time.
Date of Last Menstrual Cycle_____

I fully understand the above and consent to Chiropractic spinal x-rays. Patient Initials _____

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions, and that all of my questions have been answered to my satisfaction. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment.

Patient Name: _____ Date: _____
Patient Signature: _____ Date: _____
Signature of Parent/Guardian: _____ Date: _____
Staff Signature: _____ Date: _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
(For Private, Group or Accident Related Insurance)

Patient:

Employer:

Claim/Group #:

Insured ID#

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

HOGAN FAMILY CHIROPRACTIC
DR MIKE HOGAN or DR ANDREA FRANCO-HOGAN

as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date:_____ , 20____

_____ _____
Insured Witness