KentHagan
ChiropracticInc.

GENERAL QUESTIONNAIRE

Patient Information:

Name_____Phone ( )_____

Address_____City_____State_____Zip _____

Age_____ Birthdate_____ Sex_____ SSN #_____ E-mail_____

Employer's Name _____ Address_____

City_____State_____Zip _____

Health Insurance Information:

Insurance Co._____ Member ID #_____

Policy Holder's Name_____ Group #_____

HEALTH HISTORY

What is the name of your family physician? _____

What city are they located in? _____

Have you ever had chiropractic care before? _____ If yes, doctor name: _____ Date of last visit: _____

If you are experiencing any pain (neck pain, mid back pain, low back pain, etc.), health problems, symptoms, and/or complaints, please list in order of *severity*

1. _____ Date Problem Began_____ How? _____
2. _____ Date Problem Began_____ How? _____
3. _____ Date Problem Began_____ How? _____
4. _____ Date Problem Began_____ How? _____

Have these problems been getting ☐better, ☐worse or ☐staying the same?

Currently or in the past have you ever experience any of these complaints while working? _____

If yes, please describe what activities at work may be causing you these complaints:_____

Are there any other activities, incidents, or events outside of work that may have caused these complaints?

If yes, please explain: _____

List other doctors consulted for these conditions? _____

Have you at any time in the past ever suffered a **work injury**? _____ If yes, what is the date of the injury?

Have you been involved in an **auto accident** in the last 12 months? _____ Yes _____ No If yes, date of the auto accident? _____

Please check all medications (over the counter and/or prescribed) you are currently taking: ☐Aspirin/Tylenol ☐ Pain killers ☐ Muscle Relaxer ☐ Insulin ☐ Birth Control Pills ☐ Sleeping Pills ☐ Anti-Depressants ☐ Other: _____

_____

Have you ever had any of the following diseases or conditions?

☐**Heart Attack or Stroke**	☐**Cancer**	☐**Sinus Problems**	☐**Difficulty Breathing**	☐**Anemia**
☐**Congenital Heart Defect**	☐**Fainting/Seizure/Epilepsy**	☐**Shingles**	☐**Heart Murmur**	☐**Asthma**
☐**HIV+/Aids**	☐**Diabetes**	☐**Emphysema**	☐**Hepatitis**	☐**Ulcers/Colitis**
☐**High/Low Blood Pressure**	☐**Artificial Bones/Joints**	☐**Kidney Problems**	☐**Heart Surgery or Pacemaker**	☐**Rheumatic Fever**

Please list any other *medical conditions* that you have or have ever had.

_____

Please list any *allergies.* _____

Do you smoke? ☐ YES ☐NO How much? _____ How long? _____

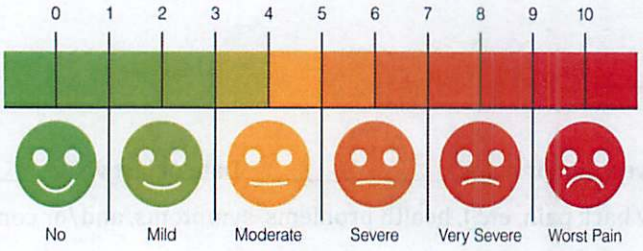
For *women*: Are you taking birth control? ☐YES ☐NO

Are you pregnant? ☐YES ☐NO How long?_____ Nursing? ☐YES ☐NO

Please list previous surgeries and dates. _____

_____

Please indicate the <u>number</u> which best describes your typical level of activities.



WHAT ARE YOUR TREATMENT

Goals:	**Concerns:**
1. _____	**1.** _____
_____	_____
2. _____	**2.** _____
_____	_____

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.) _____

2. RECREATION: hobbies, sports, and other similar leisure time activities._____

3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. _____

4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. _____

5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) _____

6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping and breathing. _____

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. **All first visit charges are payable when services are rendered.**
2. **The fee paid for x-rays is for analysis only. We are required to maintain your original x-rays. X-ray CDs may be loaned to another health provider with your prior authorization only.**

_____ _____

PATIENT'S SIGNATURE **DATE**

HAGAN CHIROPRACTIC & ASSOCIATES

95 Jackson Street
Hayward, CA 94544
Telephone: (510) 581-5813

Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first few days of treatment.
2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue, which I check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

Patient Signature Patient Name

_____

Witness Signature

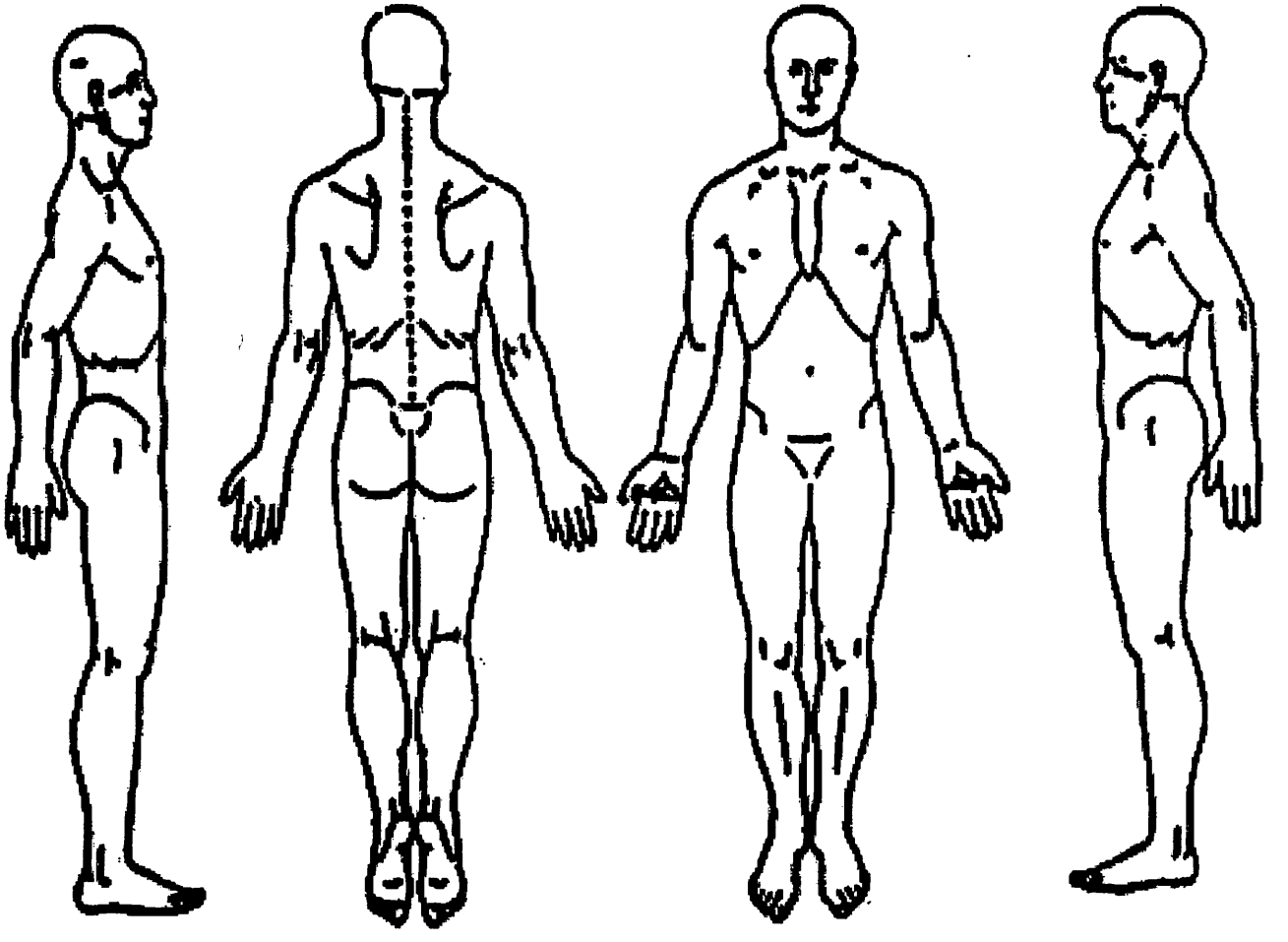
_____

Date

Dr. Kent Hagan, D.C. Dr. Jennifer Gong, D.C. Dr. Don Ehasz, D.C.

Name _____ Date _____

On the diagram below, please indicate where you are CURRENTLY experiencing pain or other symptoms.



A = ACHE
P = PINS & NEEDLES

B = BURNING
S = STABBING

N = NUMBNESS
O = OTHER

FINANCIAL POLICY

We offer several methods of payment for your chiropractic care and you may choose the plan which best suit your needs. Please read carefully and choose the plan which you prefer. This information will enable us to better serve you and help us to avoid misunderstandings in the future. If special financial arrangements are necessary, please consult with the business manager during your initial consultation.

OUR MAIN CONCERN IS YOUR HEALTH AND WELL-BEING AND WE WILL DO OUR BEST TO HELP YOU.

PLAN ONE:
The **self-pay** plan means that all fees will be paid when rendered. Fees are discounted for payment at the time of service.

PLAN TWO:
If you have **insurance,** we will bill for you as a courtesy. Payment for deductibles, if it has not been met is the responsibility of the patient as well as any copayment or remaining balance after insurance payment. We do participate in many insurance plans that may allow nominal out of pocket expense. **Your co-pay is due as services are rendered.** You are also responsible for portions of your bill that exceed your insurance limits.

Credit Cards will be accepted for all or partial payment.

If care is discontinued, the balance for care received up to that date is due in full in 30 days.

I understand that all responsibility for payment of services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. I permit this office to endorse co-issued remittances for the conveyances of credit to my account. In the event payments are not received by the agreed upon dates, I understand that a _5_% finance charge (_10_% APR) will be added to my account. I agree to pay all attorneys and collection fees if this account is turned over for collection.

PLEASE ADVISE WHICH PLAN YOU WOULD LIKE TO USE:_____

Please sign below to indicate your understanding of our financial policies. If you do not understand, please allow us to review the policies with you until they are clear.

_____Date:_____
Signature

_____
Print Name

_____Date:_____
Witness