CONFIDENTIAL PATIENT CASE HISTORY HOGAN CHIROPRACTIC SERVICES

Dear Patient: Please complete *both sides* of this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. DR WAYNE HOGAN

NAME: _____ **PHONE** _____ **CELL** _____ **EMAIL** _____

ADDRESS: _____ **DATE** _____

DATE OF BIRTH: _____ **AGE:** _____ **M** ○ **F** ○ **MARITAL STATUS:** _____ **NO. OF CHILDREN:** _____

OCCUPATION: _____ **SOCIAL SECURITY NUMBER:** _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ **REFERRED BY:** _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

N = NEVER **(Check one)**
O = OCCASIONAL
F = FREQUENT
C = CONSTANT

THIS IS A CONFIDENTIAL HEALTH REPORT.

N O F C GENERAL
- ☐☐☐☐ Allergy
- ☐☐☐☐ Chills
- ☐☐☐☐ Convulsions
- ☐☐☐☐ Dizziness
- ☐☐☐☐ Fainting
- ☐☐☐☐ Fatigue
- ☐☐☐☐ Fever
- ☐☐☐☐ Headache
- ☐☐☐☐ Loss Of Sleep
- ☐☐☐☐ Loss Of Weight
- ☐☐☐☐ Nervousness/Depression
- ☐☐☐☐ Neuralgia
- ☐☐☐☐ Numbness
- ☐☐☐☐ Sweats
- ☐☐☐☐ Tremors

N O F C MUSCLES & JOINTS
- ☐☐☐☐ Arthritis
- ☐☐☐☐ Bursitis
- ☐☐☐☐ Foot Trouble
- ☐☐☐☐ Hernia
- ☐☐☐☐ Low Back Pain Lumbago
- ☐☐☐☐ Neck Pain or Stiffness
- ☐☐☐☐ Temporomandibular Joint
- ☐☐☐☐ Pain Between Shoulders

N O F C Pain Or Numbness In:
- ☐☐☐☐ Shoulders
- ☐☐☐☐ Arms
- ☐☐☐☐ Elbows
- ☐☐☐☐ Hands
- ☐☐☐☐ Hips
- ☐☐☐☐ Legs
- ☐☐☐☐ Knees
- ☐☐☐☐ Feet
- ☐☐☐☐ Painful Tail Bone
- ☐☐☐☐ Poor Posture
- ☐☐☐☐ Sciatica
- ☐☐☐☐ Spinal Curvature Swollen
- ☐☐☐☐ Joints

N O F C GASTRO-INTESTINAL
- ☐☐☐☐ Belching Or Gas
- ☐☐☐☐ Colitis
- ☐☐☐☐ Colon Trouble
- ☐☐☐☐ Constipation
- ☐☐☐☐ Diarrhea
- ☐☐☐☐ Difficult Digestion
- ☐☐☐☐ Distension Of Abdomen
- ☐☐☐☐ Excessive Hunger
- ☐☐☐☐ Gall Bladder Trouble
- ☐☐☐☐ Hemorrhoids
- ☐☐☐☐ Intestinal Worms
- ☐☐☐☐ Jaundice
- ☐☐☐☐ Liver Trouble
- ☐☐☐☐ Nauasea
- ☐☐☐☐ Pain Over Stomach
- ☐☐☐☐ Poor Appetite
- ☐☐☐☐ Vomiting
- ☐☐☐☐ Vomiting Of Blood

N O F C EYES, EARS, NOSE, & THROAT
- ☐☐☐☐ Asthma
- ☐☐☐☐ Colds
- ☐☐☐☐ Crossed Eyes
- ☐☐☐☐ Deafness
- ☐☐☐☐ Dental Decay
- ☐☐☐☐ Earache
- ☐☐☐☐ Ear Discharge
- ☐☐☐☐ Ear Noise
- ☐☐☐☐ Enlarged Glands
- ☐☐☐☐ Enlarged Thyroid
- ☐☐☐☐ Eye Pain
- ☐☐☐☐ Failing Vision
- ☐☐☐☐ Far-Sightedness
- ☐☐☐☐ Nosebleeds
- ☐☐☐☐ Sinus Infection
- ☐☐☐☐ Sore Throat
- ☐☐☐☐ Tonsillitis

N O F C CARDIO -VASCULAR
- ☐☐☐☐ Hardening Of The Arteries
- ☐☐☐☐ High Blood Pressure
- ☐☐☐☐ Low Blood Pressure
- ☐☐☐☐ Pain Over Heart
- ☐☐☐☐ Poor Circulation
- ☐☐☐☐ Rapid Heart Beat
- ☐☐☐☐ Slow Heart Beat
- ☐☐☐☐ Swelling Of Ankles

N O F C RESPIRATORY
- ☐☐☐☐ Chest Pain
- ☐☐☐☐ Chronic Cough
- ☐☐☐☐ Difficult Breathing
- ☐☐☐☐ Spitting Up Blood
- ☐☐☐☐ Spitting Up Phlegm
- ☐☐☐☐ Wheezing

N O F C SKIN
- ☐☐☐☐ Boils
- ☐☐☐☐ Bruise Easily
- ☐☐☐☐ Dryness
- ☐☐☐☐ Hives Or Allergy
- ☐☐☐☐ Itching
- ☐☐☐☐ Skin Eruptions (rash)
- ☐☐☐☐ Varicose Veins

N O F C GENITO-URINARY
- ☐☐☐☐ Bed-Wetting
- ☐☐☐☐ Blood In Urine
- ☐☐☐☐ Frequent Urination
- ☐☐☐☐ Inability To Control Kidneys
- ☐☐☐☐ Kidney Infection Or Stones
- ☐☐☐☐ Painful Urination
- ☐☐☐☐ Prostate Trouble

N O F C FOR WOMEN ONLY
- ☐☐☐☐ Congested Breasts
- ☐☐☐☐ Cramps Or Backache
- ☐☐☐☐ Excessive Menstrual Flow
- ☐☐☐☐ Hot Flashes
- ☐☐☐☐ Irregular Cycle
- ☐☐☐☐ Lumps In Breast
- ☐☐☐☐ Menopausal Symptoms
- ☐☐☐☐ Painful Menstruation
- ☐☐☐☐ Vaginal Discharge
- ☐ Yes ☐ No: Are You Pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Chorea
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Diptheria
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Whooping Cough

Have you ever had previous Chiropractic care? YES ○ **NO** ○ **If yes, date of last care:** _____

Do you have Health and Accident Insurance? YES ○ **NO** ○ **If yes, Practioner Name:** _____

Is this an Industrial Accident Case? YES ○ **NO** ○

Confidential Patient Case History Hogan Chiropractic Services 2

What is your major complaint? _____
_____

Other Complaints? _____
How Long Have You Had This Condition? _____ Have You Had This Or Similar Conditions In The Past? _____
What Activities Aggravate Your Condition? _____

Is This Condition Getting Progressively Worse? ○Yes ○No ☐Constant ☐Comes And Goes
Is This Condition Interfering With Your : ☐Work ☐Sleep ☐Daily Routine ☐ Other _____

How Long Has It Been Since You Really Felt Good? _____
What Do You Believe Is Wrong With You? _____
List Surgical Operations And Years: _____
_____

Drugs You Now Take: ☐Nerve Pills ☐Pain Killers ☐Muscle Relaxers ☐ Tranquilizers ☐ Insulin ☐Birth Control Pills ☐Other _____
Dental Visits: ○Every Six Months ○Yearly ○Toothache or "Emergency" Only ○Complete Dentures
Age Of Mattress: _____ ○Comfortable ○Uncomfortable — Do You Have A Bed Board? _____
Are You Wearing: ☐Heel Lifts ☐Sole Lifts ☐Inner Soles ☐Arch Supports
Have You Been In An Automobile Accident? ☐Past Year ☐Past 5 Years ☐Over 5 Years ☐Never
Describe: _____
Have You Had Any Other Personal Injury Or Accident? (Broken Bones, Sit Down Falls, Head Injuries -Think back to your childhood)
☐Past Year ☐ Past 5 Years ☐Over 5 Years ☐Never *Describe: _____
Have You Ever Had Any Mental Or Emotional Disorders? ○Yes ○No *When? _____
Have Others In Your Family Had Such Disorders? ○Yes ○No *When? _____

*To allow you more space **for the above 3 answers,** they will continue at the bottom of the next page.

FAMILY HEALTH INFORMATION. (Many Health Problems Are The Result Of Heredetary Spinal Weaknesses; Thus Information About Your Family Members Will Give Us A Better Understanding Of Your Total Health Picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER: DESCRIBE BRIEFLY

Been Knocked Unconscious?	○Yes	○No	_____
Used A Cane, Crutch, Or Other Support?	○Yes	○No	_____
Been Treated For A Spine Or Nervous Disorder?	○Yes	○No	_____
Had A Fractured Bone?	○Yes	○No	_____
Been Hospitalized For Other Than Surgery?	○Yes	○No	_____

DO YOU:

Now Take Vitamins Or Minerals?	○Yes	○No	_____
Think You May Need Vitamins Or Minerals?	○Yes	○No	_____
Have An Allergy To Any Drug?	○Yes	○No	_____

DATE OF LAST:

Spinal Examination	○Less Than 6 Mo.	○6-18 Mo.	○Over 18 Mo.	○Never
Physical Examination	○Less Than 6 Mo.	○6-18 Mo.	○Over 18 Mo.	○Never
Blood Test	○Less Than 6 Mo.	○6-18 Mo.	○Over 18 Mo.	○Never
Chest X-Ray	○Less Than 6 Mo.	○6-18 Mo.	○Over 18 Mo.	○Never
Spinal X-Ray	○Less Than 6 Mo.	○6-18 Mo.	○Over 18 Mo.	○Never
Dental X-Ray	○Less Than 6 Mo.	○6-18 Mo.	○Over 18 Mo.	○Never
Urine Test	○Less Than 6 Mo.	○6-18 Mo.	○Over 18 Mo.	○Never

HABITS

• Alcohol	○Heavy	○Moderate	○Light	○None
• Tobacco	○Heavy	○Moderate	○Light	○None
• Exercise	○Heavy	○Moderate	○Light	○None
• Appetite	○Heavy	○Moderate	○Light	○None
• Coffee	○Heavy	○Moderate	○Light	○None
• Drugs	○Heavy	○Moderate	○Light	○None
• Sleep	○Heavy	○Moderate	○Light	○None

In Case Of Emergency: (Name of relative or close friend not living in your home) Name: _____
Address: _____
Phone Number: _____

Please use this additional space for any other significant information you may feel is important for us to know.

****Additional Room from Answers on Previous Page Continued Here.**

Have you had any other personal injury or accident? Broken bones, sit down falls, head injuries - think back to your childhood.

Have you ever had any mental or emotional disorders?

Have others in your family had such disorders?

HOGAN CHIROPRACTIC SERVICES

SUBSTANCE SURVEY FORM

Wayne A. Hogan D.C.
P.O. Box 591
Mechanicville, NY 12118
(518) 664-5281
Fax (518) 664-2106

NAME_____ DATE_____

Please list any prescription medications you are taking:

Medications	Diagnosis

Please list any over-the-counter medications you use:

Medications	Symptom	Frequency (Occasional, Often, Daily)

(Additional space is provided on the next page for medications.)

Please list any vitamins, supplements, herbs, or homeopathic remedies (Use other side if necessary)

Supplement	Amount Taken Daily	How long taken

Do you use: Amount Per Day

Coffee _____
Tea _____
Soft Drinks _____
Candy _____
Cigarettes _____
Alcohol _____
Antacids _____
Other Tobacco Products_____

How many desserts do you have in an average week: _____

Please list any over-the-counter medications you use:

Medications	Symptom	Frequency (Occasional, Often, Daily)

HOGAN CHIROPRACTIC SERVICES

Wayne A. Hogan D.C.
P.O. Box 591
Mechanicville, NY 12118
(518) 664-5281
Fax (518) 664-2106

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please choose the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain 0 1 (2) 3 4 (5) 6 7 (8) 9 10 **worst possible pain**

---

1 – What is your pain RIGHT NOW?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

2 – What is your TYPICAL or AVERAGE pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

OTHER COMMENTS:

_____

_____

_____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

HOGAN CHIROPRACTIC SERVICES

Wayne A. Hogan D.C.
P.O. Box 591
Mechanicville, NY 12118
(518) 664-5281
Fax (518) 664-2106

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

Total Score _____

** _____
Signature

_____
Date

**You specifically agree that any electronic signatures that you provide through this online process are valid and enforceable as your legal signature acknowledge that these electronic signatures will legally bind you to the terms and conditions cont in the related documents just as if you had physically signed the same documents with a pen.

Hogan Chiropractic Services

2018 Appointment Cancellation Policy Agreement:

Hogan Chiropractic Services is committed to providing all patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at (518) 664-5281 by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. **To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday prior.** If prior notification is not given, you will be charged* in full for the missed appointment.

All accounts must be **paid in full** prior to any future visits.

New Patient appointment changes or cancellations must be done 7 days prior to your new patient scheduled appointment. If prior notification is not given you will be ***charged in full*** for your missed appointment.

Please sign below to consent to these terms.

_____

Client Signature**

_____

(Client's Parent/Guardian if under 18)**

Only in Emergency circumstances will this fee be waived and at our discretion.

**You specifically agree that any electronic signatures that you provide through this online process are valid and enforceable as your legal signature acknowledge that these electronic signatures will legally bind you to the terms and conditions cont in the related documents just as if you had physically signed the same documents with a pen.

HOGAN CHIROPRACTIC SERVICES

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, and your responsibilities.

Full payment is expected at the time of service, unless prior arrangements have been made. We will accept a check, cash or credit card.

UNACCOMPANIED MINORS
The parents (or guardians) are responsible for payment at the time of service.

REGARDING INSURANCE
If you have insurance, we will do our best to help you receive your maximum benefits.

With the focus in our practice changing to wellness and prevention, we have found that MEDICARE has deemed our services medically unnecessary. That means that they are not covered services.

Since we do not accept insurance, you will be responsible for any fees. But in an effort to help you collect your benefits**, if you do have insurance that covers the type of Chiropractic care that we provide**, we will give you a statement with all of the necessary information on it so you can submit it for reimbursement. Please ask for clarification at the front desk if necessary.

Insurance is a contract between you and your insurance company. We are not a party to this contract, in most cases. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding **deductibles, copayments, covered charges, secondary insurance, "usual and customary" charges, etc.,** other than to supply factual information as necessary. **You are responsible for timely payment of your account**.

NEW PATIENT INFORMATION
We will call to confirm the scheduled new patient appointment at least 24 hours in advance. If the patient is not able to be contacted, we ask that you, the patient, contact our office at 664-5281, and leave a message confirming or canceling the appointment. If the appointment is not confirmed or canceled, it will be filled that day on a priority basis, and billed at the rate of a normal new patient visit.

MISSED APPOINTMENT
Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

RESPONSIBLE PARTY SIGNATURE:**_____

DATE:_____

**You specifically agree that any electronic signatures that you provide through this online process are valid and enforceable as your legal signature acknowledge that these electronic signatures will legally bind you to the terms and conditions cont in the related documents just as if you had physically signed the same documents with a pen.

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of June 1st, 2018. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient Name Printed	Date
Patient Signature**	Authorized Provider Representative**
Personal Representative Printed	Personal Representative Signature**

Description of personal representative's authority to act for the patient.

**You specifically agree that any electronic signatures that you provide through this online process are valid and enforceable as your legal signature acknowledge that these electronic signatures will legally bind you to the terms and conditions cont in the related documents just as if you had physically signed the same documents with a pen.

Consent for Use or Disclosure of Health Information

Our Privacy Policy (HIPPA Regulations)

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

_____	_____
Printed Name	Authorized Provider Representative**
_____	_____
Signature**	Date
_____	
Date	

**You specifically agree that any electronic signatures that you provide through this online process are valid and enforceable as your legal signature acknowledge that these electronic signatures will legally bind you to the terms and conditions cont in the related documents just as if you had physically signed the same documents with a pen.

HOGAN CHIROPRACTIC SERVICES

Wayne A. Hogan D.C.
P.O. Box 591
Mechanicville, NY 12118
(518) 664-5281
Fax (518) 664-2106

Patient Name: _____

Date: _____

RAND 36-Item Short Form Health Survey

RAND Health | Surveys and Tools | Medical Outcomes Studies | http://www.rand.org/health/surveys_tools/mos/mos_core_36item_survey.html

1. In general, would you say your health is:	
Excellent	1 ○
Very Good	2 ○
Good	3 ○
Fair	4 ○
Poor	5 ○

2. Compared to one year ago, how would you rate your health in general now?	
Much better now than one year ago	1 ○
Somewhat better now than one year ago	2 ○
About the same	3 ○
Somewhat worse now than one year ago	4 ○
Much worse than one year ago	5 ○

The following items are about activities you might do during a typical day. **Does your health now limit you** in these activities? If so, how much?

Choose One Number On Each Line

	Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited at All
3. **Vigorous Activities,** such as running, Lifting heavy objects, participating In strenuous sports	1 ○	2 ○	3 ○
4. **Moderate activities**, such as moving a table, Pushing a vacuum cleaner, bowling, Or playing golf	1 ○	2 ○	3 ○
5. Lifting or carrying groceries	1 ○	2 ○	3 ○
6. Climbing **several** flights of stairs	1 ○	2 ○	3 ○
7. Climbing **one** flight of stairs	1 ○	2 ○	3 ○
8. Bending, Kneeling, or Stooping	1 ○	2 ○	3 ○
9. Walking **more than a mile**	1 ○	2 ○	3 ○
10. Walking **several blocks**	1 ○	2 ○	3 ○
11. Walking **one block**	1 ○	2 ○	3 ○
12. Bathing or dressing yourself	1 ○	2 ○	3 ○

During the **past 4 weeks,** have you had any of the following problems with your work or other regular daily activities **as a result of your *physical* health?**

Choose One Number On Each Line

	Yes	No
13. Cut down the **amount of time** you spent on work or other activities	1 ○	2 ○
14. **Accomplished less** than you would like	1 ○	2 ○
15. Were limited in the **kind** of work or other activities	1 ○	2 ○
16. Had **difficulty** performing the work or other activities (for example, it took extra effort)	1 ○	2 ○

During the **past 4 weeks,** have you had any of the following problems with your work or other regular daily activities **as a result of any *emotional* problems** (such as feeling depressed or anxious)?

Choose One Number On Each Line

	Yes	No
17. Cut down the **amount of time** you spent on work or other activities	1 ○	2 ○
18. **Accomplished less** than you would like	1 ○	2 ○
19. Didn't do work or other activities as **carefully** as usual	1 ○	2 ○

20. During the **past 4 weeks,** to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?
(Choose One Number)

- Not at all 1 ○
- Slightly 2 ○
- Moderately 3 ○
- Quite a bit 4 ○
- Extremely 5 ○

21. How much **bodily** pain have you had during the **past 4 weeks**?

Choose One Number

None	1 ○
Very Mild	2 ○
Mild	3 ○
Moderate	4 ○
Severe	5 ○
Very Severe	6 ○

22. During the **past 4 weeks** how much did **pain** interfere with your normal work (including both work outside the home and housework)?

Choose One Number

Not at all	1 ○
A Little Bit	2 ○
Moderately	3 ○
Quite a bit	4 ○
Extremely	5 ○

These questions are about how you feel and how things have been with you **during the past 4 weeks.** For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the **past 4 weeks…**

Choose One Number On Each Line

	All of The Time	Most Of The Time	A Good Bit of The Time	Some Of The Time	A Little Of The Time	None of the Time
23. Did you feel full of pep?	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○
24. Have you been a very nervous person?	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○
25. Have you felt so down in the dumps that nothing could cheer you up?	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○
26. Have you felt calm and peaceful?	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○
27. Did you have a lot of energy?	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○

Choose One Number On Each Line	All of The Time	Most Of The Time	A Good Bit of The Time	Some Of The Time	A Little Of The Time	None of the Time
28. Have you felt downhearted and blue?	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○
29. Did you feel worn out?	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○
30. Have you been a happy person?	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○
31. Did you feel tired?	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○

32. During the **past 4 weeks,** how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

Choose One Number

All of the time **1** ○
Most of the time **2** ○
Some of the time **3** ○
A little of the time **4** ○
None of the time **5** ○

How TRUE or FALSE is **each** of the following statements for you.

Choose One Number On Each Line

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
33. I seem to get sick a little easier than other people	1 ○	2 ○	3 ○	4 ○	5 ○
34. I am as healthy as anybody I know	1 ○	2 ○	3 ○	4 ○	5 ○
35. I expect my health to get worse	1 ○	2 ○	3 ○	4 ○	5 ○
36. My health is excellent	1 ○	2 ○	3 ○	4 ○	5 ○

Have you taken this survey through this office before? ○ **NO** ○ **YES**
IF YES - Have you had a new injury or illness since your last survey? ○ **NO** ○ **YES**
Date of onset: _____ ***Details of illness or injury:*** _____
_____

HOGAN CHIROPRACTIC SERVICES

Wayne A. Hogan D.C.
P.O. Box 591
Mechanicville, NY 12118
(518) 664-5281

NAME _____ **DATE** _____

Ion Cleanse Checklist

INTRODUCTION

The IonCleanse is intended to support herbal, homeopathic, and vitamin detoxification protocols and procedures. Used properly, the *IonCleanse* provides a comfortable and relaxing way to rid the body of toxins without precipitating healing crises and Herksheimer's reactions

CONTRAINDICATIONS : Any person falling into one or more of the categories listed below should not use the *IonCleanse* **BEFORE** discussing with the doctor. Please check the appropriate box for each question.

Yes	No	
☐	☐	**Do you wear a pacemaker or any other battery operated or electrical implant?**
☐	☐	**Are you on heartbeat regulating medication?**
☐	☐	**Are you an organ transplant recipient**?
☐	☐	**Are you taking any medication, the absence of which would mentally or physically incapacitate you, such as psychotic episodes, seizures, etc.**

The following recommendations should be strongly considered and discussed with the doctor:

Yes	No	
☐	☐	**Are you taking medications that require that a blood level be maintained in order to be effective** (for example, blood pressure medication)?. Try to schedule your *IonCleanse* session just before the taking of a medication so that proper blood levels of medication can be maintained.
☐	☐	**Do you tend to have problems with low blood sugar?** If so, you should eat before receiving a session. The *IonCleanse* tends to lower blood sugar in diabetics and may do so with those who are hypiglycemic.
☐	☐	**Are you pregnant or breast-feeding?** Pregnant women and breast-feeding mothers are not routinely bathed in the *IonCleanse* because toxins will be mobilized from tissues and fats that **could** impair fetal development and **may** become part of the milk that is fed to a newborn infant. (**Note:** Pregnant and lactating women have used the *IonCleanse* without harm, but in general we recommend being on the safe side...)
☐	☐	**Do you have metal joint implants?** Most people with metal joint implants have had no trouble taking sessions with the *IonCleanse*. Some people have found the exposure to an electromagnetic field to be uncomfortable. In the event of discomfort, the session can be stopped immediately by removing feet from the water.
☐	☐	**Are you taking insulin for diabetes or on kidney dialysis?** In general, the *IonCleanse* can be used safely with dialysis patients, insulin-dependent diabetics, and in patients with congestive heart failure. Gentle detoxification will help the body to eliminate the toxins that the kidney and heart cannot eliminate on their own and will not interfere with medications or deplete insulin levels.

If you have special needs or concerns, we can contact the developer of this instrument to answer any questions not addressed here.

NAME_____

Date	Session #	Comments and Observations
	1	
	2	
	3	
	4	
	5	
	6	
	7	
	8	
	9	
	10	
	11	
	12	
	13	
	14	
	15	
	16	
	17	
	18	
	19	
	20	
	21	
	22	
	23	
	24	
	25	
	26	
	27	
	28	
	29	
	30	