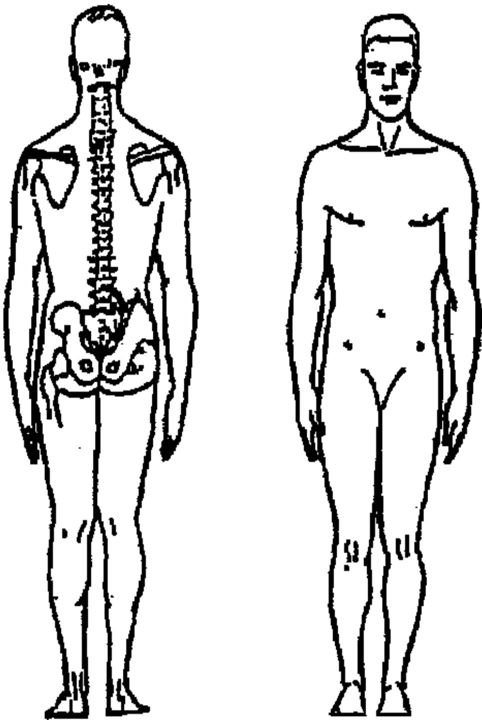
INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. **PLEASE PRINT**.

Name _________________________________ **Birth date** _________________ Today's Date________________
Address _______________________________ City __________________ State ________ Zip ________________
Phone: Home ______________ __Work _______________________Cell _____________________
E-Mail Address _______________________________Marital Status: S M W D Number of Children _____
Please circle one **payment type:** Cash Check Master Card/Visa American Express Discover

Your Employer ______________________________ Occupation ____________________ Years On Job ____ Employer Address _____________________________ City _____________________ State _____ Zip ______

Name of Spouse or Parent ______________________ Their Birth date _____________ Phone # _______________
Spouse Employed By ____________________________ Occupation __________________Years On Job ____
Employer Address ______________________________ City ____________________ State _____ Zip ______



COMPLETE THESE DIAGRAMS

If you are in pain, **please mark the exact location of your pain** on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc.

MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)

____
____
____
____
____

Is your condition due to an accident? Yes _____ No _____ Date _______________

Type of accident? Auto _____ Work/On Job _____ At Home _____ Other ______________________
Have you ever been in an auto accident? Past Year ____ Past 5 Years ____ Over 5 Years ____ Never ____

I/we agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due /payable.

Patient's Signature ____ Date _______________________
Or Guardian Signature ____ Date _______________________

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

***__Insurance cases:__** On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.

Confidential Patient Case History

Dear Patient: Please complete 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. THANK YOU.

Full Name ____ *Birth* Date ______________________

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL F – FREQUENT
C – CONSTANT

O F C

GENERAL

☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Fever
☐ ☐ ☐ Headache
☐ ☐ ☐ Loss of sleep
☐ ☐ ☐ Loss of weight
☐ ☐ ☐ Nervousness/depression
☐ ☐ ☐ Neuralgia
☐ ☐ ☐ Numbness
☐ ☐ ☐ Sweats
☐ ☐ ☐ Tremors

MUSCLE & JOINT

☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot trouble
☐ ☐ ☐ Hernia
☐ ☐ ☐ Low back pain
☐ ☐ ☐ Lumbago
☐ ☐ ☐ Neck pain or stiffness
☐ ☐ ☐ Pain between shoulders
Pain or numbness in:
☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Hands
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet
☐ ☐ ☐ Painful tail bone
☐ ☐ ☐ Poor posture
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Spinal Curvature
☐ ☐ ☐ Swollen joints

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
☐ ☐ ☐ Nausea
☐ ☐ ☐ Pain over stomach
☐ ☐ ☐ Poor appetite
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Vomiting of blood

EYES, EARS, NOSE &THROAT

☐ ☐ ☐ Asthma
☐ ☐ ☐ Colds
☐ ☐ ☐ Crossed eyes
☐ ☐ ☐ Deafness
☐ ☐ ☐ Dental Decay
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear discharge
☐ ☐ ☐ Ear noises
☐ ☐ ☐ Enlarged glands
☐ ☐ ☐ Enlarged thyroid
☐ ☐ ☐ Eye pain
☐ ☐ ☐ Failing vision
☐ ☐ ☐ Far sightedness
☐ ☐ ☐ Gum trouble
☐ ☐ ☐ Hay fever
☐ ☐ ☐ Hoarseness
☐ ☐ ☐ Nasal obstruction
☐ ☐ ☐ Near sightedness
☐ ☐ ☐ Nosebleeds
☐ ☐ ☐ Sinus infection
☐ ☐ ☐ Sore throat
☐ ☐ ☐ Tonsillitis

O F C

CARDIO-VASCULAR

☐ ☐ ☐ Hardening of arteries
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ Pain over heart
☐ ☐ ☐ Poor circulation
☐ ☐ ☐ Rapid heart beat
☐ ☐ ☐ Slow heart beat
☐ ☐ ☐ Swelling of ankles

RESPIRATORY

☐ ☐ ☐ Chest pain
☐ ☐ ☐ Chronic cough
☐ ☐ ☐ Difficult breathing
☐ ☐ ☐ Spitting up blood
☐ ☐ ☐ Spitting up phlegm
☐ ☐ ☐ Wheezing

SKIN

☐ ☐ ☐ Boils
☐ ☐ ☐ Bruise easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Hives or allergy
☐ ☐ ☐ Itching
☐ ☐ ☐ Skin eruptions (rash)
☐ ☐ ☐ Varicose veins

GENITO-URINARY

☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Blood in urine
☐ ☐ ☐ Frequent urination
☐ ☐ ☐ Inability to control kidneys
☐ ☐ ☐ Kidney infection or stones
☐ ☐ ☐ Painful urination
☐ ☐ ☐ Prostate trouble
☐ ☐ ☐ Pus in urine

FOR WOMEN ONLY

☐ ☐ ☐ Congested breasts
☐ ☐ ☐ Cramps or backache
☐ ☐ ☐ Excessive menstrual flow
☐ ☐ ☐ Hot flashes
☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ Menopausal symptoms
☐ ☐ ☐ Painful menstruation
☐ ☐ ☐ Vaginal discharge
☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Miscarriage	☐ Scarlet fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Appendicitis	☐ Diphtheria	☐ Heart disease	☐ Mumps	☐ Tuberculosis
☐ Arteriosclerosis	☐ Eczema	☐ Influenza	☐ Pleurisy	☐ Typhoid fever
☐ Arthritis	☐ Emphysema	☐ Lumbago	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Polio	☐ Venereal disease
☐ Chorea	☐ Fever blisters	☐ Measles	☐ Rheumatic fever	☐ Whooping cough

Confidential Patient Case History

What is your major complaint? ____

List surgical operation and years: ____

____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers ☐ Birth control pills

Others: ____

Age of mattress: ____________________ ☐ Comfortable ☐ Uncomfortable ☐ Do you use a bed board? _________

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never (Describe on back of page)

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? ____________________________

Have others in your family had such disorders? ☐ Yes ☐ No When? ______________________________

HAVE YOU EVER:	Yes	No	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	_______________________________
Used a cane, crutch, or other support?	☐	☐	_______________________________
Been treated for a spine or nerve disorder?	☐	☐	_______________________________
Had a fractured bone?	☐	☐	_______________________________
Been hospitalized for anything other than surgery?	☐	☐	_______________________________

DO YOU:			
Now take vitamins or minerals?	☐	☐	_______________________________
Have an allergy to any drug?	☐	☐	_______________________________

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X- ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

IN CASE OF EMERGENCY: (Name of relative or close friend): NAME __________________________ PHONE:____________________

Suggestions to Follow During Spinal Correction

1. Avoid rubbing, probing, or "poking" in the areas your doctor adjusts.
2. Avoid sudden twists or turns of movement beyond normal limits of motion, especially of the neck.
3. Avoid extreme bending of your spine in any direction; avoid stretching, reaching, or other overhead work. Be particularly careful when brushing or shampooing your hair.
4. Avoid bending or stooping sharply to pick up objects; rather, bend your knees to minimize the strain on your lower back.
5. When lifting, keep your back straight; bend your knees and let your legs bear the strain. Hold the object lifted as close to your body as possible.
6. When bathing, sit rather than recline in the tub. Lying back against the tub may cause a vertebra to slip out of its normal position. If you are tired and wish to relax it's better to lie in bed.
7. Participate in simple exercises to strengthen your body but avoid jarring activities which place stress on your neck and spine.
8. Watch your posture at all times; stand tall, sleep tall, and THINK tall!

Rest, Relaxation, and Sleep

1. Set aside a special time each day for complete mental and physical relaxation. This is important in the restoration – as well as maintenance – of normal health.
2. When sitting, choose a chair that has adequate firmness to hold your weight comfortably, and then sit straight. Avoid too soft, overstuffed chairs. Recliner chairs are acceptable if they are constructed so that when you are reclining your back is in a normal, straight position.
3. Cross your legs only at the ankles, not at the knees. Crossing your legs at the knees could aggravate an existing back condition as well as interfere with the circulation to the lower limbs.
4. Be sure to get plenty of sleep to allow your body to recuperate and repair.
5. Sleep on a firm mattress, preferably one which is neither too hard nor too soft, but just firm enough to hold your body level while at the same time soft enough so that your shoulders, buttocks, etc., will depress into the mattress.
6. Your pillow should be neither too high nor too low. The ideal pillow is one which supports your head so that your neck vertebrae will be level with the rest of your spine. Avoid sleeping on two pillows; never lie on a couch with your head on the arm rest.
7. Sleep on your back or on your side with your legs flexed slightly, not drawn up tightly. Avoid sleeping on your stomach. Raise your head off the pillow when changing positions.
8. Rise from your bed by turning on your side and swinging your legs off the bed, then push yourself into a sitting position with your arms, thus minimizing the amount of strain on your back.
9. Do not read or watch TV in bed, particularly with your head propped at a sharp or strained angle.
10. Do not sleep sitting in a chair or in cramped quarters. Lie down in bed when it is time to sleep.

IF YOU HAVE ANY QUESTIONS ABOUT ANY PHASE OF YOUR HEALTH CARE ... FEEL FREE TO ASK YOUR DOCTOR.

C 1993 Parlier Chiropractic Resource Foundation

To Order. Call 1-800-950-8044

1130-1580

HILL
CHIROPRACTIC
CENTER

220 W. Irving Blvd.
Irving, TX 75060
Phone: 972-258-6647
Fax: 972-637-8273

FEE INFORMATION FOR NEW PATIENTS

In order to keep all patients informed about every phase of their treatment program, we feel it is necessary that you be informed BEFOREHAND of the fees involved and some basic policies of the Chiropractic Center. All fees are payable at the time services are rendered. Cash, Checks, Visa, Mastercard, Discover, and American Express are accepted.

The INITIAL OFFICE VISIT consists of the following services:

1. Case History and Consultation	No charge
2. Full Spine X-rays (Front to Back and Side Views)	$150.00
3. Orthopedic-Neurological-Physical Examination-Thermal Scan	$60.00-$150.00

The SECOND OFFICE VISIT report of findings consists of the following services:

4. Urinalysis and Nutritional Consultation (as needed)	$150.00
5. Chiropractic Reductive Manipulation (Adjustment)	$60.00-$75.00

If **your case necessitates more extensive evaluation procedures, there will be addition charge(s).** By Texas State laws, all x-rays are the property of the HILL CHIROPRACTIC CENTER. Copies can be made available for an additional charge.

A routine office visit includes a Gonstead specific full spine adjustment and is $60.00. There will be an additional charge for any physiotherapy, vitamin supplements, orthopedic supports, urinalysis, nutritional consultation, re-examination, or additional x-rays. We will provide copies of your records and listings upon request to the physician of your choice. Personal emergency care spinal listing cards will also be provided at no charge for your convenience when traveling.

Upon entering this office as a new patient, if you have x-rays from your previous chiropractor, or they can be sent to us upon request and are less than one year old, new x-rays will usually not be required.
Should you be a visitor to Irving and have a spinal listing card, or spinal listings can be obtained from your Chiropractor, x-rays will usually not be required. Our fees are usual, customary, and reasonable for the Dallas-Fort Wort Metroplex area.

Treatment schedules are devised individually for each patient. Time and planning go into the development of these schedules. Therefore, we expect your appointment schedule, as determined by Dr. Hill, to be closely adhered to. Conflicts in your day to day and weekly personal schedule will arise and should be resolved quickly so you will be able to stay on your treatment program and obtain the results both you and Dr. Hill desire.

As a courtesy to you, we will supply two (2) itemized statements upon request at no charge when needed. For any additional requests there will be a $5.00 charge per statement.

Please be advised that Code H.B. 759 allows this office to charge $25.00 to your account for all checks returned from your bank, for whatever reason. An interest charge of 1.5% per month will be added to all balances over thirty (30) days past due.

Patient Signature: ______________________________ Date: ________________

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Missed Appointment Policy

At Hill Chiropractic Center we put our faith in you to keep your appointment. When we set up an appointment, a specific amount of time is reserved especially for you. Many offices double or even triple book appointments. However, double booking appointments does not allow us to give the attention needed to provide excellent quality care and for this reason we choose to not do that.

Appointment Cancellation

We have a waiting list each day for call-in appointments. Knowing ahead of time allows us to fill those spots. If for any reason you must cancel or change your appointment, it is important that you give our office **at least 24 hours notice** to offer that spot to someone else.

It is your responsibility, as the patient, to notify our office 24 hours prior to your scheduled appointment(s) if you are unable to keep the scheduled appointment. For every appointment that is missed without future notice, there is a $50.00 cancellation fee for each missed appointment.

Late Cancellations/No-Shows

A cancellation is considered late when the appointment is cancelled or rescheduled for another day less than 24 hours before the appointed time. A no-show is when a patient misses an appointment without cancelling. Both of these will result in a $50.00 missed appointment fee.

For new patients' first appointments, a no show or late cancellation will result in a full charge of the new patient fee.

By signing below, I acknowledge that I have read and understand the above policy and agree to abide by the listed terms.

Patient Name (Printed): ___________________________________ Date: _____________________

Signature of Patient or Legal Guardian: ______________________________________

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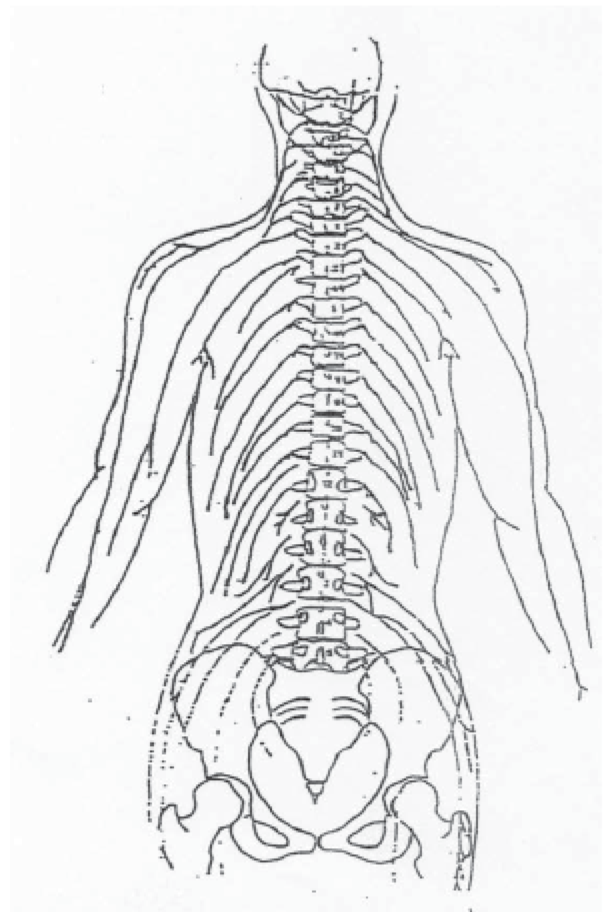
ICE PACK INFORMATION

Ice packs should be used only 20 minutes at a time on the area of complaint.

Ice packs may be used as often as once every 2 hours throughout your waking hours. Allow at least 2 hours between the end of the time you use it and the time you start again.
For example: use the ice pack from 8:00 until 8:20, then wait until 10:20 to begin and use until 10:40 and so on during waking hours.
Do not sleep on ice pack.

As your pain begins to subside, use your ice pack every 2 hours for the next day or two. Then for 4-5 days use it 2 times a day, once in the morning and once in the evening.
Ice packs can also be used a couple of times in the evening after work or daily activities.



DO NOT USE HEATING PADS, HOT WATER BOTTLES OR TAKE HOT TUB BATHS FOR ANY BACK OR NECK CONDITION: ESPECIALLY FOR LOW BACK DISCOMFORT!!!