PATIENT INFORMATION – Please Print

HILLIARD CHIROPRACTIC
112 E 4TH St **3001 N Prince St**
Portales, NM 88130 **Clovis, NM 88101**

GENERAL INFORMATION

Patient Last Name___________________________ First Name___________________________________
Parent (or Person Financially Responsible)____
Address______________________________________ City_______________ State____ Zip______________
Cell Ph________________________ Wk Ph_________________________ Hm Ph_______________________
Email____________________________________Driver Lic#____
Spouse Name__________________________ Spouse Daytime Ph#______________________________

<table>
<tr><td>Sex:
M / F</td><td>Married Single
Divorced Widowed</td><td>DOB: Age:
/ /</td><td>Soc Sec #:
- -</td></tr>
<tr><td colspan="3">Patient Employer Name___________________________________
Address____
City__________________________ State_____ Zip____________
Occupation______________________________</td><td>Employed:
Full Time Part Time
Retired Not Employed
Student:
Full Time Part Time</td></tr>
<tr><td colspan="3"></td><td></td></tr>
</table>

(Student Only) Parent or Permanent Address:
____
City_______________________ State_____ Zip________________

Past Chiropractic Care? YES / NO When?____________________
Doctor's Name__________________________
Address____
X-rays taken? YES / NO

1. Are your present problems due to an injury? YES / NO
____On the Job ____Auto Accident ____Personal Injury ____Other____________________________
2. Have you reported your accident? YES / NO _____ To Employer _____Auto Carrier _____Other
3. Have you retained an attorney? YES / NO
4. Are you now or have you ever been disabled? (Service or Work?) YES / NO When? ______________

AUTO ACCIDENT / WORKMAN'S COMPENSATION ONLY

Ins Co Name__________________________ Claim #_________________ Policy #__________________
Address______________________________ City___________________ State_____ Zip____________
Phone #______________________________ Adjustor Name_____________________________________

Attorney Name___________________________________ Contact Name__________________________
Address______________________________ City___________________ State_____ Zip____________
Phone #______________________________

RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Patient Signature____
Date_____________________________

Hilliard Chiropractic Group Inc.
112 East 4th Street, Portales, NM 88130
3001 N Prince Street, Clovis, NM 88101

Acknowledgement Form

I acknowledge that Hilliard Chiropractic's "Notice of Privacy Practices" has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Hilliard Chiropractic. The Notice of Privacy Practices also describes my rights and Hilliard Chiropractic's duties with respect to my protected health information.

Hilliard Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

______________________________ ______________________

Signature of Patient Date

____

Printed Name of Patient

Greg Bobo D.C.
Name of Privacy Officer

PATIENT CASE HISTORY

HILLIARD CHIROPRACTIC
112 E 4TH St, Portales, NM 88130
3001 N Prince St, Clovis, NM 88101

1. What is your occupation?________________________________
2. What physical demands does your occupation include? ________________________________
3. What are your hobbies? ________________________________

Give the Most current Date: Leave blank if not applicable

Spinal Exam ______________
X-ray Exam ______________
MRI or CT Exam __________
Lab Exam ________________
Last Physical _____________
Bone Density _____________

FEMALE ONLY

PapSmear_____________
Breast Exam __________

HABITS

Smoking Packs/Day_______
Drinking Alcohol _________
Coffee Cups/Day __________
Soda 12oz's/Day __________

EXERCISE

None ___________
Moderate ________
Daily ___________

LIFESTYLES & HABITS

1. How many hours of television do you watch a day? ___ < 1 ___ 1-3 ___ 3-5 ___ >5
2. Do you usually snack while watching television? YES / NO
3. How many hours per day do you use a computer at home or work? ___ < 1 ___ 1-3 ___ 3-5 ___ >5
4. How many hours per day do you ride in a car or other vehicle? ___ < 1 ___ 1-3 ___ 3-5 ___ >5
5. How often do you exercise? ___ Daily ___2-5x's/week ___ I Don't Exercise
6. How long do your exercise workouts last? ___ > 1 hour ___ 1 hour ___ 30 min's ___ < 30 min's ___ NA
7. What are your exercise activities? ___ walking ___ running/treadmill/rowing/climbing ___ swimming ___ weights ___ stretching ___ yoga/pilates ___ resistance bands ___ group exercise Other________________________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

___ Appendicitis	___ Anemia	___ Heart Disease	___ Arthritis
___ Pneumonia	___ Measles	___ Goiter	___ Epilepsy
___ Rheumatic Fever	___ Mumps	___ Influenza	___ Mental Disorder
___ Polio	___ Chicken Pox	___ Pleurisy	___ Low Back Pain
___ Tuberculosis	___ Diabetes	___ Alcoholism	___ Eczema
___ Whooping Cough	___ Cancer	___ Venereal Infection	___ AIDS
___ Stroke	___ Whiplash	___ Hypertension	___***Osteoporosis***

FAMILY HISTORY OF:

	Diabetes	Heart/Stroke	HBP	Kidney	Cancer	Back	Obesity	Arthritis
Mother	_____	_____	_____	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____	_____	_____	_____
Brother, No of ___	_____	_____	_____	_____	_____	_____	_____	_____
Sister, No of ____	_____	_____	_____	_____	_____	_____	_____	_____

OPERATIONS AND PROCEDURES

DATE	DATE	DATE
Vaccinations______________________	Tubes in ears ______________________	Sinus _________________________
Tonsillectomy____________________	Appendectomy____________________	Hernia ________________________
Gall Bladder _____________________	Female Organs ____________________	Thyroid _______________________
Back Operation __________________	Rectal Surgery ____________________	Stomach _______________________

Other ________________________________
Other ________________________________
Hip Replacement R / L____________ Knee Replacement R / L _______ Pacemaker ____________________
Do you have any other implantable medical devices in your body? YES / NO Explain: ____________________
Have you had breast implant surgery? YES / NO When? ____________________

PLEASE LIST ANY ACCIDENTS, FALLS, OR INJURIES AND DATES

Auto Collisions_________________ Treatment Received ____________________ Date __________
Recreational Vehicle ____________ Treatment Received ____________________ Date __________
Sports ________________________ Treatment Received ____________________ Date __________
Job ___________________________ Treatment Received ____________________ Date __________
Other _________________________ Treatment Received ____________________ Date __________

Have you had any of the following in the last 12 months? Please mark "2" (Previously) "3" (Presently) in front of all the following signs and symptoms. Leave blank if not applicable.

GENERAL SYMPTOMS
___ Headache
___ Fever
___ Chills
___ Night Sweats
___ Fainting
___ Dizziness
___ Convulsions
___ Loss of Sleep
___ Fatigue
___ Nervousness
___ Loss of Weight
___ Allergy (What)
___ Wheezing
___ Neuralgia
___ Numbness or pain in arms/legs/hands

GI
___ Poor Appetite
___ Poor Digestion
___ Excessive Hunger
___ Belching or Gas
___ Nausea
___ Vomiting
___ Vomiting Blood
___ Pain over Stomach
___ Constipation
___ Diarrhea
___ Colon Trouble
___ Hemorrhoids (Piles)
___ Liver Trouble
___ Jaundice
___ Gall Bladder Trouble

EENT
___ Poor Vision
___ Crossed Eyes
___ Pain In Eyes
___ Deafness
___ Earache
___ Ear Discharges
___ Nasal Obstruction
___ Nose Bleeds
___ Sore Throats
___ Hoarseness
___ Hay Fever
___ Asthma
___ Frequent Colds
___ Enlarged Thyroid
___ Tonsillitis
___ Sinus Trouble

RESPIRATORY
___ Chronic Cough
___ Spitting Blood
___ Spitting Phlegm
___ Chest Pain
___ Difficulty Breathing

GENITO-URINARY
___ Frequent Urination
___ Painful Urination
___ Blood in Urine
___ Kidney Infection
___ Bed Wetting
___ Inability to Control Urine
___ Prostate Trouble

MUSCLE/JOINTS
___ Weakness
___ Twitching
___ Stiff Neck
___ Backache
___ Swollen Joints
___ Tremors
___ Foot Trouble
___ Painful Tailbone
___ Pain B/W Shoulders
___ Hernia
___ Spinal Curvature Or Scoliosis

CARDIOVASCULAR
___ Rapid Heart
___ Slow Heart
___ High Blood Pressure
___ Low Blood Pressure
___ Pain over Heart
___ Previous Heart Trouble
___ Swelling Ankles
___ Poor Circulation
___ Varicose Veins
___ Strokes

SKIN OR ALLERGIES
___ Skin Eruptions
___ Itching
___ Bruising Easily
___ Dryness
___ Boils
___ Sensitive Skin
___ Hives or Allergy
___ Eczema
___ Allergy to Meds
____
____

FOR WOMEN ONLY
___ Painful Periods
___ Excessive Flow
___ Irregular Cycle
___ Hot Flashes
___ Cramps or Backaches
___ Miscarriage
___ Vaginal Discharge
___ Pregnant at this Time
___ Use of oral contraception
What kind and for how long?
____
____

1. List any broken bones (fractures) or dislocations: ______________________________
2. Ever on crutches? YES / NO Why? ______________________________
3. Have you ever had any spinal taps or spinal injections? YES / NO Why? ______________________________
4. Were you ever knocked unconscious? YES / NO How? ______________________________
5. Have you ever had a lapse of memory? YES / NO Why? ______________________________
6. Have you ever had X-Rays, MRI, CT Scan? YES / NO When?___________ By Whom? ______________________________
7. For what ailments were these X-Rays, MRI, CT Scan taken? ______________________________
8. Do you suffer from any other condition other than that for which you are now consulting us? ______________________________
9. Please list any medications you are taking—Prescription or Over-the-Counter: ______________________________

____

10. Are you currently taking any anti-coagulant (blood thinning) medications (e.g. coumidine, heparin, aspirin, etc) ? YES / NO

____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the Insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.
I agree that it is my responsibility to complete these clinic forms accurately. I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is my responsibility to notify the doctor if any of my information has changed or requires an update. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient in this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnose conditions nor for any medical diagnosis.

PATIENT'S SIGNATURE X ______________________________ **DATE** ______________________________

HILLIARD CHIROPRACTIC GROUP

CONSENT TO EXAMINATION AND DIAGNOSTIC PROCEDURES

I do hereby authorize the Hilliard Chiropractic Group Doctors, Chiropractic Assistants, or Staff to perform upon me examination and diagnostic procedures arising from any current or presently unforeseen conditions, which the Hilliard Chiropractic Group Doctors may consider necessary or advisable in the course of my care.

I understand and agree that Hilliard Chiropractic Group Doctors have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and conducting of a physical examination are not considered treatment, but are a part of the process of information gathering so that the doctors of Hilliard Chiropractic Group can determine whether to accept me as a patient.

CONSENT TO X-RAY

I do hereby authorize the Hilliard Chiropractic Group Doctors to take x-rays of myself (or said minor).

CONSENT TO OPEN DOOR ADJUSTING ENVIRONMENT

Hilliard Chiropractic Group has an open door adjusting area. If you require privacy, it will be provided if your request is in writing. This office utilizes an "open-adjusting" environment for ongoing patient care. "Open-adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is not the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment then other arrangements will be made for you.

______________________________ ______________________________
Printed Name of Witness | Printed Name of Patient

______________________________ ______________________________
Signature of Witness Date | Signature of Patient or (Parent/Guardian) Date

CONSENT TO X-RAY (WOMEN ONLY)

PREGNANCY RELEASE*

Date of onset of patient's last menstrual period (LMP):_____________________.

I do hereby release Hilliard Chiropractic Group, its doctors, and staff from any and all liability. I hereby affirm that I am not pregnant nor am I attempting to get pregnant as of this date and the doctor has my permission to perform an x-ray evaluation. I have been informed adequately of the potential effects of radiation on a developing fetus. If a pregnancy test has been performed, I am also aware that this test is not 100% accurate and may yield false results.

______________________________ ______________________________
Printed Name of Witness | Printed Name of Patient

______________________________ ______________________________
Signature of Witness Date | Signature of Patient or (Parent/Guardian) Date

HILLIARD CHIROPRACTIC CENTER

112 E 4TH St, Portales, NM 88130   3001 N Prince St, Clovis, NM 88101

TERMS OF ACCEPTANCE/CONSENT TO TREATMENT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion and disappointment.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: The specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of is by specific adjustment of the spine.

Potential Risks: *The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.* While rare, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to: sprains/strains, increased symptoms and pain or no improvement of symptoms or pain, fractures, disc injuries, strokes, dislocations, and serious neurological impairment.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

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 on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I, __________________________, have read and fully understand the above statement. I have also had an opportunity to ask questions and all my questions have been answered fully and satisfactorily. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek care.

____   ____________________

Patient Signature   Date

CONSENT TO EVALUATE AND TREAT A MINOR (TREATMENT OF A CHILD UNDER 18YRS).

I, __________________________, being the parent or legal guardian of __________________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

____   ____________________

Parent Signature   Date

____   ____________________

Witness Signature   Date

CHIEF COMPLAINT

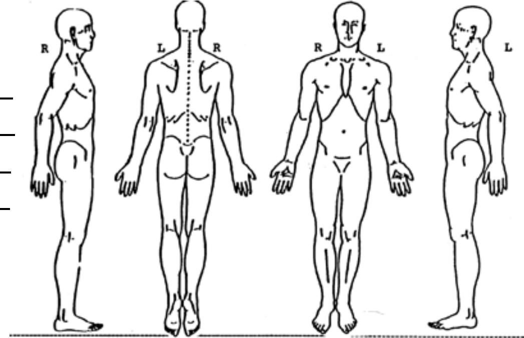
HILLIARD CHIROPRACTIC
112 E 4th St, Portales, NM 88130   3001 N Prince St, Clovis, NM 88101

Patient Name_____________________________________ Date _____________________

What is your Major Complaint ____

Site

Please Circle Location of Your Pain



1. Which complaint concerns you the most?
   Major Complaint: 1.________________________________
   2nd Complaint: 2.________________________________
   3rd Complaint: 3.________________________________
   4th Complaint: 4.________________________________

Onset

1. When did complaint start? Date__________________ GRADUALLY / SUDDENLY

2. Did any thing cause or contribute to the onset? YES / NO
   If yes please explain:____
   ____

Provoking & Palliative

1. What makes your condition **worse**? ___Nothing ___Lifting ___Trying to Stand ___Standing ___Walking ___Sitting ___Movement ___Exercise ___Inactivity ___Work Activities ___Ice ___Heat ___ Pain Meds ___OTC's Other____

2. What makes your condition **better**? ___Nothing ___Standing ___Walking ___Sitting ___Movement ___Exercise ___Inactivity ___Lying Down ___Sleep ___Hot Shower ___Stretching ___Ice ___Heat ____Pain Meds ___ OTC's Other____

Quality

1. Describe the sensation you feel. (Dull, Achy, Sharp, Shooting Pain, Burning, Throbbing, Etc)____________
   ____

2. How would you rate the intensity (severity) of your complaint on a scale of 0 – 10 now? ________________
   and at the worst since it started? ________________

Radiating

1. Do you experience PAIN or NUMBNESS or TINGLING (circle all that apply) radiating to other body parts?
   YES / NO Down the arms ___ Down the legs ___ Please explain: __________________________________

Timing

1. Is your pain Constant – YES / NO Since when: ____
2. Is your pain Intermittent – YES / NO Frequency ____________Times Per Week __________Hrs/Days
3. What percentage of awake time in one day do you feel pain? 0% --100% ____________________________

CHIEF COMPLAINT

HILLIARD CHIROPRACTIC
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1. Does the pain awaken you from your sleep? YES / NO
   If yes please explain: ______________________________

2. Have you experienced any recent unexplainable weight changes? YES / NO
   If yes please explain: ______________________________

3. Overall, has your condition been getting: BETTER WORSE NO CHANGE
   If better of worse please explain: ______________________________

4. Have you ever had anything like this before? YES / NO
   If yes please explain: ______________________________

5. Has there been any change in your bodily functions (urination, defecation, respiration digestion, vision, sexual, other) since the onset of your complaint? YES / NO
   If yes please explain: ______________________________

6. Has your condition affected your daily activities? YES / NO
   If yes please explain: ______________________________

7. Have you lost work days? YES / NO If yes, how many?______________________________

8. Have you seen any other doctors for this condition? YES / NO
   If yes, then who, and what was the treatment: ______________________________

9. Are you taking any prescription medications for this condition? YES / NO
   If yes, please list them here: ______________________________
   Have they helped? YES / NO

10. Are you taking any over the counter/non prescription medications or home remedies for this condition? YES / NO If yes please list them here: ______________________________
    ____
    Have they helped? YES / NO

DOCTOR'S NOTES

X-rays Taken C / Flex/Ext / L / T / Standing Scoliosis Other __________ **EXAM** __________

____
____
____
____
____
____
____
____