Hammond Chiropractic Life Center, Inc.

Ron Daulton Jr., D.C., FICPA

5716 Hohman Avenue
Hammond, Indiana 46320
(219) 932-8900

PATIENT HISTORY

Name:_____ Date:_____

Address:_____City:_____State:_____Zip:_____

Phone: Home (___)_____ Work (___)_____ Cell (___)_____

E-mail Address: _____Occupation:_____

Social Security #:_____ Age:_____ Date of Birth:_____

Employer's Name:_____ Employer's City/State: _____

Please check the box that applies: □ Single □ Married □ Separated □ Divorced □ Widowed

Spouse's Name:_____ Spouse's Employer:_____

Referred to our office by:_____

Nearest Relative/Contact Person:_____ Phone:(___)_____

Payment Method: □Cash □Check □Credit Card

Reason(s) for seeking Chiropractic care (check all that apply):

□ Neck pain □ Headache
□ Mid-back pain □ Low back pain
□ Other (please list)_____

Please answer the following questions:

How did this condition start?_____
_____
_____

When was the first time you were aware of this problem?_____
_____

Does anything make the condition better?_____
_____

Does anything make the condition worse?_____
_____

If you are experiencing pain, please explain what it feels like (i.e.-sharp, dull, achey, etc.)
_____

Does the pain travel, or stay in one spot?_____
_____

Name: _____ Date: _____

Please rate the pain of your condition on the following scale (circle the number that most closely resembles the amount of pain you are experiencing):

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 ***(WORST PAIN EVER)***

Is the problem constantly present, or does it come and go?_____

If the problem comes and goes, how many episodes per day do you experience?

_____

How long does each episode last?_____

Has this problem been getting better, worse, or staying the same?_____

Have you ever had this problem or similar problem before? □ Yes □ No

If yes, please explain:_____

_____

Have you ever received any treatment for this condition? □ Yes □ No If yes, where, when, and what were your results?_____

_____

Is this condition due to a work injury? □ Yes □ No

Have you received Chiropractic care in the past? □ Yes □ No When?_____

If yes, please give name of the Chiropractor:_____

Please describe the reason for previous care:_____

_____

Are you currently pregnant? □ Yes □ No

(If "No", please sign:_____)

Name of family physician:

_____

Address: _____

Are you taking any prescription drugs: _____

Any non-prescription drugs: _____

Vitamins or herbs: _____

Please answer the following:

			Comments:
Do you smoke?	□ Yes	□ No	_____
Do you drink alcohol?	□ Yes	□ No	_____
Do you have a healthy diet?	□ Yes	□ No	_____
Do you exercise regularly?	□ Yes	□ No	_____
Do you sleep well at night?	□ Yes	□ No	_____
Is your job stressful?	□ Yes	□ No	_____
Can you think of any other habits or activity that has a positive or negative effect on your health?	□ Yes	□ No	_____

Please check any condition you have had in the past or have now:

□ Back pain	□ Chest pain	□ Colon trouble
□ Neck pain	□ Difficulty breathing	□ Stomach trouble
□ Shoulder / arm pain	□ Asthma	□ Liver trouble
□ Hip / leg pain	□ High blood pressure	□ Difficulty urinating
□ Sciatica	□ Poor circulation	□ Kidney problems
□ Arthritis	□ Irregular heart beat	□ Easy bruising
□ Frequent infections	□ Skin problems	□ Other: _____

Men: □ Prostate problems Women: □ Menstrual problems

Name: _____ Date: _____

Have you ever: Comments:

Had a broken bone: □ Yes □ No _____

Had surgery: □ Yes □ No _____

Please check if any of your blood relatives have had any of the following illnesses:

□ Cancer_____ □ Liver Disease_____

□ Diabetes or Low Blood Sugar_____ □ Scoliosis_____

□ Heart Trouble_____ □ Other_____

□ High Blood Pressure / Stroke_____ _____

I hereby authorize Dr. Ronald E. Daulton to administer care to me / my child as they deem necessary (Upon my approval).

I realize that I am responsible for all fees charged by this clinic and that I will pay my portion for all services as they are performed. In the event this account is turned over to our attorneys for the collection of debt, I agree to pay interest thereon at 1-1/2% per month (18 % per annum), on any balances left due and owing. I also agree to pay all collection costs and reasonable attorney fees in the event this account or any future account of mine is turned over to our attorneys for collection, all without relief from valuation and appraisement laws should I fail to pay any amounts not paid by insurance or other benefits.

Patient's Signature: _____ Date: _____

Parent / Guardian's Signature: _____ Date: _____
(If patient is under the age of 18)

INFORMED CONSENT

We like to advise all of our patients of the following:

In recent years there have been rare incidents of injury to the vertebral artery during the course of care by medical doctors, physiotherapists and chiropractors. The risk of a stroke after cervical adjustments is 0.00025%.

To put this in perspective, the risk of stroke in the general population is 0.00057% and the risk of death from taking aspirin and other anti-inflammatory drugs is 0.04%.

Tests will be performed on you to minimize this risk and an appropriate adjusting technique will be applied.

Chiropractic care is considered to be ***one of the safest and most effective*** forms of care. If you have any questions, please ask Dr. Daulton.

I have read the above and consent to care at Hammond Chiropractic Life Center, Inc.

Signature: _____

Signature of Parent / Guardian: _____
(if patient is under the age of 18)

Information released from: The National Center for Health Statistics USA, 1993 and A Risk Assessment for Cervical Manipulation vs. Non-Steroidal Anti-inflammatory Drugs for the Treatment of Neck Pain, JMPT, Oct. 1995.

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Health Insurance Portability Accountability (HIPAA)
Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Name of Patient (PLEASE PRINT)

_____

Signature of Patient Date