

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: _____

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

Spouse's Name: _____ Referred to our office by: _____

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

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? _____

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)**

Name: _____ Date: _____

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: _____

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

Patient's Signature: _____ Date: _____

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

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

We want you to know that we follow the Health Insurance Portability Accountability Act (HIPAA). We will give you a detailed list of our policies and procedures concerning the privacy of your patient health information.

Name of Patient (PLEASE PRINT)

Patient's Signature: _____ Date: _____

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