Hammond Chiropractic Life Center, Inc.

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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)

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Patient Quality Of Life Survey

Name: _____ ***Date:*** _____

Please take several minutes to answer these questions so we can help you get better.
(Please circle as many that apply)

1. How have you taken care of your health in the past?
   - **a.** Medications
   - **b.** Emergency Room
   - **c.** Routine Medical
   - **d.** Exercise
   - **e.** Nutrition/Diet
   - **f.** Holistic Care
   - **g.** Vitamins
   - **h.** Chiropractic
   - **i.** Other (please specify): _____

2. How did the previous method(s) work out for you?
   - **a.** Bad results
   - **b.** Some results
   - **c.** Great results
   - **d.** Nothing changed
   - **e.** Did not get worse
   - **f.** Did not work very long
   - **g.** Still trying
   - **h.** Confused

3. How have others been affected by your health condition?
   - **a.** No one is affected
   - **b.** Haven't noticed any problem
   - **c.** They tell me to do something
   - **d.** People avoid me

4. What are you afraid this might be (or is beginning) to affect (or will affect)?
   - **a.** Job
   - **b.** Kids
   - **c.** Future ability
   - **d.** Marriage
   - **e.** Self-esteem
   - **f.** Sleep
   - **g.** Time
   - **h.** Finances
   - **i.** Freedom

5 Are there health conditions you are afraid this might turn into?

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic Fatigue
i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

What are you most concerned with regarding your problem?

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

What would be different/better without this problem? Please be specific

What do you desire most to get from working with us?

What would that mean to you?

Trust Your Gut Wellness Evaluation

Name:_____ **Date:**_____

In medicine today, leaky gut (aka intestinal permeability), isn't typically diagnosed. However, that doesn't mean it's not affecting your health. Many health issues related to LGS go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please take the quiz to help our doctor evaluate how we can help your condition and any underlying problems limiting your health.

Let's get started.

Please circle any that apply to you prior to taking the quiz below:

Sub-Clinical symptoms including:
Headaches and migraines

Hormone imbalance including:
PMS
Emotional imbalance

Gastrointestinal issues including:
Abdominal bloating, cramps or painful gas
Irritable Bowel Syndrome
Ulcerative Colitis
Crohn's Disease and other intestinal disorders

Respiratory Conditions including:
Chronic sinusitis
Asthma
Allergies

Autoimmune Conditions including:
Diabetes Mellitus
Lupus
Rheumatoid Arthritis
Fibromyalgia
Chronic Fatigue

Developmental and social concerns including:
Autism
ADD/ADHD

Skin Conditions: (urticaria)
Eczema
Skin rashes
Hives

Please complete our TYG wellness quiz. While there's more to it than a single quiz, the answers below can give you a good idea of how happy your gut really is. Circle the number that most closely fits, then add up your results.

TYG Wellness Questionnaire	None	Mild	Moderate	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Moderate	Severe
Asthma, hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Ulcerative colitis or celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight Trouble	0	1	2	3

YOUR TOTAL: _____