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)