

PATIENT INFORMATION:

(Please print answers to all questions)

Patient's Last Name	First Name	M.I.	Name you prefer to be called	
Home Phone #		Cellular Phone # (if applicable)		
Mailing Address (if different than home address)				
Home Street Address	Apt/Lot #	City	State	Zip Code
Birth Date	Age	Sex	Marital Status	Social Security #
	()	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Sep	
Occupation				
Employer	Work Phone #		Is it OK to call you there?	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer's Address	City		State	Zip Code
Nearest Relative or Friend, Not at Same Address	Relationship		Phone #	
Address	City		State	Zip Code
Spouse's Name	Spouse's Employer			
Spouse's Employer's Address	Spouse's Work Phone #			
Contact in case of emergency	Phone #'s		By Whom were you referred?	
1.				
2.				

RESPONSIBLE PARTY:

(Please Complete if not the same as above)

Last Name	First Name	M.I.	Home Phone #	
Street Address	City		State	Zip Code
Employer	Occupation		Work Phone #	

Patient Name:

'A' Street Clinic of Chiropractic, PLLC
Donald W. Olson, DC, FASBE, DACS
1020 'A' Street SE, Suite 4
Auburn, WA 98002

DOB:

INSURANCE

Our office will bill your insurance as a courtesy to you. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

MEDICAL INSURANCE INFORMATION

Insurance Company	Subscriber	I.D. #	Group #
Address of Insurance Company			Phone #
Other Insurance Company	Subscriber	I.D. #	Group #
Address of Insurance Company			Phone #

ACCEPTANCE AS PATIENT

I understand and agree that the doctors of the 'A' Street Clinic of Chiropractic, PLLC have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of physical and/or x-ray examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and 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 by care and treatment, any fees for professional services rendered me will be immediately due and payable.

I certify that the above information is true and correct. I hereby authorize the release of any information required. I also authorize my benefit payments to be paid directly to this office. I am financially responsible for non-covered services.

Today, I will pay by: Cash Check Credit Card

Date _____ Signature of Person Responsible _____

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DOB:

REQUIRED FOR CASE HISTORY FILE

✓ = Now
P = Past

Leave Blank if Never

- _____ Headaches
- _____ Neck Pain
- _____ Stiff Neck
- _____ Sleeping Problems
- _____ Nervousness
- _____ Tension
- _____ Irritability
- _____ Dizziness
- _____ Shoulder Pain
- _____ Arm Pain
- _____ Hand Pain
- _____ Pins & Needles In Arms
- _____ Pins & Needles In Hands
- _____ Pins & Needles in Legs
- _____ Weakness in Arms
- _____ Weakness in Hands
- _____ Weakness in Legs
- _____ Numbness in Arms
- _____ Numbness in Hands
- _____ Numbness in Legs
- _____ Numbness in Feet
- _____ Pain Between Shoulder
Blades
- _____ Shortness of Breath
- _____ Chest Pains
- _____ Low Back Pain
- _____ Pain in Legs
- _____ Pain in Feet
- _____ Hip Pain or Stiffness
- _____ Knee Pain
- _____ Buttock Pain

- _____ Menstrual Disorders
- _____ Hemorrhoids
- _____ Diarrhea
- _____ Constipation
- _____ Difficulty Urinating
- _____ Leg Cramps
- _____ Pain in Thighs
- _____ Pain in Calves
- _____ Bed Wetting
- _____ Allergies
- _____ Arthritis
- _____ Muscle Spasms
- _____ Frequent Colds
- _____ Stomach Upset
- _____ Cold Sweats
- _____ Fever
- _____ Sinus Problems
- _____ Diabetes
- _____ Feet Cold
- _____ Hands Cold
- _____ Colitis
- _____ Gall Bladder
- _____ Indigestion
- _____ Belching
- _____ Vomiting
- _____ Nausea
- _____ Hay Fever
- _____ High Blood Pressure
- _____ Fatigue
- _____ Depression

- _____ Loss of Balance
- _____ Fainting
- _____ Loss of Smell
- _____ Lights Bother Eyes
- _____ Face Flushed
- _____ Loss of Taste
- _____ Buzzing in Ears
- _____ Ringing in Ears
- _____ Loss of Memory
- _____ Loss of Hearing
- _____ Sex Problems
- _____ Swelling Joints

Please list any additional
symptoms you are
experiencing:

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DOB:

Please mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness

Pins & Needles

OOOOO
OOOOO
OOOOO
OOOOO

Burning

XXXXX
XXXXX
XXXXX
XXXXX

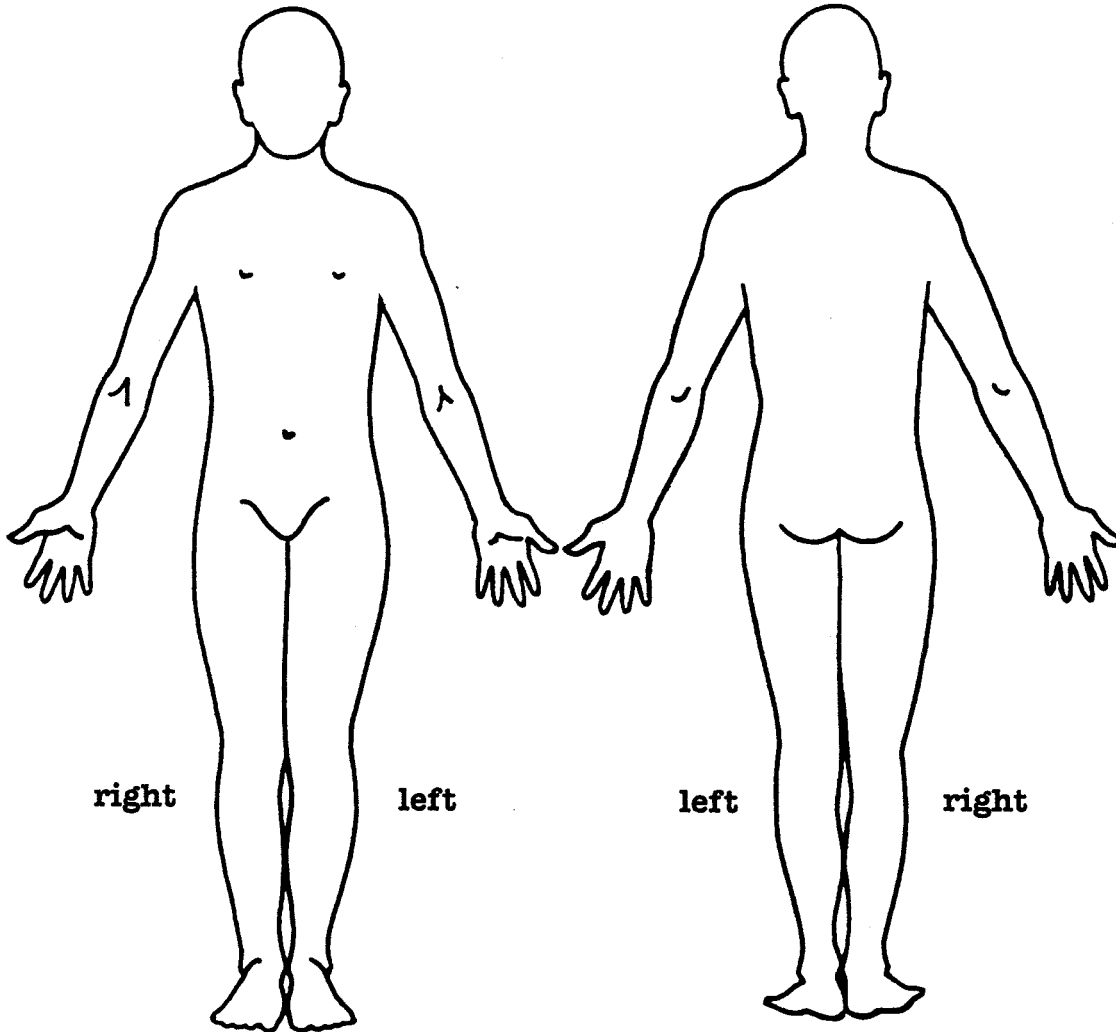
Aching

Stabbing

/////

Front

Back



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DOB:

Height _____ Weight _____ Marital Status: S [] M [] W [] D [] Sep []

Children _____ Ages _____

Are any other members of your family patients in this office? No [] Yes []

Who? _____

Have you ever had chiropractic care before? No [] Yes []

Name of doctor(s) _____

Which type of care? [] Relief of a symptom [] Rehabilitative Care
[] Wellness/Maintenance Care

Was your overall response to care favorable? Yes [] No [] N/A []

Major complaints and symptoms--please be as specific as you can. Ask for help if you need assistance filling out this section.

When did you first notice this/these? _____

How do you believe it/they began? _____

Have you lost any work? No [] Yes [] (which dates?) _____

What positions or activities aggravate your condition? _____

What positions or activities relieve your condition? _____

Have you ever had this or similar conditions in the past? Yes [] No []

If so, what & when? _____

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DOB:

Have you been treated by a Medical Physician for this ailment? Yes [] No []

If so, where and by whom? _____

Describe the type of treatment advised/prescribed and/or otherwise rendered _____

Previous physician's diagnosis (if known) _____

Length of time under care _____ Results _____

Family physician's name _____

Have you been treated for any other health condition by a physician in the past year?

Yes [] No []

If Yes, what condition? _____

Are you taking any prescribed medication or over-the-counter drugs? (aspirin included)?

Yes [] No []

If Yes, name them and what they are being taken for: _____

Will this case be covered by any insurance company? No [] Health Insurance []

Medicare [] Workers' Compensation [] Auto [] Other _____

Have you been in an auto accident:

Past year [] Past five years []

Over five years [] As Child [] Never []

Describe each in detail, including dates, type (head-on, rear-end, etc), how fast were you traveling, what got hurt, treatment & any remaining impairments _____

Have you been in any other accidents or injuries (falls, sports injuries, etc.) (even as a child)? Describe each in detail, including approximate dates.

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Are you allergic to anything you are aware of? _____

Have you ever broken any bones, (fractures)? _____

Any dislocations? _____

Do you still have your tonsils? Yes [] No []

Do you still have your appendix? Yes [] No []

What other operations have you had? _____ Year _____
_____ Year _____
_____ Year _____

Have you had any of the following in the past year?

_____ Blood tests _____ Urinalysis _____ X-Ray examination

_____ Other special treatment _____

At what hospital or office were these tests taken? _____

Name of doctor/clinic who ordered tests _____

Do you have any health problems not listed above? _____

Do you take vitamins? Yes [] No [] If Yes, please list them _____

Habits:

Cigarettes Quantity _____ For How Long ? _____

Coffee Quantity _____

Alcohol Quantity _____

Tea Quantity _____

For Women Only:
First day of last menstrual period _____
Do you take birth control pills? Yes [] No []
Do you have any reason to believe that you may be pregnant? Yes [] No []

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DOB:

- Do you have chest pain? Yes No
- Do you have a sore that does not heal? Yes No
- Do you have any unusual bleeding or discharge? Yes No
- Do you have any thickening in your breasts or elsewhere? Yes No
- Do you have difficulty in swallowing? Yes No
- Do you have a change in any wart or mole? Yes No
- Do you have a nagging cough or hoarseness? Yes No
- Do you have headaches for hours or days? Yes No
- Do you have blurred vision (other than the need for corrective lenses)? Yes No
- If Yes, Describe _____
- Do you have double vision? Yes No
- Do you have any other visual disturbances? Yes No
- If Yes, What? _____
- Do you have night sweats? Yes No
- Do you have pain in jaw? Yes No
- Do you have pain in face? Yes No
- Do you have a drooping eyelid or any change in your pupils? Yes No
- Do you have vertigo? Yes No
- Do you have any slurred speech? Yes No
- Do you have a history of stroke in your family? Yes No
- Have you ever had cancer? Yes No
- Does your pain ever wake you from a sound sleep? Yes No
- If Yes, How often? _____
- Have you significantly gained weight within the last year? Yes No
- If Yes, How many lbs.? _____ over _____ months
- Are you now losing weight without trying? Yes No
- If Yes, How many lbs.? _____ over _____ months
- Are you coughing up blood? Yes No
- Are you noticing blood in your stools? Yes No
- Are you noticing blood in your urine? Yes No
- Have you had any loss of bladder control? Yes No
- Have you had any change in bowel habits? Yes No
- Have you had any loss of bowel control? Yes No
- Have you lost consciousness recently? Yes No

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SOCIAL HISTORY

Please indicate beside each activity if you engage in it:

O = OFTEN
S = SOMETIMES
R = RARELY

- _____ Horseback riding
- _____ Bowling
- _____ Golf
- _____ Volleyball
- _____ Baseball/softball
- _____ Handball
- _____ Racquetball
- _____ Basketball
- _____ Walking (mile or less)
- _____ Walking (more than mile)
- _____ Jogging (mile or less)
- _____ Jogging (more than mile)
- _____ Dancing
- _____ Scuba diving
- _____ Back packing
- _____ Swimming
- _____ Aerobics
- _____ Resistance training
- _____ Skating/Roller Blading

- _____ Tennis
- _____ Gymnastics
- _____ Snow Skiing
- _____ Snow Boarding
- _____ Water Skiing
- _____ Hunting
- _____ Fishing
- _____ Snow Shoveling
- _____ Lawn mowing
- _____ Weed eater use
- _____ Gardening
- _____ Child care
- _____ Age(s) _____
- _____ Weight(s) _____
- _____ Climbing stairs
- _____ Football
- _____ Exercise machines
- _____ Free weights

Other Hobbies _____

FAMILY HISTORY

Please indicate if any of the following is currently or has contributed to some stress or personal lifestyle changes within the past five years.

- _____ Marriage
- _____ Birth of a child
- _____ Marital separation
- _____ Divorce
- _____ Death of spouse
- _____ Death of a family member or friend
- _____ Handicapped household member
- _____ Caregiver to family member
- _____ Spousal abuse
- _____ Change in living conditions

- _____ Dependence problems
- _____ Alcohol
- _____ Drugs
- _____ Tobacco
- _____ Change in job
- _____ Loss of job
- _____ Retirement
- _____ Change in residence
- _____ Change in financial status

Other _____

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DOB:

To properly evaluate the effect that your continuing to work will have on your recovery, we need to know the details of your usual workday as well as other tasks you are required to perform even occasionally. Please provide answers to all questions. If you do not believe a question applies to you, please mark it "n/a." (Not Applicable)

What is your job? _____

Please give a brief description of your daily job duties. Include activities which you are occasionally asked to perform.

USUAL JOB TASKS How much time of each work day do you spend:

O = Occasional F = Frequent C = Constant

- _____ Standing Type of surface (i.e. dirt, concrete, wood) _____
- _____ Sitting Is your chair comfortable? [] Yes [] No
- _____ Walking
- _____ Bending
- _____ Stooping
- _____ Crawling
- _____ Twisting
- _____ Raising arms above head
- _____ Lifting Maximum weight _____ lbs.
- _____ Driving Type of vehicle _____
- _____ Operating equipment What kind _____

JOB SATISFACTION

- Are you satisfied with your job? [] Yes [] No
- Do you dread going to work each day? [] Yes [] No
- Is your job rewarding? [] Yes [] No
- Have you changed jobs often in the past five years? [] Yes [] No
- Is your job in a noisy environment? [] Yes [] No
- Do you feel stress on your job? [] Yes [] No

Describe _____

GENERAL

- Do you work with others who can assist you to perform heavy work?
Yes [] No []
- Are there "light duty" tasks available for you to request during your recovery?
Yes [] No []

Signature _____ Date _____