Donald W. Olson, DC, FASBE, DACS

'A' Street Clinic of Chiropractic, PLLC
1020 'A' Street SE, Suite 4
Auburn, WA 98002

PATIENT INFORMATION: *(Please print answers to all questions)*

Patient's Last Name	First Name	M.I.	Another 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 #
	( )	□ F □ M	□ S □ M □ D □ W □ Sep	

Occupation

Employer	Work Phone #	Is it OK to call you there?
		□ Yes □ 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
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 #

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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.

ADVANCE BENEFICIARY NOTICE

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. This is so, despite what my, or any other carrier, determines to be medically necessary or not.

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 □ Debit/Credit Card

Date _____ Signature of Person Responsible _____

Patient Name:

DOB:

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REQUIRED FOR CASE HISTORY FILE

X = Now
P = Past
Leave Blank if Never

_____ Headaches	_____ Leg Cramps	_____ Loss of Balance
_____ Dizziness	_____ Knee Pain	_____ Fainting
_____ Lights Bother Eyes	_____ Diarrhea	_____ Loss of Smell
_____ Neck Pain	_____ Constipation	_____ Sinus Problems
_____ Stiff Neck	_____ Hemorrhoids	_____ Face Flushed
_____ Shoulder Pain	_____ Difficulty Urinating	_____ Loss of Taste
_____ Arm Pain	_____ Menstrual Disorders	_____ Buzzing in Ears
_____ Pins & Needles In Arms	_____ Cold Sweats	_____ Ringing in Ears
_____ Weakness in Arms	_____ Bed Wetting	_____ Loss of Memory
_____ Numbness in Arms	_____ Nervousness	_____ Loss of Hearing
_____ Hand Pain	_____ Tension	_____ Sex Problems
_____ Pins & Needles In Hands	_____ Irritability	_____ Swelling Joints
_____ Weakness in Hands	_____ Sleeping Problems	
_____ Numbness in Hands	_____ Allergies	
_____ Pain Between Shoulder Blades	_____ Arthritis	
_____ Mid Back Pain	_____ Fever	Please list any additional
_____ Shortness of Breath	_____ Frequent Colds	symptoms you are
_____ Chest Pains	_____ Diabetes	experiencing:
_____ Stomach Upset	_____ Feet Cold	
_____ Muscle Spasms	_____ Hands Cold	
_____ Low Back Pain	_____ Colitis	
_____ Hip Pain or Stiffness	_____ Gall Bladder	
_____ Buttock Pain	_____ Indigestion	
_____ Pain in Legs	_____ Belching	
_____ Pins & Needles in Legs	_____ Vomiting	
_____ Numbness in Legs	_____ Nausea	
_____ Weakness in Legs	_____ Hay Fever	
_____ Pain in Feet	_____ High Blood Pressure	
_____ Pins & Needles in Feet	_____ Fatigue	
_____ Numbness in Feet	_____ Depression	

Patient Name:

DOB:

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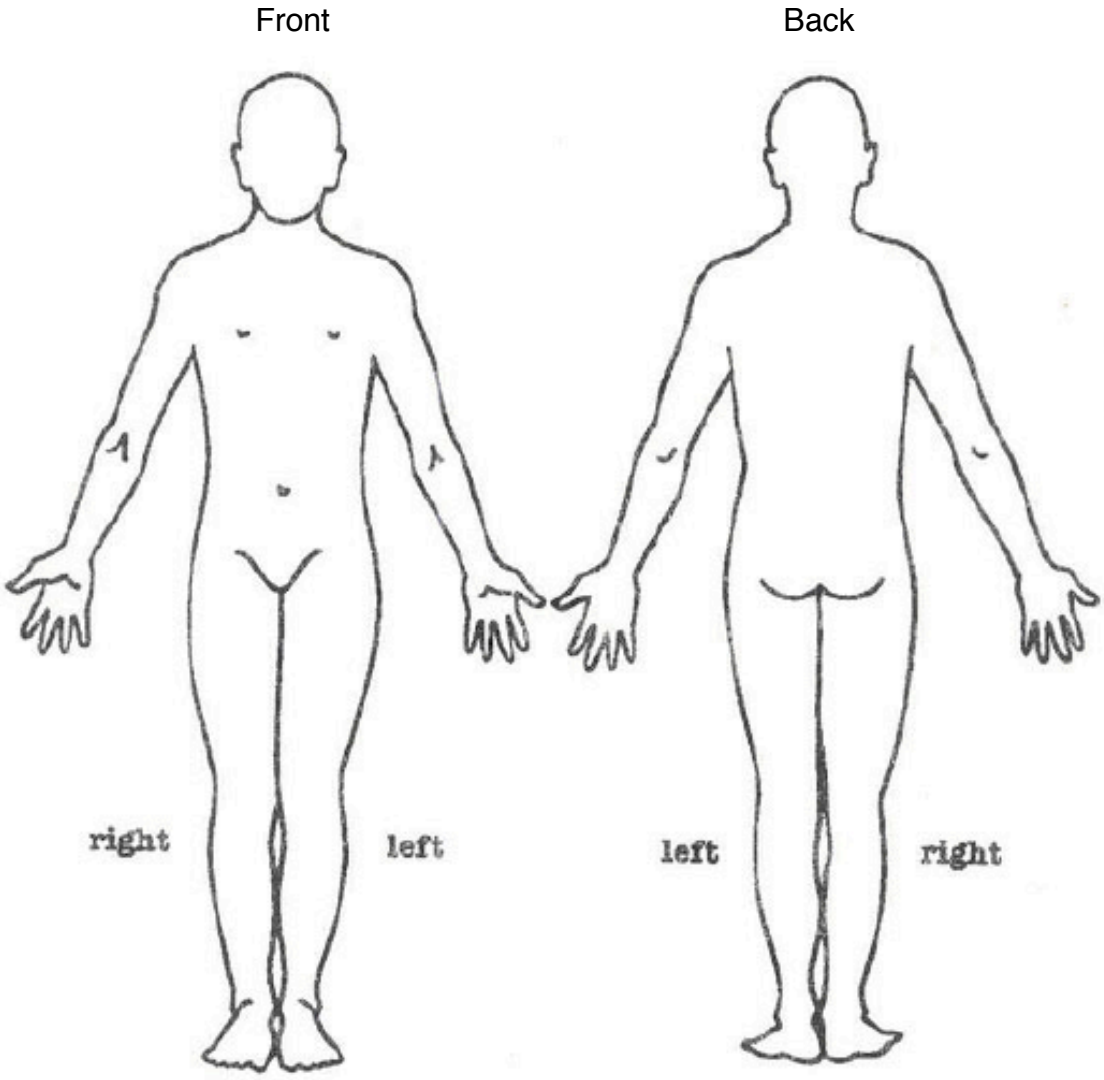
Please mark the areas on this body where you feel the described sensations using the appropriate letter. Mark areas of radiation. Include all affected areas.

A – Aching N – Numbness S – Stabbing

T – Stiffness B – Burning

P – Pins & Needles or Tingling



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Height _____ Weight _____

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? _____

What do you believe the cause to be? _____

_____

Have you lost any work days? No [ ] Yes [ ] (List Dates)_____

What makes it worse? Standing [ ] or Long Standing [ ] Sitting [ ] or Long Sitting [ ] Walking [ ] or Long Walking [ ] Bending [ ] Twisting [ ] Lifting [ ]
Other _____

What makes it better? Standing [ ] Sitting [ ] Lay down [ ] Heat [ ] Ice [ ] Stretching [ ] Self Massage [ ]
Other _____

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

If so, what & when? _____

Family physician's name _____

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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 _____

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.

_____

_____

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

Any dislocations? _____

Name:

DOB:

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Are you allergic to anything you are aware of? _____

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 _____

_____ 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/Activities:
Coffee: _____ cups per day Tea: _____ cups per day

Diet Sodas per day: ___8-12 oz ___16-20 oz ___1-2 Liter

Sports/Energy Drinks per day: ___8-12 oz ___16-20 oz

Alcohol: _____ per day/week Cigarettes:_____ per day for _____ years/months

E-Cigs/Vaping: rare / frequent / all day Cigars: ____ day/week/month for ____ years/months

Other: _____

For Women Only:
First day of last menstrual period _____ [ ] Menopause [ ] Hysterectomy
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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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
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
Family history of heart disease? Who _____
Family history of diabetes? Who _____
Family history of stroke? Who _____
Family history of cancer? Who _____

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SOCIAL HISTORY

Please indicate with appropriate letter beside each activity that you engage in it. Leave blank if never.

O = OFTEN S = SOMETIMES R = RARELY

_____ Tennis
_____ Bowling
_____ Golf
_____ Volleyball
_____ Baseball/softball
_____ Racquetball or Handball
_____ Basketball
_____ Football
_____ Soccer
_____ Gymnastics
_____ Bicycling
_____ Water Skiing
_____ Dancing
_____ Scuba diving
_____ Hiking/Back packing
_____ Swimming
_____ Resistance training
_____ Snow Skiing/Snow Boarding
_____ Skating/Rollerblading
_____ Horseback riding

_____ Fishing
_____ Hunting
_____ Walking _____ miles/week
_____ Jogging _____ miles/week
_____ Weed eater use
_____ Gardening
_____ Lawn mowing
_____ Child care
Age(s) _____
Weight(s) _____
_____ Climbing stairs
_____ Exercise machines
_____ Free weights
_____ Elastic Band
_____ Aerobics
_____ Sewing/Quilting
_____ Knitting/Crocheting
_____ Embroidery/Needlework
_____ Scrapbooking/Paper Crafts

Other Hobbies_____

SOCIAL & FAMILY HISTORY

Please indicate with an "X" any of the following which is currently or has contributed to some stress within the past five years including personal lifestyle changes.

_____ 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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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 _____