

**PATIENT INFORMATION:**

*(Please print answers to all questions)*

Patient's Last Name	First Name	M.I.	'Nick' Name
Street Address	Apt/Lot #	City	State Zip Code
Birth Date	Age	Sex	Home Phone #
	( )	<input type="checkbox"/> F <input type="checkbox"/> M	
Mother's Name	Mother's Employer		
Mother's Employer's Address	Mother's Work Phone #		
Father's Name	Father's Employer		
Father's Employer's Address	Father's Work Phone #		

**RESPONSIBLE PARTY:**

Last Name	First Name	M.I.	Home Phone #
Street Address	Apt/Lot #	City	State Zip Code

**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 #

Name:

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

DOB:

Nearest Relative or Friend, Not at Same Address	Relationship	Phone #
Address	City	State Zip Code
Contact in case of emergency	Phone #'s	
1.		
2.		
By Whom were you referred?		

**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 my child/ward 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 my child/ward as a patient.

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself/child/ward, and that all services rendered to my child/ward are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered 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.*

Date \_\_\_\_\_ Signature of Person Responsible \_\_\_\_\_

**Today, I will pay by:  Cash  Check  Visa/MasterCard**

**AUTHORIZATION FOR CARE OF MINOR**

I HEREBY AUTHORIZE THIS CLINIC AND IT'S DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON / DAUGHTER / WARD (UPON APPROVAL OF PARENT OR GUARDIAN).

SIGNED: \_\_\_\_\_ WITNESSED: \_\_\_\_\_ DATE: \_\_\_\_\_

Name:

DOB:

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### REQUIRED FOR CASE HISTORY FILE

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

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When were these first noticed? \_\_\_\_\_

How do you believe it/they began? \_\_\_\_\_

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Has the patient missed any school? No [ ] Yes [ ] (which dates?) \_\_\_\_\_

Have they 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 \_\_\_\_\_

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Previous physician's diagnosis (if known) \_\_\_\_\_

Length of time under care \_\_\_\_\_ Results \_\_\_\_\_

Family physician's name \_\_\_\_\_

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

If so, what & when? \_\_\_\_\_

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Has the patient been treated for any other health condition by a physician in the past year? Yes [ ] No [ ]

If Yes, what condition? \_\_\_\_\_

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DOB:

Are they currently 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 [ ] Auto [ ]

Other \_\_\_\_\_

Has the patient ever been in an auto accident: Past year [ ] Past five years [ ]

Over five years [ ] 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 \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any other accidents or injuries (falls, sports injuries, etc.)? Describe each in detail, including approximate dates.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any allergies you are aware of? \_\_\_\_\_

Any broken any bones, (fractures)? \_\_\_\_\_

Any dislocations? \_\_\_\_\_

Any operations? \_\_\_\_\_

Any health problems not listed above? \_\_\_\_\_

Does the patient take any vitamins? Yes [ ] No [ ] If Yes, please list them \_\_\_\_\_

\_\_\_\_\_

Name:

DOB:

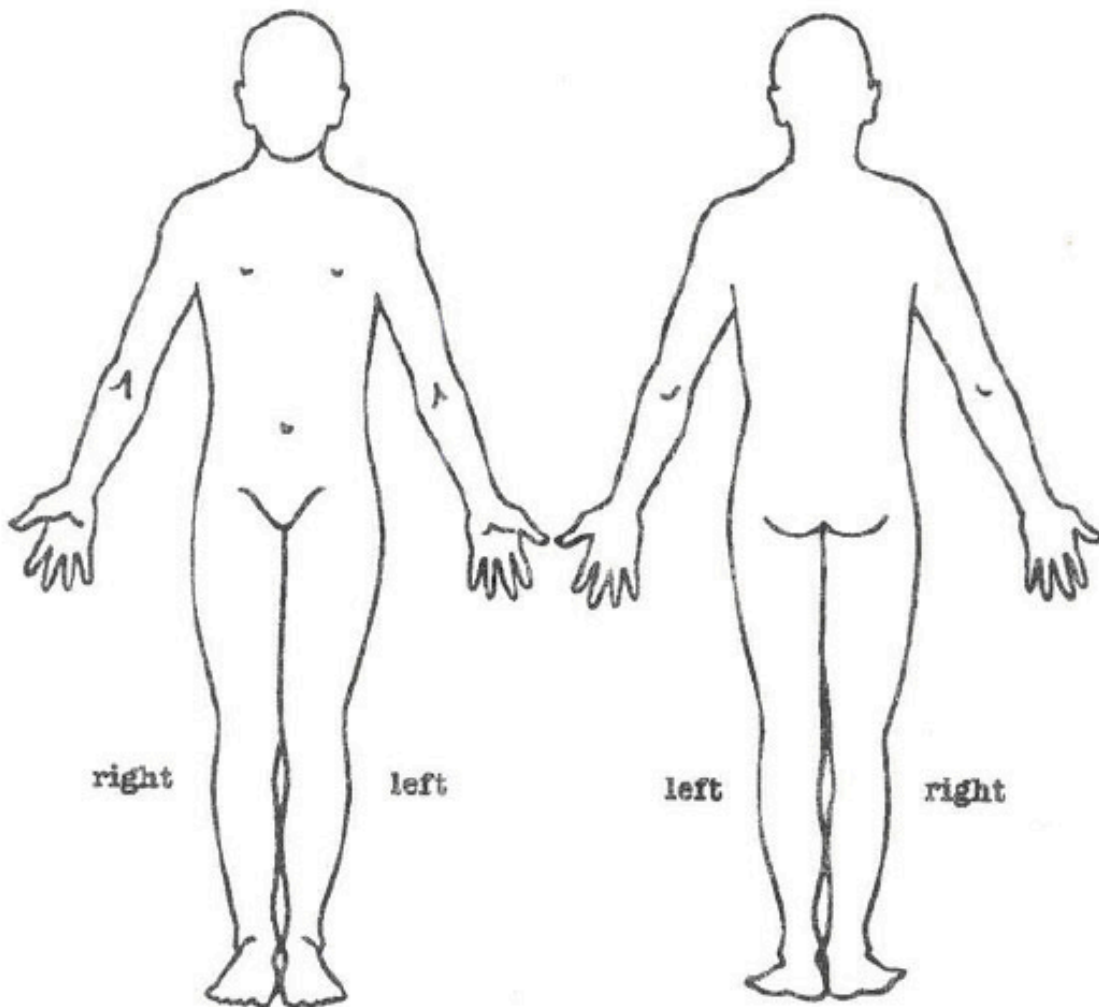
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Please mark the areas on this body where you feel the described sensations. Use the appropriate symbols.  
Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	OOOOO	XXXXX	* * * * *	/////
-----	OOOOO	XXXXX	* * * * *	/////
-----	OOOOO	XXXXX	* * * * *	/////
-----	OOOOO	XXXXX	* * * * *	/////

Front

Back



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### SOCIAL HISTORY

Please indicate beside each activity if the patient engages in it:

**O = OFTEN**  
**S = SOMETIMES**

- |   |   |
|---|---|
| <input type="checkbox"/> Horseback riding       | <input type="checkbox"/> Dancing                  |
| <input type="checkbox"/> Bowling                | <input type="checkbox"/> Back packing             |
| <input type="checkbox"/> Golf                   | <input type="checkbox"/> Snow Skiing              |
| <input type="checkbox"/> Volleyball             | <input type="checkbox"/> Snow Boarding            |
| <input type="checkbox"/> Baseball/softball      | <input type="checkbox"/> Water Skiing             |
| <input type="checkbox"/> Handball               | <input type="checkbox"/> Hunting                  |
| <input type="checkbox"/> Football               | <input type="checkbox"/> Fishing                  |
| <input type="checkbox"/> Basketball             | <input type="checkbox"/> Climbing stairs          |
| <input type="checkbox"/> Swimming               | <input type="checkbox"/> Lawn mowing              |
| <input type="checkbox"/> Tennis                 | <input type="checkbox"/> Walking (mile or less)   |
| <input type="checkbox"/> Gymnastics             | <input type="checkbox"/> Walking (more than mile) |
| <input type="checkbox"/> Skating/Roller Blading |   |

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.

- |   |   |
|---|---|
| <input type="checkbox"/> Birth of a sibling                 | <input type="checkbox"/> Marriage           |
| <input type="checkbox"/> Death of a family member or friend | <input type="checkbox"/> Divorce            |
| <input type="checkbox"/> Handicapped household member       | <input type="checkbox"/> Marital separation |
| <input type="checkbox"/> Change in residence                | <input type="checkbox"/> Abuse              |
| <input type="checkbox"/> Change in living conditions        |   |

Other \_\_\_\_\_

I certify that the above information is true and correct.

Signature \_\_\_\_\_ Date \_\_\_\_\_