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.	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 ( ) ☐ F ☐ M		Marital Status ☐ S ☐ M ☐ D ☐ W ☐ Sep	Social Security #
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 1. 2.	Phone #'s		

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.

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 □ Debit or 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
_____ Dizziness
_____ Lights Bother Eyes
_____ Neck Pain
_____ Stiff Neck
_____ L R Shoulder Pain
_____ L R Arm Pain
_____ L R Pins & Needles In Arm
_____ L R Arm Weakness
_____ L R Arm Numbness
_____ L R Elbow pain
_____ L R Wrist Pain
_____ L R Hand Pain
_____ L R Pins & Needles In Hand
_____ L R Hand Numbness
_____ L R Hand Weakness
_____ Upper Back Pain L C R
_____ Mid Back Pain L C R
_____ Pain under Shoulder blade L R
_____ Chest Pains
_____ Shortness of Breath
_____ Stomach Upset
_____ Muscle Spasms
_____ Low Back Pain L C R
_____ L R Hip Pain
_____ L R Buttock Pain
_____ L R Leg Pain
_____ L R Pins & Needles in Leg
_____ L R Leg Numbness
_____ L R Leg Weakness
_____ L R Leg Cramps

_____ L R Knee Pain
_____ L R Foot Pain
_____ L R Foot Numbness
_____ L R Pins & Needles in Feet
_____ L R Foot Cramps
_____ Arthritis
_____ Menstrual Disorders
_____ Cold Sweats
_____ Allergies
_____ Nervousness
_____ Tension
_____ Irritability
_____ Sleeping Problems
_____ Diarrhea
_____ Constipation
_____ Hemorrhoids
_____ Difficulty Urinating
_____ Diabetes
_____ Cold Foot L R
_____ Cold Hand L R
_____ Fatigue
_____ Depression
_____ Indigestion
_____ Belching
_____ Vomiting
_____ Nausea
_____ Colitis
_____ Gall Bladder
_____ Bed Wetting
_____ Fever
_____ Swelling Joints

_____ Frequent Colds
_____ Hay Fever
_____ High Blood Pressure
_____ Loss of Balance
_____ Fainting
_____ Loss of Smell
_____ Sinus Problems
_____ Face Flushed
_____ Loss of Taste
_____ Buzzing in Ears L R
_____ Ringing in Ears L R
_____ Loss of Hearing L R
_____ Loss of Memory
_____ Sex Problems

Please list any additional symptoms you are experiencing:

Name:

DOB:

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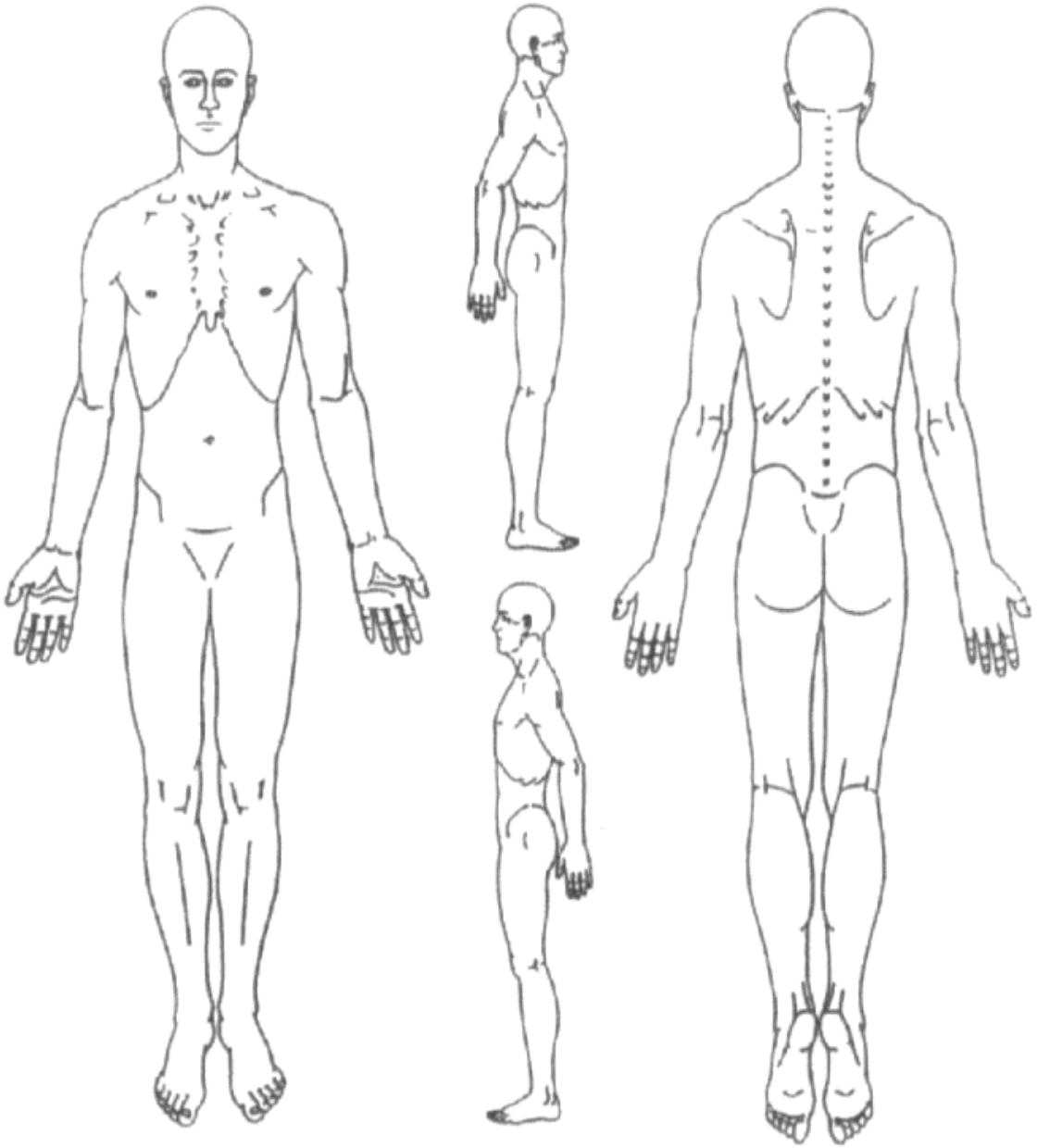
Please mark the areas on this body where you feel the described sensations **using the appropriate letter** on/over that area. Include all affected areas.

A – Aching
B – Burning
P – Pins & Needles or Tingling
S – Sharp
T – Stiffness
ST – Stabbing
N – Numbness



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

Children _____ Ages _____

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 [ ]

List in order what symptoms you are currently experiencing bothers you the most: _____

_____

_____

_____

_____

_____

When did they begin? _____

What do you feel caused them? _____

_____

_____

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

What positions and activities aggravate your condition? _____

What positions and 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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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 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 ? _____	[ ] Quit [ ] Never
Coffee	Quantity _____	For How Long ? _____	[ ] Quit [ ] Never
Alcohol	Quantity _____	For How Long ? _____	[ ] Quit [ ] Never
Tea	Quantity _____	For How Long ? _____	[ ] Quit [ ] Never

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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Do you have chest pain? [ ] Yes [ ] No
Do you have a skin 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
Leave Blank if NEVER

_____ Horseback riding
_____ Bowling
_____ Golf
_____ Volleyball
_____ Baseball/softball
_____ Racquetball or Handball
_____ Basketball
_____ Bicycling
_____ 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/Rollerblading

_____ Tennis
_____ Gymnastics
_____ Snow Skiing
_____ Snow Boarding
_____ Water Skiing
_____ Hunting
_____ Fishing
_____ Needlework/Embroidery
_____ Knitting/Crocheting
_____ Sewing/Quilting
_____ Lawn mowing
_____ Weed eater use
_____ Gardening
_____ Child care
Age(s) _____
_____ Climbing stairs
_____ Football
_____ Exercise machines
_____ Free weights

Other Hobbies _____

FAMILY HISTORY

Please indicate with an "X" any of the following which 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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To properly evaluate the effect that 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 _____