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<br>1.<br>2. | | Phone #'s | By Whom were you referred? |

**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 # |

## 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 # |

## INSURANCE

This office will process your insurance forms upon request. 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.

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 plan to pay by: ❑ Cash ❑ Check ❑ Visa/MasterCard**

Date ________________________ Signature of Patient ________________________________________________

Signature of Person Responsible (if other than the patient) ________________________________________________

Please check which symptoms you are currently experiencing (mark as a P for all that have bothered you in the 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
______ Loss of Memory
______ Loss of Hearing
______ Sex Problems
______ Swelling Joints

Please list any additional symptoms you are experiencing:

**Name:**

**DOB:**

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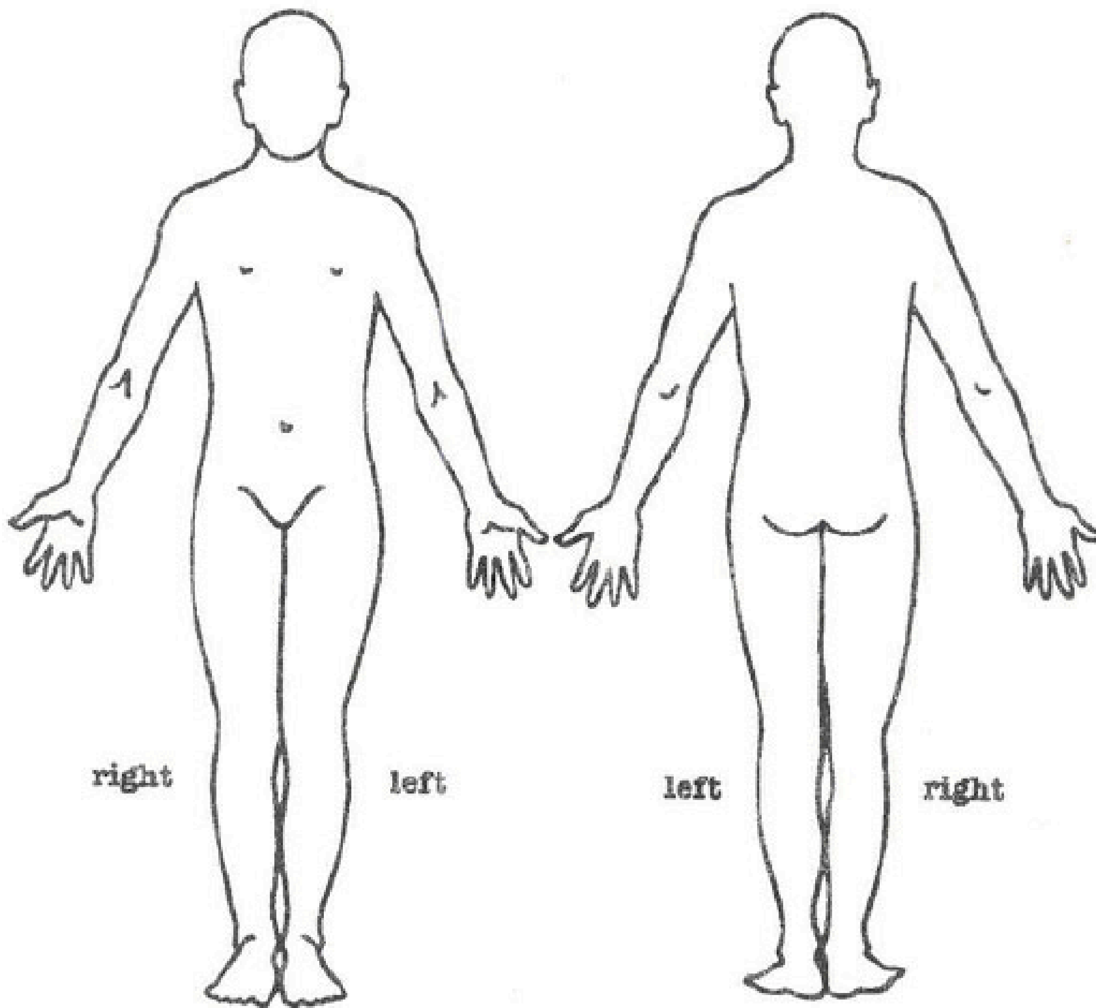
Please mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

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

Front Back



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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 [ ] (dates)_________________________________

What positions or activities aggravate your condition? _____________________________

What positions or activities relieve your condition? _______________________________

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

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Have you been in an auto accident since your last to our office? 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.)? Describe each in detail, including approximate dates.

______________________________________________________________________

______________________________________________________________________

Have you had any operations since your last visit? If so, please describe:

______________________________________________________________________

______________________________________________________________________

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 [ ]

Date ________________________ Signature of Patient ______________________________________________

Signature of Parent/Guardian (if other than the patient) ______________________________________________