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.	'Nick' Name
Street Address	Apt/Lot #	City	State / Zip Code
Birth Date	Age ( )	Sex ❑ F ❑ M	Home Phone #
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 #

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

____

____

____

____

When were these first noticed? ____

How do you believe it/they began? ____

____

____

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 ______________

____

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? ____

____

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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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 ___________________

____

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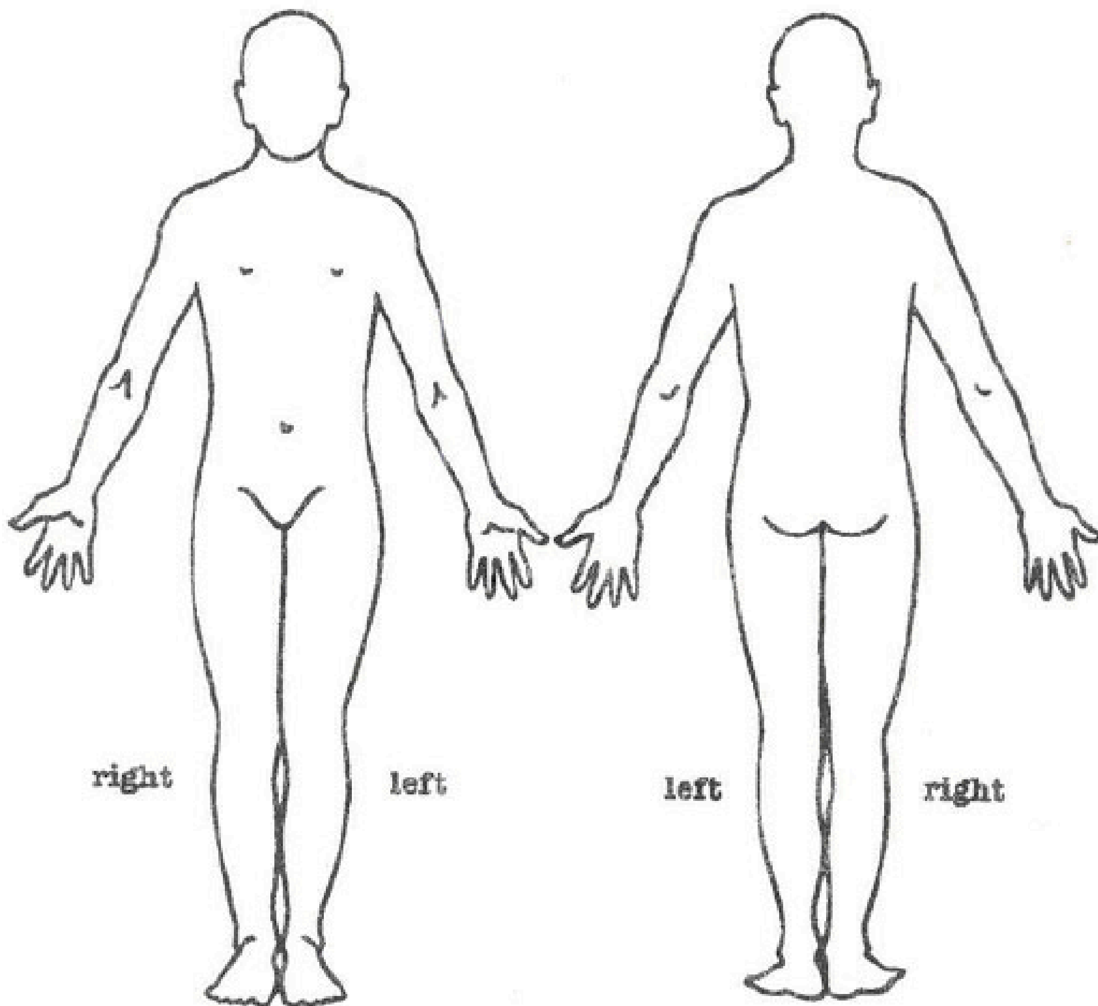
Please mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

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

_____ Horseback riding
_____ Bowling
_____ Golf
_____ Volleyball
_____ Baseball/softball
_____ Handball
_____ Football
_____ Basketball
_____ Swimming
_____ Tennis
_____ Gymnastics
_____ Skating/Roller Blading

_____ Dancing
_____ Back packing
_____ Snow Skiing
_____ Snow Boarding
_____ Water Skiing
_____ Hunting
_____ Fishing
_____ Climbing stairs
_____ Lawn mowing
_____ Walking (mile or less)
_____ Walking (more than mile)

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.

_____ Birth of a sibling
_____ Death of a family member or friend
_____ Handicapped household member
_____ Change in residence
_____ Change in living conditions

_____ Marriage
_____ Divorce
_____ Marital separation
_____ Abuse

Other ____

____

I certify that the above information is true and correct.

Signature ____ Date ___________________