

**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 Assigned At Birth <input type="checkbox"/> F <input type="checkbox"/> M	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Sep
Social Security #			
Occupation			
Employer	Work Phone #	Is it OK to call you there? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	Phone #'s		
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 #	

Patient Name:

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

DOB:

**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 \_\_\_\_\_

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### REQUIRED FOR CASE HISTORY FILE

X = Now

P = Past

**Leave Blank if Never**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Headaches                        | <input type="checkbox"/> Muscle Spasms                    | <input type="checkbox"/> Allergies                    |
| <input type="checkbox"/> Dizziness                        | <input type="checkbox"/> Leg Pain: Right, Left, Both      | <input type="checkbox"/> Diabetes                     |
| <input type="checkbox"/> Lightheadedness                  | <input type="checkbox"/> Pins & Needles in Leg            | <input type="checkbox"/> Fever                        |
| <input type="checkbox"/> Lights Bother Eyes               | <input type="checkbox"/> Right, Left, Both                | <input type="checkbox"/> Colitis                      |
| <input type="checkbox"/> Neck Pain: Center, Right or Left | <input type="checkbox"/> Leg Numbness: Right, Left, Both  | <input type="checkbox"/> Belching                     |
| <input type="checkbox"/> Stiff Neck                       | <input type="checkbox"/> Leg Weakness: Right, Left, Both  | <input type="checkbox"/> Frequent Colds               |
| <input type="checkbox"/> Jaw Pain                         | <input type="checkbox"/> Leg Cramps: Right, Left, Both    | <input type="checkbox"/> Hay Fever                    |
| <input type="checkbox"/> Shoulder Pain: Right, Left, Both | <input type="checkbox"/> Knee Pain: Right, Left, Both     | <input type="checkbox"/> High Blood Pressure          |
| <input type="checkbox"/> Arm Pain: Right, Left, Both      | <input type="checkbox"/> Ankle Pain: Right, Left, Both    | <input type="checkbox"/> Loss of Balance              |
| <input type="checkbox"/> Pins & Needles In Arm:           | <input type="checkbox"/> Foot Pain: Right, Left, Both     | <input type="checkbox"/> Fainting                     |
| <input type="checkbox"/> Right, Left, Both                | <input type="checkbox"/> Foot Numbness: Right, Left, Both | <input type="checkbox"/> Arthritis                    |
| <input type="checkbox"/> Arm Weakness: Right, Left, Both  | <input type="checkbox"/> Pins & Needles in Feet           | <input type="checkbox"/> Face Flushed                 |
| <input type="checkbox"/> Arm Numbness: Right, Left, Both  | <input type="checkbox"/> Right, Left, Both                | <input type="checkbox"/> Loss of Taste                |
| <input type="checkbox"/> Elbow pain: Right, Left, Both    | <input type="checkbox"/> Foot Cramps: Right, Left, Both   | <input type="checkbox"/> Buzzing in Ear:              |
| <input type="checkbox"/> Wrist Pain: Right, Left, Both    | <input type="checkbox"/> Sleeping Problems                | <input type="checkbox"/> Right, Left, Both            |
| <input type="checkbox"/> Hand Pain: Right, Left, Both     | <input type="checkbox"/> Fatigue                          | <input type="checkbox"/> Ringing in Ear:              |
| <input type="checkbox"/> Pins & Needles In Hand:          | <input type="checkbox"/> Swelling Joints                  | <input type="checkbox"/> Right, Left, Both            |
| <input type="checkbox"/> Right, Left, Both                | <input type="checkbox"/> Irritability                     | <input type="checkbox"/> Loss of Hearing:             |
| <input type="checkbox"/> Hand Numbness: Right, Left, Both | <input type="checkbox"/> Sex Difficulties                 | <input type="checkbox"/> Right, Left, Both            |
| <input type="checkbox"/> Hand Weakness: Right, Left, Both | <input type="checkbox"/> Tension                          | <input type="checkbox"/> Cold Hand: Right, Left,Both  |
| <input type="checkbox"/> Upper Back Pain:                 | <input type="checkbox"/> Nervousness                      | <input type="checkbox"/> Cold Foot: Right, Left, Both |
| <input type="checkbox"/> Center, Right or Left            | <input type="checkbox"/> Constipation                     | <input type="checkbox"/> Loss of bladder control      |
| <input type="checkbox"/> Mid Back Pain: In the            | <input type="checkbox"/> Hemorrhoids                      | <input type="checkbox"/> Loss of bowel control        |
| <input type="checkbox"/> Center, Right or Left            | <input type="checkbox"/> Diarrhea                         | <input type="checkbox"/> Bed Wetting                  |
| <input type="checkbox"/> Pain under Shoulder blade:       | <input type="checkbox"/> Sinus Problems                   | <input type="checkbox"/> Gall Bladder Problems        |
| <input type="checkbox"/> Right, Left or Both              | <input type="checkbox"/> Nausea                           | <input type="checkbox"/> Menstrual Disorders          |
| <input type="checkbox"/> Chest pain                       | <input type="checkbox"/> Night Sweats                     |   |
| <input type="checkbox"/> Shortness of Breath              | <input type="checkbox"/> Loss of Smell                    |   |
| <input type="checkbox"/> Stomach Upset                    | <input type="checkbox"/> Difficulty Urinating             |   |
| <input type="checkbox"/> Low Back Pain: In the            | <input type="checkbox"/> Depression                       |   |
| <input type="checkbox"/> Center, Right or Left            | <input type="checkbox"/> Indigestion                      |   |
| <input type="checkbox"/> Hip Pain: Right, Left, Both      | <input type="checkbox"/> Vomiting                         |   |
| <input type="checkbox"/> Buttock Pain: Right, Left, Both  | <input type="checkbox"/> Loss of Memory                   |   |

Please list any additional symptoms you are experiencing:

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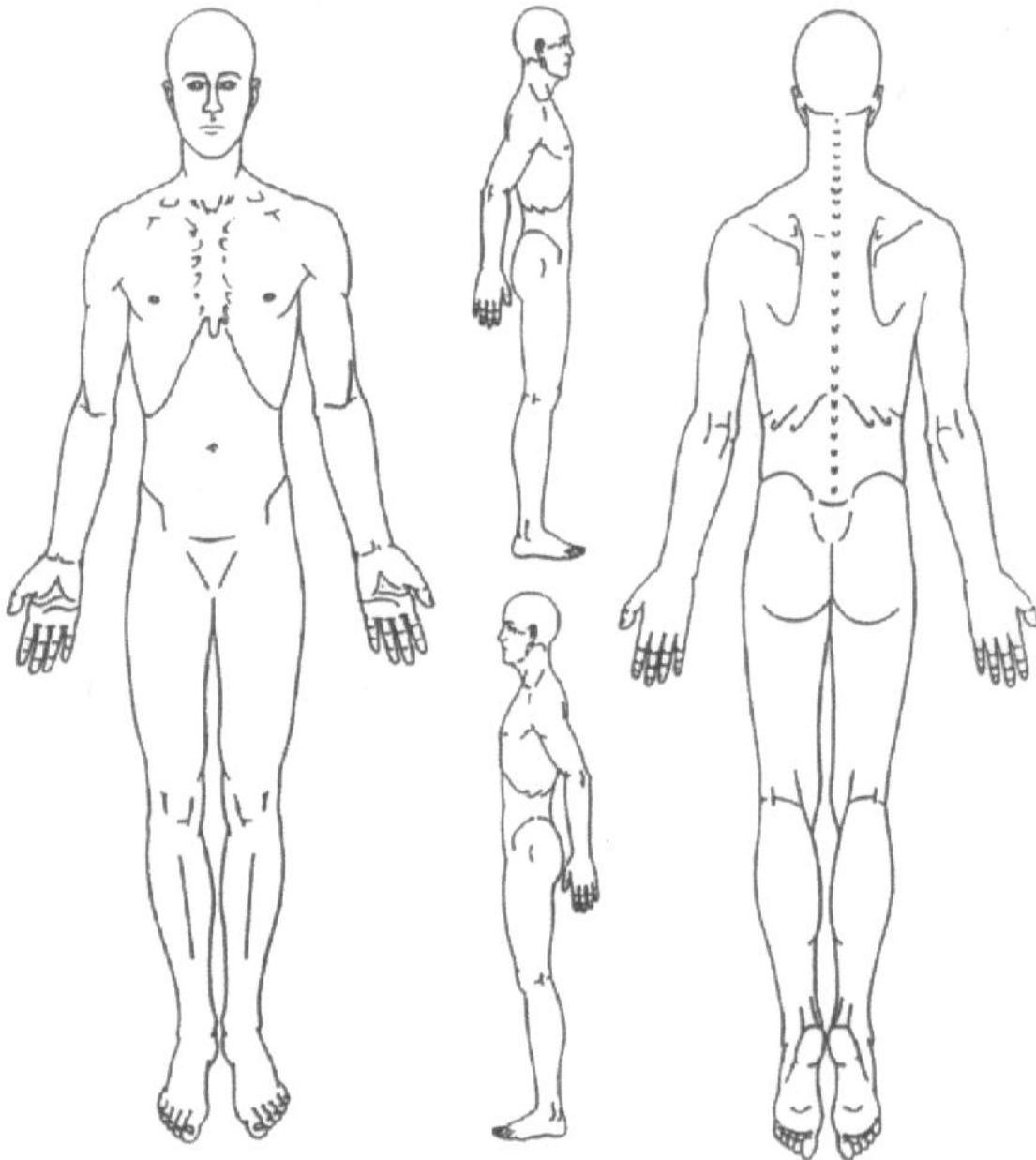
DOB:

Please mark the areas on this body where you feel the described sensations using the appropriate letter.  
If your pain travels to another area, please mark that too. Include all affected areas.

A- Aching/Dull  
S – Sharp  
B – Burning

ST – Stabbing  
N – Numbness  
T – Stiffness

P – Pins & Needles or  
Tingling



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DOB:

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?  No  Yes  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  Prolonged Standing  Sitting  or Prolonged Sitting

Walking  Prolonged 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?  No  Yes

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

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

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DOB:

Have you been treated by a Medical Physician for this ailment?  No  Yes

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?

No  Yes

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

Are you taking any prescribed medication or over-the-counter drugs? (aspirin included)?

No  Yes

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? \_\_\_\_\_

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DOB:

Are you allergic to anything you are aware of?  Yes  No

If so, please list them \_\_\_\_\_

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?  No  Yes If Yes, please list their name and brand:

\_\_\_\_\_

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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DOB:

### 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**

- |  |  |
|--|--|
| <input type="checkbox"/> Tennis                                      | <input type="checkbox"/> Fishing                   |
| <input type="checkbox"/> Bowling                                     | <input type="checkbox"/> Hunting                   |
| <input type="checkbox"/> Golf  | <input type="checkbox"/> Walking _____ miles/week  |
| <input type="checkbox"/> Volleyball                                  | <input type="checkbox"/> Jogging _____ miles/week  |
| <input type="checkbox"/> Baseball/softball                           | <input type="checkbox"/> Weed eater use            |
| <input type="checkbox"/> Racquetball or Pickleball                   | <input type="checkbox"/> Gardening                 |
| <input type="checkbox"/> Basketball                                  | <input type="checkbox"/> Lawn mowing               |
| <input type="checkbox"/> Football                                    | <input type="checkbox"/> Child care                |
| <input type="checkbox"/> Soccer                                      | Age(s) _____                                       |
| <input type="checkbox"/> Gymnastics                                  | Weight(s) _____                                    |
| <input type="checkbox"/> Bicycling                                   | <input type="checkbox"/> Climbing stairs           |
| <input type="checkbox"/> Water Skiing                                | <input type="checkbox"/> Exercise machines         |
| <input type="checkbox"/> Dancing                                     | <input type="checkbox"/> Free weights              |
| <input type="checkbox"/> Scuba diving                                | <input type="checkbox"/> Elastic Band              |
| <input type="checkbox"/> Hiking/Back packing                         | <input type="checkbox"/> Aerobics                  |
| <input type="checkbox"/> Swimming                                    | <input type="checkbox"/> Sewing/Quilting           |
| <input type="checkbox"/> Resistance training                         | <input type="checkbox"/> Knitting/Crocheting       |
| <input type="checkbox"/> Snow Skiing/Snow Boarding                   | <input type="checkbox"/> Embroidery/Needlework     |
| <input type="checkbox"/> Skating/Rollerblading                       | <input type="checkbox"/> Scrapbooking/Paper Crafts |
| <input type="checkbox"/> Horseback riding                            | <input type="checkbox"/> Gaming                    |
| <input type="checkbox"/> Cell phone usage: Est. hours per day: _____ |  |

Other \_\_\_\_\_

### 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.

- |   |   |
|---|---|
| <input type="checkbox"/> Marriage                           | <input type="checkbox"/> Dependence problems        |
| <input type="checkbox"/> Birth of a child                   | <input type="checkbox"/> Alcohol                    |
| <input type="checkbox"/> Marital separation                 | <input type="checkbox"/> Drugs                      |
| <input type="checkbox"/> Divorce                            | <input type="checkbox"/> Tobacco                    |
| <input type="checkbox"/> Death of spouse                    | <input type="checkbox"/> Change in job              |
| <input type="checkbox"/> Death of a family member or friend | <input type="checkbox"/> Loss of job                |
| <input type="checkbox"/> Handicapped household member       | <input type="checkbox"/> Retirement                 |
| <input type="checkbox"/> Caregiver to family member         | <input type="checkbox"/> Change in residence        |
| <input type="checkbox"/> Spousal abuse                      | <input type="checkbox"/> Change in financial status |
| <input type="checkbox"/> Change in living conditions        | Other _____   |

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DOB:

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 \_\_\_\_\_