

Date: _____

Patient #: _____

About You

Full Name: _____ Called Name _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (home) _____ (work) _____ (cell) _____

Email: _____

◇ Male ◇ Female ◇ Single ◇ Married ◇ Coupled ◇ Divorced ◇ Widowed

Birthdate: _____ Age _____ Social Security # _____

Occupation: _____ Employer: _____

Whom may we thank for referring you/how did you hear about our office? _____

Your Family

Spouse/Significant Other: _____

His/Her Occupation: _____ His/Her Employer: _____

Names/Ages of Children: _____

Emergency Contact: _____ Relation: _____

Phone: (home) _____ (work) _____ (cell) _____

Primary Care Physician

Who is your primary care doctor? _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

When doctors work together, it benefits you. May we have permission to update your medical physician regarding your care in our office? Yes _____ No _____

Insurance/Payment Information

Who is responsible for payment of this account? _____

Relationship to Patient _____

Insurance Company _____

Patient Insurance ID # _____

Group # _____

Subscriber's Name (Policyholder) _____

Birthdate _____ Social Security # _____

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with the above mentioned insurance company(ies) and assign directly to Dr. John P. Olsen all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Printed name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

Is patient covered by additional insurance? Yes No If Yes, please list any secondary insurance here. _____

Accident Information

Is this condition due to an accident? Yes No

Type of accident Auto Work Home Other _____

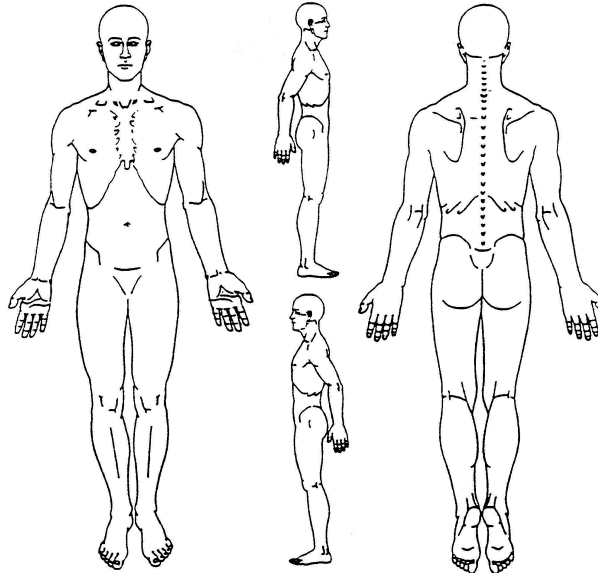
To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp Other

Attorney Name (if applicable) _____

What Brings You to Our Office?

Mark areas of pain/discomfort/numbness/tingling



What is the main reason for your visit? _____

When did your symptoms appear? _____

Is the condition getting progressively worse? _____

How severe is the pain/numbness/tingling? Rate from 1 (least pain) to 10 (severe pain) _____

Describe the character of the pain/discomfort you are experiencing (sharp, burning, tingling, shooting, aching, throbbing, stabbing, dull, etc.) _____

How often do you have this pain/discomfort? _____

Is it constant or does it come and go? _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Are there activities or movements that are painful to perform? (sitting, standing walking, bending, etc.)

What treatment have you already received for this condition? Medication Surgery Physical Therapy
 Chiropractic None Other _____

Other spine, muscle, joint, nerve, or general health concerns: _____

Health History

When was your last:

Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Dental X-Ray _____

Urine Test _____ MRI, CT, Bone Scan _____

Are You Pregnant? Yes No

What activities do you do for exercise? _____

What are the physical demands of your job? _____

Habits: Smoking

Packs/Day _____

Coffee/Caffeine Drinks

Cups/Day _____

Alcohol

Drinks/Week _____

High Stress Level

Reason _____

Injuries/Surgeries

Description

Date

Broken Bones _____

Head Injuries _____

Falls _____

Dislocations _____

Surgeries _____

Mark "Yes" or "No" for the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted	
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding		Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disc	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical		High Blood		Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	_____
Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid			_____
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		_____

Please list all Medications, Dietary Supplements, Vitamins, Herbal Remedies, or Homeopathic Remedies that you currently take. Use the back of this sheet if necessary.
