OLSEN CHIROPRACTIC

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____
City State Zip

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Employer _____

Referred By _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co
& Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co
& Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Joshua B. Olsen D.C. 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship Date

PHONE NUMBERS

Home _____ Work _____ Ext ____

Best time and place to call _____

IN CASE OF EMERGENCY CONTACT:

Name _____ Relationship _____

Home _____ Work _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____

Type of accident: Auto Work Home Other

To whom was accident reported?
Auto Insurance Employer Worker's Comp Other

Attorney Name (if applicable) _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

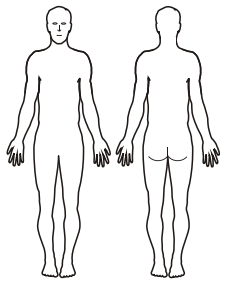
Type of Pain: Sharp Dull Throbs Numb Aches Shooting Burns
Tingles Cramps Stiffness Swelling Other

How often do you have this pain? _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down

Mark picture with an X where symptoms occur



HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy
Chiropractic Services None Other _____

Have you ever recieved chiropractic care in the past? Yes No When? _____ Results? _____

Date of last:

Physical Exam _____ Spinal X-Ray _____ Blood T est _____

Spinal Exam _____ Chest X-Ray _____ Urine T est _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Circle P = Previously C = Currently

AIDS/HIV	P	C	Emphysema	P	C	Miscarriage	P	C	Scarlet Fever	P	C
Alcoholism	P	C	Epilepsy	P	C	Mononucleosis	P	C	Stroke	P	C
Allergy Shots	P	C	Fractures	P	C	Multiple Sclerosis	P	C	Suicide Attempt	P	C
Anemia	P	C	Glaucoma	P	C	Mumps	P	C	Thyroid Problems	P	C
Anorexia	P	C	Goiter	P	C	Osteoporosis	P	C	Tonsilitis	P	C
Appendicitis	P	C	Gonorrhea	P	C	Pacemaker	P	C	Tuberculosis	P	C
Arthritis	P	C	Gout	P	C	Parkinson's Disease	P	C	Tumors, Growths	P	C
Asthma	P	C	Heart Disease	P	C	Pinched Nerve	P	C	Typhoid Fever	P	C
Bleeding Disorders	P	C	Hepatitis	P	C	Pneumonia	P	C	Ulcers	P	C
Breast Lump	P	C	Hernia	P	C	Polio	P	C	Vaginal Infections	P	C
Bronchitis	P	C	Herniated Disk	P	C	Prostate Problem	P	C	Venereal Disease	P	C
Bulimia	P	C	Herpes	P	C	Prosthesis	P	C	Whooping Cough	P	C
Cancer	P	C	High Cholesterol	P	C	Psychiatric Care	P	C	Other _____		
Cataracts	P	C	Kidney Disease	P	C	Rheumatoid Arthritis	P	C			
Chemical Dependency	P	C	Liver Disease	P	C	Rheumatic Fever	P	C			
Chicken Pox	P	C	Measles	P	C						
Diabetes	P	C	Migraine Headaches	P	C						

Exercise

None
Moderate
Daily
Heavy

Work Activity

Sitting
Standing
Light Labor
Heavy Labor

Habits

Smoking -- Packs/Day _____
Alcohol -- Drinks/Week _____
Coffee/Caffeine Drinks -- Cups/Day _____
High Stress Level -- Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had — Description — Date

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____

MEDICATIONS — ALLERGIES — VITAMINS/HERBS/MINERALS

_____ _____ _____

_____ _____ _____

_____ _____ _____

Signed: _____ Date: _____