CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Olson Chiropractic, P.C.
Dennis R. Olson, D.C.
Brenton L. Olson, D.C.
1030 SE Murphy Blvd.
Joplin, MO 64801
(417) 623-2828

_____
Date (MM/DD/YYYY)

Have you consulted a chiropractor before? ○ No ○ Yes

_____ When? _____ If so, whom? _____
Whom may we thank for referring you?

_____
Last Name First Name Middle Name (or initial)

_____
Address

_____ _____ _____
City State/Province ZIP/Postal Code

_____ _____ _____
Home Phone Cell Phone Work Phone

_____ _____ _____
Email Address Birth Date (MM/DD/YYYY) Race/Ethnicity

Gender: ○ Male ○ Female Marital Status: *(Circle One)* Single/Married/Divorced/Widowed/Separated

_____
Spouse's Name Emergency Contact Phone Number

_____
Your Occupation Employer

_____
Employer's Address City State Zip/Postal Code

_____
Primary Care Provider's Name Provider's Phone Number

1. **<u>The symptom(s)</u> that have prompted me to seek care today include:**
   _____
   _____

2. **<u>And are the result of</u> :** ○ An accident or injury ○ Work ○ Auto ○ Other _____
   (Darken circle) ○ A worsening long-term problem
   An interest in: ○ Wellness ○ Other _____

3. **<u>Onset</u>** (When did you first notice your current symptoms?)
   _____

4. **<u>Pain Intensity</u>** *(Darken circle)*
   On a scale of 0 to 10, rate your pain:
   0 ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 10
   Absent Uncomfortable Agonizing

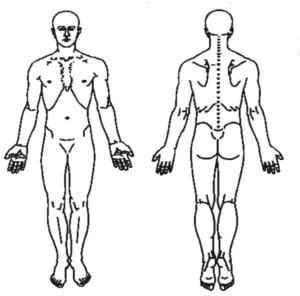
5. **<u>Duration and Timing</u>** (When did it start and how often do you feel it?)
   ○ Constant ○ Comes and Goes
   How often? _____

6. **<u>Symptoms (How it feels)</u>**
   (Darken circle)
   ○ Numbness ○ Tingling ○ Burning
   ○ Stiffness ○ Dull ○ Shooting
   ○ Aching ○ Cramps ○ Throbbing
   ○ Nagging ○ Sharp ○ Stabbing
   ○ Other:_____

7. **<u>Radiation</u>** (Does it affect other areas of your body? To what areas does the pain radiate, shoot, or travel.)
   _____

8. **<u>Aggravation or relieving factors</u>** (What makes it better or worse such as time of day, movements, or activities.)
   _____

9. Location (where it hurts) Mark area(s) on illustration.



10. Prior interventions (What have you done to relieve the symptoms?) *(Darken circle)*

- O Prescription Medication
- O Over-the-counter drugs
- O Homeopathic remedies
- O Physical therapy
- O Ice
- O Other_____
- O Surgery
- O Acupuncture
- O Chiropractic
- O Massage
- O Heat

11. Please list anything else Dr Olson should know about your current condition: _____

_____

12. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please **darken the circle** beside any condition that you have ***Had*** or currently ***Have***.

Musculosketal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Osteoporosis	O	O	Arthritis	O	O	Scoliosis	O	O	Neck Pain	O	O	Back Problems	O	O	Hip Disorders
O	O	Knee injuries	O	O	Foot/ankle pain	O	O	Shoulder problems	O	O	Elbow/Wrist Pain	O	O	TMJ Issues	O	O	Poor Posture

Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Anxiety	O	O	Depression	O	O	Headache	O	O	Dizziness	O	O	Pins/Needles	O	O	Numbness

Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	High blood pressure	O	O	Low blood pressure	O	O	High cholesterol	O	O	Poor circulation	O	O	Angina	O	O	Excessive bruising

Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Anorexia/ bulimia	O	O	Ulcer	O	O	Food sensitivities	O	O	Heartburn	O	O	Constipation	O	O	Diarrhea

Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Blurred Vision	O	O	Ringing in ears	O	O	Hearing loss	O	O	Chronic ear infection	O	O	Loss of smell	O	O	Loss of taste

Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Thyroid issues	O	O	Immune disorders	O	O	Hypoglycemia	O	O	Frequent infection	O	O	Swollen glands	O	O	Low energy

Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Fainting	O	O	Low libido	O	O	Poor appetite	O	O	Fatigue	O	O	Sudden weight loss or gain	O	O	Weakness

13. Illnesses. ***Darken the circle*** of the illness you ***Had*** or now ***Have***:

Had	Have		Had	Have	
O	O	AIDS	O	O	Malaria
O	O	Alcoholism	O	O	Measles
O	O	Allergies	O	O	Multiple Sclerosis
O	O	Arteriosclerosis	O	O	Mumps
O	O	Cancer	O	O	Polio
O	O	Chicken pox	O	O	Rheumatic fever
O	O	Diabetes	O	O	Scarlet fever
O	O	Epilepsy	O	O	Sexually transmitted disease
O	O	Glaucoma			
O	O	Goiter	O	O	Stroke
O	O	Gout	O	O	Tuberculosis
O	O	Heart disease	O	O	Ulcer

14. Operations. Surgical interventions which may or may not have included hospitalization.

- O Appendix removal
- O Bypass surgery
- O Cancer
- O Cosmetic surgery
- O Elective surgery _____
- O Eye surgery
- O Hysterectomy
- O Pacemaker
- O Spine _____
- O Tonsillectomy
- O Vasectomy
- O Other _____

15. Injuries. Have you ever…

- O Had a fractured or broken bone
- O Had a spine or nerve disorder
- O Been knocked unconscious
- O Been injured in an accident

16. Medications

_____
_____
_____
_____
_____

17. Family History. Some health issues are hereditary. List health issues of your immediate family members. _____

_____

18. Social History. *(Darken circle)*

Alcohol use	O Daily	O Weekly
Caffeine use	O Daily	O Weekly
Tobacco use	O Daily	O Weekly
Exercise	O Daily	O Weekly

_____ _____

SIGNATURE **DATE: (MM/DD/YYYY)**

CONFIDENTIAL HEALTH INFORMATION

_____

Patient Name

Consultation Notes:

_____

Doctor's Initials

Olson Chiropractic, P.C.
Dennis R. Olson, D. C.
Brenton L. Olson, D.C.