OLSON CHIROPRACTIC CLINIC
CASE HISTORY UPDATE

In order for us to best serve you, and so that we may bring your original case history up to date, please provide us with the following information.

Please Print

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Phone No. ( ) _____ SS#_____ D.O.B._____/_____/_____

Employed by_____ Occupation_____

Bus. Address_____ Bus. Ph# ( ) _____
Street City State Zip

_____ Single _____Married _____Separated _____Divorced _____Widowed

Spouse's Name_____ Employed by_____

1. List present complaints and beginning date of this condition _____

_____

_____

2. What do you believe caused this condition? _____

_____

_____

3. Describe any falls, surgery and/or traumas since last visit_____

_____

_____

4. List previous conditions you were treated for/check your response

_____ _____ favorable

_____ _____ unchanged

_____ _____ unfavorable

5. List any other doctors seen since last visit and treatment received _____

_____

_____

6. Date of last physical_____ Date of last adjustment _____

7. List medications presently taking _____

_____

_____

If you've had an accident, give date _____

Where did it occur? _____

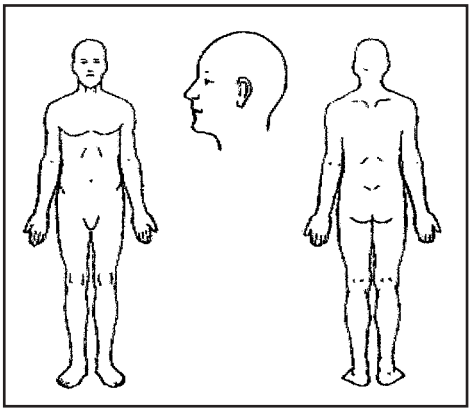
How did it occur? _____ Auto accident _____ On the Job _____ Other

Describe circumstances _____

_____

Have you lost time at work? _____

MARK PAIN AREA



Describe pain:

_____ Sharp _____ Constant

_____ Dull _____ Comes & goes

_____ Tingling _____ Worse when I _____

Female: Are you pregnant? _____ Number and ages of children _____

Name of insurance _____

Type of insurance _____

Additional comments _____

_____

_____

_____

_____

_____

_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature _____ Date _____

(If patient is a minor, name of parent, guardian, etc.)