

ABOUT THE PATIENT

Oleson Chiropractic 514 First Ave Armstrong, IA 50514

Name _____ Today's Date _____ Birthdate _____ Age _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____ Gender M F
 Significant Other's Name _____ Kid's Names and Ages _____
 Your Employer _____ Type of Work _____
 e-Mail Address _____ Have you been to a chiropractor before? No Yes
 Emergency Contact _____ ph # _____ Cell #: _____
 Name of Medical Doctor(s) _____ Referred by: _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Oleson Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: Cash Check Credit Card Car/Work Ins.

Patient / Parent Signature _____ (This represents a long term authorization for all occasions of service) _____ Date _____

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____
2. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____
3. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____
4. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

5. Does your condition affect: Sleep Work Daily Routine Sitting Driving

6. What makes it better? _____

7. What makes it worse? _____

8. What Doctor's have you seen for this? _____

9. Type of treatment: _____

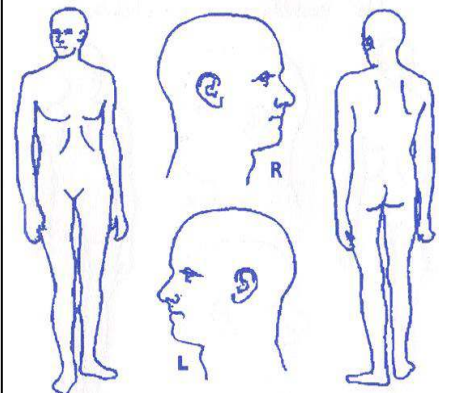
10. Results: _____

NOTES: _____

Are you pregnant?

- Yes No

Please mark All areas of concern.



GENERAL HEALTH HISTORY

Oleson Chiropractic 514 First Ave Armstrong, IA 50514

Patient Name _____ *Mark the conditions that apply to you.*

- | Past | Present | Past | Present |
|--------------------------|--|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Headaches | <input type="checkbox"/> | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Migraines | <input type="checkbox"/> | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> | <input type="checkbox"/> Allergies / Asthma | <input type="checkbox"/> | <input type="checkbox"/> Dental Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Medication Side Effects | <input type="checkbox"/> | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> Blood Thinner use |
| <input type="checkbox"/> | <input type="checkbox"/> Hands or Feet cold | <input type="checkbox"/> | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> | <input type="checkbox"/> Muscle aches | <input type="checkbox"/> | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> Trouble Walking | <input type="checkbox"/> | <input type="checkbox"/> Depression |
| <input type="checkbox"/> | <input type="checkbox"/> Leg / Foot Numbness | <input type="checkbox"/> | <input type="checkbox"/> Alcohol Use |
| <input type="checkbox"/> | <input type="checkbox"/> Fainting | <input type="checkbox"/> | <input type="checkbox"/> ___High or ___Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> Gall Bladder Trouble | <input type="checkbox"/> | <input type="checkbox"/> Stroke History |
| <input type="checkbox"/> | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> | <input type="checkbox"/> Pain all Over |
| <input type="checkbox"/> | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> | <input type="checkbox"/> Tension / Irritability |
| <input type="checkbox"/> | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> | <input type="checkbox"/> Heart Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Other _____ | | |

1. List any medications are you taking: _____

2. Please list all doctors you are currently seeing: _____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": No Yes, Name _____

PAST HISTORY

4. List any past auto collisions: _____ Was any care received? _____

5. List any past work injuries: _____ Was any care received? _____

6. List any past sport, recreational, or home injuries _____

7. Please describe any past conditions and treatment received: _____

8. Please list any past hospitalizations and surgeries: _____

FAMILY HISTORY

Father's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other _____

Mother's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other _____

Is there any other family history you want us to know? _____



Dr. Greg E. Oleson
514 1st Avenue
Armstrong, IA 50514
(712) 868-3265

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ Last Name: _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: ___/___/___ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____

**OLESON CHIROPRACTIC
514 FIRST AVENUE
ARMSTRONG, IA 50514**

FORM: NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

OLESON CHIROPRACTIC uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

OLESON CHIROPRACTIC may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

OLESON CHIROPRACTIC may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations, a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request accounting of your health records.

You may complain to Dr. Greg E. Oleson and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

OLESON CHIROPRACTIC must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints, please contact Dr. Greg E. Oleson at (712) 868-3265.

Patient Signature

Date