Oleston
CHIROPRACTIC
traditional & holistic approach

Welcome To Our Office!

Date:_____

First Name _____Middle Initial_____Last Name_____

Address:_____

City:_____State:_____Zip Code:_____

Home Phone:_____Cell Phone:_____

DOB: _____ Age: _____Email:_____

Employer:_____ Marital Status: M/ S/ D/ W Number of Children: _____

Emergency Contact :_____Contact Phone:_____

Family Physician:_____Phone Number:_____

Who may we thank for referring you to us?_____

1. What are the complaints for which you are seeking treatment?

_____ _____ _____

_____ _____ _____

2. If you have pain, please describe and give location: _____
_____

3. How often do you experience your symptoms?

□ Constantly (76-100% of the time)
□ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time)
□ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp
□ Dull
□ Diffuse
□ Achy
□ Burning
□ Shooting
□ Stiff
□ Numb
□ Tingly
□ Sharp with motion
□ Shooting with motion
□ Stabbing with motion
□ Electric like with motion
□ Other_____
□ N/A

Name_____

5. How are your symptoms changing with time?
□ Getting Worse □ Not Changing □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?
□ Not at all □ Slightly □ Moderately □ Substantially □ Extremely

8. How much has the problem interfered with your social activities?
□ Not at all □ Slightly □ Moderately □ Substantially □ Extremely

9. Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER Physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?_____

12. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

13. What aggravates your problem?
_____

14. What alleviates your problem?
_____

15. What concerns you the most about your problem; what does it prevent you from doing?
_____

16. What is your: Height_____ Weight _____Date of Birth _____
Occupation _____

17. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

18. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

19. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus □Other_____
□ Heart Problems □ Cancer □ ALS □None

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Name_____

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ Chronic Sinusitis	□	□ Dizziness
□	□ Neck Pain	□	□ High Blood Pressure	□	□ Diabetes
□	□ Upper Back Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Mid Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Low Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Shoulder Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Elbow/Upper Arm Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Wrist Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Hand Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hip Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Upper Leg Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Knee Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Lower Leg Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue	□Other:_____	
□	□ Tumor	□	□ Muscular Incoordination _____		
□	□ Asthma	□	□ Visual Disturbances		

21. List all medications you are currently taking:

_____

22. List all of the vitamins/supplements you are currently taking:

_____

23. List all surgical procedures you have had:

_____

24. What activities do you do at work?

□ Sit:	□ Most of the day	□ Half the day	□ A little of the day
□ Stand:	□ Most of the day	□ Half the day	□ A little of the day
□ Computer work:	□ Most of the day	□ Half the day	□ A little of the day

25. Have you ever been hospitalized? □ No □ Yes

if yes, why

_____

26. Have you ever been treated by a chiropractor? □ No □ Yes

If so, explain when/why: _____

Results? Great Good Fair Mixed Poor

27. Have you had significant past trauma? □ No □ Yes _____

_____

28. Anything else pertinent to your visit today? _____

Name_____

CONSENT TO TREAT: I hereby request and consent to the performance of chiropractic treatment, including various modes of adjunctive therapy by Dr. Abigail Perri. This consent is extended to other chiropractors or chiropractic assistants, who now or in the future, are employed by, working with, or associated with this office. I understand that there are some risks to treatment and I will rely on the doctor to exercise appropriate judgment during the course of care, based on the facts known at this time, and in my best interest.

Signature_____ Date_____

CONSENT TO TREAT A MINOR CHILD: I hereby authorize Oleston Chiropractic, PA to administer chiropractic treatment as deemed necessary for my child.

Print Name_____ (Parent/Legal Guardian)

Signature_____ (Parent/Legal Guardian) Date_____

FINANCIAL/INSURANCE POLICY: I understand and agree that health and automobile insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Oleston Chiropractic, PA will submit claims to my health insurance as an out-of-network/non-participating provider to assist me in making collection from the insurance company. Any amount authorized to be paid directly to Oleston Chiropractic, PA will be credited to my account upon receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I further agree that if my account is referred to a collection agency and/or attorney, I agree to pay the collection agency fees, attorney's fees, and court costs associated with the collection process.

Signature_____ Date_____