ODLAND
Chiropractic Clinic, P.C.

Dr. Rick Odland
Dr. Todd Marlette

Patient Information Date _____

Name _____ Gender: Female _____ Male _____
SS#_____ Date of Birth _____ Age _____ Marital Status ___ No. Children _____
Address _____City _____State _____ Zip _____
Home Phone _____ Cell Phone _____ Spouse's Name _____
Occupation _____ Employer _____ Work Phone _____
Emergency Contact _____ Phone _____
Address _____City _____ State _____ Zip _____
Have you ever had Chiropractic care before _____ if yes, date of last Chiropractic treatment _____
Referred by (please list how you heard of us) _____

Patient Health Questionnaire

What are your symptoms? _____
_____
When and how did your symptoms begin? _____
_____
Have you had similar symptoms before? Yes _____ No _____ Not this bad _____ When _____
How do your symptoms feel?

Sharp	Shooting
Dull ache	Burning
Numb	Tingling
Throbbing	Stabbing

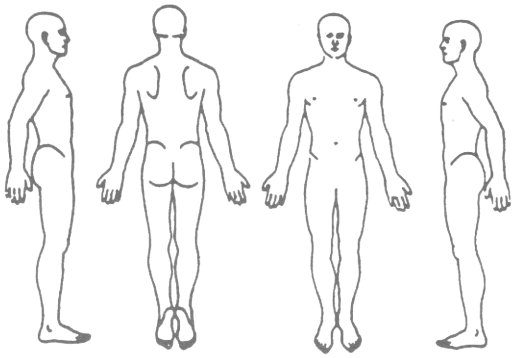
How are your symptoms changing?

Getting better
Getting worse
Not changing

How bad are your symptoms at their:

Worst 0 1 2 3 4 5 6 7 8 9 10
Best 0 1 2 3 4 5 6 7 8 9 10

Circle area of pain



What makes your symptoms worse? _____
What makes your symptoms better? _____
Who have you seen for your symptoms? 1. No one 2. Other Chiropractor 3. Medical Doctor 4. Physical Therapist 5. Other _____
In addition to reducing pain and symptoms, what else do you hope to learn from your treatments? _____
_____

Please continue on the back page

For each of the symptoms or conditions below, place a check next to the symptoms or conditions that you currently have.

__ Headaches
__ Neck Pain
__ Pain Between Shoulders
__ Mid Back Pain
__ Low Back Pain
__ Shoulder Pain
__ Elbow Pain / Arm Pain
__ Wrist Pain
__ Hand Pain
__ Hip Pain
__ Knee / Leg pain
__ Ankle / Foot Pain
__ Jaw Pain
__ Joint Swelling / Stiffness
__ Arthritis
__ Bursitis
__ Sciatica
__ Neuralgia
__ Muscle Pain
__ General Fatigue
__ Decrease Quality of Sleep
__ Visual Disturbances
__ Changes in Vision
__ Dizziness
__ Fainting
__ Epilepsy
__ Convulsions
__ Fever
__ Night Sweats
__ Deafness
__ Earache
__ Changes in Hearing

__ Low Blood Pressure
__ High Blood pressure
__ Rapid Heart Beat
__ Slow Heart Rate
__ Poor Circulation
__ Heart Attack
__ Chest Pains
__ Angina
__ Stroke
__ Kidney Stones
__ Kidney Problems
__ Bladder Infection
__ Frequent Urination
__ Inability to Urinate
__ Painful Urination
__ Bed-wetting
__ Blood in Urine
__ Loss of Bladder Control
__ Prostate Problems
__ Excessive Thirst
__ Excessive Hunger
__ Loss of Appetite
__ Loss of Weight
__ Hernia
__ Stomach Pain
__ Constipation
__ Diarrhea
__ Ulcer
__ Liver / Gall Bladder Problems
__ Nausea
__ Vomiting
__ Sore Throat

__ Enlarged Glands
__ Sinus Congestion
__ Sinus Infection
__ Chronic Cough
__ Breathing Problems
__ Spitting up Blood
__ Spitting up Phlegm
__ Bruise Easily
__ Dermatitis / Eczema / Rash
__ Varicose Veins
__ Psoriasis
__ Cancer
__ Tumor
__ Asthma
__ Allergies
__ Diabetes
__ HIV / AIDS
__ Nervousness / Depression
__ Smoking / Use of Tobacco
__ Drug or Alcohol Dependence
__ Multiple Sclerosis

Females only
__ Are you Pregnant
__ Cramps or Backache
__ Excessive Menstrual Flow
__ Irregular Cycle
__ Painful Menstruation
__ Menopausal Symptoms
__ Birth Control Pills
__ Hormone Replacement

Indicate if an immediate family member has had any of the following
__ Arthritis __ Heart Problems __ Stroke __ Diabetes __ Cancer __ other _____

List any Hospitalizations or Surgical Procedures _____

_____

List any medications that you are taking _____

_____

Have you ever been in an auto accident _____ describe injuries _____

_____

List any injuries where you were knocked unconscious, fractured a bone, or had any type of injury _____

_____

List any other information you feel is important _____

_____

I realize that I am responsible for any copayments and deductibles for all covered services and any noncovered services my insurance does not cover. I understand any outstanding balances may have interest charged. Please ask if you have any questions.

Patient Signature _____ Date _____