# ODLAND
## Chiropractic Clinic, P.C.

Dr. Rick Odland
Dr. Todd Marlette
Dr. Mark Bledsoe

**Patient Information** Date _____

Name _____ Gender: Female _____ Male _____
SS#_____ Date of Birth _____ Age _____ Marital Status ___ No. Children _____
Email _____
Address _____City _____State _____ Zip _____
Home Phone _____ Cell Phone _____ Spouse's Name _____
Occupation _____ Employer _____ Work Phone _____
Emergency Contact _____ Phone _____
Have you ever had Chiropractic care before _____ if yes, date of last Chiropractic treatment _____
Referred by: __ Friend/Family (Name)_____ __ Local Best __ Insurance __ Internet
__ Other, please explain _____

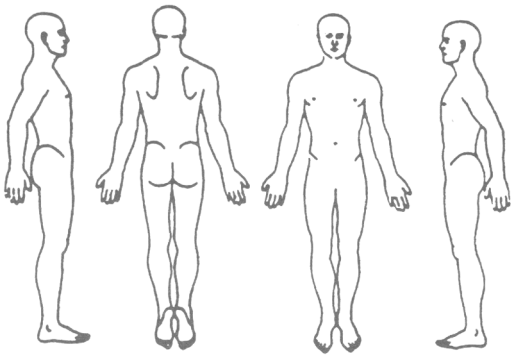
**Patient Health Questionnaire**

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:
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

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. Medical Doctor 3. Other Chiropractor
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
__ Fibromyalgia
__ Multiple Sclerosis
__ 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
__ COVID-19
__ Nervousness / Depression
__ Smoking / Use of Tobacco

**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 _____

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 _____