AWENDER CHIROPRACTIC

PT #____________
Date____________

333 West Maude, Suite 105, Sunnyvale, CA 94085

1-888-DrAwender

1-888-372-9363

PATIENT INFORMATION

Name ____SS#___________________________

Address _________________________ City ________________ State _______ Zip_____________

Home Phone(____)_________________________Email _________________________________

Sex M F Age ____ Date of Birth ___/___/___ Marital Status: S M D W # of Children___

Name of Spouse _______________________ Your Occupation_______________________________

Employer___________________________________Work Phone(____)_________________________

What is the purpose of this visit?____

Where is the pain? ___________________________________ When did it start?______________

What where you doing when you first noticed it? ____

When do you feel it most? AM PM Standing Sitting Walking Laying Down

What does it feel like? Sharp Dull Stabbing Aching Other _____________________

Was this caused by an accident? Yes No

If Yes then what type of accident? Auto Work Home Other______________

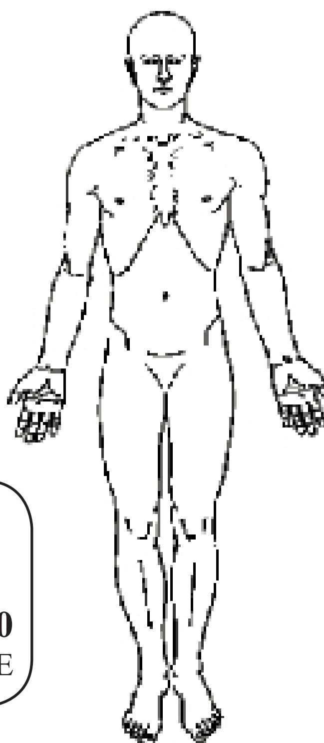
Date of Accident ___/___/___ Have you made a report? Yes No

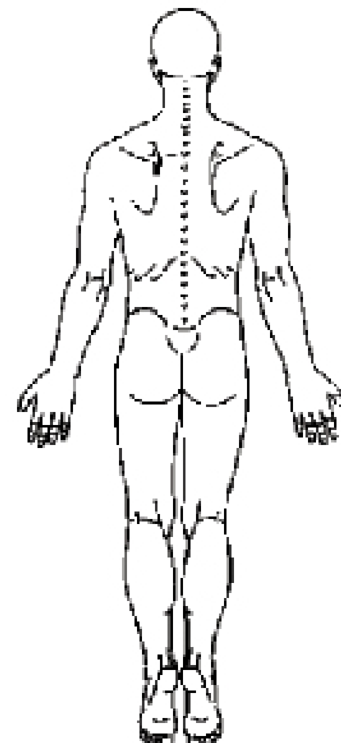
How did you hear about us? ____

PAIN DISABILITY INDEX

On the Diagram to the right, please indicate where you are experiencing pain or other symptoms.

A = Ache **B** = Burning **N** = Numbness
P = Pins & Needles **S** = Stabbing
O = Other





PAIN SCALE

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE SLIGHT MODERATE SEVERE

-OVER-

Do you suffer from any of the following conditions? (check all that apply)

Allergies	Digestive problems	Jaw problems
Arthritis	Depression	Low back pain
Asthma	Ears ringing	Leg pain
Arm/shoulder pain	Fatigue	Mid back pain
Blurred vision	Foot/toe numbness	Neck pain
Carpal tunnel	Gout	Tension
Diabetes	Hand/finger numbness	Urinary tract infections
Difficulty sleeping	Headaches	
Dizziness	Heartburn/acid reflux	

Have you seen or have been seen by any other health care professional for your condition(s)?
Yes No If Yes then who? MD DO DC PT Other________________________
Name____________________ Treatment________________________ Did it help? Yes No

Please list any past injuries from falls, auto accidents, fractures, sports injuries, etc...
____
____

Are you currently taking or have taken any medications for pain, allergies, asthma, heart problems, blood pressure, cholesterol lowering, diabetes, Anti-inflammatory, depression/anxiety, neurontin, anti seizure, or any others? Yes No
If yes than what are you taking?____
____

Have you been to a chiropractor before? Yes No
Who was your chiropractor?____
What did you go in for?__________________________ Did it help? Yes No
Why did you stop care?____

PAYMENT IS EXPECTED AT THE TIME OF VISIT

Who is responsible for this account?____
Relationship to patient Self Spouse Parent Guardian Other_________________
Drivers licence#_______________________ **Social Security #**________-________-_________
Insurance company_________________________ **Policy number**_____________________

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benifits. I Authorize the use of this signature on all insurance submissions.

Signature of patient, parent or guardian____
Please print the above name_________________________________ **Date**____/____/______

Please provide the front desk a copy of your insurance card or other insurance information.