AWENDER CHIROPRACTIC

PT #_____
Date_____

333 West Maude, Suite 105, Sunnyvale, CA 94085

1-888-DrAwender

1-888-372-9363

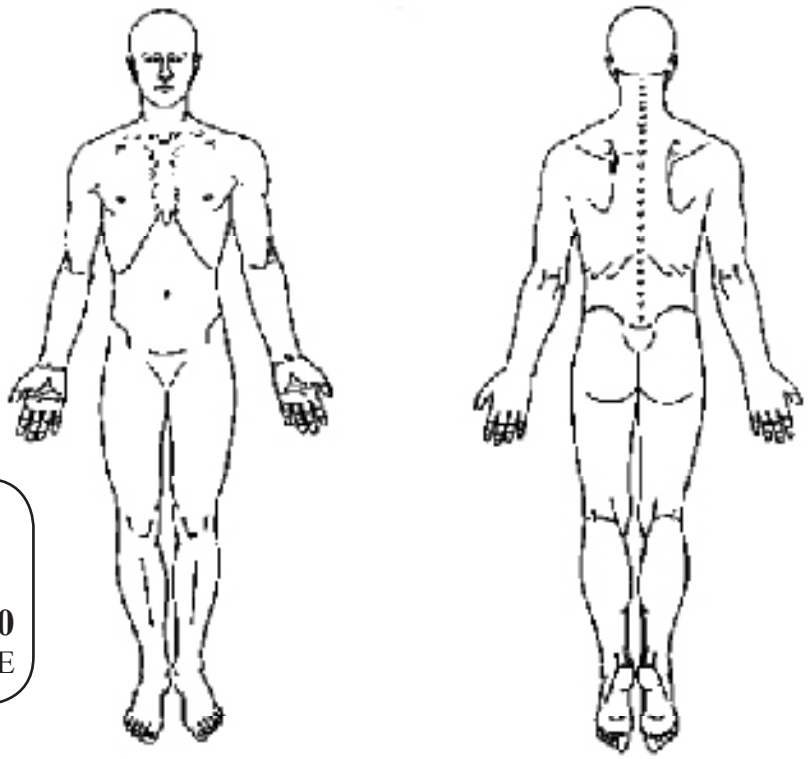
PATIENT INFORMATION

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.