Dr. Frank Panoussi

Chiropractor

First name _____ Last name _____ Middle initial _____

Address _____ City _____ Zip code _____

Phone # _____ Soc. Sec. # _____ Birth date _____

Marital status: Single Married Widowed Divorced Sex: Female / Male Age_____

Email address _____ Occupation:_____

Employer _____ Employers address _____

City _____ Zip code _____ Phone # _____

Name of spouse _____ Spouse's occupation _____

Employer _____ Employers address _____

City _____ Zip code _____ Phone # _____

Nearest relative (not living with you) _____Phone # _____

Address _____ City _____Zip code _____

Referred by _____

Were you hurt: ☐ At Work ☐ Auto Accident ☐ Other: _____

What medications are you taking? _____

Family history of: ☐ Heart disease ☐ Cancer ☐ Diabetes ☐ Arthritis

☐ Back problems ☐ Disc problems ☐ Other: _____

Name of policy holder _____ Relationship to patient _____

Insurance company _____

Address _____ City _____ Zip code _____

Phone # (_____)_____ Member ID # _____ Group # _____

Policy # _____ Cert # _____ Employee # _____

Major pain or problem today _____

How did it happen? _____

_____

Are you pregnant? _____ When were you last x-rayed _____

By whom _____

Check symptoms you have noticed: *Use N if problem Now, use P if problem in the Past, Leave blank if OK*

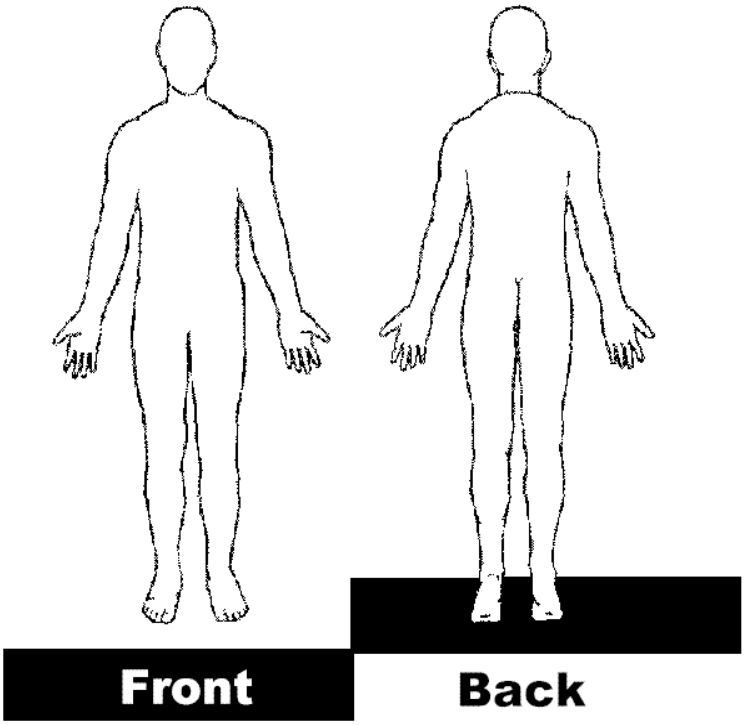
( ) Headaches	( ) Pain in shoulder	( ) Low back pains
( ) Head feels heavy	( ) Muscle spasms in shoulder	( ) Low back muscle spasms
( ) Light headed	( ) Pain in neck	( ) Pain into buttock
( ) Loss of balance	( ) Stiff neck	( ) Pain into thigh
( ) Dizzy	( ) Muscle spasms in neck	( ) Pain down leg
( ) Nervous	( ) Pain in arm and hand	( ) Pain in ankle
( ) Fatigue	( ) Pins & needles in arms/hands	( ) Pain in foot
( ) Loss of hearing	( ) Loss of grip strength	( ) Blurred vision
( ) Mid back pain	( ) Chest pain	( ) Pain between shoulders

Today's problem or pain started when: _____

_____

How bad is your pain? (0 = no pain, 10 = unbearable pain)
0 1 2 3 4 5 6 7 8 9 10

Mark an X on the figure below where you have pain or other symptoms.



Pains are: □ Sharp □ Dull □ Throbbing □ Aches
□ Shooting □ Tingling □ Burning □ Other _____

How often are your symptoms present?
□ Constant □ Intermittent □ Occasionally

What activities aggravate your condition?_____

_____

Is condition worse during certain times of the day?

_____

Is this condition interfering with work? □ Yes □ No
Is this condition interfering with sleep? □ Yes □ No
Is this condition interfering with routine?□Yes □No
Is condition getting progressively worse? □Yes □No
Other doctors seen for this condition: _____

_____

Any home remedies:_____

_____

Previous serious illness: (Please list & describe)
Cancer _____
Fractures_____
Other_____

_____

This office will gladly prepare medical claim forms, but we cannot render services on the assumption that our charges will be paid by the insurance company. You are responsible for payment whether or not paid by insurance.

I hereby authorize Frank Panoussi, D.C. to 1.) administer any treatment he considers for my health and well being, and I release Frank Panoussi, D.C. from all medical responsibilities if I consider to discontinue such treatment before such treatment is all completed, and 2.) furnish to the above insurance company all information which said insurance company may request.

ASSIGNMENT OF BENEFITS
I, the undersigned, do hereby authorize payment directly to Frank Panoussi, D.C., the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid.

Patient Signature _____ **Date** _____