Raymond Lanjopoulos D.C. Family Chiropractors (517) 627-4547

Patient Number: _____

PATIENT INFORMATION (Please answer all questions that apply to you)

Last Name: _____ First Name: _____ M.I: _____ Social Security #: _____

Address: _____ Single ____ Married ____ Other_____

Zip: _____ City/State: _____

Home Phone #: _____ Work Phone #:_____ Birthdate: _____ Sex: M F

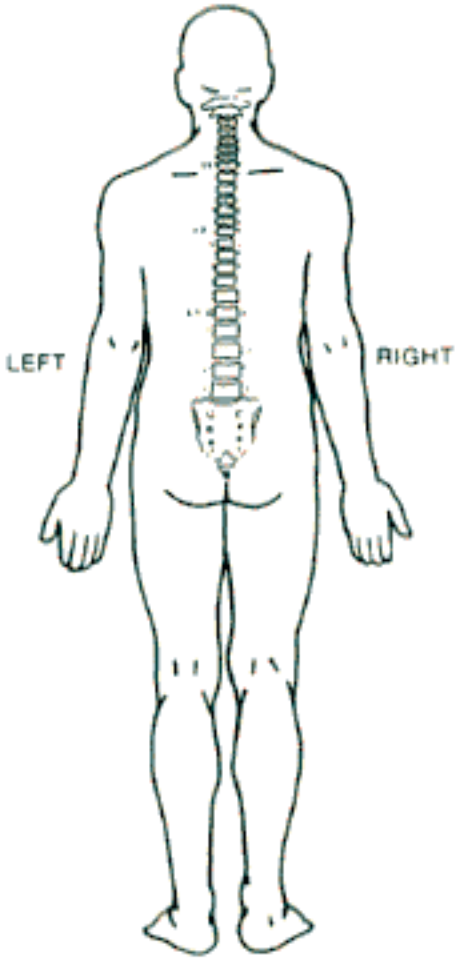
Occupation: _____ Employer: _____ Referred by: _____

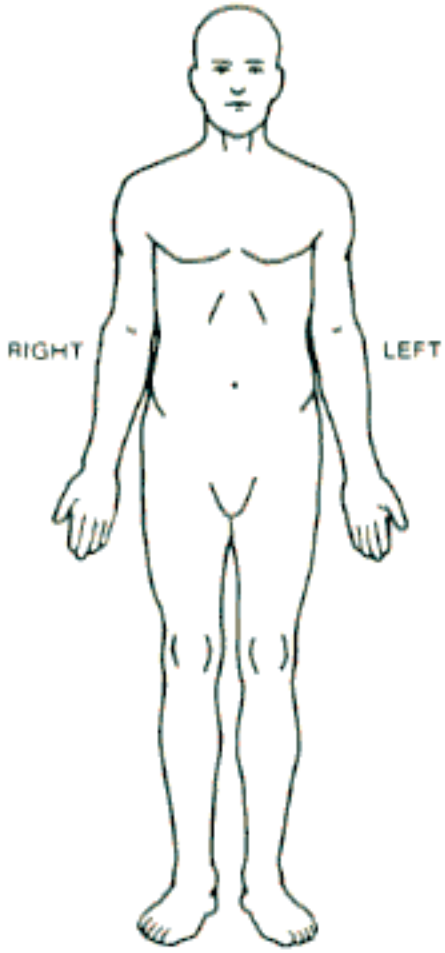
Employer's Address:_____

Is your condition due to a work injury? Yes( ) No( )
Is your condition due to an auto accident or personal injury? Yes( ) No( )
Is there any chance that you are pregnant? Yes( ) No( )

Health History

What is your major complaint? _____
How long have you had this condition?_____
Other doctors that have treated you for this condition: _____
List surgeries: _____
Broken bones: _____ Auto accidents: _____
List medications you are taking: _____





Major Complaints

1._____
_____
2._____
_____
3._____
_____
4._____
_____
5._____
_____

N - Numbness P - Pain T - Tingling A - Ache S - Soreness ST - Stiffness

Please check any that apply:

( ) headache
( ) neck pain
( ) neck stiffness
( ) double vision
( ) numbness in arms
( ) dizziness
( ) pain radiating into neck
( ) shoulder/arm pain (L or R)
( ) upper back pain
( ) mid back pain
( ) chest pain
( ) shortness of breath
( ) low back pain
( ) numbness in legs
( ) numbness in feet
( ) leg pain (L or R)
( ) anxiety
( ) neuritis
( ) fatigue
( ) swelling
( ) tension
( ) cold feet
( ) cold hands
( ) irritability
( ) fainting
( ) pain behind eyes
( ) tremors
( ) nausea/vomiting
( ) excessive perspiration
( ) restriction of motion
( ) sinus trouble
( ) depression

( ) difficulty in rising to walk after sitting
( ) difficulty in standing
( ) difficulty in walking
( ) difficulty in bending
( ) difficulty in lifting
( ) equilibrium problems
( ) pain while sitting
( ) pain while walking
( ) pain while standing

Family Health Information:

Please give details of any family health conditions (e.g. hytension, heart problems, diabetes, back problems, cancer, etc.)

Name:	Relation:	Past/Present Health Problems:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Assignment

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____
Patient's Signature Date

Release of Information

I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case; and hereby release this clinic of any consequences thereof.

_____ _____
Patient's Signature Date

Financial Responsibility

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, copayment and any services rejected by my insurance company.

_____ _____
Patient's Signature Date

_____ _____
Guardian/Parent's Signature Authorizing Care Date

Payment method Cash, check, credit card. Visa, Mastercard or Discover

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(For Doctor's Use Only):

Primary Subluxation: _____ Component Diagnosis: _____ _____ _____ _____

Secondary Subluxation: _____ Component Diagnosis: _____ _____ _____ _____

Notes:

Re evaluation Date: _____