

LYNNHAVEN CHIROPRACTIC CLINIC

Dr. Tracy M. Sawyer

228 N. Lynnhaven Road, Suite 115, Virginia Beach, VA 23452

(757) 498-4824

Name _____ DOB _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

SSN _____ Occupation _____ Marital Status M S W D

Employer _____ Employer's Address _____

Name of Bank _____ Health Insurance Company _____

Spouse's Name _____ Children? Yes No Ages _____

Spouse's SSN _____ Occupation _____ Employer _____

Reason for this visit (major complaint(s) & date of onset) _____

PAIN SCALE: Please circle the number that best describes your pain: 0 1 2 3 4 5 6 7 8 9 10
 none little medium severe

Are you on any Medications? Yes No Name of Medication(s) _____

If you are female, is there any possibility of pregnancy? Yes No If yes, number of weeks _____

If due to an accident, please complete the following:

Date of accident _____ Location _____

How did the accident occur? Auto collision On the job injury Other _____

CHECK THE FOLLOWING YOU ARE OR HAVE BEEN EXPERIENCING

Headaches	Arthritis	Tingling/Numbness in Arm
Neck Pain/Stiffness	Tension	Tingling/Numbness in Hand
Back Pain	Dizziness	Tingling/Numbness in Leg
Shoulder Pain	Shortness of Breath	Tingling/Numbness in Foot
Chest/Rib Pain	Depression	Elbow Pain
Hip Pain	Fatigue	Wrist/Hand Pain
Muscle Cramps/Spasms	Irritability	Knee Pain
Sleeping Difficulty	Ankle/Foot Pain	Other _____

I understand that I am responsible for any amount not promptly covered by insurance carriers. Fees are payable at the time services are rendered, unless other arrangements are made in advance. X-rays remain the property of this clinic. Accounts 30 days past due will be assessed at 1-1/2% service charge monthly. I agree to pay any and all fees and costs for the collection of my account, should it become delinquent and forwarded to a third party for collection purposes. This includes, but not limited to, collection agency and/or attorney fees of twenty-five percent (25%) of the unpaid balance and court costs. I authorize the release of any medical information necessary to process this claim and request payment of medical insurance benefits to Lynnhaven Chiropractic Clinic or Dr. Tracy M. Sawyer.

Date _____ Signature _____

Name Printed _____