

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 enter 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

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

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