PATIENT INFORMATION

LYNNHAVEN CHIROPRACTIC CLINIC * (757) 498-4824
Dr. Tracy Sawyer
228 N. Lynnhaven Rd., Ste. 115, Virginia Beach, VA 23452

Name_____ DOB_____ Date_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

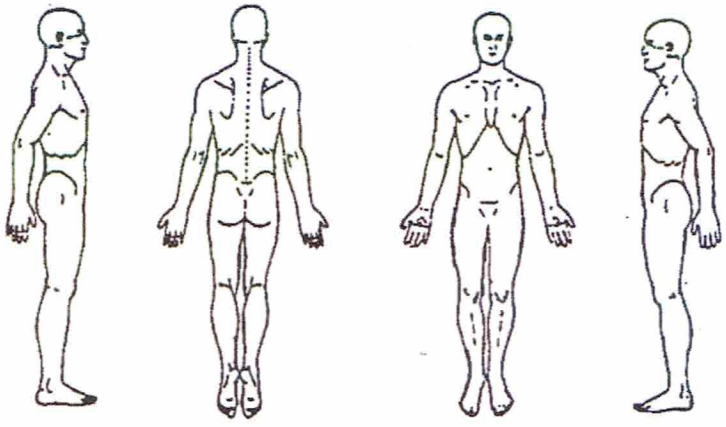
Cell Phone_____ Email_____

Occupation_____ Employer_____

SSN_____ Health Insurance Company_____

Spouse's Name_____ Children? ☐ Yes ☐ No Ages_____

Mark the exact location of your pain below:



DESCRIPTION:

- ☐ Sharp Pain
- ☐ Dull Pain
- ☐ Ache
- ☐ Weak
- ☐ Throbbing
- ☐ Numb
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

FREQUENCY:

- ☐ Constant (76-100%)
- ☐ Frequent (51-75%)
- ☐ Occasional (26-50%)
- ☐ Intermittent (25% or less)

INTENSITY (circle)

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Severe Pain**

Have your symptoms:

☐ Decreased ☐ Not Changed ☐ Increased?

What is your chief complaint? _____

When and how did it start? _____

Does it radiate to any areas of your body? Where? _____

Have you ever had this problem before? Please explain: _____

Have you ever received any treatment for this condition? If yes, by whom, where, when, and what were the results? _____

What aggravates it? _____

What makes it better? _____

Surgeries	Dates	Medications	Reasons

If you have *ever* had a listed symptom in the *past*, please check that symptom in the *Past Column*. If you are *presently* troubled by a particular symptom, check that symptom in the *Present Column*. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

Past	Present	Condition
☐	☐	Autoimmune Disorder_____
☐	☐	Cancer, Explain_____
☐	☐	Diabetes
☐	☐	Depression
☐	☐	Blood Disorder/Clots
☐	☐	Lung Disorder (Emphysema)
☐	☐	Stroke
☐	☐	Heart Attack
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	Aneurysm
☐	☐	Chest Pain/Angina
☐	☐	Abdominal Pain
☐	☐	Colitis/Irritable Colon/Celiac Disease
☐	☐	Bowel/Bladder Changes
☐	☐	Kidney Disorders/Stones
☐	☐	Prostate Problems
☐	☐	Liver/Gallbladder Problems
☐	☐	Hepatitis
☐	☐	Asthma
☐	☐	Epilepsy/Seizures
☐	☐	Dermatitis/Eczema/Rash
☐	☐	Thyroid Disorder
☐	☐	Dizziness/Vertigo/Fainting

Past	Present	Condition
☐	☐	Osteoporosis/Osteopenia
☐	☐	Headaches
☐	☐	Jaw Pain (R____L____)
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Middle Back Pain
☐	☐	Lower Back Pain
☐	☐	Hand Pain (R____L____)
☐	☐	Lower Arm or Wrist Pain (R____L____)
☐	☐	Upper Arm or Elbow Pain (R____L____)
☐	☐	Shoulder Pain (R____L____)
☐	☐	Foot Pain (R____L____)
☐	☐	Lower leg, Ankle or Knee Pain (R____L____)
☐	☐	Upper Leg or Hip Pain (R____L____)
☐	☐	Scoliosis
☐	☐	Fractures/Broken Bones_____
☐	☐	Fibromyalgia
☐	☐	Rheumatoid Arthritis
☐	☐	Other_____

_____

If a family member has had any of the following, please mark the appropriate box:

☐ Cancer	☐ Autoimmune Disorders
☐ Diabetes	☐ High Blood Pressure
☐ Heart Problems	☐ Stroke
☐ Lung Problems	☐ Other_____

Please check any of the following that apply to you:

Yes	No	
☐	☐	Exercise_____Times Per Week
☐	☐	Have You Been To A Chiropractor Before?

Past	Present	
☐	☐	Tobacco Use
☐	☐	Alcohol Use
☐	☐	Caffeinated Drinks

Doctor's Notes:

I certify I have read and understand the above information. I understand that I am responsible for any amount not covered by my insurance carrier. I agree to pay all fees and costs for collection of my account if it is forwarded to an attorney for collection, including attorney fees of 33% of the unpaid balance and court costs. I authorize the release of medical information necessary to process my insurance claims.

_____ _____

Patient or Guardian Signature Date