Strickland Chiropractic Clinic, Inc.
4935 Century Street NW Suite 101, Huntsville, Alabama 35816

Patient # _____

Date _____

Name _____
Last First MI

Address_____ _____
Street City State Zipcode

Phone _____ _____ _____
Cell Work Home

Permission to send text appointmnet reminder Yes No

Permission to email Yes No Email_____

Age _____ Date of Birth_____

Place of Employment_____

Emergency Contact_____ Phone_____

Reason for coming in today_____

_____

How did you hear about us? Friend Family Website Doctor _____

Who may we thank for this referral?_____

Payment is expected in full when services are rendered. As we work on an appointment only basis, if you miss an appointment or do not cancel at least 24 hours in advance, you will be charged a $25 fee. This fee is NOT covered by Insurance. This fee must be paid before your next appointment.

Patient Signature (or Guardian) _____

Witnessed by _____

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HISTORY AND PHYSICAL

Patient Name_____
Last First MI

Date of Birth _____ Male Female Married Single Other

Family Physician_____ Date of last Physical _____/_____/_____

Were there any abnormal findings? If so, please describe _____

_____

SOCIAL HISTORY

Do you Smoke? Yes____ No_____ Packs per day _____

Do you drink Alcoholic beverages Yes____ No_____ Drinks per day_____

Are you allergic to latex products Yes____ No_____

Are you allergic to any Medications Yes____ No_____

Please list all Medications you are allergic to

_____ _____

_____ _____

_____ _____

_____ _____

List all medications you are currently taking

Medications	Dosage	Times/Day

Previous Operations or Hospitalizations:

Date	Hospital/Facility	Reason

Have you had in the past 6 months any MRI's, CT's, Bone Scans, X-Rays or any other diagnostic testing? If Yes tell us

When (date)	Where (facility)	What (what area was scanned)

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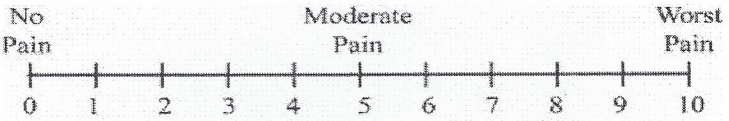
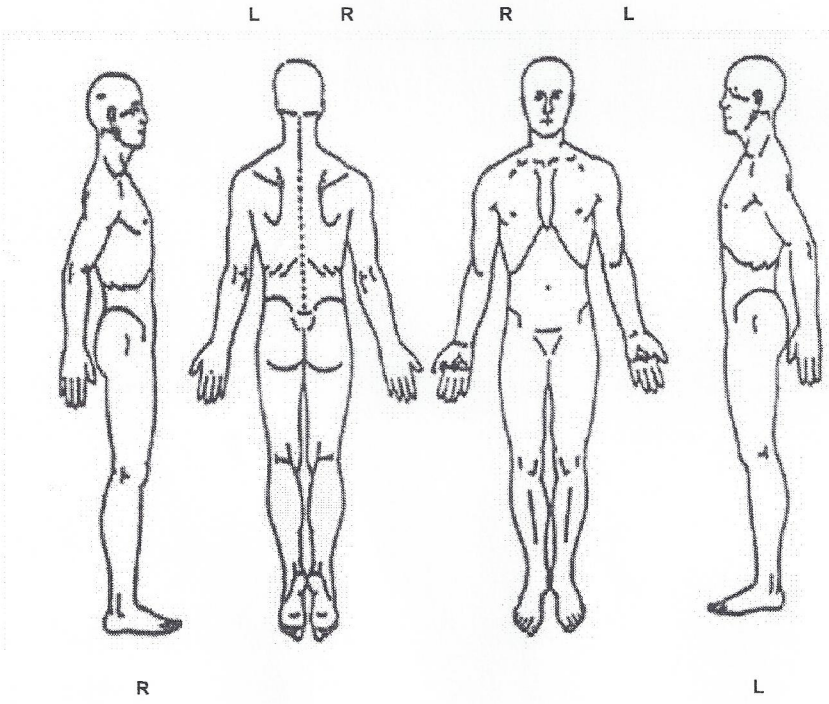
Please circle your pain level
(What your pain is TODAY)



Tell us where you hurt. Please read carefully,

Mark the area on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use appropiate letters as listed below.

Ache= A **Numbness= N** **Pins/Needles= P** **Burning = B** **Stabbing= S** **Throbbing= T**



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Do you have or have you had recently (Please Circle Yes or No)

EYE/EAR		NOSE/THROAT/NECK		CARDIOVASCULAR	
Glaucoma	Yes No	Hoarseness	Yes No	Chest Pain	Yes No
Cataracts	Yes No	Change in Voice	Yes No	Irregular Heartbeat	Yes No
Glasses/Contacts	Yes No	Nose Bleed	Yes No	Low Blood Sugar	Yes No
Loss of Hearing	Yes No	Thyroid	Yes No	Heart Attack	Yes No
RESPIRATORY		**GASTROINTESTINAL**		**URINARY**	
Asthma	Yes No	Stomach Ulcers	Yes No	Bloody Urine	Yes No
Wheezing	Yes No	Gallbladder Trouble	Yes No	Frequent Urine	Yes No
Shortness of Breath	Yes No	Pancreatitis	Yes No	Nighttime Urination	Yes No
Pain with Breathing	Yes No	Colitis	Yes No	Trouble Starting	Yes No
Coughing up Blood	Yes No	Blood in Stool	Yes No	Trouble Stopping	Yes No
		Hiatal Hernia	Yes No	Pain with Urination	Yes No
		Liver Trouble	Yes No	Prostate Problems	Yes No
GENITAL		**NEUROLOGICAL**		**SKIN**	
Sores on genitals	Yes No	Headaches	Yes No	Infections	Yes No
Infections	Yes No	Fainting/Blackouts	Yes No	Psoriasis	Yes No
Herpes	Yes No	Seizures/Epilepsy	Yes No	Skin Cancer	Yes No
AIDS	Yes No	Strokes	Yes No	Rashes	Yes No
AIDS related Disease	Yes No	Paralysis	Yes No		
METABOLIC		**BLEEDING DISORDER**		**FEMALE MEDICAL HISTORY**	
Diabetes	Yes No	Anemia	Yes No	Are you Pregnant	Yes No
Low Blood Sugar	Yes No	Bleeding	Yes No	Are you on the Pill	Yes No
				Date of last Cycle	_____
				Postmenopausal	Yes No
				Number of years	_____

Have you ever been diagnosed with Cancer? Yes No

If yes, Please Describe _____

BONE & JOINT

Arthritis	Yes No
Rheumatoid Arthritis	Yes No
Gout	Yes No
Lupus	Yes No
Osteoarthritis	Yes No

FAMILY HISTORY

Diabetes	Yes No	Type I _____ Type II _____
Cancer	Yes No	Mother Father
Heart Disease	Yes No	Mother Father
High Blood Pressure	Yes No	Mother Father
Strokes	Yes No	Mother Father
Tuberculosis	Yes No	Mother Father

Patient Signature/Guardian:_____ Date :_____

Consent to Chiropractic Manipulation and Care

I request and consent to the performance of chiropractic manipulation and other chiropractic procedures that may include acupuncture, ultrasound, traction, soft tissue manipulation, and/or muscle stimulation. These will be performed and/or supervised by Dr. Kenneth B. Strickland or Dr. Sandra L. Strickland. I understand that the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgements based upon the facts known to the doctors at that time. It is not reasonable to expect the doctor to anticipate or explain all risks and complications. I understand that the incidence of complications is low, but may include soreness, dizziness, bleeding from acupuncture, bruising, fractures, disc injuries, strokes, sprains, dislocations, which relate to physical aberrations unknown or undetectable by the doctor.

I have read or have been read the above consent form. I have the opportunity to ask questions about the content and by signing below, agree to treatment.

Signature _____ **Date**_____

Privacy Practices

As required by the Health Insurance Portability and Accountability Act of 1996, Strickland Chiropractic Clinic, Inc may not use or disclose your health information without your permission. Our Notice of Privacy Practices is available at our front desk and on our website: Stricklandchiropractic.com Your signature on this form indicates that you are giving permission for the uses described therein.

I,_____(print name), hereby authorize Strickland Chiropractic Clinic, Inc. to release health information to my insurance or attorney for the purpose of reimbursement. I assign all medical benefits and payments to Dr. Kenneth B. Strickland or Dr. Sandra L. Strickland. I give permission to the doctors to discuss my case with other Physicians or healthcare providers on my behalf. They may also release information to the following people:

Name_____ Phone_____

Name:_____ Phone_____

Payment is expected in **FULL** for services as they are rendered to me and I am personally responsible for the grand total due Strickland Chiropractic Clinic, Inc. If my account must be turned over to an attorney for collection, I am responsible for all legal fees.

Patient Signature_____ **Date** _____

Strickland Chiropractic Clinic Inc. Financial Policy

Thank you for choosing Strickland Chiropractic as part of your health care team. We are committed to providing the best possible care for you. In order to achieve this goal, we need your assistance in understanding our payment policy. Please understand that payment of your bills is considered part of your treatment. Please read, initial after each section, and sign at the bottom prior to your treatment.

It is our office policy to collect 100% payment for any deductibles, co-pays, co-insurance and non-covered charges at EACH visit. We accept as forms of payment: CASH, PERSONAL CHECK*, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS.*Returned checks will be subject to a $30.00 collection charge in addition to the original check amount. INITIALS _____

HEALTH/MEDICAL INSURANCE: You must provide us a copy of your health insurance card. We will submit your primary/preferred insurance claims as a courtesy to you. However, your insurance policy is an agreement between you and your insurance company, not between your insurance company and this clinic. It is important that you understand your health and accident benefits listed in your policy. There are many variations in insurance policies. It would be in your best interest for you to call your insurance company to determine your CHIROPRACTIC benefits. Monitoring any policy limitations is considered the responsibility of the patient. As a courtesy to our patients, our office will also attempt to contact your insurance company to verify coverage and benefits, BUT this is not a guarantee of what the insurance company will pay. Our office will do our best to ESTIMATE what your patient portion will be at each visit. You will be sent a statement for any difference in the amount paid at each visit and the actual amount due once your claims have been processed and paid. If your insurance company fails to process a claim for any reason, you will be required to pay for services and seek reimbursement from your insurance company. INITIALS _____

NON-COVERED EXPENSES: Our office is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are directly responsible for payment of medical supplies. You may be responsible for payment of charges reduced or denied due to the insurance company's arbitrary determination of usual and customary rates. There may also be charges that your insurance does not cover due to limitations of your policy, or what they consider reasonable and necessary or deem to be experimental or investigational. It is your responsibility to know what the policy limitations are. Our goal is to improve your condition successfully based on what the doctor deems reasonable and necessary treatment, and not on what your policy limitations are. Therefore, unless you alert us prior to treatment, you will be financially responsible for non-covered expenses. INITIALS _____

MISSED APPOINTMENT POLICY: Attending your scheduled appointments is crucial to successful treatment of your condition. If you need to cancel or reschedule an appointment, please allow us the courtesy of 24 hours notice so that we may schedule someone else in need at that time. If you fail to give notice or if you do not show up for your appointment, you will be charged a fee of $25.00. INITIALS _____

I have read, understand, and agree to this Financial Policy.

Patient Signature: Date: