Welcome to Strickland Chiropractic

Patient#_____ Date:_____

Name:_____

Last *First* *MI*

Address:_____

Street *City* *State* *Zip*

Phone:_____ _____ _____

Cell *Work* *Home*

Permission to send text appointment reminder? Y N

Permission to email? Y N Email:_____

Age:____ Birthdate:_____

Emergency Contact:_____Phone:_____

Reason for coming in today:_____

_____

How did you hear about us? friend family website doctor *(circle one)*

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 is not covered by your insurance company. This fee must be paid before your next appointment.

Patient Signature (or guardian)_____

Witnessed by:_____

History

Do you have any of the following: use an X

_____hearing loss	_____cancer	_____shoulder pain
_____sinus issues	_____g-bladder issue	_____elbow
_____headaches	_____bladder issue	_____wrist pain
_____vision issues	_____colon issue	_____hand pain
_____facial tingling	_____constipation	_____mid back pain
_____thyroid issue	_____incontinence	_____low back pain
_____dizziness	_____arthritis	_____leg tingling
_____stroke history	_____gout	_____sciatica/leg pain
_____chest pain	_____diabetes	_____hip pain
_____high BP	_____pregnancy	_____knee pain
_____heart issue	_____neck pain	_____ankle pain
_____pacemaker	_____jaw pain	_____foot pain
_____lung issue	_____arm tingling	_____muscle pain

Other?_____

What medicines are you currently taking?_____

_____

_____

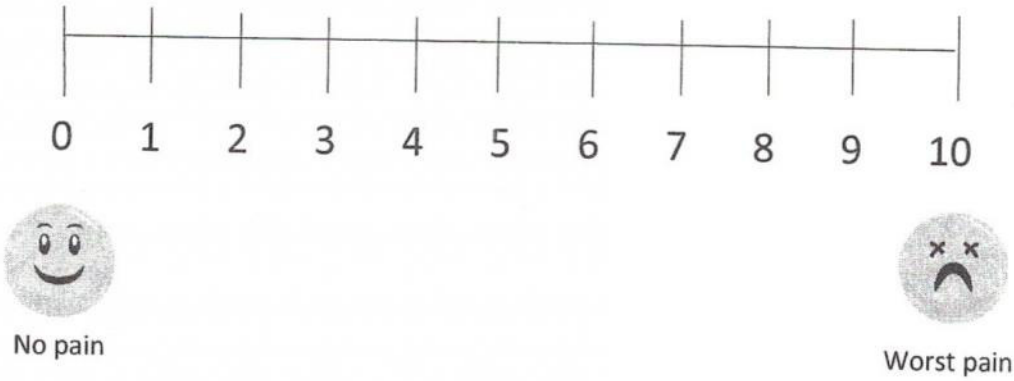
Have you had any recent MRI, CT, or X-rays taken? When?_____

Where?_____ Of what?_____

Your Name:_____***Date:***_____

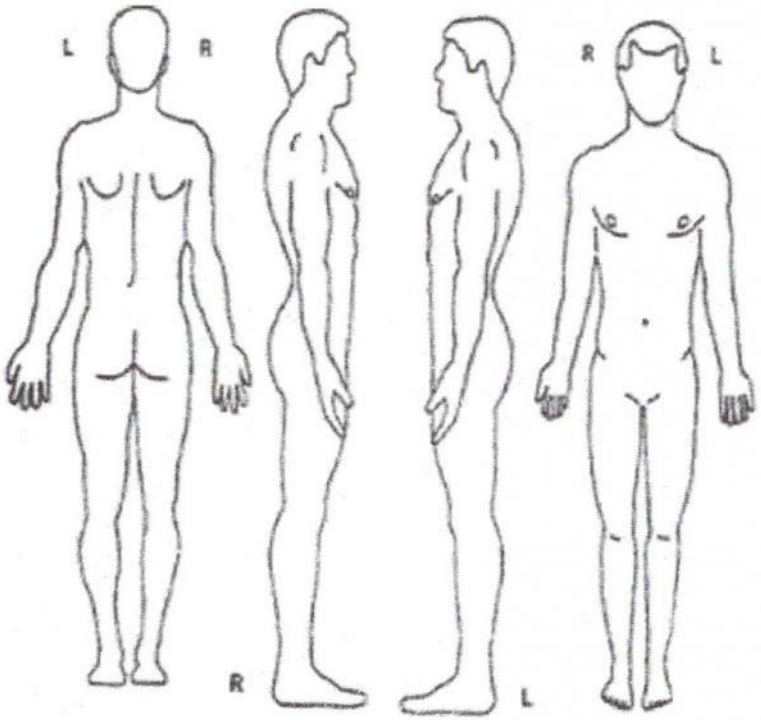
Strickland Chiropractic Clinic, Inc.
4935 Century Street NW, Suite 101, Huntsville, AL 35816

VISUAL ANALOG PAIN SCALE



Tell us where you hurt. Please read carefully.
Mark the areas 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 appropriate letters as listed below.

Ache – A Numbness – N Pins/Needles – P Burning – B Stabbing – S Throbbing - T



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 judgments 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 my health information to my insurance company or attorney for the purpose of reimbursement. I assign all medical benefits and payments to Dr. Kenneth B. 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:**_____

Witnessed By:_____