STRICKLAND CHIROPRACTIC CENTER
Dr. J Lee Strickland

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Date: _____
Address: _____ Cell Phone: _____
City: _____ Zip:_____ Home Phone: _____
Sex: _____ Age: _____
Employer: _____ Marital Status: _____ Birth Date:_____
Employers Address: _____
_____ Occupation: _____
Email: _____ Work Phone:_____ Ext: _____

Spouses Name: _____ Birth Date: _____ Age: _____
Spouses Employer: _____ Occupation: _____
Spouses Email: _____ Work Phone: _____ Ext: _____

Who should we thank for referring you?_____

Conditions: Check all conditions you have or have had in the past.

○ Aids	○ Diabetes	○ Measles	○ Thyroid Problems
○ Alcoholism	○ Emphysema	○ Migraine Headaches	○ Tonsillitis
○ Anemia	○ Epilepsy	○ Mononucleosis	○ Tuberculosis
○ Anorexia	○ Fractures	○ Multiple Sclerosis	○ Tumors, Growths,
○ Appendicitis	○ Goiter	○ Mumps	○ Typhoid Fever
○ Arthritis	○ Gonorrhea	○ Osteoporosis	○ Ulcers
○ Asthma	○ Gout	○ Pacemaker	○ Whooping Cough
○ Bleeding Disorder	○ Heart Disease	○ Pneumonia	○ Other:_____
○ Breast Lump	○ Hepatitis	○ Polio	_____
○ Bronchitis	○ Hernia	○ Prosthesis	_____
○ Bulimia	○ High Blood Pressure	○ Psychiatric Care	_____
○ Cancer	○ High Cholesterol	○ Rheumatoid Arthritis	_____
○ Cataracts	○ HIV Positive	○ Rheumatic Fever	
○ Chemical Dependency	○ Kidney Disease	○ Scarlet Fever	
○ Chicken Pox	○ Liver Disease	○ Stroke	

MEDICATIONS: Medications You Are Currently Taking

_____
_____
_____
_____
_____

Allergies:_____
_____

PRIMARY PHYSICIAN:

_____
Group Name: _____
_____
Address:_____
_____
Phone: _____

PRESENT COMPLAINT

Date of onset: _____
Briefly describe condition and how it happened (if known):_____
_____
_____
How long has condition lasted: _____ **What makes the pain better**:_____
Pain came on: Gradual Suddenly _____
Pain is: Occasional Frequent Constant
Describe the pain: Sharp Dull Burning Other: _____
Does the pain: Stay in one Spot Radiate Go up or down the spine Other:_____
What time of day is the pain worse: Morning Afternoon Evening Night All the time
Does the pain effect your work: Y N How? _____
Does the pain effect your sleep: Y N How? _____
Have you seen other doctors for this condition? Y N Who?_____
Were X-Rays taken? Y N **If Yes, of what areas**: _____
Are you pregnant? Y N **Date of last menstrual period**: _____

NECK, BACK, EXTRMITIES Check symptoms you have currently.

NECK
- ○ Pain in neck
- ○ Neck stiffness
- ○ Neck weakness
- ○ Pinched nerve in neck
- ○ Neck feels out of place
- ○ Muscle spasms in neck
- ○ Grinding/popping sound in neck.

SHOULDER
- ○ Pain in Should Joint: L R
- ○ Pain across shoulders
- ○ Can't raise arm: L R
  - ○ Above shoulder level
  - ○ Over head
- ○ Tension in shoulders
- ○ Pinched nerve shoulders: L R

MID - BACK
- ○ Mid-back pain
- ○ Mid-back stiffness
- ○ Pain between shoulder blades
- ○ Pain from front to back
- ○ Muscle spasms in mid-back

ARMS & HANDS
- ○ Pain in upper arm: L R
- ○ Pain in elbow: L R
- ○ Pain in forearm: L R
- ○ Pain in hand: L R
- ○ Pain in fingers: L R
- ○ Pins & needles in arm: L R
- ○ Pins & needles in fingers: L R
- ○ Numbness in arm: L R
- ○ Numbness in fingers: L R
- ○ Weakness of arm: L R
- ○ Weakness of hand: L R
- ○ Cold hands: L R

LOW BACK
- ○ Low back pain
- ○ Low back stiffness
- ○ Low back weakness
- ○ Pinched nerve in low back
- ○ Low back feels out of place
- ○ Muscle spasms in low back

- ○ Pain in Buttocks
- ○ Pain in hip joint
- ○ Pain down Leg: L R

- ○ Pain in knee: L R
- ○ Pain in ankle: L R
- ○ Pain in foot: L R
- ○ Weakness of leg: L R
- ○ Weakness of knee: L R
- ○ Leg cramps: L R

OTHER SYMPTOMS:
_____
_____
_____
_____
_____
_____
_____

ASSIGNMENT & RELEASE

I, the undersigned, have insurance with_____ and assign directly to Dr. _____ all medical benefits, if any, other wise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Signature of Insured/Guardian Date