IDEAL CHIROPRACTIC

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VISION:

To be a primary healthcare center dedicated to optimizing the health and well-being of our patients.

MISSION:

To add value to your life.

GOALS:

1. Stabilize Autonomic Function

   Order bloodwork and other diagnostic tests to find out which organ systems are not working at optimum levels and support them with lifestyle and dietary changes along with nutritional supplementation.

2. Balance your Hemispheres

   Do the neurological tests to find out which part of the brain has a decreased frequency of firing and use Brain Based Therapy to stimulate that area and balance brain function.

3. Prevent Further Neurological Degeneration

   Malfunction of the CNS can lead to Alzheimer's, Dementia, Parkinsons, Neuropathy and other chronic conditions.

4. To enhance, extend, and have maximum positive impact on your life.

   Joint pain decreases your quality of life and restricts your independence.

IDEAL CHIROPRACTIC

CONFIDENTIAL PATIENT INFORMATION (Please Print)

Date: _____ E-mail Address_____
Full Name: _____ _____
Name of Wife, Husband or Guardian: _____
Address:_____
City _____ State _____ Zip Code _____

Telephone Number ( )_____ Cell Phone Number ( )_____
Social Security No._____-____-_____ Birthdate:_____ No. of Children_____

Currently Pregnant?____ Marital Status: S__ M___D___W__ Student: No___ Part time ___ Full time___
Occupation:_____
Employer's Name / Phone #_____
Spouse's Occupation / Employer:_____
Name and phone # of Emergencey Contact:_____
How did you hear about our office?_____

List Chiropractors you have seen before:

1. Name:_____ When visited: _____
2. Name:_____ When visited: _____

List Medical Doctors consulted within the past year:

1. Name: _____Reason for visit? _____
2. Name: _____ Reason for visit? _____

Please list all your reasons for visiting our office:

1._____ 4._____

2._____ 5._____

3._____ 6._____

*List **ALL*** medications you take, (prescriptions and over-the-counter - use additional pages if needed)

Drug name:	Dosage:	How long have you taken this and for what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

*List **ALL*** nutritional supplements you take. (Use additional pages if needed)

Name of Supplements:	Dosage:	How long have you taken this and for what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

List ALL previous hospializations, surgeries, accidents, fractures and illnesses, (use additional pages) (Example: All past Auto, Sports, Work, Home related).

1. Type_____ _____ When_____ Hospitalized? Yes _____ No____
2. Type_____ When _____ Hospitalized? Yes_____ No____
3. Type_____ When_____ Hospitalized? Yes_____ No_____

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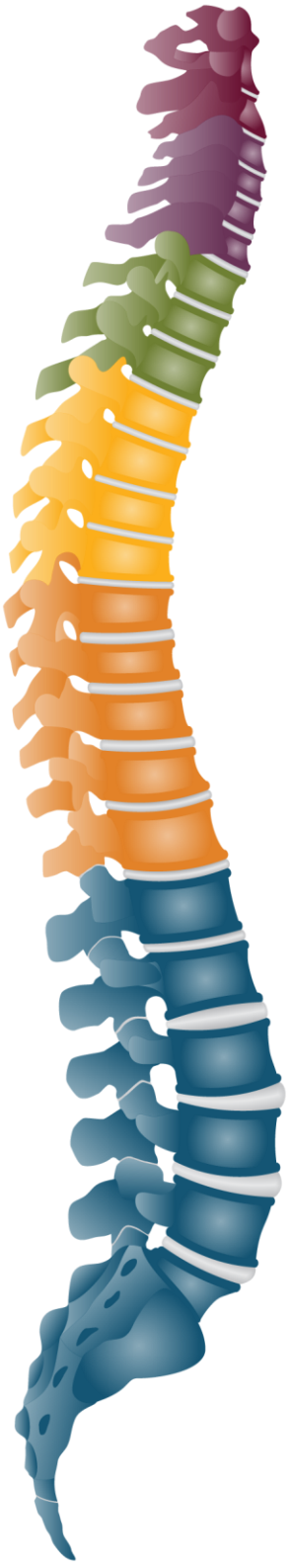
Patient Review of Systems

The nervous system controls and coordinates all functions and structures of the human body.

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGION	FUNCTIONS	SYMPTOMS (PAST / PRESENT)	
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐☐ Colic & Excessive Crying ☐☐ Ear & Sinus Infections ☐☐ Allergies & Congestion ☐☐ Immune Deficiency ☐☐ Headaches & Migraines ☐☐ Vertigo & Dizziness ☐☐ Sore Throat & Strep ☐☐ Swollen Tonsils & Adenoids ☐☐ Vision & Hearing Issues ☐☐ Low Energy & Fatigue ☐☐ Difficulty Sleeping ☐☐ Pain, Numbness & Tingling in Arms to Hands	☐☐ Epilepsy & Seizures ☐☐ Sensory & Spectrum ☐☐ ADD / ADHD ☐☐ Focus & Memory Issues ☐☐ Anxiety & Stress ☐☐ Balance & Coordination ☐☐ Speech Issues ☐☐ TMJ / Jaw Pain ☐☐ Stiff Neck & Shoulders ☐☐ Depression ☐☐ High Blood Pressure ☐☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐☐ Reflux / GERD ☐☐ Chronic Colds & Cough ☐☐ Asthma	☐☐ Bronchitis & Pneumonia ☐☐ Functional Heart Conditions
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐☐ Gallbladder Pain / Issues ☐☐ Jaundice ☐☐ Fever	☐☐ Indigestion & Heartburn ☐☐ Stomach Pains & Ulcers ☐☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐☐ Behavior Issues ☐☐ Hyperactivity ☐☐ Chronic Fatigue ☐☐ Chronic Stress	☐☐ Allergies & Eczema ☐☐ Skin Conditions / Rash ☐☐ Kidney Problems ☐☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐☐ Constipation ☐☐ Chrohn's, Colitis & IBS ☐☐ Diarrhea ☐☐ Bed-wetting ☐☐ Bladder & Urination Issues ☐☐ Cramps & Menstrual Issues ☐☐ Cysts & Endometriosis ☐☐ Infertility ☐☐ Impotency ☐☐ Hemorrhoids	☐☐ Sciatica & Radiating Pain ☐☐ Lumbopelvic / SI Joint Pain ☐☐ Hamstring Tightness ☐☐ Disc Degeneration ☐☐ Leg Weakness & Cramps ☐☐ Poor Circulation & Cold Feet ☐☐ Knee, Ankle & Foot Pain ☐☐ Weak Ankles & Arches ☐☐ Lower Back Pain ☐☐ Gluten & Casein Intolerance

Patient Name: Date: / /

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Please Check all of the following conditions your family has experienced.

Mother:	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke
Father:	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke
GrandMother (M):	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke
GrandFather (M):	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke
GrandMother (P):	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke
GrandFather (P):	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke
Sisters:	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke
Brothers:	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke

List any other health conditions that you or your family have had that are not listed: _____

_____

Do you consume any of the following? (leave blank what doesn't apply)

Tobacco products (packs/day) ___ How many years? ___ Alcohol drinks/day___ How many years? ___

Coffee/Tea cups/day ___ Regular or decaf? ___ Soft Drinks # day ___ Regular or diet? ___

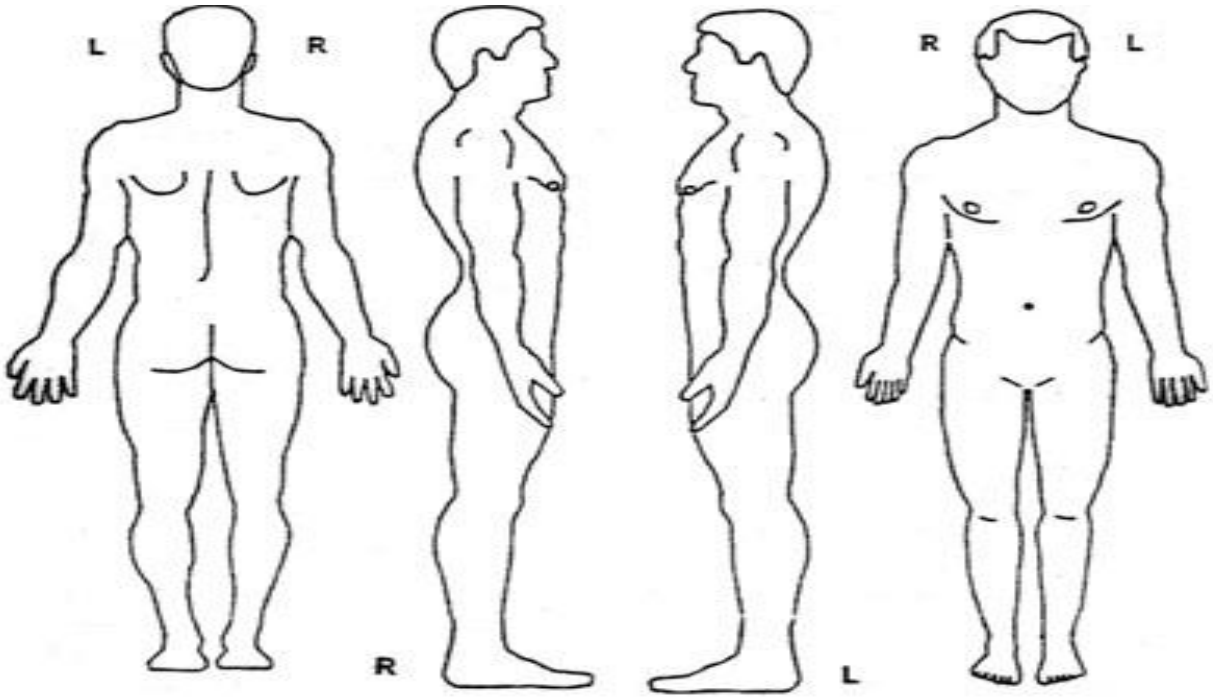
Do you use artificial sweeteners?___ Yes ___ No If yes please list? _____

Level of exercise? ___ None ___ Moderate (days per week) ___ ___ Strenuous (days per week) ___

Have you experienced any unexplained or rapid weight changes in the last six months? ___ Yes ___ No ___ lbs

Please mark off the areas of your complaint on the diagram below. Use the following symbols:

P = pain, N = numbness, T = tingling, B = burning, C = Cramping



IDEAL CHIROPRACTIC

Assignment and Instruction for Direct Payment to the Doctor

Private and Group, Accident and Health Insurance

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Ideal Chiropractic
1520 N. Commerce Ste. C
Ardmore OK 73401

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.
This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or Attorney involved in this case.

Dated at Ideal Chiropractic this _____day of _____ , _____

Signature of Policy Holder _____

Signature of Claimant, if other than Policy Holder_____

Notice of Patient Privacy Policy

I certify that I have been given given/offered/or read a copy of the current **Notice of Patient Privacy Policy.** I take responsibility for the information and had further clarification of terms or definitions I did not understand if that was the case.

_____	_____	_____
Print Name	Signature	Date

IDEAL CHIROPRACTIC

Informed Consent for Chiropractic

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spine column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application offered to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of care we encounter non-chiropractic or unusual finding, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name	Signature	Date

Doctor Signature	Date

Minors: I,_____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child t receive chiropractic care.

Females: Pregnancy Release:
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual cycle:_____

Signature	Date

Witness	Date