LOUISIANA CHIROPRACTIC CENTER

PATIENT INFORMATION

PATIENT NAME: _____ **MALE FEMALE**
(PLEASE PRINT CLEARLY)
ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

CELL (_____) _____ **WRK PHONE (_____)** _____

HOME (_____) _____ **E-MAIL:** _____

DATE OF BIRTH ___/___/_____ **SOCIAL SECURITY# XXX-XX-- _ _ _ _**

MARITAL STATUS: S M D W **# OF CHILDREN: _____**

EMPLOYER: _____

OCCUPATION: _____

SPOUSE'S NAME: _____

IN CASE OF AN EMERGENCY CONTACT: _____

RELATIONSHIP: _____ **PHONE:** _____

HOW DID YOU HEAR ABOUT LOUISIANA CHIROPRACTIC CENTER?

RELATIVE/FRIEND: _____

PHONE BOOK: ____ TV: ____ NEWSPAPER: ____ SIGN: ____ ONLINE: ____

OTHER _____

INSURANCE INFORMATION
(PLEASE GIVE CARD(S) TO FRONT DESK)

CHECK ALL THAT APPLY TO YOUR CURRENT CONDITION:

___ LOW BACK PAIN	**___ ARM/SHOULDER PAIN**	**____ NECK PAIN**
___ MID BACK PAIN	**___ DIZZINESS**	**____ HEADACHES**
___ ARM NUMBMESS	**___ LEG NUMBNESS**	**____ FATIGUE**

WHAT IS YOUR PRIMARY COMPLAINT? _____

_____

WHAT IS YOUR SECONDARY COMPLAINT? _____

_____

LIST ANY PREVIOUS SURGERIES OR ILLNESSES
(PLEASE INCLUDE DATES)

_____

_____

ARE YOU PREGNANT? _____**YES** _____**NO** _____**NOT SURE**

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SYMPTOMS & INJURIES

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WHEN DID YOU BEGIN TO EXPERIENCE THE SYMPTOMS OR WHEN DID THE INJURY OCCUR?

_____

IS THERE ANYTHING THAT MAKES THE SYMPTOMS BETTER OR WORSE?

_____

JUDGE THE SEVERITY OF YOUR PAIN FROM 1(LEAST) TO 10 (SEVERE): _____

ARE YOUR PAINS:

____**SHARP**	____**DULL**	____**THROBBING**	____ **NUMBNESS**
____**ACHING**	____**SHOOTING**	____**BURNING**	____ **TINGLING**
____**CRAMPS**	____**STIFFNESS**	____**SWELLING**	

____**OTHER** _____

WHERE IS YOUR PAIN THE GREATEST? (PLEASE BE SPECIFIC)

_____

_____

DOES YOUR PAIN RADIATE DOWN YOUR ARMS OR LEGS? ____**YES** ____**NO**

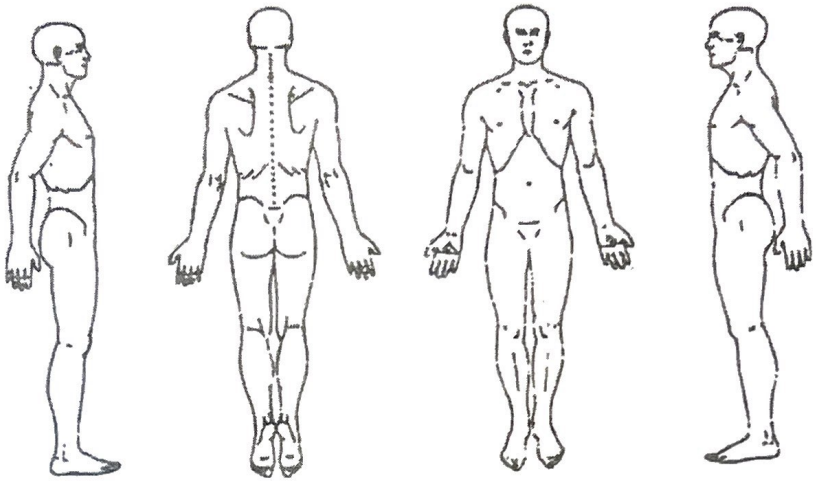
_____

HAVE YOU BEEN ABLE TO WORK SINCE THIS INJURY? ___ **YES** ___ **NO**

IF NOT, HOW MANY DAYS OF WORK HAVE YOU MISSED? _____

IS THE CONDITION PROGRESSIVELY GETTING WORSE? ___ **YES** ___ **NO**

PLACE AN "X" ON THE PICTURE WHERE YOU HAVE PAIN, NUMBNESS OR TINGLING



IS THE PAIN CONSTANT, OR DOES IT COME AND GO? _____

DOES THE PAIN INTERFERE WITH
_____WORK _____SLEEP _____ DAILY ROUTINE _____ RECREATION

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS CONDITION? YES NO

DR'S NAME/CLINIC_____ **LAST SEEN** ____/___/___

ARE YOU TAKING ANY VITAMINS OR SUPPLEMENTS AT THIS TIME? YES NO

_____

I understand and agree to authorize Dr. Patrick Ford, clinic staff doctor and all clinic employees to administer whatever examination and treatment procedures they deem necessary.

PATIENT SIGNATURE_____ **DATE** _____

DOCTOR'S NOTES:

_____

_____

_____

_____

LOUISIANA CHIROPRACTIC CENTER

2325 SEVERN AVE,. SUITE 3
METAIRIE, LA 70001
(504) 828-5285

123 CHARTRES STREET
NEW ORLEANS, LA 70130
504-338-3726

Notice of Privacy Practices for Protected Health Information

This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1) Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment or treatment of your health condition.
2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, PPO or your employer if they are potentially responsible for the payment of your services.
3) Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4) Your chiropractor and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.
You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time.

Our Privacy Pledge

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1) We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
2) We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
3) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
4) We are permitted to use your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
5) We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding examples, any other use or disclosure of your health information will only be made with your written authorization.

Your right to revoke authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1) If we have already released your health information before we receive your request to revoke your authorization.
2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization, please write to us at:

Louisiana Chiropractic Center, LLC
2325 Severn Ave
Suite 3
Metairie, LA 70001

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the service that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for six years from the date that the record was created or as long as the information remains in our files.

Your right to amend your health information

You have the right to request that we amend your health information for six years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records be made in writing and for you to give us a reason to support the change you are requesting us to make.

Your rights to receive an accounting of the disclosure we have made of your records

Louisiana law requires that we furnish you, upon your request, a copy of any information related in any way to you which we have transmitted to any company, or any public or private agency, or any person.
We may charge reasonable copying fees for this service which are set forth in the statutes as well as a handling charge and actual postage.

We may deny access to a record if we reasonably conclude that knowledge of the information contained in the record would be injurious to the health or welfare of the patient or could reasonably be expected to endanger the life or safety of any other person.

Your right to obtain a paper copy of this notice

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.
We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement, we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect you right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

Louisiana Chiropractic Center
2325 Severn Ave
Suite 3
Metairie, LA 70001

To contact us

If you would like further information about our privacy policies and practices please contact:

Louisiana Chiropractic Center
2325 Severn Ave
Suite 3
Metairie, LA 70001
(504)828-5285

This notice is effective as of _____. This notice will expire seven years after the date which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

_____ _____
PATIENT PRINTED NAME DATE

_____ Dr. Patrick M. Ford
PATIENT SIGNATURE AUTHORIZED PROVIDER REPRESENTATIVE

_____ _____
PARENT OR GUARDIAN PRINTED PARENT OR GUARDIAN SIGNATURE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT FOR THE PATIENT

LOUISIANA CHIROPRACTIC CENTER

Patient Consent

Chiropractic

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means and without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Physician's procedure often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

Analysis

A Chiropractic Physician conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no physician can promise you specific results. This depends upon the inherent recuperative powers of the body.

Diagnosis

Although Chiropractic Physicians are experts in Chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concerns as to the nature of his/her total condition. Your Chiropractic Physician may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

Informed Consent for Chiropractic Care

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a Chiropractic adjustment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illness or deformities which would otherwise not come to the attention of the Chiropractic Physician. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Chiropractic Physician provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the same time, based upon the facts then known, is in my best interests.

Results

The purpose of Chiropractic services is to promote natural health through the reduction if the VSS or VSC since there are so many variables; it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond to Chiropractic may come under the control or be helped through medical science. The fact is that the Science of Chiropractic and Medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

_____

Patient Name (Please Print)

_____ _____

Patient / Parent or Guardian Signature Date

_____ _____

Witness Signature Date

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504-338-3726

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Dr. Ford and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, authorizations or other health related information that may be of interest to you and for the purpose of marketing products and services for *Louisiana Chiropractic LLC* to you. We are specifically requesting authorization to market the following products and/or services to you: Appointment reminders, newsletters, birthday cards, mailings, etc. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organization to which your health care information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose, based on the authorization you are giving us, may be subject to re-disclosure by the organization(s) listed above and may no longer be protected by federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us permission, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

The notice is effective as of _____. This authorization will expire seven years after the date on which you last received service from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient Name Printed Date

_____ Dr. Patrick M Ford

Patient / Parent or Guardian Signature Authorized Provider Representative

Insurance Manager/Any and All Interactions with Patient's Privacy Matters

Description of personal representative's authority to act for the patient.

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Office Policies and Procedures

1. Symptoms: Regardless of the reason you came to our office, it is important to understand the difference between symptoms and their cause. As your spine is corrected you will have good days and bad days. Don't get caught up in this roller coaster; it is normal. You will be happiest and get the best results if you understand that this is a process designed to get you functioning at your peak level and get you on the road to wellness. This takes time and is a lifelong process. Stay focused on this outcome so you are pleased with your results and enjoy the journey.

2. Appointments: A certain number of adjustments in a given time period is necessary to get the best results from your care and create wellness in your life. While we can't predict the exact number of adjustments you will need, we do know that consistency creates the best results. Therefore, it is absolutely necessary that you keep your appointments. If you need to change an appointment, please call in advance to reschedule, giving us more than 24 hour notice so you stay on target for wellness. It is your responsibility to get here. We will do all we can to accommodate you. **Please note: Part of your treatment may include massage therapy. If you are unable to keep your appointment, please give us 24 hours notice. If notice is given with less than 24 hours, you will be charged for the appointment.**

3. Daily Visit Procedure: Each time you arrive for your adjustment, process to the adjusting room. Place a piece of face paper on the table, lay down on your stomach and relax until the doctor becomes familiar with your spine to adjust you. Once the doctor learns your spine, your adjustments will take only a few minutes and will be very focused. Please help keep things moving by laying down quietly and relaxing for your adjustment. Our open environment allows you to receive your care quickly and efficiently with minimal waiting. Should you feel the need for a private adjustment or consultation, inform our staff and we will gladly accommodate you, at no extra charge, of course.

4. Exercise: Many people try to correct their spine with exercise. Research shows that people who exercise on an injured spine that has healed improperly will tend to experience more rapid deterioration of their spinal bones, disks and nerves. However, when you exercise in conjunction with your Chiropractic adjustments, you will be dramatically enhanced. We recommend that you do some type of aerobic exercise, such as walking, at least once a day.

5. Nutrition: Good nutrition is important to maximize your health and healing capacities. A diet filled with fresh fruits and vegetables will fulfill your nutritional needs on a daily basis. For more detailed information on nutrition, we highly recommend that you shop and consult with Whole Foods Grocery Store.

6. Results: We are very results oriented; however, many factors that we have no control over affect how quickly you respond to your care. These include your age, occupation, how long you have had your vertebral subluxations, and how many subluxations are present in your spine. Regardless of these circumstances, your body has an incredible ability to heal itself. The recommendations we make will consider these factors along with the current conditions of your spine. We will do all we can to get you to Wellness Care as quickly as possible.

_____ _____

Patient Name (Please Print) Date

_____ _____

Patient / Parent or Guardian Signature Date

Congratulations on choosing Chiropractic!
Now follow through with your family, and enjoy the health
Benefits that come with a Chiropractic Lifestyle.

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METAIRIE, LA 70001
(504) 828-5285

123 CHARTERS STREET
NEW ORLEANS, LA 7013
(504) 338-3726

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Louisiana Chiropractic Center or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information. Including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____ Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Note that some of your treatment may be performed in an "open" area. Private areas are always available to discuss your health information upon request.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____

Patient or Legally Authorized Individual Signature Date

_____ _____

Print Patient's Full Name Time

_____ _____

Witness Signature Date

LOUISIANA CHIROPRACTIC CENTER

REGARDING MASSAGE APPOINTMENTS:

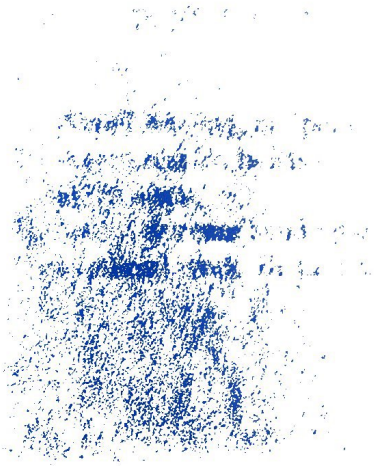
As of 8/1/2024 we will no longer be filing insurance for massage. The cost per 1 hour massage will be $75.00.

We have noticed an increase in patients missing appointments and not calling to cancel or reschedule. Because we allow a certain amount of time for each patient, this means someone else could be seen in this time period.

ANY APPOINTMENT NOT CANCELLED OR RESCHEDULED 24 HOURS PRIOR TO THEIR APPOINTMENT TIME WILL BE CHARGED A $40.00 FEE. NO EXCEPTIONS.

Thank you for your cooperation and understanding.

PATIENT SIGNATURE _____ DATE _____



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Patient Reaction

When undergoing Chiropractic adjustment to re-align the spine and reset vertebrae that are out of place, it is not unusual to experience varying degrees of discomfort and symptomatic disturbances. These discomforts are a part of what we call "Reaction".

"Reaction" is the body's response to an adjustment. An adjustment enables the spinal column to normalize itself. Following an adjustment, irritation of nerve is reduced, muscle tonality is normalized, discs are re-shaped to provide the normal cushioning between vertebrae, and tension on cartilage caused by stress is lessened.

"Reaction" occurs most commonly between the first and the tenth adjustment, but may vary with the individual and the severity of his/her condition. When and if reaction occurs it may last from one to several days, but in the vast majority of cases, diminishes in two to three days. Approximately 50% of Chiropractic patients experience reaction, so if you are among this group there is no cause for alarm.

Actually, "Reaction" is a healthy change occurring within the body. The mechanics of the change can best be understood by explaining that the spine is being adjusted to a normal position. Therefore, there is an element of physical change which involves bones, muscles, ligaments, nerves, blood vessels, connective tissue and cartilage. All of these tissues and structures must adapt to the new (Normal) position. And this adaptation process, which is part of the change to a healthier condition in the body, is often accompanied by "Reaction".

Keep in mind that any reaction following a Chiropractic adjustment is due to the removing of obstructions caused by pressure upon the spinal nerves, and is in fact, a sure sign that the normal flow of nerve energy is being restored to the affected areas. In that sense, we can say, Reaction is simply another way of saying Reactivation, which is Nature's way of telling you that you are getting well!!!

Removing subluxations or correcting spinal function is similar to straightening teeth. Both take time and may sometimes cause some discomfort, but the results are worth it.

SUGGESTIONS TO FOLLOW DURING SPINAL CORRECTION, AND LATER FOR PREVENTION

1. Avoid rubbing, or "poking" in the areas your doctor adjusts.
2. Avoid sudden twists and turns of movements beyond normal limits of motion, especially of the neck.
3. Avoid extreme bending of your spine in any direction; avoid stretching, reaching or other overhead work. Be particularly careful when brushing or shampooing your hair.

4. Avoid bending or stooping sharply to pick up objects; rather, bend your knees to minimize the strain on your lower back.

5. When lifting, keep your back straight, bend your knees and let your legs bear the strain. Hold the object lifted as close to your body as possible.
6. When bathing, sit rather than recline in the tub. Lying back against the tub may cause a vertebra to slip out of its normal position. If you are tired and wish to relax, it's better to lie in bed.
7. Participate in simple exercises to strengthen your body, but avoid jarring activities, which place stress on your neck and spine.
8. Watch you posture at all times, stand tall, sit tall, sleep tall and THINK tall!!!!!

REST, RELAXATION AND SLEEP

1. Set aside a special time each day for complete mental and physical relaxation. This is important in the restoration- as well as maintenance- of normal health.
2. When sitting, choose a chair that has adequate firmness to hold your weight comfortably, and then sit straight. Avoid too soft, overstuffed chairs. Recliner chairs are acceptable if they are constructed so that when you're reclining, your back is in a normal, straight position.
3. Cross your legs only at the ankles, not at the knees. Crossing your legs at the knees could aggravate an existing back condition as well as interfere with the circulation to the lower limbs.
4. Be sure to get plenty of sleep to allow your lower body to recuperate and repair.
5. Sleep on a firm mattress, preferably one which is neither too hard nor too soft, but just firm enough to hold your body level while, at the same time, soft enough so that your shoulders, buttocks, etc. will depress the mattress.
6. Your pillow should be neither too high nor too low. The ideal pillow is one which supports your head so that your neck vertebrae will be level with the rest of your spine. Avoid sleeping on two pillows; never lie on a couch with your head on an arm rest.
7. Sleep on your back or on your side with your legs flexed slightly, not drawn up tightly. Avoid sleeping on your stomach. Raise your head off the pillow when changing positions.
8. Rise from your bed by turning on your side and swinging your legs off the bed then push yourself into a sitting position with your arms, thus minimizing the amount of strain on your back.
9. Do not read or watch TV in bed with your head propped at a sharp or strained angle.
10. Do not sleep sitting in a chair or in cramped quarters. Lie down in bed when it is time to sleep.

IF YOU HAVE ANY QUESTIONS ABOUT ANY PHASE OF YOUR HEALTH CARE, FEEL FREE TO ASK DR. FORD.

Chiropractic care is all about Wellness!

Your spinal column, made up of 24 independent vertebrae, is what allows your body to move, twist, and bend through every motion of your busy day. It also encases and helps protect the delicate nerve tissue that carries every communication between your brain and body. This is why we believe the first step to a healthy and active lifestyle is a healthy spine.

Congratulations! You are on your way to better health!

We have two locations:
2325 Severn Ave., Metairie and 123 Chartres St., New Orleans
Both offer full Chiropractic services and Massage as well.
Let us know which is best for you!

For your Wellness Care, we offer Massages by Licensed Massage Therapists!

STOP

Your mission is complete...
You may return your paperwork at the window.

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METAIRIE, LA 70001
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123 CHARTRES STREET
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504-338-3726

Name: _____ Date: _____

YOUR PERSONAL RECOMMENDATIONS FOR CHIROPRACTIC CARE

Your health care choices are yours to make. Our first goal is to always see you feel better and regain your health. However, we would like to explain Chiropractic, so you can further understand about your health care and your personal choices. For your information, the figures used in the following three types of care are averages derived from the clinical experience of thousands of Chiropractors. They are merely guidelines for the patient to realize that spinal control and rehabilitation are long term processes, that become longer the older the patient is, and the longer the time since the initial injury.

1-RELIEF CARE & VERTEBRAL SUBLUXATION CARE

Relief Care: The relief of pain and discomfort, malfunction, postural problems and motion disorders. This will halt the Vertebral Subluxation Complex. With your subluxation problem, this is what we have found in your spine.

Subluxations Degeneration Phase:

Cervical Spine _____

Thoracic Spine _____

Lumbosacral Spine _____

The recommendations for care, in your particular case, are based on your individual examination findings and our experience with many other cases similar to yours.

Your Initial Intensive Care Needs:
This schedule applies whether you want Relief Care or Vertebral Subluxation Complex stabilization.
Time Frame: 8 to 12 weeks (longer in resistant or chronic cases)
Visit Frequency:
_____ visits per week for _____ weeks
_____ visits per week for _____ weeks
_____ visits per week for _____ weeks

Progressive Examination _____

Comparative Examination _____

You will then decide if you want to continue with your Chiropractic procedures. You will ask yourself, am I happy with the way I feel, or do I want to go into:

2. RECONSTRUCTIVE CARE (REHABILITATIVE CARE)

The visit schedule for reconstructive care will be decided upon the re-examination of your spine.

Goal: Spinal reconstruction- Slows, stops or reverses the Vertebral Subluxation Complex and extends past relief and into changing how your spine functions, and its actual reconstruction. Time; 6 months to 3 ½ years. Yes, it is a long time, but your body is used to its old habits and needs retraining.

(Less in the very young.)
PHASE I: 6 months to 1 ½ years
PHASE II: 1 ½ years to 2 ½ years
PHASE III: 2 ½ years to 3 ½ years
PHASE IV: No prognosis available.
Visit Frequency: Less frequent (once a week or every 2 weeks and occasionally less)

3. MAINTENANCE OR SUPPORTIVE CARE

Here you reach another choice. Since every case responds differently and has its particular Vertebral Subluxation Complex severity and Subluxation Degeneration Phase, maintenance care is even more individualized than reconstructive care. Visit frequency is determined purely by your particular and shifting needs during maintenance care.

Goal: Maintaining your best spine and nerve function. Allowing the healing of the Vertebral Subluxation Complex and Subluxation Degeneration to slowly continue, or be maintained, rather than allowing the old habits to come back. We can help you maintain the best energy and health levels. This is what we call **wellness!!!**

Time Frame: Lifetime
Visit Frequency: According to the individual's needs.

We are here to assist you in every way we can. If you have any questions or concerns, please do not hesitate to ask. Thank you for joining our Chiropractic family!!!

Dr. Patrick Ford

MET FQ

DED: MET: @

VISIT LMT: USED: @ INS: ATTY: COPAY: PI: CELL:

DATE		DESCRIPTION OF SERVICE	CHARGE	PAID BY	PAYMENT	BALANCE

LOUISIANA CHIROPRACTIC CENTER

2325 SEVERN AVE,. SUITE 3
METAIRIE, LA 70001
(504) 828-5285

123 CHARTRES STREET
NEW ORLEANS, LA 70130
504-338-3726

Name: _____ Date: _____

YOUR PERSONAL RECOMMENDATIONS FOR CHIROPRACTIC CARE

Your health care choices are yours to make. Our first goal is to always see you feel better and regain your health. However, we would like to explain Chiropractic, so you can further understand about your health care and your personal choices. For your information, the figures used in the following three types of care are averages derived from the clinical experience of thousands of Chiropractors. They are merely guidelines for the patient to realize that spinal control and rehabilitation are long term processes, that become longer the older the patient is, and the longer the time since the initial injury.

1-RELIEF CARE & VERTEBRAL SUBLUXATION CARE

Relief Care: The relief of pain and discomfort, malfunction, postural problems and motion disorders. This will halt the Vertebral Subluxation Complex. With your subluxation problem, this is what we have found in your spine.

Subluxations Degeneration Phase:

Cervical Spine _____

Thoracic Spine _____

Lumbosacral Spine _____

The recommendations for care, in your particular case, are based on your individual examination findings and our experience with many other cases similar to yours.

Your Initial Intensive Care Needs:
This schedule applies whether you want Relief Care or Vertebral Subluxation Complex stabilization.
Time Frame: 8 to 12 weeks (longer in resistant or chronic cases)
Visit Frequency:
_____ visits per week for _____ weeks
_____ visits per week for _____ weeks
_____ visits per week for _____ weeks

Progressive Examination _____

Comparative Examination _____

You will then decide if you want to continue with your Chiropractic procedures. You will ask yourself, am I happy with the way I feel, or do I want to go into:

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123 CHARTERS STREET
NEW ORLEANS, LA 7013
(504) 338-3726

Patient Name: _____ **Date:** _____
Examined By: _____

Height: _____ Weight: _____ Resp: _____ Pulse: _____
B.P. Left: _____ B.P. Right: _____ Date of LMP: _____

EXAMINATION STANDING

1. Patient ambulated: well without assistance/ with a protected stance/ needed assistance/ needed support/ was unable to ambulate/ other
2. General Appearance: Good / Fair / Debilitated / Poor
3. Gait: Visual Limp Lt _____ Rt _____
   Walked Toe in Lt _____ Rt _____
   Walked Toe out Lt _____ Rt _____
4. Posture Standing: Normal / Protective Stance / Slumping
   Antalgic Posture Flexed _ Lt _____ Rt _____

POSTURE ANALYSIS:

	Left	Center	Right
Head Tilt	_____	_____	_____
Shoulder High On	_____	_____	_____
Thoracic Curvature	_____	_____	_____
Lumbar Curvature	_____	_____	_____
Ilium High On	_____	_____	_____

DORSOLUMBAR ROM:

	Degrees	Pain Quality	Pain Location
Flexion (95)	_____	_____	_____
Extension (35)	_____	_____	_____
Lt Lat Flex (40)	_____	_____	_____
Rt Lat Flex (40)	_____	_____	_____
Lt Rotation (35)	_____	_____	_____
Rt Rotation (35)	_____	_____	_____

Trendelenburg Left _____ Right _____
Kemps Neg _____ Pos _____ Level _____
Radiates Post Thigh _____ Ant Thigh _____ SI Joint _____

EXAMINATION SITTING:

CERVICAL ROM:

	Degrees	Pain Quality	Pain Location
Flexion (45)	_____ /	_____ /	_____
Extension (55)	_____ /	_____ /	_____
Lt Lat Flex (40)	_____ /	_____ /	_____
Rt Lat Flex (40)	_____ /	_____ /	_____
Lt Rotation (70)	_____ /	_____ /	_____
Rt Rotation (70)	_____ /	_____ /	_____
Mains Test:	Pos / Neg		

CERVICAL ORTHOPEDIC

	Left	Right	Pain
Cervical Distraction	_____ /	_____ /	_____
Lat Flex Cerv Comp	_____ /	_____ /	_____
Spurlings Test	_____ /	_____ /	_____
Bakody Manuever (TOS)	_____ /	_____ /	_____

Valsalvas

Pos _____ Neg _____ NP _____ TH _____ LBP _____ SI _____

DEEP TENDON REFLEXES:

	Left	Right
Triceps (C6, C7, C8)	_____ /	_____
Biceps (C5, C6)	_____ /	_____
Brachioradialis	_____ /	_____
Patellar	_____ /	_____
Achilles	_____ /	_____

LUMBAR ORTHOPEDIC:

Bechterews Sign (Disc) Lt _____ Rt _____ Pain Radiates _____

ORTHOPEDIC:

Soto Hall	Neg _____	Pos _____
Lindners (radicular pain)	Neg _____	Pos _____
Milgrams (disc)	Neg _____	Pos _____
Lasagues	Lt _____	Rt _____
Braggard (nerve root)	Lt _____	Rt _____
Lasagues Rebound (psoas/disc)	Lt _____	Rt _____
Iliac Crest Comp (SI lesion)	Lt _____	Rt _____
Gaenslen (SI)	Lt _____	Rt _____
Patrick Fabere (SI/HIP)	Lt _____	Rt _____

MUSCLE TESTS: (5 strong, 4 diminished, 3 holds gravity, 2 can't hold gravity, 1 slight tremor, 0 no response)

Tibialis Anterior (L4)	Lt _____	Rt _____
Extensor Hallicus Longus (L5)	Lt _____	Rt _____
Peroneus Longus/Brevis (SI)	Lt _____	Rt _____
(Seated Muscle Tests)		
Deltoid (C5)	Lt _____	Rt _____
Biceps Brachii (C6)	Lt _____	Rt _____
Wrist Extensors (C7)	Lt _____	Rt _____
Finger Flexors (C8)	Lt _____	Rt _____
Finger Abduction/Adduction	Lt _____	Rt _____

EXAMINATION PRONE :

Hibbs (SI)	Lt _____	Rt _____
Nachlas	Lt _____	Rt _____

SPINAL EXAMINATION: (list specific level and side)

	Cervical	Thoracic	Lumbar	Pelvis
Muscle Spasm	_____	_____	_____	_____
Edema Cutaneous Changes	_____	_____	_____	_____
Areas of Pain and Tenderness	_____	_____	_____	_____

DERMATOMES:

Mark in red on the diagram and label as hyper or hypo-esthesia

	Left / Right		Left / Right
C5	_____/_____	L4	_____/_____
C6	_____/_____	L5	_____/_____
C7	_____/_____	S1	_____/_____
C8	_____/_____		
T1	_____/_____		

Diagnostic Impression:

_____

_____

_____

_____

Treatment Plans: _____

_____

FOR MEDICARE PATIENTS:

Nature of Illness: Acute Chronic Non-Acute Non-Life Threatening
Routine Symptomatic Acute Manifestation of Chronic Condition

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123 CHARTERS STREET
NEW ORLEANS, LA 7013
(504) 338-3726

Confidential Patient Case History

Name: _____ **Date:** _____

Referred By: _____

CHIEF COMPLAINT: _____

_____
_____
_____
_____

Date of Onset: _____

Mode of Onset: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PAIN:

Quality: Dull / Sharp / Stabbing / Achy / Tingling / Numbness / Burning / Cramping / Stiffness / Pins & Needles

Severity: Mild / Moderate / Severe

Frequency: Constant / Intermittent _____

Radiation Of: Where? _____

Has Pain Progressively: Improving / Getting Worse / About the Same / Comes & Goes

Aggravating Factors: Standing / Walking / Sitting / Lying / Bending / Lifting / Twisting / Coughing / Sneezing

Other: _____

Relieving Factors: _____

_____

_____

_____

When is the pain worse: Morning / Noon / Afternoon / Night

Has it disturbed your sleep? Yes / No

Do any positions relieve the pain? Yes / No **If yes:** Sitting / Walking / Lying: Prone / Supine / Side

Has it affected any other systems? Yes / No **If yes:** Urinary / Bowel / Cardiac / Respiratory / Ocular

Is the patient disabled from work? Yes / No **If yes:** Date Range: ___/_____/_____ to _____/_____/_____

Patient's work consist of: Sitting / Standing / Light Labor / Heavy Labor

Have you ever had a similar condition? Yes / No

When: _____

Duration: _____

Treatment: _____

Have you administered any home remedies? Yes / No

What: _____

Results: _____

Have you consulted any other Doctors for this condition? Yes / No

Name: _____ **Specialty:** _____ **Facility:** _____

Name: _____ **Specialty:** _____ **Facility:** _____

Name: _____ **Specialty:** _____ **Facility:** _____

Name: _____ **Specialty:** _____ **Facility:** _____

Are you still under his/her care? Yes / No

Last Treatment / Consult Date: _____/_____/_____

Has he/she presented any medications? Yes / No

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Has he/she recommended surgery? Yes / No

Diagnosis: _____

_____

MEDICATIONS:

Name:_____ **Dosage:** ____ **Name:**_____
Dosage: ____
Name:_____ **Dosage:** ____ **Name:**_____
Dosage: ____
Name:_____ **Dosage:** ____ **Name:**_____
Dosage: ____
Name:_____ **Dosage:** ____ **Name:**_____
Dosage: ____

Blood Pressure Pills
Pain Killers
Birth Control Pills
Muscle Relaxers
Vitamins
Supplements

PAST ILLNESSES:

Serious Illnesses: _____
_____
_____

Injuries/Accidents (Date): _____
_____
_____
_____

Surgeries (Type/Date): _____
_____
_____
_____

Previous chiropractic care? Yes / No
Doctor's Name: _____ **Facility:** _____
Last Visit: __/____/____
Why: _____
Were X-Rays taken: Yes / No **Date Taken:** ____/____/____ **What Type:** _____
Results of treatment:_____

Do you exercise? Yes / No **Type:** Mild Moderate
Strenuous
Do you smoke? Yes / No **Frequency:**_____
Do you drink alcohol? Yes / No **Frequency:**_____
How many hours do you sleep per night? _____

SYSTEMS REVIEW:

Have you noticed any of the following? (Spinal cord pressure symptoms)

1. Headaches
2. Dizziness
3. Blurred Vision
4. Depression
5. Nervousness/Irritability
6. Fatigue
7. Difficulty Sleeping
8. Loss of Concentration
9. Nausea

RESPIRATORY:

Cough/Sputum/Hemoptysis/Wheezing/Dyspnea/Pain

CARDIOVASCULAR:

Pain/Palpatation/Edema/Dyspnea/Syncope/Varicosities

GASTROINTESTINAL:

Weight/Appetite/Nausea/Pain/Bowel Habits/Stool/Hemorrhoids
Indigestion/Thirst/Vomiting/Gas/Bleeding/Jaundice

GENITOURINARY:

Frequency/Bleeding/Menses/Pain/Incontinence

MUSCULOSKELETAL:

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2. Dizziness
3. Blurred Vision
4. Depression
5. Nervousness/Irritability
6. Fatigue
7. Difficulty Sleeping
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Indigestion/Thirst/Vomiting/Gas/Bleeding/Jaundice

GENITOURINARY:

Frequency/Bleeding/Menses/Pain/Incontinence

MUSCULOSKELETAL:

Pain/Stiffness/Fracture/Weakness/Swelling

NERVOUS:

Seizure/Vertigo/Tremor/Weakness/Swelling

ALLERGY:

Pt.#

Patient Name

(Last) (First) (Init.)

Date of Birth Age

X-RAY SUMMARY		MAJOR COMPLAINTS
Postural Analysis = PA Palpabral = PT Pain/Tenderness Hyperemia = H Response		
Antalgia = A Lt = Left / Rt = Right		
EDEMA=O MS.SPASM=X		
ROM		
1.	1. CERVICAL	
2.	2. THORACIC	
3.	3. LUMBAR	
4.	4.S	
5.	S.I.	
6.	5.EX	
7.		
8.		
9.		
10.		
11.		
12.		

	1	2	3	4	5	6	7	8	9	10	11	12
	C0 C1	C0 C1	C0 C1	C0 C1	C0 C1	C0 C1	C0 C1	C0 C1	C0 C1	C0 C1	C0 C1	C0 C1
	C2 C3	C2 C3	C2 C3	C2 C3	C2 C3	C2 C3	C2 C3	C2 C3	C2 C3	C2 C3	C2 C3	C2 C3
	C4 C5	C4 C5	C4 C5	C4 C5	C4 C5	C4 C5	C4 C5	C4 C5	C4 C5	C4 C5	C4 C5	C4 C5
	C6 C7	C6 C7	C6 C7	C6 C7	C6 C7	C6 C7	C6 C7	C6 C7	C6 C7	C6 C7	C6 C7	C6 C7
	T1 T2	T1 T2	T1 T2	T1 T2	T1 T2	T1 T2	T1 T2	T1 T2	T1 T2	T1 T2	T1 T2	T1 T2
	T3 T4	T3 T4	T3 T4	T3 T4	T3 T4	T3 T4	T3 T4	T3 T4	T3 T4	T3 T4	T3 T4	T3 T4
	T5 T6	T5 T6	T5 T6	T5 T6	T5 T6	T5 T6	T5 T6	T5 T6	T5 T6	T5 T6	T5 T6	T5 T6
	T7 T8	T7 T8	T7 T8	T7 T8	T7 T8	T7 T8	T7 T8	T7 T8	T7 T8	T7 T8	T7 T8	T7 T8
	T9 T10	T9 T10	T9 T10	T9 T10	T9 T10	T9 T10	T9 T10	T9 T10	T9 T10	T9 T10	T9 T10	T9 T10
	T11 T12	T11 T12	T11 T12	T11 T12	T11 T12	T11 T12	T11 T12	T11 T12	T11 T12	T11 T12	T11 T12	T11 T12
	T13	T13	T13	T13	T13	T13	T13	T13	T13	T13	T13	T13
	L1 L2	L1 L2	L1 L2	L1 L2	L1 L2	L1 L2	L1 L2	L1 L2	L1 L2	L1 L2	L1 L2	L1 L2
	L3 L4	L3 L4	L3 L4	L3 L4	L3 L4	L3 L4	L3 L4	L3 L4	L3 L4	L3 L4	L3 L4	L3 L4
	L5 L6	L5 L6	L5 L6	L5 L6	L5 L6	L5 L6	L5 L6	L5 L6	L5 L6	L5 L6	L5 L6	L5 L6
	S	S	S	S	S	S	S	S	S	S	S	S
	RT IL	RT IL	RT IL	RT IL	RT IL	RT IL	RT IL	RT IL	RT IL	RT IL	RT IL	RT IL
	LT IL	LT IL	LT IL	LT IL	LT IL	LT IL	LT IL	LT IL	LT IL	LT IL	LT IL	LT IL

10. MOST SEVERE PAIN
9.
8.
7.
6.
5.
4.
3.
2.
1. NO PAIN

OFF WORK_____ RETURNED_____ LT. DUTY_____ REG. DUTY _____

Exam Information Date: _____
1.

Dx Impression: _____

Tx Plan: _____

Exam Information Date: _____
2.

Hx update: _____

Dx Impression: _____

Tx Plan: _____

ELECTRIC STIMULATION

- CERVICAL SPINE _____
- THORACIC SPINE _____
- LUMBAR SPINE _____
- OTHER _____

COMMENT _____

TRACTION

CERVICAL SPINE _____

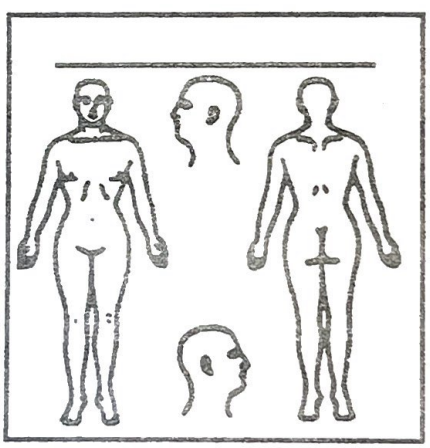
LUMBAR SPINE _____

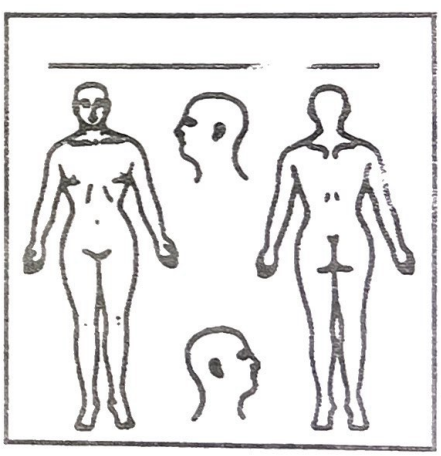
OTHER _____

COMMENTS: _____

X-RAY

LEFT		RIGHT
	C1	
	C2	
	C3	
	C4	
	C5	
	C6	
	C7	
	T1	
	T2	
	T3	
	T4	
	T5	
	T6	
	T7	
	T8	
	T9	
	T10	
	T11	
	T12	
	L1	
	L2	
	L3	
	L4	
	L5	
	SACRUM	
	R ILL.	
	L ILL.	
	COCX	





TREATMENT PROCEDURES: _____

Name: Account:

Diag:

Year Mo/Day	Standard Procedures Therapy	Standard Procedures Adjust	Service Code	Daily Notes:

ACCT. #

ACCT. TYPE

NAME DOB AGE SEX

ADJ. RM. PROCEDURE

STREET CITY STATE ZIP

OCCUPATION OFFICE PH. RES. PH.

INSURANCE EMPLOYER SS #

S M D W SPOUSE OCCUPATION

REFERRED BY

PRESENT COMPLAINT

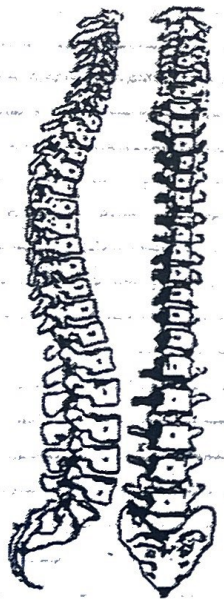
NEW COMPLAINT - DATE:

CONTRAINDICATIONS

EXAM DATE:			POST:		POST:		POST:	
	L	R	L	R	L	R	L	R
Cervical								
Flex. 65								
Ext. 50								
Rot. 80								
Lat. Flex. 40								
For. Comp.								
Dorso-Lumbar								
Flex. 95								
Ext. 35								
Rot. 35								
Lat. Flex. 40								
For. Comp.								
Reflexes								
Triceps								
Biceps								
Radial								
Patellar								
Achilles								
Dermatomes								
Ulnar								
Medial								
Radial								
Back								
Legs								
Neuro-Vascular								
Adson's								
Eden's								
Hyperabduction								
Georges								
Orthopedics								
Kemps								
Well Leg Raise								
Kernig's								
Lasegues								
Braggard's								
Goldthwell								
"Faber"								
Soto Hall								
Milgrams								

Left Side		Right Side
	At.	
	Ax.	
	3C	
	4	
	5	
	6	
	7	
	1	
	2	
	3	
	4	
	5	
	6	
	7	
	8	
	9	
	10	
	11	
	12	
	1L	
	2	
	3	
	4	
	5	

PAIN/SPASM AREAS



POSTURAL EXAM

HEAD TILT	HEAD ROT.	LOW HIP	LOW SHD.	EXT. FOOT ROT.

Georges Test

HT

WT

BP

C-Rom

LS-Rom

Misc.

CERVICAL COMMENTS:

THORACIC COMMENTS:

LOW BACK COMMENTS:

EXTREMITY COMMENTS:

TCMC-1

Name: Account:

Year	Standard Procedures		Diag:	
	Therapy	Adjust		
Mo/Day			Service Code	Daily Notes: