



Christ Centered Care

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WHAT THE CLINIC IS ABOUT:

We are a clinic that utilizes complimentary principles in evaluating and supporting the health of our patients. We believe the solution to our health care problems are rooted in the foundation of nutrient depletion, emotional instability, and avoidance of toxic substances in our environment.

We do not use nutrition for the treatment, prevention, cure, or substitution for proven therapy or doctors advice, but do support the human frame so it is able to better protect, restore, and regulate itself. We are feeding the cells of the body which is the foundation for restorative health.

I, _____, understand the above statement, and I have not been coerced in any manner.

Signature: _____ Date _____

PLEASE COMPLETE ALL INFORMATION

Name _____ SS# _____

Address _____

Street Address _____ City _____

State _____ Zip Code _____

Day Time Phone () _____

Other Phone () _____

E-Mail _____

Place of Employment _____ Occupation / Job _____

Work Address _____ Work Phone () _____

City _____ State _____ Zip Code _____

Person Responsible For Payment _____

Relationship to Patient _____

Address of Responsible Person _____

City _____ State _____ Zip Code _____

We can not guarantee that all services offered at our clinic and / or laboratory done will Be reimbursed by insurance. The Clinic will not be responsible for reimbursement.

Our clinic provides some of the latest scientific-based modalities of Anti-Aging and Complimentary Medicine has to offer. There are no guarantees in Medicine and the Results are not only based on the plan recommended but the individual also.

I understand that, I, or my listed responsible party, am fully responsible for services provided and payment is due when services are rendered.

Signature: _____ *Date:* _____

Adult History Form

Medical History Please check all that apply to you (either now or in the past).

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heat Attach | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Abnormal Mammogram | <input type="checkbox"/> Cancer (Any Kind) | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> COPD | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Allergies not from meds | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Urinary track Infections |
| <input type="checkbox"/> Anemia (any kind) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Weight Gain / Loss |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Sinus Infections | _____ |

Family History Please check all that apply to the following members of the patients: Father, Mother, Siblings, Grandparent, other.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Sickle Cell Disease Trait |
| <input type="checkbox"/> Cancer (any kind) | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid Disorder |

Surgical History Please check all operations that apply to you.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Circumcision | <input type="checkbox"/> Hemorrhoid surgery | <input type="checkbox"/> Tonsillectomy + / - Adenoids |
| <input type="checkbox"/> Breast Biopsy | <input type="checkbox"/> Gallbladder surgery | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Other _____ | | | |

Social History

Tobacco Use: Never Past Currently / amount _____

Cigarettes Cigars Snuff Chewing tobacco

Alcohol Use: Never Past Currently / amount _____

Wine Beer Liquor

Caffeine Use: Type / amount: _____

Please list any medications (prescription or over the counter) that you regularly take:

Is there anything else you want the doctor to know?

We are a Christian faith based clinic and we believe that God has designed a body which will heal itself when balanced with the appropriate spiritual, physical and mental components. We respect the different beliefs of people and will honor our patient's wishes. Your preference can change at anytime with notification.

- My preference is for Dr. Lucky and / or staff to pray with me.
- My preference is for Dr. Lucky and / or staff to anoint me with oil. (This is biblical)
- My preference is not for Dr. Lucky and / or staff to pray with me.

Signature _____, Date _____