# WELCOME TO ATLANTIS BRAIN & CHIROPRACTIC CENTER!

**THANK YOU**

Thank you very much for giving us the opportunity to serve you! We are excited to be part of your health care team and will strive to do our best to help you reach your health care goals. We take this privilege very seriously and want you to be well informed about what we do. If you have any questions about anything, please do not hesitate to ask.

**CHIROPRACTIC NEUROLOGY**

We have found that most people are familiar with the terms "chiropractic" and "neurology" but most have not heard of them together as in "chiropractic neurology." Chiropractic neurology evaluates the physiological integrity of the nervous system. Patients seeking care can have "functional" and/or "ablative" deficits in their nervous systems. Patients with functional deficits (functional disconnection) are good candidates for chiropractic neurology. Patients with ablative lesions (e.g. disease processes, tumors, etc.) will be referred for co-management with other providers.

**WHAT TO EXPECT**

Atlantis Brain & Chiropractic Center understands that people are unique and have different conditions, different health care goals, and even different budgets. It is for this reason, that we offer different new patient options: Focused, Detailed, and Comprehensive. Regardless of which option you choose, you can rest assured that we will do our absolute best to help you achieve your health care goals as quickly as possible.

**TREATMENT**

After the exam, we will schedule a report of findings to discuss the results of your exam, treatment recommendations, how we will monitor your progress, cost, and scheduling. If you are a good candidate for chiropractic neurological care, the following may be performed or given: home therapy instructions, spinal/extremity adjustments, laser therapy, Vibracussor therapy, Interactive Metronome therapy, and individualized brain-based therapies such as gaze stability exercises, vestibular rehab exercises, peripheral nerve nerve stimulation, microcurrent stimulation, photohemodynamic therapy, photobiomodulation, slow eye movement exercises, fast eye movement exercises, vestibuloocular stimulation, light stimulation, complex movement therapy, caloric stimulation, auditory stimulation, olfactory stimulation, primitive reflex inhibition, balance training, Blaze Pod training, and cognitive improvement exercises. These innovative treatments are usually beneficial and seldom cause any problems. In the unlikely event you feel they are causing problems, please let us know right away.

**COST**

To keep health care costs down, we do request payment at the time of service and if requested, will be glad to give you the necessary paper work so you can submit your bill to your insurance company.

**RESULTS**

Due to the complexities of the human body, we cannot promise a specific result in any case. We have found that two similar conditions may respond quite differently to care. The fact is that the sciences of chiropractic and neurology will never be so exact as to provide definite answers to all problems. (We are thankful though that the majority of our patients do very well under our care!) In a small minority of patients, the results are less than expected and are usually from not following our recommendations.

**SIGNATURE**

I,_____ have read and fully understand the above statements. I, therefore, accept
(Print name)

chiropractic neurological care on this basis.

_____ _____

(Signature of patient or legal guardian) (Date)

## COMPREHENSIVE HEALTH HISTORY

*To help us serve you to the best of our ability, please complete **ALL** questions and bring with you to your appointment.*

Date: _____ Who may we thank for referring you? _____

Legal name: _____ What would you like us to call you? _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ Age: _____ Sex: M ❒ F ❒ Marital status: _____ Children: _____

Phone number: _____ Email address: _____

Occupation: _____ Employer: _____

Are your job duties physically demanding for you? Yes ❒ No ❒ Do you like your job? Yes ❒ No ❒

Preferred language: English ❒ Spanish ❒ Other (please specify) ❒ _____

What is your highest level of education? _____

Does your immediate family have a history of the following? Cancer ❒ Arthritis ❒ Diabetes ❒ Heart disease ❒

What health conditions have you had in the past? _____

_____

What injuries and traumas have you had in the past? (Such as motor vehicle accidents, falls, concussions, fractures, etc.)

_____

_____

What surgeries have you had in the past? _____

_____

What hospitalizations (other than surgeries listed above) have you had in the past? _____

_____

What medications, vitamins, or supplements do you currently take? _____

_____

What medications are you allergic to? _____

Please list any uncommon chemicals you are exposed to at work or home? _____

How many do you consume in an average day? Coffee _____ Cola _____ Diet soda _____ Alcoholic beverages _____

How often do you smoke? Never ❒ Use to smoke ❒ Currently smoke some days ❒ Currently smoke every day ❒

What are your hobbies? _____ Right handed ❒ Left handed ❒

What are your exercise activities? _____

What is your typical diet? _____

Do you feel much stress at home? Yes ❒ No ❒

Have you ever been diagnosed with any of the following?

Joint instability ❒ Osteoporosis ❒ Benign bone tumors of the spine ❒

Bleeding disorders or anticoagulant therapy ❒ Radiculopathy with progressive neurological symptoms ❒

Parkinson's disease ❒ Alzheimer's disease ❒

Have you ever been diagnosed with any of the following?

Acute rheumatoid arthritis ❒ Ankylosing spondylitis ❒ Healed fractures with signs of instability ❒

Unstable os odontoideum ❒ Spinal malignancies ❒ Spinal infections ❒ Myelopathy ❒ Cauda equina syndrome ❒

Vertebrobasilar insufficiency syndrome ❒ Major artery aneurysm ❒ Stroke ❒

## PRIMARY COMPLAINT

What is your primary complaint? (pain, dizziness, numbness, learning difficulties, etc.) _____

_____

What were you doing when you first felt it? _____

Was there any illness, trauma, or significant event prior? Yes ❒ No ❒ If yes, please describe: _____

_____

When did it begin? _____ Is this problem related to either of the following? Work accident ❒ Auto accident ❒

How severe is it? (0 = no symptom at all, 10 = excruciating symptom) 0 1 2 3 4 5 6 7 8 9 10

How much of the time do you feel it? 1% - 25% ❒ 25% - 50% ❒ 50% - 75% ❒ 75% - 100% ❒

Does it travel to another part of your body? Yes ❒ No ❒ If yes, where: _____

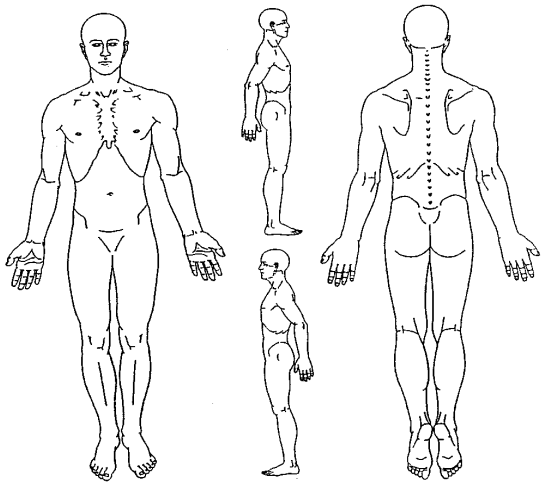
What makes it better? _____

What makes it worse? _____

Since it began, has it? Improved ❒ Stayed the same ❒ Worsened ❒ Been on and off ❒

Use the letters below to indicate the type and location of your sensations right now:

A = Ache B = Burning N = Numbness P = Pins and needles S = Stabbing O = Other



What activities of daily living are you having trouble with? Bending ❒ Climbing ❒ Housework ❒ Driving ❒
Arising out of a chair ❒ Lifting weights ❒ Opening jars ❒ Pulling ❒ Pushing ❒ Reaching ❒
Reading ❒ Running ❒ Shopping ❒ Sleeping ❒ Standing ❒ Walking ❒ Writing ❒

What prior treatments/medications have you done for it? _____

_____

Have you had any of the following diagnostics tests for this: X-rays ❒ MRI ❒ CT scan ❒ EMG/NCV ❒ Other ❒

What are you most concerned with regarding your problem? _____

_____

What do you desire most to get from working with us? _____

_____

## SYSTEMS HISTORY

*Complaints are often associated with specific regions or networks in the nervous system. Please indicate if you **regularly** experience any of the following symptoms.*

### RIGHT FRONTAL LOBE

Problems with fleeing bad or dangerous situations? Yes ❒ No ❒
Easily overwhelmed or depressed? Yes ❒ No ❒
Problems with decision making, planning, or organizational skills? Yes ❒ No ❒
Disorganization, lack of focus, and forgetfulness along with excessive movement and fidgeting (ADHD)? Yes ❒ No ❒
Changes in behavior, mood, or personality? Yes ❒ No ❒
Problems with the ability to express thoughts or words? Yes ❒ No ❒
Problems understanding social cues or poor eye contact? Yes ❒ No ❒
Getting stuck on thinking about something? Yes ❒ No ❒
Problems controlling the left side of the body? Yes ❒ No ❒
Clumsiness or poor coordination? Yes ❒ No ❒

### LEFT FRONTAL LOBE

Problems with aggressiveness? Yes ❒ No ❒
Easily agitated or irritated? Yes ❒ No ❒
Poor time management or is always late? Yes ❒ No ❒
Disorganization, lack of focus, and forgetfulness without excessive movement and fidgeting (ADD)? Yes ❒ No ❒
Problems following rules? Yes ❒ No ❒
Difficulty with fine motor skills (dyspraxia) such as buttoning a shirt? Yes ❒ No ❒
Tends to write very large or has poor handwriting? Yes ❒ No ❒
Stumbles over words when fatigued? Yes ❒ No ❒
Problems controlling the right side of the body? Yes ❒ No ❒
Exhibited delays in learning to crawl, stand, or walk? Yes ❒ No ❒

### RIGHT PARIETAL LOBE

Poor spatial orientation or bumps into things? Yes ❒ No ❒
Poor sense of balance? Yes ❒ No ❒
Does not like being touched? Yes ❒ No ❒
Does not like the feel of clothing on arms or legs? Yes ❒ No ❒
Does not notice strong smells such as burning wood, popcorn, or cookies? Yes ❒ No ❒
Problems with reading comprehension? Yes ❒ No ❒
Gets lost easily? Yes ❒ No ❒
Prefers bland food? Yes ❒ No ❒
Unusual sensations on either side of the body (e.g. numbness, tingling, coldness)? Yes ❒ No ❒

### LEFT PARIETAL LOBE

Unusual sensations on only the right side of the body (e.g. numbness, tingling, coldness)? Yes ❒ No ❒
Unaware of the environment? Yes ❒ No ❒
Problems with reading out loud (decoding)? Yes ❒ No ❒
Problems with calculating? Yes ❒ No ❒

Problems with writing? _____ Yes ❒ No ❒
Poor auditory processing? _____ Yes ❒ No ❒
Delays in speaking attributed to ear infections? _____ Yes ❒ No ❒
Experiences motion sickness? _____ Yes ❒ No ❒
Mixing up "rights" and "lefts"? _____ Yes ❒ No ❒

**RIGHT TEMPORAL LOBE**

Difficulty remembering a tune? _____ Yes ❒ No ❒
Difficulty recognizing voices? _____ Yes ❒ No ❒
Speaks in a monotone fashion? _____ Yes ❒ No ❒
Difficulty discriminating pitch? _____ Yes ❒ No ❒
Difficulty with the recognition of people or objects? _____ Yes ❒ No ❒
Difficulty hearing in a crowd? _____ Yes ❒ No ❒
Feeling that you have already experienced something that is actually happening for the first time? _____ Yes ❒ No ❒
Episodes of "spacing out"? _____ Yes ❒ No ❒

**LEFT TEMPORAL LOBE**

Difficulty remembering lyrics? _____ Yes ❒ No ❒
Difficulty with rhythm and beat? _____ Yes ❒ No ❒
Difficulty remembering names? _____ Yes ❒ No ❒
Difficulty understanding other people speaking? _____ Yes ❒ No ❒
Pain, itchiness, or ringing in either ear? _____ Yes ❒ No ❒
Changes in smell or taste? _____ Yes ❒ No ❒
Difficutly with short-term memory or long-term memory? _____ Yes ❒ No ❒
Difficulty saying what you want to say? _____ Yes ❒ No ❒

**RIGHT OCCIPITAL LOBE**

Difficulty perceiving depth, motion, or shape? _____ Yes ❒ No ❒
Difficulty recognizing the "big picture"? _____ Yes ❒ No ❒
Difficulty seeing things to the left? _____ Yes ❒ No ❒
Difficulty discriminating greens, blues, or purples? _____ Yes ❒ No ❒

**LEFT OCCIPITAL LOBE**

Difficulty understanding letters or symbols? _____ Yes ❒ No ❒
Difficulty recognizing details? _____ Yes ❒ No ❒
Difficulty seeing things to the right? _____ Yes ❒ No ❒
Difficulty discriminating reds, oranges, or yellows? _____ Yes ❒ No ❒

**MESENCEPHALON**

Cloudy vision, blurred vision, or double vision? Yes ❒ No ❒
Eye strain? Yes ❒ No ❒
Difficulty stabilizing your focus? Yes ❒ No ❒
Movement of your visual environment? Yes ❒ No ❒
Light sensitivity? Yes ❒ No ❒
Sound sensitivity? Yes ❒ No ❒
Anxiety or panic attacks? Yes ❒ No ❒

**PMRF**

High blood pressure or rapid heart rate? Yes ❒ No ❒
Cardiac arrhythmias? Yes ❒ No ❒
Cold hands or feet? Yes ❒ No ❒
Dry eyes? Yes ❒ No ❒
Constipation or diarrhea? Yes ❒ No ❒
Irritable bowel syndrome? Yes ❒ No ❒
Choking on food? Yes ❒ No ❒
Increased sweating on one side of the body? Yes ❒ No ❒
Breathing difficulties? Yes ❒ No ❒
Difficulties with initiating or controlling urination? Yes ❒ No ❒
Sexual dysfunction? Yes ❒ No ❒

**BASAL GANGLIA**

Tics or tremors? Yes ❒ No ❒
Slowness of movements? Yes ❒ No ❒
Stiffness, cramping, or twitching? Yes ❒ No ❒
Obsessive or compulsive tendencies? Yes ❒ No ❒
Slurring or stuttering? Yes ❒ No ❒

**CEREBELLUM**

Nausea or vomiting? Yes ❒ No ❒
Dizziness or vertigo? Yes ❒ No ❒
Dizzy or light headed when looking at moving objects? Yes ❒ No ❒
Dizzy or light headed when you stand up? Yes ❒ No ❒
Difficulty walking a straight line? Yes ❒ No ❒
Falling or leaning to one side? Yes ❒ No ❒
Spinning or moving when you are still? Yes ❒ No ❒
Incoordination of your arms or legs? Yes ❒ No ❒

Please describe anything else you think we should be aware of.

## MEDICAL INFORMATION RELEASE

Name: _____ Date of birth: _____/____/_____

**RELEASE OF INFORMATION**

❒ I authorize the release of my medical information including the information from my history, consultation, examination, report of findings, diagnosis, and treatments rendered to me. In addition to my insurance company, this information may be released to the individuals listed below and will remain in effect until terminated by me in writing.

Spouse: _____

Child(ren): _____

Other: _____

Other: _____

❒ I DO NOT authorize the release of medical information.

**MESSAGES**

If you need to leave a message for me, please call me at:

❒ my home

❒ my work

❒ my cell

If unable to reach me:

❒ you may leave a detailed message

❒ please leave a message asking me to return your call

❒ _____

Signed: _____ Date: ____/____/_____

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

_____ _____

Patient name (please print) Date

_____-

Parent, Guardian, or Patient's legal representative (please print)

_____

Signature

## PARENTAL CONSENT FOR TREATMENT AND CARE OF MINORS

***Only complete if patient is a minor.***

I, _____, being the parent and/or legal guardian of the

print adult's name

minor age child, _____, _____,

print child's name date of birth

hereby give consent for necessary or appropriate treatment and care by the health care providers affiliated with Atlantis Brain & Chiropractic Center, which may include, without limitation, Atlantis Brain & Chiropractic Center arranging for and/or authorizing consultation, evaluation, referral, treatment, for the above-named minor.

This consent shall remain in effect unless it is revoked in writing.

Signed this _____ day of _____, 20___

Parent / Legal Guardian: _____ _____

print name sign name

Relationship to minor: _____

Address: _____

Phone: _____

*Please attach a copy of the parent/guardian valid ID or driver's license to this consent form.