

# 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: spinal/extremity adjustments, laser therapy, percusser therapy, scar tissue release, microcurrent auricular therapy, Interactive Metronome therapy, vibration therapy, Neurosage therapy, brain photobiomodulation, far infrared therapy, Vagal nerve stimulation, and individualized brain-based therapies and 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.

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(Signature of patient or legal guardian)

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(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: \_\_\_\_\_

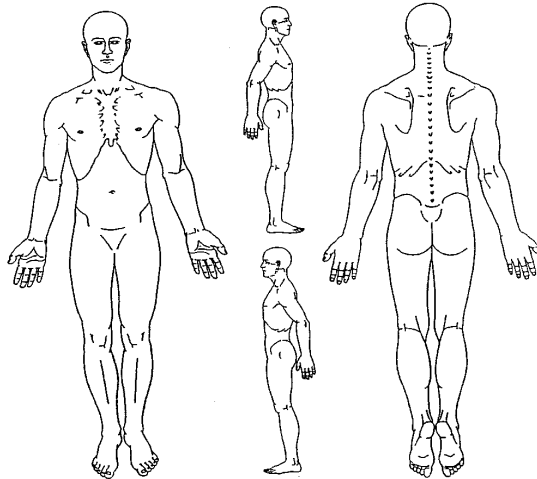
What makes it better? \_\_\_\_\_

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 brain. 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   
Difficulty 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

## PONTOMEDULLARY RETICULAR FORMATION

- 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

Complaints are also often associated with retained primitive reflexes. Please indicate if you **regularly** experience any of the following symptoms. (There may be some overlap from the above section.)

### MORO REFLEX

- Startles easily? \_\_\_\_\_ Yes  No
- Gets motion sickness easily? \_\_\_\_\_ Yes  No
- Sensitive to light, sounds, and touch? \_\_\_\_\_ Yes  No
- Frequent infections? \_\_\_\_\_ Yes  No
- Poor stamina? \_\_\_\_\_ Yes  No
- Often in "Fight or Flight" mode? \_\_\_\_\_ Yes  No
- Hyperactivity? \_\_\_\_\_ Yes  No
- Low self-esteem? \_\_\_\_\_ Yes  No
- Easily distracted? \_\_\_\_\_ Yes  No
- Overreacts? \_\_\_\_\_ Yes  No
- Impulsive or aggressive? \_\_\_\_\_ Yes  No
- Withdrawn, timid, or shy? \_\_\_\_\_ Yes  No
- Poor digestion? \_\_\_\_\_ Yes  No

### TONIC LABYRINTHINE REFLEX

- Poor organizational skills? \_\_\_\_\_ Yes  No
- Poor sequencing skills? \_\_\_\_\_ Yes  No
- Poor coordination? \_\_\_\_\_ Yes  No
- Poor sense of time? \_\_\_\_\_ Yes  No
- Fear of heights? \_\_\_\_\_ Yes  No
- Bumps into things and people more than normal? \_\_\_\_\_ Yes  No

### SYMMETRIC TONIC NECK REFLEX (STNR)

- Poor posture? \_\_\_\_\_ Yes  No
- Difficulty catching and/or tracking a ball? \_\_\_\_\_ Yes  No
- Poor depth perception? \_\_\_\_\_ Yes  No
- Poor hand-eye coordination? \_\_\_\_\_ Yes  No
- Difficulties with adjusting focus from far to near? \_\_\_\_\_ Yes  No
- Learning problems? \_\_\_\_\_ Yes  No
- Difficulty aligning numbers for math problems? \_\_\_\_\_ Yes  No
- Difficulty recognizing social cues? \_\_\_\_\_ Yes  No
- ADD/ADHD characteristics? \_\_\_\_\_ Yes  No
- Anchors feet behind chair while sitting? \_\_\_\_\_ Yes  No

**ASYMMETRIC TONIC NECK REFLEX (ATNR)**

- Poor balance when moving head side to side? \_\_\_\_\_ Yes  No
- Difficulty in things that require crossing the midline of the body? \_\_\_\_\_ Yes  No
- Mixed laterality (uses right foot, left hand or uses right or left hand interchangeably)? \_\_\_\_\_ Yes  No
- Poor expression of ideas on paper? \_\_\_\_\_ Yes  No
- Awkward gait? \_\_\_\_\_ Yes  No
- Difficulty in school? \_\_\_\_\_ Yes  No
- Math and reading issues? \_\_\_\_\_ Yes  No
- Shoulder, neck, and hip problems? \_\_\_\_\_ Yes  No

**SPINAL GALANT REFLEX**

- Bedwetting after age six? \_\_\_\_\_ Yes  No
- Fidgety or wiggly (especially when sitting)? \_\_\_\_\_ Yes  No
- Sensory issues with food texture or tags or waistbands in clothing? \_\_\_\_\_ Yes  No
- Poor short-term memory? \_\_\_\_\_ Yes  No
- Poor concentration? \_\_\_\_\_ Yes  No

**PALMAR REFLEX**

- Poor dexterity? \_\_\_\_\_ Yes  No
- Poor fine motor skills? \_\_\_\_\_ Yes  No
- Messy handwriting? \_\_\_\_\_ Yes  No
- Sticks tongue out when using hands? \_\_\_\_\_ Yes  No
- Poor ability to put thoughts on paper? \_\_\_\_\_ 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.