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 functional integrity of the nervous system. Patients seeking care can have "functional" and/or "ablative" deficits in their nervous systems. Patients with functional deficits 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. Depending on which option you choose, the following may be performed: consultation, spinal/extremity exam, neurological exam, Interactive Metronome exam, cognitive exam, computerized balance exam, video-oculography exam, and autonomic exam.

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, 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, Fit Light 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 will be glad to give you a superbill so you can submit it 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 better, 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: _____
Email address: _____
Home phone number: _____ Work phone number: _____ Cell phone number: _____
Occupation: _____ Employer: _____
Are your job duties physically demanding for you? Yes ❒ No ❒ Do you like your job? Yes ❒ No ❒

Race: White ❒ American Indian or Alaska Native ❒ Asian ❒ Black or African American ❒
Native Hawaiian or other ❒ Pacific Islander ❒ Unspecified ❒
Ethnicity: Not Hispanic or Latino ❒ Hispanic or Latino ❒ Unspecified ❒
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 ❒
How would you like us to communicate with you (if necessary)? Phone ❒ Email ❒ Regular mail ❒
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: _____

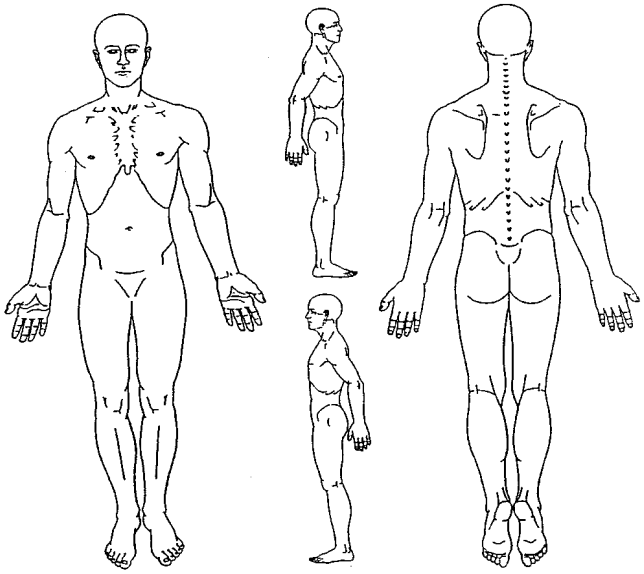
What makes it worse? _____

What makes it better? _____

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

SMELL AND TASTE

Have there been any changes to smell or taste? _____ Yes ❒ No ❒
Have you noticed any spontaneous smells or tastes? _____ Yes ❒ No ❒

VISION

Have you noticed any cloudiness, haziness, blurring, or double vision? _____ Yes ❒ No ❒
Do you have difficulty stabilizing your focus? _____ Yes ❒ No ❒
Do you ever experience movement of your visual environment? _____ Yes ❒ No ❒
Do you experience any pain in or around your eyes? _____ Yes ❒ No ❒
Are you more sensitive to light in one or both eyes? _____ Yes ❒ No ❒

HEARING

Have you noticed any changes to your hearing in either ear? _____ Yes ❒ No ❒
Do you find it difficult to listen when there is background noise? _____ Yes ❒ No ❒
Do you experience any ringing or whooshing noises in either ear? _____ Yes ❒ No ❒
Do you experience any pain or itchiness in or around either ear? _____ Yes ❒ No ❒
Do you experience a “fullness” or “blocked” sensation in either ear? _____ Yes ❒ No ❒

BALANCE

Do you find it harder to walk a straight line? _____ Yes ❒ No ❒
Do you tend to deviate more to the left or right when walking? _____ Yes ❒ No ❒
Do you feel as though you are falling or leaning to one side? _____ Yes ❒ No ❒
Do you feel as though you are spinning or moving when you are still? _____ Yes ❒ No ❒
Have you experienced any nausea or vomiting in the last week? _____ Yes ❒ No ❒
Do you feel dizzy or light headed when looking at moving objects? _____ Yes ❒ No ❒
Do you feel dizzy or light headed when you change your posture? _____ Yes ❒ No ❒

MOTOR

Do you have any difficulty with chewing or swallowing food? _____ Yes ❒ No ❒
Have you noticed any difficulties with your speech (e.g. slurring or stuttering)? _____ Yes ❒ No ❒
Have you noticed any clumsiness (e.g. using tools and utensils, or tripping)? _____ Yes ❒ No ❒
Have you noticed any tremors or uncontrollable movements? _____ Yes ❒ No ❒
Have you noticed any stiffness, cramping, or twitching anywhere? _____ Yes ❒ No ❒
Have you noticed any weakness or wasting of muscles? _____ Yes ❒ No ❒

SENSORY

Have you noticed any changes in skin sensitivity anywhere? _____ Yes ❒ No ❒
Have you noticed any unusual sensations anywhere (e.g. tingling, coldness)? _____ Yes ❒ No ❒

SYSTEMS HISTORY (CONTINUED)

AUTONOMIC

Have you noticed any changes with salivation or tearing? _____ Yes ❒ No ❒
Have you noticed any changes in sweating on either side of the body? _____ Yes ❒ No ❒
Have you noticed any coldness or puffiness in your arms or legs? _____ Yes ❒ No ❒
Do you experience any arrhythmia or rapid changes in heart rate? _____ Yes ❒ No ❒
Do you experience any breathing difficulties? _____ Yes ❒ No ❒
Do you have any problems with digestion or bowel movements? _____ Yes ❒ No ❒
Do you suffer from ulcers or irritability in the GI tract? _____ Yes ❒ No ❒
Do you have any difficulties with initiating or controlling urination? _____ Yes ❒ No ❒
Have you experienced any signs of sexual dysfunction? _____ Yes ❒ No ❒

COGNITIVE

Have there been any changes in decision making, planning, or organizational skills? _____ Yes ❒ No ❒
Have there been any changes in attention levels or concentration? _____ Yes ❒ No ❒
Have there been any changes in behavior, mood, or personality? _____ Yes ❒ No ❒
Have there been any changes in the ability to express thoughts or words? _____ Yes ❒ No ❒
Have there been any changes in the comprehension of speech or the written word? _____ Yes ❒ No ❒
Have there been any problems with the recognition of people or objects? _____ Yes ❒ No ❒
Have there been any changes with regard to orientation or spatial awareness? _____ Yes ❒ No ❒
Have there been any changes in short or long-term memory? _____ Yes ❒ No ❒
Have you experienced any seizures, anxiety, or panic attacks? _____ 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.