



## NEUROLOGICAL & METABOLIC CASE HISTORY

What is the main problem/symptom that you are having? (Be as specific as possible)

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List other symptoms you are currently experiencing even if not related to complaint listed above:

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Describe what you are feeling (diffuse, dull, achey, sharp, burning, cramping)?

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When did this begin? \_\_\_\_\_

How did this begin? \_\_\_\_\_

Have you had this or similar conditions in the past? Yes No If yes, when? \_\_\_\_\_

What makes your condition worse? \_\_\_\_\_

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What makes your condition better? \_\_\_\_\_

Do you experience Numbness or Tingling? Yes No If yes, where? \_\_\_\_\_

Does it radiate down the arm(s), leg(s), back or other? \_\_\_\_\_

SYMPTOM INTENSITY: Please circle the number describing the intensity of symptoms.

None/0      1      2      3      4      5      6      7      8      9      10/Unbearable

When you are awake, how often are you feeling these symptoms? ( 0-100%) \_\_\_\_\_

Does this affect you at night?    Yes                  No

When do you experience this throughout the day (AM/PM/All Day)? \_\_\_\_\_

How many days per week do you experience your main complaint? \_\_\_\_\_

Is this progressively getting worse?    Yes                  No

Is your condition:      Constant                  Comes & goes

Have you had any treatment for this problem in the past? Yes No If yes, when/by whom? \_\_\_\_\_

How did the previous method(s) work for you? \_\_\_\_\_

Are there any conditions that run in your family? Yes No If yes, what condition(s) and what family member?

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When was your last: Physical \_\_\_\_\_ Blood/lab work \_\_\_\_\_ X-ray \_\_\_\_\_ MRI \_\_\_\_\_

Have you been treated for your current condition before? Yes No If yes, when/by whom? \_\_\_\_\_

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Surgical History: Please list the type and reason of surgery, and year performed (e.g. left breast for cancer in 2004)

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## REVIEW OF SYSTEMS

Changes in or loss of smell? Normal, Loss, increased or decreased? _____	Yes	No
Monovision correction? _____	Yes	No
Visual changes or loss of vision? _____	Yes	No
Difficulty with visual focus or acuity? _____	Yes	No
Double vision? If yes, in which direction? _____	Yes	No
Dry eyes, dry mouth or excessive tearing or saliva? _____	Yes	No
Weakness or numbness of the face? _____	Yes	No
Difficulty hearing or ringing in your ears? _____	Yes	No
Maintaining balance with or without head movements? _____	Yes	No
Light headedness/dizziness when rising from a lying or seated position? _____	Yes	No
Sensations of spinning? If yes, which direction? _____	Yes	No
Difficulty swallowing foods? _____	Yes	No
Poor digestion, constipation, diarrhea, or abnormal bowel movements? (circle) _____	Yes	No
Bladder control issues? _____	Yes	No
Changes in sexual function or ability? _____	Yes	No
Increasing food sensitivities? Gluten / Dairy Other: _____	Yes	No
Excessive Bloating? _____	Yes	No
Difficulty shrugging or raising your shoulders or arms? _____	Yes	No
Slurring your words or your tongue feeling thick? _____	Yes	No
Sweaty hands or feet? _____	Yes	No
Cold hands or feet? _____	Yes	No
Noticeable sweating difference on the right or the left? _____	Yes	No

**Please Circle any of the following conditions or complaints that you have or are experiencing**

AD/HD	Adrenal Disorder	Anxiety	Arthritis	Asthma
Atypical Facial Pain	Arm or Leg Pain	Autoimmune Condition	Balance Problems	Bleeding Disorder
Blood Sugar Issues	Blurred Vision	Buzzing in Ear (s)	Carpal Tunnel	Cancer _____
Celiac Disease	Chest Pains	Chronic Fatigue	Colitis/Diverticulitis	Compression Fractures
Concussion	Connective Tissue	COPD	Depression	Diabetes (Type 1 or 2)
Digestive Issues	Dizziness (sitting up/standing up)	Double Vision	Dyslexia	Ear Infections
Fibromyalgia	Food Sensitivity	Fusions (spinal)	Gout	Gall Bladder Issue
Headache	Heart Disease	Hepatitis A, B, C	Herpes	High Blood Pressure
Hip Replacement	HIV/AIDS	Immune Deficiency	Insomnia	Joint Pain
Kidney Disease	Liver Disease	Low Back Pain	Migraine	Multiple Sclerosis
Neck Pain	Osteoporosis/Penia	Regional Pain Syndrome (CRPS)	Rotator Cuff Issues	Shoulder Pain
Stroke/TIA	STI/STD	Tremors	Trigeminal Neuralgia	TMJ
Thyroid Issues	Tuberculosis	Tingling, Burning, Numbness in Hands or Feet		Vertigo

**Arizona Chiropractic Neurology Center**

**Informed Consent Document**

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

**The nature of the chiropractic adjustment**

The primary treatment we use as a Doctor of Chiropractic is spinal manipulative therapy (SMT, CMT). We will use this procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as you move your joints. That may cause an audible “pop” or “click”, much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

**Analysis/Examination/Treatment**

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Spinal manipulative therapy
- Palpation
- Vital Signs
- Range of motion testing
- Orthopedic testing
- Neurological testing
- Postural analysis
- EMS/TENS/Galvanic
- Imaging and Lab studies as indicated
- hot/cold therapy
- Stretching
- massage therapy
- exercise rehabilitation
- Microcurrent
- low level laser therapy
- SSEP
- Functional medicine/supplements
- Other\_\_\_\_\_

**The material risks inherent in chiropractic care**

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and physiotherapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strains, ligament sprains, cervical myelopathy, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke (CVA). Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. Cauda Equina Syndrome has been reported in rare cases which requires immediate medical care.

**The probability of those risks occurring**

Statistically, Chiropractic Care has been demonstrated to be one of the safest of all healthcare practices. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the raking of your history and examination. CVA has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur one in five million cervical adjustments. Two major studies (2008, 2015) showed there was not causation between CMT and CVA but rather the patient was already presenting with arterial dissection. The other complications are also generally described as rare.

**The availability and nature of other treatment options**

Other treatment options for your condition may include:

- Self-administered, over-the-counter (OTC) analgesics, ice, head or rest.
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and pain killers.
- Hospitalization/Surgery

If you choose to use on of the above noted “other treatment” options, you should be aware that there are severe risks associated with these treatments. Many patients taking OTC NSAID’s such as Ibuprofen and Acetaminophen are not aware that every year there are thousands of deaths associated with their use. No medicine should ever be taken without discussing their side effects and inherent statistical danger with their primary care physician or pharmacist. The PDR is also a good reference regarding pharmaceutical use.

**The risks and dangers attendant to remaining untreated**

Remaining untreated may create adhesions or scar tissue that can weaken the area and reduce mobility. Further joint degeneration may occur as well as the development of chronic pain syndromes. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

*I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.*

**DATED:\_\_\_\_\_ PATIENTS NAME:\_\_\_\_\_ SIGNATURE\_\_\_\_\_**

**SIGNATURE OF PARENT OR GUARDIAN (if minor)\_\_\_\_\_**

**DATED:\_\_\_\_\_ DOCTOR’S NAME:\_\_\_\_\_ SIGNATURE\_\_\_\_\_**

**PATIENT FINANCIAL RESPONSIBILITY PATIENT RECORD OF DISCLOSURES/HIPAA ACKNOWLEDGEMENT**

Thank you for choosing Arizona Chiropractic Neurology Center. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our Patient Financial Responsibility Policies and HIPAA Acknowledgement.

**INSURANCE:** The patient (or patient’s guardian, if a minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you; however, it is the patient’s responsibility to know the details of their insurance in addition to any lapses in insurance coverage. If you do not inform us of special requirements required by your plan, and we provide medically necessary services that are not covered by your plan, we may bill you directly for those charges.

**COPAYS, DEDUCTIBLES & CO-INSURANCE:** All patients are responsible for their copayments, deductibles, and past due balances at the time of service.

**CANCELLATION/NO SHOW OF APPOINTMENTS:** When an appointment is not kept, it creates an unused appointment slot that could have been used for another patient. It is very important that you call to cancel your appointment. If for any reason you need to cancel or reschedule an appointment, please notify our office within 24 hours to avoid a fee of \$30.00.

**RETURNED CHECKS:** There will be a \$25 service fee for any check returned for insufficient funds.

**PLEASE NOTE THAT ANY BENEFIT INFORMATION FURNISHED IS NOT A GUARANTEE OF PAYMENT NOR A DETERMINATION OF MEDICAL NECESSITY AND FINAL CLAIM DETERMINATION WILL BE MADE UPON RECEIPT AND REVIEW OF THE CLAIM. THE PATIENT IS RESPONSIBLE FOR ALL BALANCES OUTSTANDING.**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home.

**I wish to be contacted in the following manner (check all that apply):**

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

I authorize Dr. Berry, Dr. Teames and Dr. Santo to discuss my protected health information with the following family members or healthcare providers that are caring for me. I authorize the release of my medical health records from/to other healthcare providers that are caring for me.

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

I understand that I may revoke this authorization at any time, which will then apply to any future disclosures of my protected health information. I have been given the opportunity to review the Notice of Privacy Practices available in the office.

Signature of Patient/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

# Media Release Form

This statement authorizes Arizona Chiropractic Neurology Center permission to use my name, likeness and/or voice in any and all of its publications, including website entries, social media, without payment or any other consideration. I am aware that I may be asked a variety of questions and that the contents of the interview may be published or aired for public view. Should there be questions that make me uncomfortable, I reserve the right to refuse to answer said questions or participate in discussions, and additionally reserve the right to terminate the interview, photo or video session at anytime. I understand and agree that materials produced will become the property of Arizona Chiropractic Neurology Center and will not be returned. I hereby irrevocably authorize Arizona Chiropractic Neurology Center to edit, alter, copy, exhibit, publish or distribute any video, interview or photograph for purposes of publicizing Arizona Chiropractic Neurology's programs or for any other lawful purposes. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the media. I hereby hold harmless, release and forever discharge Arizona Chiropractic Neurology Center from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I hereby certify that I am 21 years of age and am competent to contract in my own name. I have read this release before signing and I fully understand the contents, meaning, and impact of this release.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Date)

**If the person signing is under age 21, there must be consent by a parent or guardian, as follows:**

I hereby certify that I am the parent or guardian of \_\_\_\_\_, named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

\_\_\_\_\_  
(Parent/Guardian's Signature)

\_\_\_\_\_  
(Parent/Guardian's Printed Name)

\_\_\_\_\_  
(Date)