Welcome to Arizona Chiropractic Neurology Center

Patient and Contact Information History and Review of Systems

3800 W. Ray Rd. #12 Chandler, AZ 85226 Phone: (480) 756-2600 Fax: (480) 756-0800

Please fill out the following form in as much detail as possible. All your health information is kept confidential.

Name_____

Today's Date _____ Age _____ Address_____

City _____ State _____ ZIP _____

Gender: Male Female Height _____ Weight _____ DOB _____

Home Phone (_____) _____ Cell (_____) _____ Work (_____) _____

Email_____

Occupation_____

Emergency Contact name _____ Emergency Number (_____) _____

List of current/previous doctors:

Primary Care Physician _____

Other (please specify)_____

How did you hear about our office? _____

Medication List: *Please list the name of each current prescribed and over the counter medications, prescribed use and any side effects/reactions*

Medication	Purpose of Taking Medication	Any Side-Effects

NEUROLOGICAL & METABOLIC CASE HISTORY

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

_____

_____

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

_____

_____

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

_____

_____

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?_____

_____

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?

_____

_____

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? _____

_____

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

_____

_____

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 HIPPA Acknowledgment.

CANCELLATION/NO SHOW OF APPOINTMENTS: A 50% NON-REFUNDABLE deposit is required at the time of your initial booking for all new patients. For all existing patients, failure to provide 24-hour advanced notification for cancellation or rescheduling existing visits is subject to a missed appointment fee.

RETURNED CHECKS: There is a $25 service fee for any check returned for insufficient funds.

☐ **Please acknowledge the cancellation/no-show policy by placing a check or X in the box.**

☐ Please acknowledge that any recordings done at ACNC by any person cannot be used, broadcast or reproduced without expressed written consent from Dr.Trevor Berry DC,DACNB by placing a check or X in the box.

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 the healthcare providers at Arizona Chiropractic Neurology 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: _____

Metabolic Assessment Form™

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Lowered gastrointestinal motility, constipation	0	1	2	3
Raised gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?		Yes	No	

Category VIII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?		Yes	No	

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

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Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*

Perimenopausal		Yes	No	
Alternating menstrual cycle lengths		Yes	No	
Extended menstrual cycle (greater than 32 days)		Yes	No	
Shortened menstrual cycle (less than 24 days)		Yes	No	
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?		Yes	No	
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

_____

Please list any natural supplements you currently take and for what conditions:

_____

Brain Region Localization Form

INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please answer every question, do not skip any questions. Follow the 0 to 4 key, and select which best fits for all of your answers.

KEY:

0 = I never have symptoms (0% of the time)
1 = I rarely have symptoms (Less than 25% of the time)
2 = I often have symptoms (Half of the time)
3 = I frequently have symptoms (75% of the time)
4 = I always have symptoms (100% of the time)

NAME: DATE:

Frontal lobe Prefrontal, Dorsolateral and Orbitofrontal 0 1 2 3 4 (Areas 9, 10, 11, and 12)						
1.	Difficulty with restraint and controlling impulses or desires					
2.	Emotional instability (lability)					
3.	Difficulty planning and organizing					
4.	Difficulty making decisions					
5.	Lack of motivation, enthusiasm, interest and drive (apathetic)					
6.	Difficulty getting a sound or melody out of your thoughts (Perseveration)					
7.	Constantly repeat events or thoughts with difficulty letting go					
8.	Difficulty initiating and finishing tasks					
9.	Episodes of depression					
10.	Mental fatigue					
11.	Decrease in attention span					
12.	Difficulty staying focused and concentrating for extended periods of time					
13.	Difficulty with creativity, imagination, and intuition R					
14.	Difficulty in appreciating art and music R					
15.	Difficulty with analytical thought L					
16.	Difficulty with math, number skills and time consciousness L					
17.	Difficulty taking ideas, actions, and words and putting them in a linear sequence L					

Frontal Lobe Precentral and Supplementary 0 1 2 3 4 Motor Areas (Area 4 and 6)						
18.	Initiating movements with your arm or leg has become more difficult					
19.	Feeling of arm or leg heaviness, especially when tired					
20.	Increased muscle tightness in your arm or leg					
21.	Reduced muscle endurance in your arm or leg					
22.	Noticeable difference in your muscle function or strength from one side to the other					
23.	Noticeable difference in your muscle tightness from one side to the other					
Frontal Lobe Broca's Motor Speech Area (Area 44 and 45)		0	1	2	3	4
24.	Difficulty producing words verbally, especially when fatigued					
25.	Find the actual act of speaking difficult at times					
26.	Notice word pronunciation and speaking fluency change at times					
Parietal Somatosensory Area and Parietal Superior Lobule 0 1 2 3 4 (Areas 3,1,2 and 7)						
27.	Difficulty in perception of position of limbs					
28.	Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall					
29.	Frequently bumping body or limbs into the wall or objects accidently					
30.	Reoccurring injury in the same body part or side of the body					
31.	Hypersensitivities to touch or pain perception					

Brain Region Localization Form

INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please answer every question, do not skip any questions. Follow the 0 to 4 key, and select which best fits for all of your answers.

KEY:

0 = I never have symptoms (0% of the time)
1 = I rarely have symptoms (Less than 25% of the time)
2 = I often have symptoms (Half of the time)
3 = I frequently have symptoms (75% of the time)
4 = I always have symptoms (100% of the time)

Parietal Inferior Lobule (Area 39 and 40)		0	1	2	3	4
32.	Right/left confusion L	○	○	○	○	○
33.	Difficulty with math calculations L	○	○	○	○	○
34.	Difficulty finding words L	○	○	○	○	○
35.	Difficulty with writing L	○	○	○	○	○
36.	Difficulty recognizing symbols or shapes R	○	○	○	○	○
37.	Difficulty with simple drawings R	○	○	○	○	○
38.	Difficulty interpreting maps R	○	○	○	○	○
Temporal Lobe Auditory Cortex (Areas 41, 42)		**0**	**1**	**2**	**3**	**4**
39.	Reduced function in overall hearing	○	○	○	○	○
40.	Difficulty interpreting speech with background or scatter noise	○	○	○	○	○
41.	Difficulty comprehending language without perfect pronunciation	○	○	○	○	○
42.	Need to look at someone's mouth when they are speaking to understand what they are saying	○	○	○	○	○
43.	Difficulty in localizing sound	○	○	○	○	○
44.	Dislike of left predictable rhythmic, repeated tempo and beat music	○	○	○	○	○
45.	Dislike of non-predictable rhythmic with multiple instruments R	○	○	○	○	○
46.	Noticeable ear preference when using your phone	right, left, no preference				
Temporal Lobe Auditory Association Cortex (Area 22)		**0**	**1**	**2**	**3**	**4**
47.	Difficulty comprehending meaning of spoken word L	○	○	○	○	○
48.	Tend toward monotone speech without fluctuations or emotions R	○	○	○	○	○

Medial Temporal lobe and Hippocampus		0	1	2	3	4
49.	Memory less efficient	○	○	○	○	○
50.	Memory loss that impacts daily activities	○	○	○	○	○
51.	Confusion about dates, the passage of time, or place	○	○	○	○	○
52.	Difficulty remembering events	○	○	○	○	○
53.	Misplacement of things and difficulty retracing steps	○	○	○	○	○
54.	Difficulty with memory of locations (addresses) R	○	○	○	○	○
55.	Difficulty with visual memory R	○	○	○	○	○
56.	Always forgetting where you put items such as keys, wallet, phone, etc. R	○	○	○	○	○
57.	Difficulty remembering faces R	○	○	○	○	○
58.	Difficulty remembering names with faces L	○	○	○	○	○
59.	Difficulty with remembering words L	○	○	○	○	○
60.	Difficulty remembering numbers	○	○	○	○	○
61.	Difficulty remembering to stay or be on time L	○	○	○	○	○
Occipital Lobe (Area, 17, 18, and 19)		**0**	**1**	**2**	**3**	**4**
62.	Difficulty in discriminating similar shades of color	○	○	○	○	○
63.	Dullness of colors in visual field	○	○	○	○	○
64.	Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach out for objects	○	○	○	○	○
66.	Floater or halos in visual field	○	○	○	○	○

Brain Region Localization Form

INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please answer every question, do not skip any questions. Follow the 0 to 4 key, and select which best fits for all of your answers.

KEY:

0 = I never have symptoms (0% of the time)
1 = I rarely have symptoms (Less than 25% of the time)
2 = I often have symptoms (Half of the time)
3 = I frequently have symptoms (75% of the time)
4 = I always have symptoms (100% of the time)

Cerebellum - Spinocerebellum						01234
67.	Difficulty with balance, or balance that is worse on one side					
68.	A need to hold the handrail or watch each step carefully when going down stairs					
69.	Feeling unsteady and prone to falling in the dark					
70.	Proness to sway to one side when walking or standing					
Cerebellum - Cerebrocerebellum		**0**	**1**	**2**	**3**	**4**
71.	Recent clumsiness in hands					
72.	Recent clumsiness in feet or frequent tripping					
73.	A slight hand shake when reaching for something at the end of movement					
Cerebellum - Vestibulocerebellum		**0**	**1**	**2**	**3**	**4**
74.	Episodes of dizziness or disorientation					
75.	Back muscles that tire quickly when standing or walking					
76.	Chronic neck or back muscle tightness					
77.	Nausea, car sickness, or sea sickness					
78.	Feeling of disorientation or shifting of the environment					
79.	Crowded places cause anxiety					
Basal Ganglia Direct Pathway		**0**	**1**	**2**	**3**	**4**
80.	Slowness in movements					
81.	Stiffness in your muscles (not joints) that goes away when you move					
82.	Cramping of hands when writing					
83.	A stooped posture when walking					
84.	Voice has become softer					
85.	Facial expression changed leading people to frequently ask if you are upset or angry					
Basal Ganglia Indirect Pathway		**0**	**1**	**2**	**3**	**4**
86.	Uncontrollable muscle movements					
87.	Intense need to clear your throat regularly or contract a group of muscles					
88.	Obsessive compulsive tendencies					
89.	Constant nervousness and restless mind					
Autonomic Reduced Parasympathetic Activity		**0**	**1**	**2**	**3**	**4**
90.	Dry mouth or eyes					
91.	Difficulty swallowing supplements or large bites of food					
92.	Slow bowel movements and tendency for constipation					
93.	Chronic digestive complaints					
94.	Bowel or bladder incontinence resulting in staining your underwear					
Autonomic Increased Sympathetic Activity		**0**	**1**	**2**	**3**	**4**
95.	Tendency for anxiety					
96.	Easily startled					
97.	Difficulty relaxing					
98.	Sensitive to bright or flashing lights					
99.	Episodes of racing heart					
100.	Difficulty sleeping					

MediaReleaseForm

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)

Vestibular Localization Form

PART 1 INSTRUCTIONS: PATTERNS OF DIZZINESS

The purpose of this questionnaire is to identify difficulties you may be experiencing. Please answer every question, do not skip any questions. Circle yes or no where asked.

NAME: DATE:

Patterns of Dizziness	
How would you explain your dizziness: Lightheaded Yes / No Disorientation Yes / No False sense of motion that you are moving Yes / No If yes, in which direction _____ False sense of motion the world is moving Yes / No If yes, in which direction _____	
Please describe your dizziness without using the word "dizzy":	
Are your dizziness symptoms (circle one): Recent (first episode) Reoccurring Chronic	
What is the typical duration of your symptoms (circle one)? A few seconds Several seconds to a few minutes Several minutes to one hour Days Weeks	
Do you have hearing loss with your vertigo?	Yes / No
Do you have any ringing in your ear with your vertigo?	Yes / No
Is there any correlation with timing of your symptoms and taking a new medication (aspirin, antibiotics, diuretics, etc.)?	Yes / No Maybe
Is there any correlation with timing of your symptoms and exposure to any environmental chemicals or toxins?	Yes / No Maybe
Can your symptoms of dizziness be reduced by visually fixating on a target?	Yes / No
Are your symptoms of dizziness worse in the dark?	Yes / No
Are there any other symptoms you experience besides false sense of motion? What? (ex. Nausea, anxiety, racing heart rate, etc.) _____	Yes / No
Is there anything that can aggravate your vertigo? What?_____	Yes / No
Does anything help your symptoms? What?_____	Yes / No
Do any of the following movements cause you to feel disorientated or dizzy? Turning to the right Yes / No Turning to the left Yes / No Suddenly stopping in a car or a plane landing Yes / No Suddenly starting to move forward in a car or plane Yes / No Looking out the window of a train or moving vehicle with your back facing the direction of movement Yes / No Looking out the window of a train or moving vehicle with your front facing the direction of movement Yes / No Moving side-to-side Yes / No Suddenly moving up or down on an elevator Yes / No	

Vestibular Localization Form

PART 2 INSTRUCTIONS: DIZZINESS SYNDROMES

The purpose of this questionnaire is to identify difficulties you may be experiencing. Please select yes or no.

Perilympathic Fistula and Superior Canal Dehiscence	Yes / No
Did your dizziness start after trauma to your ear by sudden changes of pressure to your ear?	Yes / No
Did your dizziness start after heavy weight bearing or excessive straining with bowel movements?	Yes / No
Can sneezing, straining, or changes of pressure trigger your dizziness?	Yes / No
Can putting your head down to one side trigger your dizziness?	Yes / No
Can loud noises or sounds at times trigger your dizziness?	Yes / No
Have you started to notice your own voice much louder than before?	Yes / No
Have you notice any distortions of sensations of sound?	Yes / No
Benign Paroxysmal Positional Vertigo	
Can positional changes such as turning over in bed, bending over and then straightening up, or tilting your head trigger your symptoms?	Yes / No
Are your symptoms of dizziness prompted by eye or head movements and then decrease in less than one minute?	Yes / No
Does your dizziness become less noticeable each time you repeat the same movement?	Yes / No
Do your episodes of dizziness come in sudden and brief spells?	Yes / No
Vestibular Neuronitis	
Did your dizziness come on suddenly?	Yes / No
Did your dizziness start after a recent viral or bacterial infection?	Yes / No
Do you have a history of Herpes Zoster outbreaks?	Yes / No
Did your dizziness start during a period of exhaustion or weakened immune system?	Yes / No
Meniere's	
Do you notice a feeling of fullness in the ear or on the side of your head accompanying your episodes of dizziness?	Yes / No
Do you have episode of ringing in your ear accompanying your episodes of dizziness?	Yes / No
Have you experienced two or more episodes of vertigo lasing at least 20 minutes each?	Yes / No
Vestibular Migraine	
Do you experience flickering light spots (visual aura) before your episodes of dizziness or headaches?	Yes / No
Do you experience a throbbing headache before or after your episodes of dizziness?	Yes / No
Do you become extremely sensitive to light and sound before or after you episodes of dizziness?	Yes / No
Have you noticed your episodes of dizziness can be provoked by stress, low blood sugar levels, diet, chocolate, red wine, caffeine, cheeses or MSG?	Yes / No