SAN DIEGO CHIROPRACTIC NEUROLOGY BY ALBINDER AND JAHANGIRI

(619)-344-0111

PATIENT CONTACT INFORMATION

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

Name:____

Today's Date:________________ Date of Birth:________________

Address:____

City:_____________________ State: ______ ZIP:____________

Gender:

Marital Status:

Home Phone:_________________ Cell:_________________ Work:___________________

Email:____

Contact you via:

Cell phone Provider:_________________________

Occupation:__________________________ Employer/School:________________________________

Spouse/Partners Name:_________________________ Employer:_____________________________

Spouse/Partners Work Phone:___________________ Cell:_____________________

Emergency Contact Name:_______________________________ Relationship:____________________

Emergency Contact Cell:_______________________________ Work:___________________________

Signature: ____ **Date:** ______________________

HIPAA Notice of Privacy Practices

____[Name]

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operation (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operation: We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided by this notice.

3. Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

Kyle Kamran Jahangiri, DC DACNB
Steven Albinder, DC DACNB
Alexis Jahangiri, DC
San Diego Chiropractic Neurology
(619)-344-0111

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: ______________________________ Signature: __________________________________
Date: _________

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). 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
--Muscle strength testing	--Postural analysis	--EMS
--Radiographic studies	--hot/cold therapy	--TENS
--Stretching	--massage therapy	--exercise rehabilitation
--Microcurrent	--low level laser therapy	--SSEP --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 with 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.

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 between one in a million and one in five million cervical adjustments. 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 Ibuprophen 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**___________________________

Metabolic Assessment Form™

Name: ______________________ **Age:** ______ **Sex:** _____ **Date:** ______________________

PART I

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

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

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:

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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 (Areas 9, 10, 11, and 12)	0	1	2	3	4
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 Motor Areas (Area 4 and 6)	0	1	2	3	4
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 (Areas 3,1,2 and 7)	**0**	**1**	**2**	**3**	**4**
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					

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	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	L					
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	L					
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						

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KEY:

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4 = I always have symptoms (100% of the time)

	Cerebellum - Spinocerebellum	0	1	2	3	4
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.	Proneness 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					

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Brain Region Localization Form

INSTRUCTIONS:

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

Epileptiform Activity	Yes / No
Have you ever been diagnosed with a seizure disorder?	Yes / No
Have you ever been diagnosed with epilepsy?	Yes / No
Have you ever been told that you seemed frozen, absent, or tuned out at times without any recollection of the event?	Yes / No
Have you ever experienced sudden muscle stiffness and rigidity throughout your body?	Yes / No
Have you ever experienced sudden muscle jerks throughout your body?	Yes / No
Have you ever experienced a total loss of your muscle tone that lead to loss of control of your muscles or a fall?	Yes / No
Have you ever been told that you stare into space while you're lip smacking, chewing, or fidgeting that you are not aware of?	Yes / No
Do you ever experience sudden emotional responses such as anxiety, sadness, cry, or laugh for no real reason?	Yes / No
Do you ever experience sudden racing heart rate, sudden loss of bladder function, intestinal spasm, respiration, sweating, or any other sudden changes of function?	Yes / No
Do you ever experience sudden involuntary muscle contractures or jerks in any individual parts of your limbs or face?	Yes / No
Do you ever experience sudden involuntary head rotation and your eyes move forcefully to one side?	Yes / No
Do you ever experience sudden involuntary shift in your eyes to the side or upwards?	Yes / No
Do you ever experience sudden vocalization of random words or notice a sudden inability to speak?	Yes / No
Do you ever experience any spontaneous sensations of tingling, pins and needles" numbness, coldness, burning or other random sensations in any region of your body?	Yes / No
Do you ever experience a ringing sensation in your ears (tinnitus), sounds, or voices spontaneously?	Yes / No
Do you ever experience spontaneous perception of smells such as burning rubber, foul smells, or other odors without finding the source of the odor?	Yes / No
Do you ever experience flashing lights, stars, or jagged lines in your visual field?	Yes / No

SIGNATURE: DATE:

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San Diego Chiropractic Neurology

Financial Policies

Welcome to San Diego Chiropractic Neurology (SDCN). We are pleased to have you as a patient and we are committed to providing you with exceptional medical care. We are a unique practice, utilizing state-of-the-art diagnostic and treatment protocols as well as a broad spectrum of additional services. In order to best serve you, we want you to be fully informed of our financial policies prior to your first visit. Please read and initial each section below, indicating your understanding and agreement with each statement.

_____ I understand that a co-pay does not cover all expenses incurred during an office visit and that I am responsible for all co-payments, deductibles, and co-insurances. I am also responsible for all charges for services/supplies that are noncovered or deemed experimental, investigational, or not medically necessary. Any services rendered or tests performed may or may not be a covered benefit of my insurance plan and it is my responsibility to verify coverage.

_____ I understand that lab testing (blood, stool, urine, salivary) is potentially recommended for all new patients and are procedures that are not billable with the exception of the Diagnostic Solutions GI Map where potentially half of the cost can be covered by insurance.

_____ I understand that appointments at SDCN are in high demand. Please contact us 48 hours in advance if you must cancel your appointment. Your first missed appointment will be waived the no call/no show fee if you choose not to arrive on time or keep your appointment without notification. Two consecutive missed appointments without notification will incur a $60 fee and three consecutive missed appointments without notification will result in removal from the practice.

_____ I understand that any self pay, fee-based services or products require full payment at the time of service. This includes, but is not limited to, alternative therapies, supplements, and non-covered products and services. This also includes all services rendered to Private Pay patients who do not have insurance.

Signed: ____ Date: _______________________________
(patient or responsible party if patient is a minor)

Print name: ____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient name: ____________________________

Date of birth: ______________________________

Previous name: ___________________________

I authorize San Diego Chiropractic Neurology to release healthcare information and discuss my treatment with the following people:

Name:_______________________________ Relationship:_______________________________

Name:_______________________________ Relationship:_______________________________

Name:_______________________________ Relationship:_______________________________

Name:_______________________________ Relationship:_______________________________

This authorization applies to:

- ❏ Healthcare information
- ❏ Billing information

Other:______________________________

Signed: ____

(Patient or responsible party, if patient is a minor)

Print name: ____

Date: _____________

INSURANCE INFORMATION

Please provide your insurance card or cards so we may keep a copy on file. Any time there is a change to your insurance, or new cards are issued, it is your responsibility to provide the updated cards to our office.

Patient name:_________________________________

Primary insurance company: _________________________________

Effective date:_______________

Policy holder name: _________________________________

Date of birth:________________

Relationship to patient: SELF SPOUSE CHILD OTHER _____________

Secondary insurance company: _______________________________

Effective date: _______________

Policy holder name: _________________________________

Date of birth: ________________

Relationship to patient: SELF SPOUSE CHILD OTHER _____________

If you are not the Policy Holder on either of your insurance plans, please complete the following: I hereby authorize San Diego Chiropractic Neurology to release and discuss my healthcare and/or financial information with the Policy Holder of my insurance plan, named here:

____

Signed: ____

Print name: ____ Date: _______________

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS AND CERTIFICATION OF ACCURATE INFORMATION

I hereby authorize San Diego Chiropractic Neurology to release information which is normally required in the course of my treatment for the sole purpose of processing any insurance claim(s) submitted. I hereby authorize my insurance company to send payment directly to San Diego Chiropractic Neurology for any insurance benefits for services rendered. I understand that I am financially responsible for any unmet deductible, co-pays and for any charges of services not covered by my insurance. I have reviewed the preceding information and I certify that this information is correct. I further understand that I am responsible for any financial loss due to inaccurate or incomplete information provided by me.

Signed: ____

(Patient or responsible party, if patient is a minor) Print name:

____ Date: _____________

DIRECT ASSIGNMENT OF BENEFITS & RIGHTS

PROVIDER: **PATIENT:** **Date:**

In consideration of your undertaking to render care, I agree to the following:

1. RELEASE OF INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any Insurance company, attorney or adjuster In order to process any claim for reimbursement of charges incurred by me at your treatment facility.
2. RIGHT TO RECEIVE INFORMATION: I authorize my chiropractic provider the authority to affix my necessary signature as noted below to obtain medical information from any hospital, medical provider, etc. as It relates to the care being provided by my chiropractic doctor.
3. RIGHT TO RECEIVE PAYMENT: I irrevocably authorize and assign to you, the chiropractic provider, the right to receive direct payment from my attorney or any Insurance company which may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled.
4. ASSIGNMENT OF RIGHT TO SUE: In the event any insurance company or attorney obligated by contractual agreement to make payment to me for your service charges refuses to make such payment upon demand by you, I irrevocably hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me.
5. RIGHT TO LIEN: I also irrevocably assign to you, the chiropractic provider, and grant the right of lien against any and all claims against any third party whose negligence may have caused my Injury, Including their insurance, up to the amount of the bill for treatment, as it relates to my healthcare as provided by you.
6. RIGHT FOR INFORMATION: I irrevocably authorize my attorney, legal representative, insurer or any other party regarding my care or case to release financial information about proposed settlement, settlement/verdict payments or amounts owed included, but not limited to other providers or legal representatives, liens, billing amounts, and balances. I also instruct all representatives to include all financial information from all facets of my case including, but not limited to third party, uninsured motorist and underinsured motorists.
7. I irrevocably waive the Statute of Limitations regarding my doctor's right to recover from me directly.
8. I hereby acknowledge that I am receiving (or about to receive) health care services and I am advised that they are willing to wait for payment for these services, provided there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined either (a) there Is no insurance company obligated to pay for the services, or if the insurance company Involved refuses to acknowledge an assignment to the Doctor(s) or make other provisions for the protection of the interest of the Doctor(s); or (b) if a liability claim exists and my attorney refuses to agree to protect the interest of the Doctor(s) or If I have not engaged the services of an attorney, payment for services rendered by the above-named Doctor(s) will be made on a current basis and my account paid In full immediately. In any event, I hereby promise to pay my bill in full within (10) days from the date my liability claim Is settled or after the passage of three (3) months from the date of my last treatment, whichever comes first.
9. If any payment for any services rendered under this agreement becomes delinquent, the patient or patient's guardian shall be responsible for payment of any and all court costs, attorney's fees, service of process fees and any additional reasonable costs incurred in order to collect or that are associated with collecting monies due on the patient's· account.

Dated Signature ___ day of _____ 20 __

Patient Signature___________________________________

Witness Signature ___________________________________