

Neurological Rehabilitation Center LLC

Thank you for carefully
answering each question!

Patient: Black ink,
Doctor: Red ink

Patient Name: _____ Date: _____

Childhood Neurodevelopmental Form (Page 1):

Step 1: All new patients must fill out all appropriate new patient questionnaires & forms prior to their initial assessment. **Step 2:** Initial examination & review of patient forms. (You will be advised if there is the need of any additional procedures such as X-rays, MRI, CAT Scan, or lab testing.) **Step 3:** Your consultation with the doctor to discuss your health problems & to determine what program best fits your individual needs. (You will be informed of specific recommendations in regards to your condition.) **Step 4:** Your Specific Rehabilitation Program will be scheduled to begin.

Responsible Party's Confidential Information:

First Name: _____ Last Name: _____

Middle Initial: _____

Date of Birth: _____ Age: _____ SSN: _____ Driver License #: _____

Relationship to Patient: Self Parent Grandparent Guardian Other : _____

Gender: Male Female Marital Status: Married Single Divorced Widow

Spouse/Partner's Full Name: _____

Street Address: _____

_____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

Work Status: Employed Retired Disabled Full-time Student Part-time Student

Name of Employer: _____ Occupation _____

Employer Address: _____

State: _____ Zip Code: _____ Work Phone: _____

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Childhood Information (Page 2):

First Emergency Contact Information:

First Name: _____ Last Name: _____

Middle Initial: _____

Relationship to Patient: Self Parent Grandparent Guardian Other : _____

Street Address:

_____ City:

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone:

Second Emergency Contact Information:

First Name: _____ Last Name: _____

Middle Initial: _____

Relationship to Patient: Self Parent Grandparent Guardian Other : _____

Street Address:

_____ City:

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone:

Agreement for Patients

Neurological Rehabilitation Center LLC stresses that it is always YOUR CHOICE to choose which care you receive. We will honor and support your choice, and your Doctor will respect your needs and desires when recommending your treatment program. Please understand that most of the services provided are not reimbursable by insurance, if you have insurance and we can bill services this will be reduced from the total cost of the program. **Our patients are responsible for all payments, and payment for the program is due at the start of the program or prior to the program starting _____ (Initial).** If you feel your insurance would cover any care we provide, we will be happy to give copies of any paperwork needed so that you may be reimbursed by your insurance company.

Doctor's Notes: _____

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Childhood Information (Page 3):

Your appointment times are carefully scheduled to deliver efficient and adequate care to all of our patients. Missed appointments may deny other patients from receiving care during that time slot; **therefore, we have instituted a \$35.00 "missed appointment" fee should you not notify us of a schedule conflict within 24 hours of your next appointment.**

MISSED APPOINTMENT POLICY/CANCELLATION POLICY

By signing below, you affirm that you accept and understand these policies.

Responsible Party's Signature Date

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. The practitioners at Neurological Rehabilitation Center LLC are only participating with BCBS of Arizona, and do not participate in any other HMO/PPO organizations. I understand that the Doctor's Office will prepare any necessary forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time of services.

Responsible Party's Name Print: _____
Date_____

Responsible Party's Signature: _____
Date_____

Patient's Name Print: _____
Date_____

Patient's Signature: _____
Date_____

Doctor's Notes: _____

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Childhood Information (Page 4):

History Information:

ALLERGIC / SENSITIVE / INTOLERANT to any of the following foods: Milk/Dairy Wheat/Gluten
Eggs Corn Yeast Chocolate Citrus Fish/Shellfish Strawberries Other : _____

With any pets? Yes No If yes, please explain: _____

Any allergies that the child has been diagnosed with, or you suspect he/she has:

Does anyone in the house smoke? Yes No If yes, what? _____

Medical Information:

Is the child currently taking (or recently discontinued) any PRESCRIBED medications?

List: _____

Has the child recently been hospitalized? Or had any operations? Yes No

List: _____

Has the child used any of the following that the child utilizes: Ear Tubes Eye Glasses Contact Lenses Dental E
Knee/Leg Brace Neck Brace Implants Shunt

How is the child's dental health? Excellent Good Fair Poor

How is the child's eye sight? Excellent Good Fair Poor

When was the last eye exam: _____

How is the child's hearing? Excellent Good Fair Poor

When was the last hearing exam: _____

Has the child ever had an: X-Ray CAT-Scan MRI EKG Bone Scan None If any please explain

Result: _____

Doctor's Notes: _____

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Childhood Information (Page 5):

Doctor's Notes: _____

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Childhood Information (Page 6):

Family History

Has any blood relative (NOT CHILD) ever had any of the following?

ADD/AD(H)D: Relative _____

Arthritis: Relative _____

Asperger's Syndrome (AS): Relative _____

Asthma: Relative _____

Autism: Relative _____

Bleeding Disorder: Relative _____

Bipolar Disorder: Relative _____

Cancer: Relative _____

Developmental Delay : Relative _____

Diabetes Type I / II: Relative _____

Emphysema: Relative _____

Hepatitis B or C: Relative _____

Hypothyroidism: Relative _____

Learning Disability: Relative _____

Mental Illness/Suicide: Relative _____

Migraine Headaches: Relative _____

Multiple Sclerosis: Relative _____

Obsessive Compulsive Disorder (OCD): Relative _____

PDD: Relative _____

Siezure Disorder/Epilepsy: Relative _____

Speech Delay: Relative _____

Tourette's Syndrome: Relative _____

Doctor's Notes: _____

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Childhood Information (Page 7):

Nutrition:

Child consume any of the following?

Milk - Rarely Often Approx glasses per day_____

Difficulty digesting Milk/Dairy (Lactose Intolerant) No Not Aware Yes

Gluten containing grains/cereals - No Rarely Often

Orange/Apple - Rarely Often Approx glasses per day_____

Orange/Apple - Rarely Often Approx glasses per day_____

Water directly from Tap - Rarely Often Approx glasses per day_____

Alcoholic Beverages - Rarely Often Approx glasses per day_____

How many meals plus snacks per day does child eat on average?

1 2 3 4 5 6 Graze

Child eat fruits and vegetables? Frequently Rarely Almost Never

How many times/week, on average, does child eat Fish/Seafood?

More than 3xs 1 - 2X/Wk Rarely Almost Never

What fats/Oils does child consume?

Olive Oil Coconut Oil Flax Oil Safflower Oil Sunflower Oil Peanut Oil Grape
Macadamia Oil Mayonnaise Margarine Crisco Corn Oil Soybean Oil Canola Oil

Is child on any special diet?

Dairy-Free Wheat/Gluten-Free Yeast-Free Feingold Low Carbohydrate High Protein No Sugar

Doctor's Notes: _____

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Childhood Information (Page 8):

Nutrition Continued:

What diet type does child primarily consume?

Carbohydrate – Bread, pasta, cereal, rice, potatoes, juices, sweets, etc

Protein – Meat, Fish, Fowl, eggs, nuts, etc.

Vegetarian – No meat at all

Special Diet – Large variety of protein, vegetables, and carbohydrates

Does the child seem to have excessive thirst? No Sometimes Often

Does the child seem “addicted” to sugars, sweets, and carbohydrates?

Sometimes Often

Does the child get headaches after eating sugar, bread, pastas, fruit or cereal?

Sometimes Often

Do the child’s language skills seem to have regressed? No Sometimes Often

List the foods in child’s “usual” (please be specific)

ast

List the five foods consumed MOST frequently (Please be specific)

Doctor’s Notes: _____

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Childhood Information (Page 10):

Has difficulty making friends 1 2 3 4 5 6
7 8 9 10

Shows poor self esteem 1 2 3 4 5
6 7 8 9 10

Violent behavior 1 2 3 4 5
6 7 8 9 10

Physically hurts self or others 1 2 3 4 5
6 7 8 9 10

Attention / Hyperactivity

Trouble staying seated for class work 1 2 3 4 5 6
7 8 9 10

Fidgets excessively in seat 1 2 3 4 5
6 7 8 9 10

Easily distracted 1 2 3 4 5
6 7 8 9 10

Acts before thinking 1 2 3 4 5
6 7 8 9 10

Interrupts, often calls out 1 2 3 4 5
6 7 8 9 10

Acts before thinking 1 2 3 4 5
6 7 8 9 10

Requires assistance to accurately complete assignment 1 2 3 4 5 6 7 8
9 10

Doctor's Notes: _____

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Childhood Information (Page 11):

Excessively states or appears "spaced out"

1 2 3 4 5 6 7

8 9 10

HAS THE CHILD (not a family member) EVER BEEN DIAGNOSED WITH:

ADD or ADHD

Allergies/Hayfever

Asperger's syndrome (AS)

Asthma

Anemia

Autism

Bladder/Urine Infection (UTI)

Blood Pressure Problems

Bronchitis/Pneumonia

Colitis/Crohn's Disease

Croup

Cystic Fibrosis

Developmental Delay

Diabetes Type I (Juvenile Diabetes)

Dysentery/Food Poisoning

Dyslexia

Ear Infection (Otitis Media)

Easy Bruising

Eating Disorder

Eczema/Psoriasis - Skin Problems

Enlarged Heart

Epilepsy (Seizures)

Gastric Reflux or Ulcers

Goiter

Heart Murmur/Arrhythmia

Hemochromatosis (Iron Overload)

Hepatitis/ Jaundice

Hep A Hep B Hep C

Hives

Hyperthyroidism

Hypothyroidism

Irritable Bowel (IBS)

Juvenile Rheumatoid Arthritis

Kidney Infection

Kidney Stones

Learning Disorder

Lyme Disease

Meningitis

Mental Retardation

Migraine Headaches

Mononucleosis

Multiple Sclerosis (MS)

Obsessive Compulsive Disorder (OCD)

Pervasive developmental disorder

Pharyngitis

Sinusitis

Speech Delay

Strep Throat

Syphilis/Chlamydia/STD

Tourette's

Yeast Infections

Other:

Doctor's Notes: _____

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Childhood Information (Page 12):



Now the main reason and goals of appointment:

Authorize Michael Robert Compton, DC to administer chiropractic care and whomever he may so
his assistant, to assist in neurological rehabilitation as he deems necessary to my son/daughter,
_____ (name) for the duration of care here at Neurological Rehabilitation
_____ (date)

Do you rate your ability, resources, and desire to make the necessary lifestyle, medical, dietary,
and nutrition commitments and modifications for your child in order to significantly impact the
"long term" course of current disease of disorder.

I can do everything it may take Likely only moderate changes Likely I can manage

Do you choose and desire Complementary/Integrative/Alternative Treatment(s) for your child's medical
and understand that along with significant benefits that can often be achieved there may be, as
with all treatments, some inherent risk?

To my knowledge, all of the above information is accurate, and true.

Parent Signature: _____ Date: _____

Doctor's Notes: _____

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Childhood Information (Page 13):

Doctor's Notes: _____

