Welcome to Lakernick Brain Center, Inc.

It is our pleasure to welcome you to Lakernick Brain Center, Inc. The examination and treatments available at are based on functional neurology, a discipline that builds on clinical neuroscience and uses various strategies to help improve or re-establish optimal neurological processes. For many individuals who have dealt with neurological or cognitive impairments, functional Neurologists can provide carefully determined, cautious and safe care that holds the prospect of potentially improving neurological function.

These interventions can include various sources of input through visual, physical, and other neurologic channels. Therapeutic goals are determined by a thorough examination, assessment, review of records and consultation with the patient and additional specialists as required. Our doctors training includes an additional 4 years of clinical education after the Doctor of Chiropractic Degree.

Many of our patients have been through years of other types of care and recovery, and have struggled to live within the limits imposed on them by their injuries. It is our hope that we can help you improve on those limitations; however, we must stress that we cannot make any promise of cure or improvement. After a careful intake process and examination, our Doctors will discuss treatment options with you and, if there is a reasonable expectation of some degree of clinical improvement, offer you the option of continuing under care. That care may or may not result in some degree of improvement. Any improvement may or may not be continuous, intermittent, or permanent.

The human body is a wonderful, marvelous creation; it is capable of being self organizing, self-developing, and self-healing. There are lien constraints on what our bodies are capable of doing, however, and it is impossible to predict how responsive individuals may be to functional neurological applications. Every person is unique. That uniqueness is an important attribute of our in individuality, but it also means that no two people respond to care in exactly the same manner.

We take pride in our ability to offer innovative, science-based approaches in the attempt to address what, for many, are profound limitations in their function and quality of life. We look forward to partnering with you and your support community to explore what your individual responses may bring to your life and your future.

Patient Data ________________________________ Date ______________

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss (check one)

First Name: ______________________Middle Initial:_Last__________________________

Address:____

____

City: ______________________ State:_________________ Zip Code:______________

Home Phone: (_____)_________________________________

Cell Phone: (_____)_________________________________

Work Phone: (_____)_________________________________

Date of Birth: _____/____/_____ Age_________ Gender: ☐ Male ☐ Female

Home email:____

Marital Status: (check one) ☐ Married ☐ Single ☐ Other

Employment Status:

☐ Employed ☐ Full time Student ☐ Part time Student ☐ Other

Race:

☐ White	☐ Black/African American	☐ Hispanic	☐ American Indian / Alaskan Native
☐ Asian	☐ Asian Indian	☐ Chinese	☐ Filipino
☐ Japanese	☐ Korean	☐ Vietnamese	☐ Native Hawaiian or other Pacific Island
☐ Samoan	☐ Guamanian or Charmorro	☐ Other	☐ I choose not to specify

Multi-Racial (check one) ☐ Yes ☐ No ☐ Unknown

☐ English	☐ Spanish	☐ American Sign Language	☐ Chinese	☐ French	☐ German
☐ Tagalog	☐ Vietnamese	☐ Italian	☐ Korean	☐ Russian	☐ Polish
☐ Arabic	☐ Portuguese	☐ Japanese	☐ French Creole	☐ Greek	☐ Hindi
☐ Persian	☐ Udru	☐ Gujarati	☐ Armenian	☐ German	
				☐ I choose not to specify	

Verification Question (choose only one question by placing a check mark in the box, then write your answer to the question).

- ☐ What is the name of your favorite pet?
- ☐ In what city were you born?
- ☐ What high school did you attend?
- ☐ What was the make of your first car?
- ☐ What is your mother's maiden name?
- ☐ On what street did you grow up?
- ☐ What is your favorite movie?
- ☐ When is your anniversary?

Verification Answer to the Chosen question ______________________________________

Answers must be, at least 6 characters.

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former smoker ☐ Never been a smoker

If yes, how often do you smoke: ☐ Current every day smoker ☐ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Current medications, including frequency and dosage if known. If there are no current medications, check here: ☐

		Start Date of Medication
1.	______________________________	______________________________
2.	______________________________	______________________________
3.	______________________________	______________________________
4.	______________________________	______________________________

List any known allergies you have had to any medications If no allergies are known, check here: ☐

1.	________________________	3.	________________________
2.	________________________	4.	________________________

Briefly list your main health problems ____

____

Has any doctor diagnosed you with Diabetes presently? ☐ Yes ☐ No

If yes to Diabetes was your blood lab-work test for hemoglobin A1c>9.0%? ☐ Yes ☐ No

If yes, other comments regarding Diabetes:

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ☐ Yes ☐ No

To be performed by clinic staff
Height: _______inches Weight: ____________pounds BP: __________/____________

Is it ok to call you at work?

☐ Yes ☐ No

How did you hear about our clinic? Or who referred you?

☐ Family Member	☐ Attorney	☐ Internet Website	☐ Health Class
☐ Friend	☐ Yellow Pages	☐ Billboard	☐ Brochure
☐ Physician	☐ Newspaper Ad	☐ TV Commercial	☐ Direct Mail Ad
☐ Employer	☐ Sign on Building	☐ Radio	☐ Other

If you selected "Yellow Pages", please indicate which Yellow Pages: ________________________

If you selected family member, "friend, or "physician" please enter the name below:

____

If selected "other" please describe:____

Medical Conditions:

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke

Surgeries:

☐ Appendectomy	☐ Cardiovascular procedure	☐ Cervical disc procedure	☐ Hysterectomy
☐ Joint replacement	☐ Laminectomies	☐ Radical prostatectomy	☐ Transurethral prostate surgery

Allergies:

☐ Eggs	☐ Fish and Shellfish	☐ Milk or Lactose	☐ Peanut
☐ Soy	☐ Sulfites	☐ Wheat/Gluten	

Social History:

☐ Caffeine used occasionally	☐ Caffeine used often	☐ Chew tobacco occasionally	☐ Chew tobacco often
☐ Drink alcohol occasionally	☐ Drink alcohol often	☐ Exercise not at all	☐ Exercise occasionally
☐ Exercise often	☐ Experience stress occasionally	☐ Experience stress often	☐ Smoke 1 pack or less per day
☐ Smoke more than 1 pack a day	☐ Wear seat belts always	☐ Wear Seat belts never	☐ Wear seatbelts usually

Family History:

☐ Arthritis (parent)	☐ Arthritis (sibling)	☐ Cancer (parent)	☐ Cancer (sibling)
☐ Cholesterol (parent)	☐ Cholesterol (sibling)	☐ Diabetes (parent)	☐ Diabetes (sibling)
☐ Heart problems (parent)	☐ Heart problems (sibling)	☐ High blood pressure parent)	☐ High blood pressure sibling)
☐ Psychiatric (parent)	☐ Psychiatric (sibling)	☐ Stroke (parent)	☐ Stroke (sibling)
☐ Thyroid (parent)	☐ Thyroid (sibling)		

Substance Use:

☐ Alcohol (past)	☐ Alcohol (present)	☐ Amphetamines (past)	☐ Amphetamines (present)
☐ Barbiturates (past)	☐ Barbiturates (present)	☐ Cocaine (past)	☐ Cocaine (present)
☐ Crystal Meth (past)	☐ Crystal Meth (present)	☐ Heroine (past)	☐ Heroine (Present)
☐ Marijuana (past)	☐ Marijuana (present)		

Male Children:

- [ ] Under 6 years
- [ ] Under 10 years
- [ ] Under 19 years

Female Children:

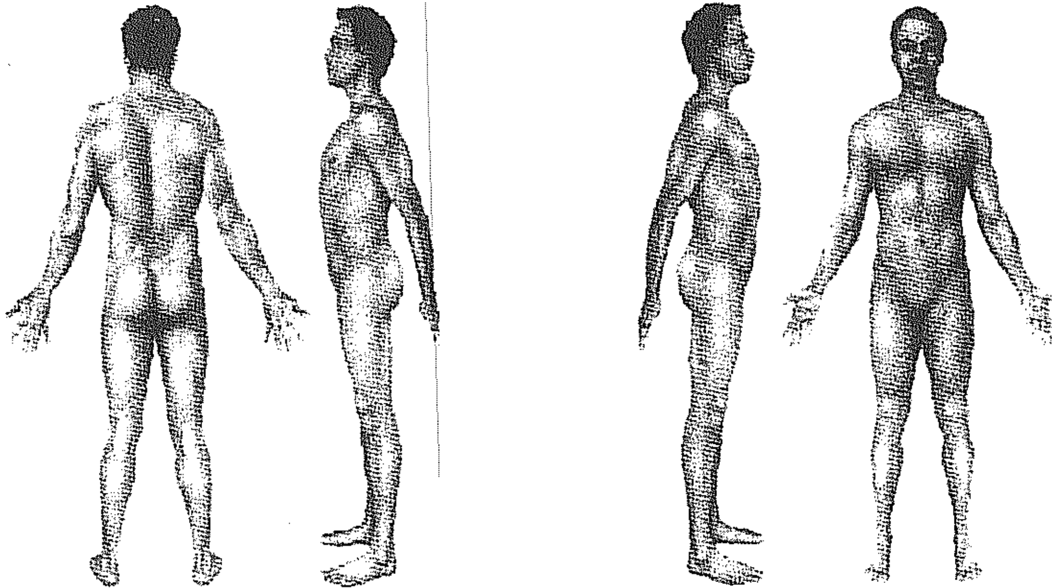
- [ ] Under 6 years
- [ ] Under 10 years
- [ ] Under 19 years

Occupational Activities:

- [ ] Administration
- [ ] Business Owner
- [ ] Clerical/Secretarial
- [ ] Computer User
- [ ] Construction
- [ ] Daycare/Childcare
- [ ] Executive Legal
- [ ] Food Service Industry
- [ ] Healthcare
- [ ] Heavy Equipment Operator
- [ ] Heavy Manual Labor
- [ ] Home Services
- [ ] Household
- [ ] Light Manual Labor
- [ ] Manufacturing
- [ ] Medium Manual Labor

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

= Numbness　　X = Burning　　/ = Stabbing　　0 = Pins & Needles　　+ = Dull Ache



Describe your symptoms: ____
____
____

When did your symptoms start? Month ____________ Day ____________ Year ____________

How did your symptoms begin? ____
____
____

How often do you experience your symptoms?

☐ Constantly (75-100% of the day)　☐ Frequently (51-75% of the day)　☐ Occasionally (26-50% of the day)　☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms:

☐ Sharp　☐ Dull Ache　☐ Numb　☐ Shooting
☐ Burning　☐ Tingling　☐ Stabbing

How are your symptoms changing?

☐ Getting Better　☐ Not Changing　☐ Getting Worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

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

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework?

- ☐ Not at all
- ☐ A little bit
- ☐ Moderately
- ☐ Quite a bit

During the past 4 weeks, how much of the time has your conditions interfered with your social activities?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

In general, would you say your overall health right now is….

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

Who have you seen for your symptoms?

- ☐ No one
- ☐ Other Chiropractor
- ☐ Medical Doctor
- ☐ Physical Therapist

What treatment did you receive for your symptoms?

- ☐ Adjustments
- ☐ Physical Therapy
- ☐ Medication
- ☐ Surgery

When did you receive this treatment?

- ☐ In the last month
- ☐ 2 – 3 months ago
- ☐ 3 – 6 months ago
- ☐ 6 months to 1 year ago
- ☐ 1 - 2 years ago
- ☐ 2 – 5 years ago
- ☐ 5 – 10 years ago

What tests have you had for your symptoms?

- ☐ X-ray
- ☐ MRI
- ☐ CT Scan
- ☐ Other

When were these tests done?

- ☐ In the last month
- ☐ 2 – 3 months ago
- ☐ 3 – 6 months ago
- ☐ 6 months to 1 year ago
- ☐ 1 - 2 years ago
- ☐ 2 – 5 years ago
- ☐ 5 – 10 years ago
- ☐ 1 - 2 years ago

Have you had similar symptoms in the past?

- ☐ Yes
- ☐ No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

- ☐ This Office
- ☐ Other Chiropractor
- ☐ Medical Doctor
- ☐ Physical Therapist
- ☐ Other

What is your occupation?

- ☐ Professional/Executive
- ☐ White Collar Secretarial
- ☐ Tradesperson
- ☐ Laborer
- ☐ Homemaker
- ☐ Full-time Student
- ☐ Retired
- ☐ Other

If you are not retired, a homemaker or a student, what is your work status?

- ☐ Full-time
- ☐ Part-time
- ☐ Self-employed
- ☐ Unemployed
- ☐ Out of work
- ☐ Other

Thank you. Please return to the front desk.

Have you had trouble with any of the following:

Cardiovascular No ☐

	Present	Past	No
Poor Circulation	☐	☐	☐
High Blood Pressure	☐	☐	☐
Aortic Aneurism	☐	☐	☐
Heart Disease	☐	☐	☐
Vascular Disease	☐	☐	☐
Heart Attack	☐	☐	☐
Chest Pain	☐	☐	☐
High Cholesterol	☐	☐	☐
Pace Maker	☐	☐	☐
Jaw Pain	☐	☐	☐
Irregular Heartbeat	☐	☐	☐
Swelling of Legs	☐	☐	☐

Respiratory No ☐

	Present	Past	No
Asthma	☐	☐	☐
Tuberculosis	☐	☐	☐
Shortness of Breath	☐	☐	☐
Emphysema	☐	☐	☐
Cold/Flu	☐	☐	☐
Cough/Wheezing	☐	☐	☐

Genitourinary No ☐

	Present	Past	No
Kidney Disease	☐	☐	☐
Lower Side Pain	☐	☐	☐
Burning Urination	☐	☐	☐
Frequent Urination	☐	☐	☐
Blood in Urine	☐	☐	☐
Kidney Stone	☐	☐	☐

Ears/Nose Throat No ☐

	Present	Past	No
Dizziness	☐	☐	☐
Hearing Loss	☐	☐	☐
Sinus Infection	☐	☐	☐
Nosebleed	☐	☐	☐
Sore Throat	☐	☐	☐
Difficulty Swallowing	☐	☐	☐
Bleeding Gums	☐	☐	☐

Hematologic/Lymphatic No ☐

	Present	Past	No
Hepatitis	☐	☐	☐
Blood Clots	☐	☐	☐
Cancer	☐	☐	☐
Easy Bruising	☐	☐	☐
Easy Bleeding	☐	☐	☐
Fever/Chills/Sweats	☐	☐	☐

Eyes No ☐

	Present	Past	No
Glaucoma	☐	☐	☐
Double Vision	☐	☐	☐
Blurred Vision	☐	☐	☐

Allergic Immunologic No ☐

	Present	Past	No
Hives	☐	☐	☐
Immune Disorder	☐	☐	☐
HIV/AIDS	☐	☐	☐
Allergy Shots	☐	☐	☐
Cortisone Use	☐	☐	☐

Integumentary No ☐

	Present	Past	No
Skin Lesions	☐	☐	☐
Skin Ulcers	☐	☐	☐
Skin Disease	☐	☐	☐
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
Rashes	☐	☐	☐

Gastrointestinal No ☐

	Present	Past	No
Gallbladder Problems	☐	☐	☐
Bowel Problems	☐	☐	☐
Constipation	☐	☐	☐
Liver Problems	☐	☐	☐
Ulcers	☐	☐	☐
Diarrhea	☐	☐	☐
Nausea/Vomiting	☐	☐	☐
Bloody Stools	☐	☐	☐

Psychiatric No ☐

	Present	Past	No
Depression	☐	☐	☐
Anxiety Disorder	☐	☐	☐
Unusual Stress	☐	☐	☐

Have you had trouble with any of the following:

Poor Appetite	☐	☐	☐

Musculoskeletal		**No ☐**	
	Present	**Past**	**No**
Gout	☐	☐	☐
Arthritis	☐	☐	☐
Joint Stiffness	☐	☐	☐
Muscle Weakness	☐	☐	☐
Osteoporosis	☐	☐	☐
Broken Bones	☐	☐	☐
Joints Replaced	☐	☐	☐

Endocrine			**No ☐**
	Present	**Past**	**No**
Thyroid Disease	☐	☐	☐
Diabetes	☐	☐	☐
Hair Loss	☐	☐	☐
Menopausal	☐	☐	☐
Menstrual Problems	☐	☐	☐

Constitutional		**No ☐**	
	Present	**Past**	**No**
Weight Loss/Gain	☐	☐	☐
Energy Level Problem	☐	☐	☐
Difficulty Sleeping	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

Neurological			**No ☐**
	Present	**Past**	**No**
Babinski	☐	☐	☐
Stroke	☐	☐	☐
Seizures	☐	☐	☐
Head Injuries	☐	☐	☐
Brain Aneurism	☐	☐	☐
Numbness	☐	☐	☐
Severe Headaches	☐	☐	☐
Pinched Nerves	☐	☐	☐
Parkinson's Disease	☐	☐	☐
Carpal tunnel	☐	☐	☐
Spinning/Balance	☐	☐	☐

Patient Data ______________________________ Date ____________

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss (check one)

First Name:________________ Middle Initial:_____ Last________________________

Address:____

____

City: ____________________ State:________________ Zip Code:_____________

Home Phone: (_____) ________________ Cell Phone:(_____) ________________

Work Phone: (_____) ______________________________

Date of Birth: ______/_____/_____ Gender: ☐ Male ☐ Female

Social Security Number: ________-______-______

Employment Status:

☐ Employed ☐ Full time Student ☐ Part time Student ☐ Other

Spouse Data

Is your spouse a patient in the clinic? ☐ Yes ☐ No

First Name:________________ Middle Initial:_____ Last________________________

Home Phone: (_____) ______________________________

Employer Data:

Name:____

Address:____

____

City:________________________ State:______________ Zip Code:_____________

Emergency Contact Data:

Contact:____

Contact Phone: (_____) ______________________________