

Pediatric Intake Form (12 Year Old and Under)

1. First Name: _____ Last Name: _____ DOB: _____

2. MRN #: _____

3. Home Address

Address 1 _____ Address 2 _____
City _____ State _____ Zip Code _____

4. Contact Information

Mobile Phone _____ Home Phone _____
Primary Email Address _____ Social Security Number _____

5. Demographic Information

Sex: Male Female Marital Status: Single Married Divorced Widowed Other

6. Personal Information

Height - Feet: _____ Height - Inches: _____
Weight (in pounds): _____

7. Do you have Blue Cross Blue Shield?

Yes No

8. Insurance Payer

Insurance Payer _____

9. Insurance Policy Information (BCBS only):

Insurance Plan Name _____ ID/Policy Number: _____ Group Number: _____
Relationship to Patient: Self Spouse Parent Employer Caregiver Other
Insured's First & Last Name: _____ Insured's Date of Birth: _____

10. Insurance Card Upload

11. Emergency Contact Information

Emergency Contact Name:

Contact Phone Number:

Relationship to Patient:

12. Referral Information

Referring Physician:

Referring Patient:

How did you hear about us?

Word of mouth Advertisement Social media Direct mail or email campaign Event Internet

Other:

Child's History

13. Have you ever received a formal diagnosis?

Yes No

If yes, please specify:

14. Chief complaint in order of importance 1-5

	Complaint
1	
2	
3	
4	
5	

15. Pregnancy and Delivery Complications:

Yes No

If yes, please specify:

16. Has formula ever been supplemented?

Yes No

17. Any issues early on with the following?

Sucking

Latching

Illnesses

Eczema

Collic

Reflux (excessive spitting up)

Other

None

18. Breastfed?

Yes No

19. Age when food was introduced?

28. How many words do they speak?

1-5

5-20

20-50

50+

Non Verbal

29. Does this child make eye contact?

Yes

No

30. Do they look in a mirror?

Yes

No

31. Do they recognize or know body parts?

Yes

No

32. Do they care about their appearance? Clothes, etc?

Yes

No

33. Do they have friends?

Yes

No

34. Do they play with other kids?

Yes

No

35. Where are they in school and what grade?

	Answer
Location	
Grade	

36. Do they know the following:

Letters

Numbers

Colors

Shapes

37. Do they read at all?

Yes

No

38. Can they do math?

Yes

No

39. Can they do any of the following:

Write

Color

Draw

40. Is there any learning disability in school?

Yes

No

If yes, please specify:

41. What are the most difficult subjects?

42. What are the child's best subjects?

43. Are there any emotional issues, tantrums, etc.?

Yes No

If yes, please specify:

44. Are there any major sensory issues, hyper/hyposensitivities?

Yes No

If yes, please specify:

45. Do they feel pain?

Yes No

46. Are they a picky eater?

Yes No

47. Do they have any food preferences?

Yes No

If yes, please specify:

48. What do they drink?

49. Have you eliminated any of the following from their diet?

Gluten Dairy Soy
 Other

If other, please specify:

50. Do they have a sense of smell or taste?

Yes No

51. Please describe their muscle tone:

High Low Within Normal Limits

52. Describe their motor skills?

Gross Fine

53. What is their hand dominance?

Right Left Ambidextrous

54. Do they have any issues with the following?

	Yes	No
Balance		
Motion Sickness		
Afraid of High Places		
Dizziness		

55. Do they spin themselves?

Yes

No

56. Do they have any stims or tics?

Yes

No

If yes, please specify:

57. Do they have any OCD behaviors?

Yes

No

If yes, please specify:

58. Do they have any unusually strong skills, such as the following?

Early Reading

Early Speech

Memorizing Songs

Memory for Details

Memory for Locations

Other

If other, please specify:

Daily Activities

59. What does the child prefer for playtime?

60. How much daily screen time?

61. Do they prefer to be indoors or outdoors?

Familial Health History

62. Does either parent have any chronic health issues?

Yes

No

If yes, please specify:

63. Is there anyone in your immediate family who has experienced the following? If yes, please select and indicate who.

	Mother	Father	Brother(s)	Sister(s)	Child 1	Child 2	Child 3	Maternal Grandmother	Maternal Grandfather	Paternal Grandfather	Paternal Grandmother	Other
Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Autoimmune Disease												
Arthritis												
Kidney Disease												
Thyroid Problems												
Seizures/Epilepsy												
Psychiatric Disorders												
Anxiety												
Depression												
Asthma												
Allergies												
Eczema												
ADHD												
Autism												
Irritable Bowel Syndrome												
Dementia												
Substance Abuse												
Genetic Disorders												
Other												

Supplements

64. Please list regularly used supplements as well as dosage and frequency for each

	Supplement	Dosage / Frequency
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

65. Have you ever had any of the following test ran?

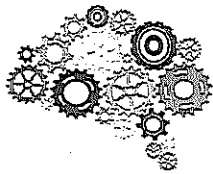
- Blood Test
- MRI
- Gentetic
- Stool Testing
- EEG
- Allergy
- Other

If other, please specify:

66. Has the child received any other treatment? Were they beneficial? Did you notice any improvement and which was the most effective?

Parent / Legal Guardian

Signature



DR. ROBERT MELILLO

MELILLO ADULT PRIMITIVE REFLEX SYMPTOM CHECKLIST

- 0 – 100% inhibited reflex
- 1 - 25% retained reflex
- 2 - 50% retained reflex
- 3 - 75% retained reflex
- 4 - 100% retained reflex

SCORING:

- 1 - 2 Checks = 0
- 3 - 4 Checks = 1
- 5 - 6 Checks = 2
- 7 - 8 Checks = 3
- 9 - 10 Checks = 4

FEAR PARALYSIS REFLEX

Retained Fear Paralysis Reflex may lead to any of the symptoms listed below:

	0	1	2	3	4
• Anxiety seemingly unrelated to reality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Hypersensitivity to touch, sound, changes in visual field	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Dislike of change or surprise, Poor adaptability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Breath holding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Fear of social embarrassment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Insecure / Lack of trust in oneself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Overly clingy or may be unable to accept or demonstrate affection easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Negativism, defeatist attitude, Won't try new activities, especially where comparison or excellence is expected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Temper tantrums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Immediate motor paralysis under stress – can't think and move at the same time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

_____ **Total Number**

MORO

Symptoms of a retained Moro Reflex include:

- Excessive blinking
- Hypersensitivity to sudden, noise, Light or movement
- A hyper startle response, followed by rapid heartbeat
- Difficulty with new or stimulating experiences
- Impulsive behavior
- Vestibular problems (Imbalance, dizziness, motion sickness, vertigo)
- Anxiety, Flushing uncontrollably when embarrassed or nervous
- Frequent ear and throat infections
- Depleted energy, fatigue, mood swings
- Dislike of change
- Sensitivity to foods or food additives, Chronic digestive problems from childhood

0	1	2	3	4
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_____ **Total Number**

TONIC LABYRINTHINE REFLEX (TLR)

- Poor posture
- Toe walker as a kid or as an adult
- Poor balance and coordination
- Poor eye movement control
- Visual-perceptual difficulties
- Afraid of heights
- Difficulty judging space, distance, depth and speed . .
- Poor concentration
- Fatigue while reading or when working or studying at a desk
- Motion sickness

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_____ **Total Number**



DR. ROBERT
MELILLO

SPINAL GALANT

- Can't sit still; fidgety
- Short term memory problems
- Bedwetting beyond age 5, Chronic bladder control issues
- Sensitive to tight clothing around waist or tags on clothes
- Constant noise making
- Attention and concentration problems
- Difficulty coordinating normal walking gait.
- May affect fluency and mobility in physical activities or sports
- Can contribute to the development of scoliosis (curvature) of the spine.
- Body tends to tilt to one side, can cause chronic back, or neck pain

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_____ **Total Number**

ASYMMETRICAL TONIC NECK REFLEX

- Poor handwriting
- Difficulty reading and tracking
- Left-right confusion (Mixed laterality), Ambidextrous
- Difficulty copying
- ADHD.OCD characteristics
- Missing parts of a line when reading
- Difficulty catching a ball
- Poor at sports, dancing or Bilateral integration
- In adults there can be chronic shoulder and/or neck problems
- Eye hand coordination difficulty
- Judgment of distance may be affected

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_____ **Total Number**



SYMMETRICAL TONIC NECK REFLEX

- Poor posture (– when head bends, the arms will bend causing a tendency to slump when sitting – often will end up almost lying on the desk to write)

0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Tend to “hook feet” under desk for support

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- Clumsy

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------
- Eyes fatigue when reading or focusing near on screen

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- As a child you skipped, missed, or shortened crawling or crawled in unusual way

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- Difficulty sitting with legs crossed (“W” position when sitting on the floor)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- Poor upper and lower body integration, affecting gross motor skills

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- Poor hand-eye coordination

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- Messy eater

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------
- Poor organization and planning skills

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

_____ **Total Number**

ROOTING AND SUCK REFLEX

Retained Juvenile Suck Reflex may lead to:

- Speech and articulation problems, stuttering

0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Difficulty swallowing and chewing

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------
- Difficulty speaking and doing manual tasks at the same time

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------
- Involuntary tongue or mouth movements when writing or drawing

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- Poor manual dexterity, especially when chewing or speaking

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- Hypersensitivity around lips and mouth

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- Oral fixation, always need to be doing something with mouth, smoking, chewing gum, biting lip, sucking candy, etc.
- Dribbling, and drooling
- Poor manual dexterity when speaking
- Hormonal imbalances or deficiencies

0	1	2	3	4
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

_____ **Total Number**

PALMER GRASP REFLEX

Palmar reflex retention may lead to:

- Poor fine motor skills and manual dexterity
- Inappropriate pencil grip and poor handwriting
- Weak immune system
- Difficulty processing ideas on to paper
- Poor posture and/or back pain when working at a desk or computer
- Constant need to always touch and hold things in hand
- Difficulty or slow reading
- Poor memory for details
- Not good with math or numbers
- Mixed dominance , Ambidextrous or left handed

0	1	2	3	4
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_____ **Total Number**

BABINSKI REFLEX

Plantar reflex retention may lead to:

- Difficulty or delay learning to walk (beyond 14 months)
- Running awkwardly
- Poor balance
- Can't press toes in to the ground

0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- | | 0 | 1 | 2 | 3 | 4 |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| • Problems with sports requiring balance and coordination while running | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Low back pain while walking and/or standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Shin soreness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Recurrent ankle twisting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Difficulty walking in the dark (vision is not able to assist balance) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Calf or Achilles tendonitis, injury or pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

_____ **Total Number**

NAME: _____ DATE: _____

CHECK [✓] ALL SYMPTOMS OR CHARACTERISTICS THAT APPLY; THEN, ADD THE TOTAL NUMBER OF CHECKS BELOW EACH SECTION.

MOTOR CHARACTERISTICS OF A RIGHT-BRAIN DELAY

- Clumsiness and an odd posture
- Poor coordination
- Not athletically inclined and has no interest in popular childhood participation sports
- Low muscle tone – muscles seem kind of floppy
- Poor gross motor skills, such as difficulty learning to ride a bike and/or runs and/or walks oddly
- Repetitive/stereotyped motor mannerisms (spins in circles, flaps)
- Fidgets excessively
- Poor eye contact
- Walks or walked on toes

_____ TOTAL NUMBER OF CHECKS

MOTOR CHARACTERISTICS OF A LEFT-BRAIN DELAY

- Fine motor problems (poor or slow handwriting)
- Difficulty with fine motor skills (dyspraxia), such as buttoning a shirt
- Poor or immature hand grip when writing
- Tends to write very large
- Stumbles over words when fatigued
- Exhibited delay in crawling, standing, and/or walking
- Loves sports and is good at them
- Good muscle tone
- Poor drawing skills
- Difficulty learning to play music
- Likes to fix things with the hands and is interested in anything mechanical
- Difficulty planning and coordinating body movements

_____ TOTAL NUMBER OF CHECKS

TOTAL RIGHT BRAIN CHECKS _____ TOTAL LEFT BRAIN CHECKS: _____

SENSORY CHARACTERISTICS OF A RIGHT-BRAIN DELAY

- Poor spatial orientation – bumps into things often
- Sensitive to sound
- Confusion pointing to different body parts when asked
- Poor sense of balance
- High threshold for pain – doesn't cry when gets cut
- Likes to spin, go on rides, swing, etc. – anything with motion
- Touch things compulsively
- A girl uninterested in makeup or jewelry
- Does not like the feel of clothing on arms or legs; pulls off of clothes
- Doesn't like being touched and doesn't like to touch things
- Incessantly smells everything
- Prefers bland food
- Does not notice strong smells, such as burning wood, popcorn, cookies
- Avoids food because of the way it looks
- Hates having to eat and is not even interested in sweets
- Extremely picky eater

_____ TOTAL NUMBER OF CHECKS

SENSORY CHARACTERISTICS OF A LEFT-BRAIN DELAY

- Doesn't seem to have many sensory "issues" or problems
- Good spatial awareness
- Good sense of balance
- Eats just about anything
- Has a normal to above average sense of taste and smell
- Likes to be touched
- Not sensitive to clothing
- Poor auditory or central processing
- Seems not to hear well, although hearing tests normal
- Delay in speaking was attributed to ear infections
- Gets motion sick and has other motion sickness issues
- Not under-sensitive or oversensitive

_____ TOTAL NUMBER OF CHECKS

TOTAL RIGHT BRAIN CHECKS _____ TOTAL LEFT BRAIN CHECKS: _____

EMOTIONAL SYMPTOMS OF A RIGHT-BRAIN DEFICIENCY

- Child spontaneously cries and/or laughs and has sudden outbursts of anger or fear.
- Worries a lot and tends to have phobias of many things
- Holds onto past "hurts"
- May have sudden emotional outburst that appear over-reactive, and inappropriate
- Experiences panic and/or anxiety attacks
- Sometimes displays dark or violent thoughts
- Face lacks expression; doesn't exhibit much body language
- Lacks empathy
- Lacks emotional reciprocity
- Fearless, a dangerous risk taker

_____ Total Number of Checks

EMOTIONAL SYMPTOMS OF A LEFT-BRAIN DEFICIENCY

- Overly happy and affectionate; loves to hug and kiss
- Frequently moody and irritable, depressed
- Loves doing new or different things but gets bored easily
- Lacks motivation
- Withdrawn and shy
- Excessively cautious or pessimistic and is extremely negative
- Doesn't seem to get any pleasure out of life
- Socially withdrawn
- Cries easily; feelings get hurt easily
- Seems to be in touch with own feelings
- Empathetic to other people's feelings; reads people's emotions well
- Gets embarrassed easily
- Very sensitive to what others think about them

_____ TOTAL NUMBER OF CHECKS

TOTAL RIGHT BRAIN CHECKS _____ TOTAL LEFT BRAIN CHECKS: _____

BEHAVIORAL CHARACTERISTICS OF A RIGHT-BRAIN DELAY

- Thinks analytically all the time
- Often miss the gist of the story
- Always the last to get the joke
- Gets stuck in set behavior; can't let it go
- Lacks social tact and/or is antisocial and/or socially isolated
- Poor time management; is always late
- Disorganized
- Problem paying attention
- Is hyperactive and/or impulsive
- Has obsessive thoughts or behavior
- Argues all the time and is generally uncooperative
- Exhibits signs of an eating disorder
- Failed to thrive as an infant
- Echolalia (mimicking sounds or words, repeatedly without really understanding the meaning)
- Appears bored, aloofness, and abrupt
- Considered strange by other children
- Inability to form friendships
- Inability to share enjoyment, interests, or achievements with other people
- Acts inappropriately giddy or silly
- Child has inappropriate social interactions (one-sided social interaction does not listen or care what another person is saying).
- Talks incessantly and asks repetitive questions
- No or little joint attention (pointing to object to get your attention)
- Didn't look at self in the mirror as a toddler

_____ TOTAL NUMBER OF CHECKS

TOTAL RIGHT BRAIN CHECKS _____ TOTAL LEFT BRAIN CHECKS: _____



BEHAVIORAL CHARACTERISTICS OF A LEFT-BRAIN DELAY

- Procrastinates
- Extremely shy, especially around strangers
- Very good at nonverbal communications
- Is well liked by other children and teachers
- Does not have any behavioral problems in school
- Understands social rules
- Poor self-esteem
- Hates doing homework
- Very good at social interaction
- Makes good eye contact
- Likes to be around people and enjoys going to parties
- Doesn't like to go to sleep-overs
- Not good at following routines
- Can't follow multiple-step directions
- Seems to be very in touch with their own feelings
- Jumps to conclusions

_____ TOTAL NUMBER OF CHECKS

TOTAL RIGHT BRAIN CHECKS _____ TOTAL LEFT BRAIN CHECKS: _____

ACADEMIC CHARACTERISTICS OF A RIGHT-BRAIN DELAY

- Poor math reasoning (word problems)
- Poor reading comprehension and pragmatic skills
- Issues with the big picture
- Very analytical
- Problem understanding jokes
- Very good at finding mistakes (spelling)
- Very literal
- Doesn't always reach conclusions when speaking
- Early speech Precociousness (talked well early), even if slightly delayed
- IQ could be very high, but IQ's run the whole spectrum; IQ's often fall in the above-normal range in verbal ability and in the below-average range in performance abilities
- Was an early word reader
- Interested in unusual topics
- Learns in rote (memorizing) manner
- Learns in extraordinary-amounts of specific facts about a subject
- Impatient
- Speaks in monotones; little voice inflection
- Poor nonverbal communicator
- Doesn't like loud noises and complains that volume is too low
- Speaks out loud regarding what he or she is thinking
- Talks "in your face" – is space invader
- Good reader but does not enjoy reading
- Analytically; lead by logic
- Follows rules without questioning them
- Good at keeping track of time
- Easily memorizes spelling and mathematical formulas
- Enjoys observing rather than participating
- Would rather read an instruction manual before trying something new
- Math is often the first academic subject to be viewed as problematic

_____ TOTAL NUMBER OF CHECKS

TOTAL RIGHT BRAIN CHECKS _____ TOTAL LEFT BRAIN CHECKS: _____

ACADEMIC CHARACTERISTICS OF A LEFT-BRAIN DELAY

- Very good at big picture skills
- Good at abstract "thought free" association
- Poor analytical skills
- Very visual; loves images and patterns
- Constantly questions why you're doing something or why rules exist
- No sense of time
- Child enjoys touching and feeling actual objects
- Has trouble prioritizing
- Unlikely to read instruction manual before trying something new
- Is naturally creative but, needs to apply themselves to develop their potential
- Would rather do things instead of observing
- Uses good voice inflection when speaking
- Misreads or omits common small words
- Child stumbles through longer words
- Reading too slow and laboriously
- Has difficulty naming colors, objects and letters as a toddler
- Needs to hear or see concepts many times in order to learn them
- Has shown a downward trend in achievement test scores or school performance
- Schoolwork is inconsistent
- Started as a late talker
- Has difficulty pronouncing words (poor with phonics)
- Had difficulty learning the alphabet, nursery rhymes or songs when young
- Has difficulty finishing work or finishing a conversation
- Acts before thinking and makes careless mistakes
- Tends to misread, omit or repeat words; child reads slowly
- Daydreams a lot
- Difficulty sequencing events in the proper order
- Letters are sometimes written backward
- Poor at basic math operations
- Poor memorization skills
- Child has poor academic ability
- Child has a lower verbal higher nonverbal IQ test results

- Performs poorly on verbal tests
- Needs to be told things several times before they understand
- Started to stutter as a child
- Doesn't read directions well and is a poor test taker (misinterprets questions)

_____ TOTAL NUMBER OF CHECKS

COMMON IMMUNE CHARACTERISTICS OF A RIGHT BRAIN DELAY

- Tends to have an over active immune response (has allergies)
- Rarely gets cold and infections
- Has had or has eczema or asthma
- Skin has little white bumps, especially on the back of the arms
- Erratic behavior – good one day, bad the next
- Craves certain food, especially dairy and wheat products

_____ TOTAL NUMBER OF CHECKS

TOTAL RIGHT BRAIN CHECKS _____ TOTAL LEFT BRAIN CHECKS: _____

COMMON IMMUNE CHARACTERISTICS OF A LEFT BRAIN DELAY

- Gets chronic ear infections
- Prone to tumors; usually benign or cysts
- Has been on antibiotics a lot
- Has had tubes put in the ears (or seriously considered)
- Catches cold frequently
- No allergies

_____ TOTAL NUMBER OF CHECKS

COMMON AUTONOMIC CHARACTERISTICS OF A RIGHT BRAIN DELAY

- Problems with bowel function; constipation, diarrhea
- Rapid heart rate and/or high blood pressure for age
- Appears bloated, especially after meals, and often complains of stomach pains
- Has body odor
- Sweats a lot
- Hands are always moist and clammy

_____ TOTAL NUMBER OF CHECKS

COMMON AUTONOMIC CHARACTERISTICS OF A LEFT BRAIN DELAY

- Still wets the bed
- Has or had an irregular heartbeat (arrhythmia or heart murmur)

_____ TOTAL NUMBER OF CHECKS

TOTAL RIGHT BRAIN CHECKS _____ TOTAL LEFT BRAIN CHECKS: _____

Now ADD UP each section for RIGHT checks and LEFT checks

TOTAL NUMBER OF CHECKMARKS RIGHT BRAIN : _____

TOTAL NUMBER OF CHECKMARKS LEFT BRAIN : _____

HEMISPHERIC WEAKNESS RIGHT OR LEFT : _____



Financial Policy

1. It is the policy of this office that all services rendered be ultimately the responsibility of the patient, including those that are not reimbursed by third party payers.
2. All payments/co-payments/deductibles are payable when services are rendered or at the beginning of each week or month as credit to your account with no exceptions, unless prior arrangements have been made. If you choose to pay in advance you will be saving time at the front desk. If you are prepaid and pre-scheduled no wait is necessary, you can return your chart to the front desk counter and leave.
3. This office does not promise that an insurance company will reimburse for the usual and customary charges submitted by this office. We will honor what they communicate to us at the time of benefit verification, but as they do not guarantee benefits until claim is processed and released, neither can we.
4. This office will accept payment from secondary insurance but will not file with a secondary insurance and cannot guarantee charges will be reimbursed. Unpaid balances older than **60 days** will become patient's responsibility automatically.
5. Since we do not own your policy and occasionally we experience difficulty in collecting from the carrier, we may ask for your active assistance in rectifying a situation on any of your bills older than **30 days**. 30 days after your acknowledgment we send you a bill.
6. SFCWC will NOT enter into a dispute with an insurance company over the amount of reimbursement.
7. It is the patient's responsibility to communicate to this office any changes in status of his/her insurance company policy, or new information on auto accident and worker's compensation. Failure to do so will result in patient being responsible for bills up to the date of our acknowledgment.
8. Returned checks will be subject to an additional \$35.00 collection fee. All balances over 30 days will be subject to a late fee of **10% of total owed every 30 days or a past due fee of \$10, whichever one is greater.**
9. All accounts not paid within **90 days** will automatically be turned over to SFCWC's Attorney. If SFCWC must file a lawsuit for unpaid balances, Patient agrees to cover all Attorney fees and Court costs.
10. All patients whose visitation schedule is once per month (or longer) will not be eligible for insurance assignment; since that frequency constitutes a well visit, insurances will not cover maintenance care.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions in regard to your health care, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for a mutual benefit.

I HAVE READ, UNDERSTOOD, AND AGREED WITH THE ABOVE FINANCIAL AGREEMENT.

Patient Signature: _____ Date: ____ / ____ / ____

I HAVE READ, UNDERSTOOD, AND AGREED WITH THE OFFICE AND APPOINTMENT POLICIES explained to me of which I hold the original copy.

Patient Initials: _____

Smiley Family Chiropractic & Wellness Center

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY. *This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated.*

NO CONSENT REQUIRED - The Practice may use and/or disclose your PHI for the purposes of:

- (a) **Treatment** -- In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.
- (b) **Payment** -- In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether it will cover the treatment expense.
- (c) **Health Care Operations** -- In order for the Practice to operate in accordance with applicable law and insurance requirements and for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI to evaluate the performance of the Practice's personnel in providing care to you.

The Practice may also use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

- (a) **De-identified Information** -- Information that does not identify you and, even without your name, cannot be used to identify you.
- (b) **Business Associate** -- To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.
- (c) **Personal Representative** -- To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
- (d) **Emergency Situations** --
 - (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or
 - (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency.
- (e) **Communication Barriers** -- If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.
- (f) **Public Health Activities** -- Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.
- (g) **Abuse, Neglect or Domestic Violence** -- To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.
- (h) **Health Oversight Activities** -- Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.
 - (i) **Judicial and Administrative Proceeding** -- For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
 - (j) **Law Enforcement Purposes** -- In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.
 - (k) **Coroner or Medical Examiner** -- The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.
 - (l) **Organ, Eye or Tissue Donation** -- If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
 - (m) **Research** -- If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.
 - (n) **Avert a Threat to Health or Safety** -- The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
 - (o) **Workers' Compensation** -- If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.
 - (p) **Disclosure of immunizations** to schools required for admission upon your informal agreement.

APPOINTMENT REMINDER - The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment

reminders are used by the Practice: a postcard mailed to you at the address provided by you; and telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

DIRECTORY/SIGN-IN LOG - The Practice maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

FAMILY/FRIENDS - The Practice may disclose to your family member, other relative, a close friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure. (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

PRACTICE'S REQUIREMENTS - The Practice:

- is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- is required to abide by the terms of this Privacy Notice.
- reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- will distribute any revised Privacy Notice to you prior to implementation.
- will not retaliate against you for filing a complaint.

YOUR RIGHTS - You have the right to:

- (a) Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.
- (b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.
- (c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.
- (d) Inspect and obtain a copy of your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.
- (e) Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with Practice's denial, you will have the right to submit a written statement of disagreement.
- (f) Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy).
- (g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.
- (h) Receive notice of any breach of confidentiality of your PHI by the Practice.
- (i) Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.
- (j) Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.
- (k) Request copies of your PHI in electronic format.

To obtain more information on or have your questions about your rights answered, you may contact the Practice's Privacy Officer, Dr. Jessica Smiley, at 423-442-2100 or via email at drsmiley_sfcwc@hotmail.com.

QUESTIONS AND COMPLAINTS - You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below that is the Privacy Officer and Contact person appointed for this practice. The Privacy Officer Dr Jessica.

You may file a complaint with the Privacy Officer if you believe that your privacy rights have been violated relating to the release of your protected health information. You may also, submit a complaint to the Department of Health and Human Services the address of which will be provided to you by the Privacy Officer. We will not retaliate against you in any way if you file a complaint.

EFFECTIVE DATE - This Notice is in effect as of 6/29/2022

_____ (Patient)

_____ (Date)

New Member Intake and Financial Policies – Consents

Contact

Smiley Family Chiropractic & Wellness Center will contact me via phone, text, or email. Contact purposes are typically, but not limited to being informative in nature – appointment reminders and/or info about closings and important dates. On occasion I may send notifications about current research or goings on in the field of chiropractic, Functional Medicine, Functional Neurology, Functional Endocrinology, or health in general. Dr. Jessica Smiley, Dr. Peter Koeller, Dr. Sara Wiatrek, and Dr. Nicole vonAschwege will also use these contacts to follow up when that is necessary. Your contact info will never be sold or solicited. I authorize Smiley Family Chiropractic & Wellness Center to utilize smileyfamilychiropractic@msn.com and/or drsmiley_sfcwc@hotmail.com, or (423)442-2100 and/or (423)295-4406 to contact me when needed.

_____initial

Insurance and Billing

I understand that Smiley Family Chiropractic & Wellness Center, will not in any way bill my insurance, nor will they give billing codes for reimbursement from insurance for any services outside of Chiropractic (Chiropractic services include: examinations, X-rays, re-evaluations, and adjustments). I understand that I am responsible for full payment for any service at the time of service, unless otherwise agreed upon. I agree that if an invoice is emailed or mailed after the service that I will submit payment within 30 days of receiving the invoice, unless otherwise agreed upon. If payment is not received within 30 days Smiley Family Chiropractic & Wellness Center may begin collection procedures if deemed necessary and/or begin to add a late fee of 10% of the total owed or a past due fee of \$10, whichever one is greater to the uncollected balance per month from the date of service.

_____initial

Cancellation Policy

I fully acknowledge that Smiley Family Chiropractic & Wellness Center will enforce a cancellation policy if I fail to cancel my appointment less than 24 hours in advance for Functional Neurology or Functional Medicine appointments and more than 7 days for Intensive Functional Neurology appointments. The policy is as detailed below:

- If a Functional Neurology or Functional Medicine appointment is not cancelled within 24 hours 50% of the scheduled appointment will be collected.
- If an Intensive Functional Neurology appointment is cancelled between 8-14 days before the appointment, 50% of the scheduled appointment will be collected. If an appointment is cancelled within 0- 7 days a 100% of the scheduled appointment will be collected.

If you do not show up to your scheduled appointment, your card will be charged for 100% of the scheduled appointment fee.

_____initial

HIPPA

I have read or been given the chance to read over the HIPPA guidelines (posted on the website/form)

_____initial

Medical Information

I agree to allow Smiley Family Chiropractic & Wellness Center to obtain and/or send medical information as deemed medically necessary for my care. I also agree to allow Smiley Family Chiropractic & Wellness Center to consult with providers that I am seeing or have seen as needed for my care.

_____initial

Media Release

I authorize Smiley Family Chiropractic & Wellness Center to use various photos and videos as deemed necessary for educational and academic purposes. Mediums that these photos and videos may be used for includes but is not limited to; lectures and social media (Smiley Family Chiropractic & Wellness Center's Facebook Page and Instagram). Due to the nature of what we do in the office it is important that people see and understand this new form of healthcare. Our goal with any information shared is to further the understanding of functional neurology, laser therapy, chiropractic, and other modalities or methods utilized. All photos and videos will be tactful.

- I agree
- I disagree

Non-Refundable Deposit

I understand that for scheduling intensive appointments, the office will request a nonrefundable deposit of \$1,000 to hold the appointments. I understand that the deposit amount will go toward the full cost of the intensive and is non-refundable and non-transferable.

_____initial

Acknowledgement

By signing below, you acknowledge that you have fully read or have had the chance to read all information contained within this document and have had an opportunity to ask any questions or concerns and are in agreement with these terms and information.

_____initial

Date ___/___/___

Signature

Date ___/___/___

Parent or legal guardian (if under the age of 18)

Terms of Acceptance

This document serves to inform you about potential risks that can be associated with care in our office. Please read and ask questions as needed.

Dr. Jessica Smiley, Dr. Peter Koeller, Dr. Sara Wiatrek, and Dr. Nicole vonAschwege are licensed Chiropractors in the state of Tennessee. Our doctors have completed postgraduate courses in Neuroscience, Functional Medicine, and Neuro Emotional Technique. Dr. Smiley is board certified by the American Veterinary Chiropractic Association in animal chiropractic. With that being said, please read each statement accordingly:

Smiley Family Chiropractic and Wellness Center will not claim to treat or cure any medical conditions, but rather will attempt to restore balance and function to your health and wellness. This process may include examinations, chiropractic adjustments, functional neurology assessments and therapies, music/acoustic therapy, color / light therapy, vestibular rehab, physical therapy exercises, muscle work (muscle stripping, massage, stretching, rehab), supplemental recommendations, diet alteration, blood chemistries, stool samples, saliva samples, various intake forms, and other methods and modalities may be used as well.

If any dietary or supplemental recommendations are made at Smiley Family Chiropractic and Wellness Center, we advise you to bring these recommendations to your medical providers before beginning. Any recommendations made are not intended to diagnose, treat, cure, or manage any medical condition. Chiropractic, Functional Medicine, and Functional Neurology comprise various methods of establishing balance within one's body. The methods that Smiley Family Chiropractic and Wellness Center utilizes should not replace that of traditional medical approaches, and it is always advised that anyone under our care should follow up with their medical providers to discuss any care recommendations. At times, an adjustment/manipulation/fast stretch may be performed to help improve your function and eliminate the effects of vertebral subluxation. As with all types of health care interventions, there are some risks to care, including but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, dislocations, strains and sprains. There are very rare occurrences when stroke has been linked to an adjustment - many studies have been performed on this topic, some try to demonstrate a very weak association, but most studies show that chiropractic manipulations are not directly linked to this type of injury. The methods that our doctors utilize to minimize all the above-mentioned risks. Historically, Chiropractic is a very safe and effective means to achieve a more optimal state of health and wellness. In this practice our doctors will need to perform an exam prior to commenting on the state of your health and prior to making any recommendations.

Smiley Family Chiropractic and Wellness Center may use various types of photobiomodulation during your appointments. This will involve the use of a laser / light. Laser therapy has been heavily researched and proven safe and effective for many different conditions over the past several decades. We do not claim to treat, cure, manage, or diagnose any medical condition with photobiomodulation. We are simply improving the overall function of your body via the various proven effects of the laser / light therapy.

Smiley Family Chiropractic and Wellness Center acknowledges the scope of Chiropractic in the state of Tennessee is very limited and we will stay within this scope of practice. All therapies and procedures performed will be geared toward the following goals: to reduce the effects of the vertebral subluxation complex via various reflexogenic systems, to establish balance within your body, and to improve your overall health and wellness. If you have any concerns or reservations prior to care with Smiley Family Chiropractic and Wellness Center, please do not hesitate to ask. If you ever experience something that causes any concern, please discuss the matter with us immediately.

By signing below, you acknowledge that you have fully read or have had the chance to read all information contained within this document and have had opportunity to ask about any questions or concerns and agree with these terms and information.

Signature

Date

Parent or Legal Guardian (if under age 18)

Date