MID-ATLANTIC
BRAIN & NEUROLOGICAL
REHABILITATION

Intake Form

Congratulations on Getting Started!!!

For your first appointment, please bring the following items:

1.

Any previous blood work, imaging,
lab analyses or medical records.

2.

Your completed paperwork.

3.

Shorts and a tank top
(or loose-fitting and non-restricting clothing)
to be worn during exam.

4.

A spouse, relative or friend to make sure
any of their questions are answered

6.

We ask that you please do not wear eye make-up to your exam
as it interferes with our testing equipment.

7.

Your completed paperwork.

Please Note: To secure your examination appointment, please completely fill out this form and provide it to the front desk staff upon arrival for your appointment. If we do not receive your form completely filled out, we may have to reschedule your appointment.

MABNR 1400 Forest Glen Road, Suite 225 • Silver Spring, MD 20910 • Tel (240)-766-8881 Fax (240)-766-3763 • www.mabnr.com

1. PATIENT DEMOGRAPHICS

Last Name | First Name | M.I. | Preferred Salutation | Date

Gender | Age | Date of Birth | Social Security Number

Circle Status: Married | Single | Partnered | Widowed | Separated | Divorced

Street Address | City | State | Zip

Home Phone | Mobile Phone | Work Phone

2. EMERGENCY CONTACT

Name/Relationship | Best Phone Number to Contact

3. EMPLOYMENT INFORMATION

Employer Name | Occupation

4. PATIENT ACCOUNT

Are you here because you were injured in a:

☐ Vehicle Collision ☐ Work Related Injury ☐ Other ☐ None of These

5. INSURANCE INFORMATION

Company Name: _____ Insured's Name: _____

Insured's SSN: ____-____-_____ Birth Date: ___/___/___ Employer of Insured: _____

6. HEALTH COMPLAINTS

What is your primary complaint?_____

When did the primary complaint start?_____

Have your symptoms changed? How? _____

Is the primary complaint: Local ☐ Widespread ☐ **Did it come on:** Immediately ☐ Rapidly ☐ Gradually ☐

Using the scale below, rate how your **primary** complaint affects your life (circle only one box below).

0	1	2	3	4	5	6	7	8	9	10
no pain or discomfort	complaint causes slight discomfort	complaint that does not affect my activity	complaint that rarely affects my daily activities	complaint that often affects my daily activities	complaint that impedes my daily activities	complaint that impedes my work/ school schedule	complaint that prevents me from working at all	complaint that prevents working and all physical activity	complaint that keeps me bedridden	complaint that causes thoughts of suicide

7. LIFESTYLE

List any prescription or over-the-counter medications you are currently taking.

Medication / Reason

1. _____

2. _____

3. _____

4. _____

How many hours of television do you watch every day? ☐ <1 ☐ 1-2 ☐ 3-5 ☐ >5

How many hours a day do you use your computer at work or home? ☐ <1 ☐ 1-2 ☐ 3-5 ☐ >5

How many hours a day do you ride in a car or other vehicle? ☐ <1 ☐ 1-2 ☐ 3-5 ☐ >5

How often do you exercise? _____ What type of exercise? _____

How often do you use tobacco?	☐ Never	☐ Daily	☐ Monthly	☐ Yearly
How many servings of alcohol do you consume weekly?	☐ 0	☐ 1-2	☐ 3-5	☐ >5
How many servings of caffeine do you consume weekly?	☐ 0	☐ 1-2	☐ 3-5	☐ >5
How many servings of soda do you consume weekly?	☐ 0	☐ 1-2	☐ 3-5	☐ >5

Child's Name: _____ Age: ___ Height: ___ Weight: ___ Sex: M☐ F☐

Child's Name: _____ Age: ___ Height: ___ Weight: ___ Sex: M☐ F☐

Rate your stress level: ___ (0 = No Stress, 10 = Severe Stress)

Please list all previous surgeries and hospitalizations (include dates): _____

_____

Please list all allergies or sensitivities:_____

Please list all dates of motor vehicle collisions, if any: _____

Please list any fractures or dislocations: _____

WOMEN ONLY

Are you pregnant? ☐Yes ☐No Taking Birth Control? ☐Yes ☐No Date of Last Menstruation? ___/___/___

8. MEDICAL HISTORY

Make the following conditions as they currently pertain to you:

Alcoholism	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Irritable Bowel	☐ Yes ☐ No	Allergies	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Bladder Problems	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Stomach Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Low Back Pain	☐ Yes ☐ No	Thyroid Disorder	☐ Yes ☐ No	Acid reflux	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Head Pain	☐ Yes ☐ No	Sleep Disorders	☐ Yes ☐ No	AIDS	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Arteriosclerosis	☐ Yes ☐ No	Breast Lumps	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Eczema	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Lyme Disease	☐ Yes ☐ No
Fibromyalgia	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No
Measles	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
STD	☐ Yes ☐ No						

Please describe any other medical problems that you have had in the past or present. This will include any surgeries or treatments for injuries or diseases as well as conditions that were not treated. This includes injuries, accidents and falls.

_____

_____

_____

Have you ever been knocked out, had a lapse in memory or injured your head or neck? ☐ Yes ☐ No.

If yes, Please explain:_____

9. FAMILY HISTORY

Please indicate disease and family relationship with you.

Diabetes _____ Depression _____
Heart Disease _____ Headaches _____
High Blood Pressure _____ Bleeding Disorder _____
High Cholesterol _____ Stroke _____
Cancer _____ Thyroid Disease_____
Kidney Problems _____ Epilepsy _____

10. CURRENT COMPLAINTS

Please check the appropriate box for any of the following symptoms, which you now have or have had previously. THIS IS A CONFIDENTIAL HEALTH REPORT.

Please add letter next to symptom: **Current = C**; **Past = P**.

Cardiovascular

☐ Hardening of the Arteries
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Pain Over Heart
☐ Poor Circulation
☐ Rapid Heartbeat
☐ Chest Pain

Respiratory

☐ Chronic Cough
☐ Difficulty Breathing
☐ Wheezing
☐ Spitting up Blood
☐ Spitting up Phlegm

Skin

☐ Bruise Easily
☐ Dryness
☐ Skin Eruptions (rash)
☐ Discolorations
☐ Varicose Veins

Genitourinary

☐ Bed-Wetting
☐ Blood in Urine
☐ Frequent Urination
☐ Kidney Infection
☐ Kidney Stones
☐ Painful Urination
☐ Prostate Problems
☐ Pus in Urine

Eyes, Ears, Nose, Throat

- ☐ Eye Pain Strain
- ☐ Vision Problems
- ☐ Ear Pain
- ☐ Ear Noises
- ☐ Ear Discharge
- ☐ Hearing Loss
- ☐ Nose Pain
- ☐ Nose Bleeds / Discharge
- ☐ Nasal Obstruction
- ☐ Sore Mouth
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Difficult Speech
- ☐ Sinus Infection
- ☐ Jaw Pain

Gastrointestinal

- ☐ Appetite Changes
- ☐ Difficulty Chewing or Swallowing
- ☐ Excessive Thirst
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody / Black Stool
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gallbladder Problems
- ☐ Weight Trouble

Women Only

- ☐ Back Ache or Cramps
- ☐ Excessive Menstrual Flow
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Menopausal Symptoms
- ☐ Painful Menstruation
- ☐ Vaginal Discharge
- ☐ Vaginal Pain
- ☐ Breast Pain
- ☐ Miscarriage

Nervous System

- ☐ Numbness / Tingling
- ☐ Loss of Feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Loss of Memory
- ☐ Muscle Jerking
- ☐ Loss of Taste / Smell
- ☐ Cold Feet / Hands
- ☐ Convulsions
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

Musculoskeletal

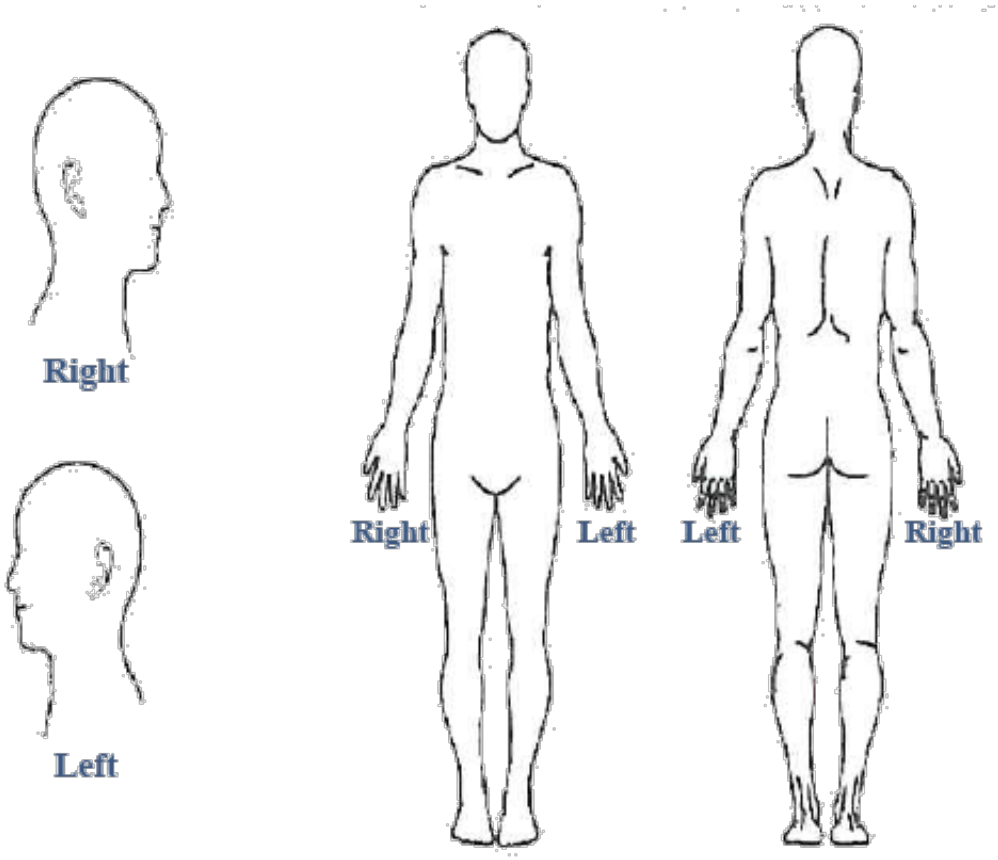
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Swollen Joints
- ☐ Painful Joints
- ☐ Stiff Joints
- ☐ Sore Muscles
- ☐ Weak Muscles
- ☐ Muscle Spasm
- ☐ Walking Problems
- ☐ Sciatica
- ☐ Arthritis
- ☐ Other _____

Pain, Numbness, Cramp

- ☐ Back
- ☐ Neck
- ☐ Head
- ☐ Shoulders
- ☐ Shoulders
- ☐ Arms
- ☐ Elbows
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Other _____

Please Outline on the Diagram Areas of Discomfort

A = Aching	B = Burning	C = Cold	R = Radiating
H = Hypersensitivity	N = Numbness	S = Stabbing	T = Tingling



Out of all your concerns, which is the most troublesome to you?

Please circle the level of pain and / or discomfort
you are experiencing to the above condition.

No Pain — 1 2 3 4 5 6 7 8 9 10 — Worst Pain Imaginable

MABNR 1400 Forest Glen Road, Suite 225 • Silver Spring, MD 20910 • Tel (240)-766-8881 Fax (240)-766-3763 • www.mabnr.com

11. SYMPTOM CHECKLIST

For the following symptoms, please select a corresponding number to indicate the severity of your symptoms. If you have a symptom that is not listed, please use the other box and rate it using the following criteria.

0 = None **1 - 2 = Mild** **3 - 4 = Moderate** **5 - 6 = Severe**

Headaches	0	1	2	3	4	5	6	Don't "Feel Right"	0	1	2	3	4	5	6
"Pressure in Head"	0	1	2	3	4	5	6	Difficulty Concentrating	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6	Difficulty Remembering	0	1	2	3	4	5	6
Nausea or Vomiting	0	1	2	3	4	5	6	Fatigue or Low Energy	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6	Confusion	0	1	2	3	4	5	6
Blurred Vision	0	1	2	3	4	5	6	Drowsiness	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6	Trouble Falling Asleep	0	1	2	3	4	5	6
Sensitivity to Light	0	1	2	3	4	5	6	More Emotional	0	1	2	3	4	5	6
Sensitivity to Noise	0	1	2	3	4	5	6	Irritable	0	1	2	3	4	5	6
Feeling Slowed Down	0	1	2	3	4	5	6	Sadness	0	1	2	3	4	5	6
Feeling in a Fog	0	1	2	3	4	5	6	Nervous or Anxious	0	1	2	3	4	5	6

Does mental activity increase your symptoms? ☐ Yes ☐ No

Does mental physical increase your symptoms? ☐ Yes ☐ No

12. DETAILED HISTORY

Please answer the all the questions as completely and thoroughly as you can. Though some questions may not seem to pertain, they are all important to help diagnose and formulate a plan of action specifically for you and make proper referrals. If needed, list number, then use spaces or back of page to explain more details.

For medical history: **Current = C**; **Past = P**.
Include dates if possible for both if longer than 6 months ago.

Independent or Concurrent Therapies

1. __ Chiropractic
2. __ Chiro for Family / Pets
3. __ Acupuncture
4. __ Therapeutic Massage
5. __ Naturopathic
6. __ Eastern Medicine
7. __ Nutritional Consult
8. __ Medical Treatment
9. __ Specialist
10. __ Natural Healer
11. __ Spiritual Healer
12. __ Energy work

Diagnostic or Routine Exams: Please list area, Dr. and reason ordered, date and location of exam if known.

13. __ X-rays
14. __ MRI
15. __ CAT Scans
16. __ Blood Draw
17. __ Ultrasound
18. __ Upper / Lower GI
19. __ DEXA Scan
20. __ Breast Exam
21. __ Prostate Exam
22. __ Eye Exam
23. __ Dental Exam
24. __ Colonoscopy
25. Other _____
26. Other _____
27. Other _____

General Health: List Times of Day or any Correlating Factors.

28. __ Poor Appetite
29. __ Heavy Appetite
30. __ Change in Appetite
31. __ Unexplained Weight Gain/Loss
32. __ Poor Sleep
33. __ Wake Feeling Tired
34. __ Decreased Sleep
35. __ Heavy Sleep
36. __ Insomnia
37. __ Apnea/ Narcolepsy
38. __ Sudden wakening at nighttime
39. __ Hours of Sleep / Night
40. __ Day Napping __ amount
41. __ Night Sweats
42. __ Sudden Energy Drop
43. __ Strong Thirst
44. __ Fatigue
45. __ Chills
46. __ Sudden Temp Changes
47. __ Poor Circulation
48. __ Peculiar Tastes / Smells
49. __ Night Pain
50. __ Hot / Cold
51. __ Night Pain
52. __ Radiating Pain
53. __ Numbness / Tingling
54. __ Pins and Needles
55. __ Sweats Easily
56. __ Excessive Sweating
57. __ Body Odor Change
58. __ Stress
59. __ Bowel / Bladder Changes
60. __ Bleed / Bruise Easily (where?)

Appliances or Aids

61. __ Glasses / Prisms
62. __ Contacts
63. __ Orthotics
64. __ Joint Replacement
65. __ Prosthetics
66. __ Implants of Any Kind
67. __ Braces
68. __ Splints
69. __ Pace Maker
70. __ Hearing Aids
71. Other _____
72. Other _____

Neuropsychological

73. __ Seizures
74. __ Depression
75. __ Anxiety
76. __ Poor Memory
77. __ Foggy Thinking
78. __ Bad Temper
79. __ Concussion
80. __ Easily Stressed
81. __ Considered / Attempted Suicide
82. __ Treated for Emotional Concerns
83. __ Antidepressant Meds
84. __ Other Neurological or Psychological Concerns

13. LIFESTYLE AND SOCIAL HISTORY

Stress Screening: Yes / No

290. __ Can you relax when you want?
291. __ Have trouble dealing with stress?
292. __ Are you in therapy or counseling? Does it help?
293. __ Is your family safe to express true emotions?
294. __ Are romantic relationships fulfilling?
295. __ Does stress leads to digestive problems?
296. __ Do you abuse food/ alcohol/ tobacco to deal with unpleasant feelings?
297. __ Do you vent unpleasant emotions in a satisfying way?
298. __ Do you avoid conflicts at your expense?
299. __ Do you feel your health is out of your hands?
300. __ Have you tried to deal with stress, but couldn't succeed?
301. __ Do you feel capable of resolving your problems, but simply need to know how?
302. __ How much do you love yourself? 0.....100%

Do you find any dysfunction or concern in the following areas? (Yes/No)

303. __ Relationships with Family
304. __ Relationships with Friends
305. __ Social Skills
306. __ Career
307. __ Work
308. __ Leisure
309. __ Hobbies
310. __ Past Time Activities
311. __ Intimate Relationships
312. __ Sex
313. __ Religious Life
314. __ Spiritual Path
315. __ Childhood religious teachings
316. __ Past relationships
317. __ Childhood
318. __ School

14. BRAIN FUNCTION ASSESSMENT

0 = none/never 1 = mild/occasional 2 = moderate/frequent 3 = severe/constant

Section 1: Brain Endurance

A decrease in attention span **0 1 2 3**
Mental fatigue **0 1 2 3**
Difficulty learning new things **0 1 2 3**
Difficulty staying focused and concentrating for extended periods of time **0 1 2 3**
Experiencing fatigue when reading sooner than in the past **0 1 2 3**
Experiencing fatigue when driving sooner than in the past **0 1 2 3**
Need for caffeine to stay mentally alert **0 1 2 3**

Section 2: Posture and Movement

Twitching or tremor in your hands and legs when resting **0 1 2 3**
Handwriting has gotten smaller and more crowded together **0 1 2 3**
A loss of smell to foods **0 1 2 3**
Difficulty sleeping or fitful sleep **0 1 2 3**
Stiffness in shoulders and hips that goes away when you start to move **0 1 2 3**
Constipation **0 1 2 3**
Voice has become softer **0 1 2 3**
Facial expression that is serious or angry **0 1 2 3**
Episodes of dizziness or light-headedness upon standing **0 1 2 3**
A hunched over posture when getting up and walking **0 1 2 3**

Section 3: Memory and Cognition

Memory loss that impacts daily activities **0 1 2 3**
Difficulty planning, problems solving, or working with numbers **0 1 2 3**
Difficulty completing daily tasks **0 1 2 3**
Confusion about dates, the passage of time, or place **0 1 2 3**
Difficulty understanding visual images and spatial relationships (addresses and locations) **0 1 2 3**
Difficulty finding words when speaking **0 1 2 3**
Misplacement of things and inability to retrace steps **0 1 2 3**
Poor judgment and bad decisions **0 1 2 3**
Disinterest in hobbies, social activities or work **0 1 2 3**
Personality or mood changes **0 1 2 3**

Section 4: Temporal Lobe

Reduced function in overall hearing **0 1 2 3**
Difficulty understanding language with background or scatter noise **0 1 2 3**
Ringing or buzzing in the ear **0 1 2 3**
Difficulty comprehending language without perfect pronunciation **0 1 2 3**
Difficulty recognizing familiar faces **0 1 2 3**
Changes in comprehending the meaning of sentences, written or spoken **0 1 2 3**
Difficulty with verbal memory and finding words **0 1 2 3**
Difficulty remembering events **0 1 2 3**
Difficulty recalling previously learned facts and names **0 1 2 3**
Inability to comprehend familiar words when reading **0 1 2 3**
Difficulty spelling familiar words **0 1 2 3**
Monotone, unemotional speech **0 1 2 3**
Difficulty understanding the emotions of others when they speak (nonverbal cues) **0 1 2 3**
Disinterest in music and a lack of appreciation for melodies **0 1 2 3**
Difficulty with long-term memory **0 1 2 3**
Memory impairment when doing basic activities of daily living **0 1 2 3**
Difficulty with directions and visual memory **0 1 2 3**
Noticeable differences in energy levels throughout the day **0 1 2 3**

Section 5: Occipital Lobe

Difficulty coordinating visual input and hand movements, resulting in an inability to efficiently reach for objects **0 1 2 3**
Difficulty comprehending written text **0 1 2 3**
Floaters or halos in your visual field **0 1 2 3**
Dullness of colors in your visual field during different times of the day **0 1 2 3**
Difficulty discriminating similar shades of color **0 1 2 3**

Section 6: Frontal Cortex

Difficulty with detailed hand coordination **0 1 2 3**
Difficulty with making decisions **0 1 2 3**
Difficulty with suppressing socially inappropriate thoughts **0 1 2 3**
Socially inappropriate behavior **0 1 2 3**
Decisions made based on desires, regardless of the consequences **0 1 2 3**
Difficulty planning and organizing daily events **0 1 2 3**
Difficulty motivating yourself to start and finish tasks **0 1 2 3**
A loss of attention and concentration **0 1 2 3**

Section 7: Parietal Lobe

Hypersensitivities to touch or pain	0 1 2 3
Difficulty with spatial awareness when moving, laying back in a chair or leaning against a wall	0 1 2 3
Frequently bumping into the wall or objects	0 1 2 3
Difficulty with right-left discrimination	0 1 2 3
Handwriting has become sloppier	0 1 2 3
Difficulty finding words for written or verbal communication	0 1 2 3
Difficulty recognizing symbols, words or letters	0 1 2 3

Section 8: Pontomedullary Brainstem

Difficulty swallowing supplements or large bites of food	0 1 2 3
Bowel motility and movements slow	0 1 2 3
Bloating after meals	0 1 2 3
Dry eyes or dry mouth	0 1 2 3
A racing heart	0 1 2 3
A flutter in the chest or an abnormal heart rhythm	0 1 2 3
Bowel or bladder incontinence, resulting in staining your underwear	0 1 2 3

Section 9: Basal Ganglia Direct Pathway

A decrease in movement speed	0 1 2 3
Difficulty initiating movement	0 1 2 3
Stiffness in your muscles (not joints)	0 1 2 3
A stooped posture when walking	0 1 2 3
Cramping of your hand when writing	0 1 2 3

Section 10: Basal Ganglia Indirect Pathway

Abnormal body movements (such as twitching legs)	0 1 2 3
Desires to flinch, clear your throat, or perform some type of movement	0 1 2 3
Constant nervousness and a restless mind	0 1 2 3
Compulsive behaviors	0 1 2 3
Increased tightness and tone in specific muscles	0 1 2 3

Section 11: Cerebellum

Difficulty with balance, or balance that is noticeably worse on one side	0 1 2 3
A need to hold the handrail or watch each step carefully when going down stairs	0 1 2 3
Episodes of dizziness	0 1 2 3
Nausea, car sickness, or seasickness	0 1 2 3
A quick impact after consuming alcohol	0 1 2 3
A slight hand shake when reaching for something	0 1 2 3
Back muscles that tire quickly when standing or walking	0 1 2 3
Chronic neck or back muscle tightness	0 1 2 3

15. DETAILED DESCRIPTION OF YOUR SYMPTOMS

Please share a detailed description of your condition including each individual symptom and/or concern. This may include both physical and mental health, as well as acute and/or chronic conditions. You may want to address the following:

- What is the frequency?
- Describe the pain/condition
- Where is it located?
- How often do you get it?
- Does it change in presentation?
- What makes it better/worse?
- What tests have you had for each condition? What providers have you seen for the conditions/symptoms?
- Any other factors which may be associated

All of this information can be in whatever format you prefer. Some patients prefer a narrative; others find a listing of events by year to be more concise or organized. Whatever composition style you choose is acceptable **as long as it is concise and organized**.

16. ACCOUNT AUTHORIZATION

I hereby give my authorization to treat me or my minor child as named herein on this form. Office policy requires payment in full for all services and goods rendered at the time of your visit to the office, unless other arrangements have been made with the office Manager. I clearly understand and agree that all services and goods rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and/or treatment, any fees for professional services or goods rendered to me will be immediately due and payable. I hereby authorize payment of any and all benefits, medical or otherwise, to the physician for the services and/or goods rendered. I further authorize the physician and/or supplier to release my information as required to process any and all insurance claims. I understand the above information in its entirety and hereby guarantee that this form was completed accurately to the best of my knowledge. I also understand that it is my responsibility to inform this office, in a timely manner, of any and all changes to this information.

Patient Signature *(Parent or Guardian Signature if Patient is a Minor).*	**Date Signed:**