

CHIROPRACTIC MEMPHIS

**AUTISM SPECTRUM DISORDER/ADD/ADHD/HYPERACTIVITY DISORDER/DYSLEXIA
CONFIDENTIAL PATIENT INFORMATION**

(Please Print)

Date: _____ E-Mail Address _____

Full Name: _____

Name of Parent or Guardian: _____

Address: _____

City _____ State _____ Zip Code _____

Telephone Number () _____ Cell Phone Number () _____

Social Security No. -- --

Birthdate: _____

Name and address of Nearest Relative: _____

(Not living with you)

How did you hear about our office? _____

List Chiropractors you have seen before:

1. Name: _____

When: _____

2. Name: _____

When _____

List Medical Doctors consulted within the past year:

1. Name: _____ Address: _____

When: _____ Reason for visit? _____

2. Name: _____ Address: _____

When: _____ Reason for visit? _____

All Current Medications _____

| List your child's developmental disorder according to severity | Date parent 1st noticed symptom | Date Diagnosed | Is disorder getting better or worse? |
|--|---------------------------------|----------------|--------------------------------------|
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ |

1. Specific goals you as a parent want to see:

Improve _____

Behaviors you do not want to see anymore _____

2. Have any other family members been diagnosed with Autism Spectrum Disorders, ADD, ADHD, or Dyslexia?

Yes _____ No _____ If yes, please list relationship _____

3. Have any other family members been diagnosed with Autoimmune Disease, Rheumatoid Arthritis, Lupus, Scleroderma, MS, ALS, Thyroid Disease, Autoimmune Diabetes, Grave's, other?

_____ Yes _____ No _____ If yes, please list relationship _____

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4. Mom's Health During Pregnancy

Was mom overweight? Yes _____ No _____ If yes, weight _____

Was mom sick? Yes _____ No _____ Name illness _____

How many births has the mother had? _____

How many miscarriages? _____

Did mom use fertility drugs? Yes _____ No _____

Health of siblings _____

Maternal stress during pregnancy: divorce? Yes _____ No _____; car accident? Yes _____ No _____;
physical trauma? Yes _____ No _____; broken bones? Yes _____ No _____; if yes, explain _____

death in family? Yes _____ No _____; job loss? Yes _____ No _____

Mom's exposure to toxins (example: mold, pesticides) Yes _____ No _____ if yes, explain _____

Known infection(s) mom had during pregnancy

Yeast? _____; bacterial? _____; viral? _____

Did mom drink alcohol during pregnancy? Yes _____ No _____; smoke? Yes _____ No _____; drink
coffee? Yes _____ No _____; excessive bleeding? Yes _____ No _____; vomiting? Yes _____ No _____

5. Birth Process

What type of delivery? _____

Any birth trauma? Yes _____ No _____ if yes, explain _____

Was delivery induced? Yes _____ No _____ Natural? Yes _____ No _____ Epidural? Yes _____ No _____

APGAR score _____ at one minute _____ at 5 minutes

6. Infant toxic exposure

Mold in house? Yes _____ No _____; pesticide? Yes _____ No _____; other _____

7. Infections

Name all infections first two years of child's life:

_____ Age of onset _____; _____ Age of onset _____

_____ Age of onset _____; _____ Age of onset _____

_____ Age of onset _____; _____ Age of onset _____

Is child on antibiotics now? Yes _____ No _____

At what age did child first start antibiotics? _____ What age was the first illness? _____

8. Please list **ALL** surgeries and child's age at time of surgery:

9. Motor Development

Child's age when first held head up _____; rolled over _____; sat up _____; crawled _____; walked _____

Did child display any "cute" or out of the ordinary behavior when learning to crawl or walk?

Yes _____ No _____ if yes, explain _____

Age potty trained: _____ age stopped wetting bed: _____ age of first words "mama", "dada" _____

Age child spoke 2 to 3 words together _____

Has child lost language? Yes _____ No _____; if yes, what age and how far did they regress?

How many words was your child using in a sentence before regression? _____

Has child lost eye contact? Yes _____ No _____; if yes, at what age: _____

How long did mother breast feed? Months _____ Never _____

Age child started bottle-feeding? _____; formula? Yes _____ No _____; soy based? Yes _____ No _____
casein based? Yes _____ No _____

Age cow's milk was introduced _____; age wheat & grains were introduced? _____

10. Vaccine Response

Seizures? Yes _____ No _____ When did seizures start? _____ How long did they last? _____

Bowel symptoms? Yes _____ No _____, if yes, explain _____

Swelling at injection site? Yes _____ No _____ Fever? Yes _____ No _____

11. Current Diet

What is your child eating now? Look back over past 3 days and be as accurate as possible.

Does your child refuse to eat certain foods? Yes _____ No _____; which foods? _____

List all sweets that your child eats: _____

How many glasses of milk does your child drink per day? _____

How much cheese consumption per day? _____ Slices of bread per day? _____

How many sodas per day? _____ How many glasses of sweet tea? _____

How many glasses of fruit juice? _____ How many sports drinks per day? _____

Does your child eat salty food or crave salty food? Yes _____ No _____

Fast food meals per day? _____ Meat intake per day? _____ ounces; What type? _____

Veggies per day? _____

12. GI Tract

How many bowel movements per day? _____ Is your child constipated? Yes _____ No _____

Bloating? Yes _____ No _____ Dark circles under eyes? Yes _____ No _____

Is your child's behavioral symptoms worse during _____ damp; _____ hot; _____ misty; _____ moldy; _____ other weather?

Does your child wake up at night laughing or giggling? Yes _____ No _____

Does your child put pressure on stomach? Yes _____ No _____

Name of person responsible for payment: _____

Do you have insurance that covers Chiropractic care? Yes _____ No _____

Names of Insurance Company: _____ Policy No. _____

PLEASE COMPLETE BACK SIDE OF PAGE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that **Chiropractic Memphis** may prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to **Chiropractic Memphis** will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 treatment, any fees for professional services rendered me will be immediately due and payable. I understand that I am responsible for all attorney fees or collection fees related to the collection of my account. I agree to pay interest at the rate of 1.5% per month (18% per annum) on any unpaid balance.

Patient's Signature _____ Date _____
Guardian or Spouse's Signature _____ Date _____
Information taken by _____ Date _____

The Economic Impact of Attention-Deficit/Hyperactivity disorder in Children and Adolescents

- **William E. Pelham, PhD1, E. Michael Foster, PhD2 and Jessica A. Robb, BA1**
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• **Abstract**

• Using a cost of illness (COI) framework, this article examines the economic impact of attention-deficit/hyperactivity disorder (ADHD) in childhood and adolescence. Our review of published literature identified 13 studies, most conducted on existing databases by using diagnostic and medical procedure codes and focused on health care costs. Two were longitudinal studies of identified children with ADHD followed into adolescence. Costs were examined for ADHD treatment-related and other health care costs (all but 1 study addressed some aspect of health care), education (special education, 2 studies, disciplinary costs; 1 study), parental work loss (2 studies), and juvenile justice (2 studies).

Based on this small and as yet incomplete evidence base, we estimated **annual COI of ADHD in children and adolescents at \$14,576 per individual (2005 dollars)**. Given the variability of estimates across studies on which that number is based, a reasonable range is between **\$12,005 and \$17,458 per individual**. Using a prevalence rate of **5%**, a conservative estimate of the **annual societal COI for ADHD in childhood and adolescence is \$42.5 billion, with a range between \$36 billion and \$52.4 billion**. Estimates are preliminary because the literature is incomplete; many future researches on COI of ADHD are provided.

Study: Autism costs strain family finances

National survey shows impact of caring for a child with chronic disorder.

PATIENT NAME: _____

DATE: _____

MASTER HEMISPHERIC CHECKLIST

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 arms)
- Fidgets excessively
- Poor eye contact
- Walks or walked on toes when younger

_____ TOTAL

MOTOR CHARACTERISTICS OF A LEFT BRAIN DELAY

- Fine motor problems (poor or slow handwriting)
- Difficulty with fine motor skills, such as buttoning a shirt
- Poor or immature hand grip when writing
- Tends to write very large for age or grade level
- 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

SENSORY CHARACTERISTICS OF A RIGHT BRAIN DELAY

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

_____ TOTAL

PLEASE TURN OVER AND COMPLETE BACK PAGE

SENSORY CHARACTERISTICS OF A LEFT BRAIN DELAY

- Doesn't seem to have many sensory issues or problems, such as a sensitivity to sound
- Has good spatial awareness (aware of surroundings)
- Has good sense of balance
- Eats just about anything
- Has a normal to above-average sense of taste and smell
- Likes to be hugged and held
- Does not have any oddities concerning clothing
- Has auditory processing problems
- 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
- Is not undersensitive or oversensitive to pain

_____ TOTAL

EMOTIONAL CHARACTERISTICS OF A RIGHT BRAIN DEFICIENCY

- Spontaneously cries and/or laughs and has sudden outbursts of anger or fear
- Worries a lot and has several phobias
- Holds on to past "hurts"
- Has sudden emotional outbursts that appear overreactive and inappropriate to the situation
- Experiences panic and/or anxiety attacks
- Sometimes displays dark or violent thoughts
- Face lacks expression; doesn't exhibit much body language
- Too uptight, cannot seem to loosen up
- Lacks empathy and feelings for others
- Lacks emotional reciprocity
- Often seems fearless and is a risk taker

_____ TOTAL

EMOTIONAL CHARACTERISTICS OF A LEFT BRAIN DEFICIENCY

- Overly happy and affectionate; loves to hug and kiss
- Frequently moody and irritable
- Loves doing new or different things but gets bored easily
- Lacks motivation
- Withdrawn and shy
- Excessively cautious, pessimistic, or 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 him or her

_____ TOTAL

BEHAVIORAL CHARACTERISTICS OF A RIGHT BRAIN DELAY

- Logical thinker
- Often misses the gist of a story
- Always the last to get a 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
- Has a problem paying attention

- Is hyperactive and/or impulsive
- Has obsessive thoughts or behaviors

- Argues all the time and is generally uncooperative
- Exhibits signs of an eating disorder
- Failed to thrive as an infant
- Mimics sounds or words repeatedly without really understanding the meaning
- Appears bored, aloof, and abrupt
- Considered strange by other children
- Inability to form friendships
- Has difficulty sharing enjoyment, interests, or achievements with other people
- Inappropriately giddy or silly
- Acts inappropriately in social situations
- Talks incessantly and asks the same question repetitively
- Has no or little joint attention, such as the need to point to an object to get your attention
- Didn't look at self in mirror as a toddler

_____ TOTAL

BEHAVIORAL CHARACTERISTICS OF A LEFT BRAIN DELAY

- Procrastinates
- Is extremely shy, especially around strangers
- Is very good at nonverbal communication
- Is well liked by other children and teachers
- Does not have any behavioral problems in school
- Understands social rules
- Has poor self-esteem
- Hates doing homework
- Is very good at social interaction
- Makes good eye contact
- Likes to be around people and enjoys social activities, such as going to parties
- Doesn't like to go to sleepovers
- Is not good at following routines
- Can't follow multiple-step directions
- Is in touch with own feelings
- Jumps to conclusions

_____ TOTAL

ACADEMIC CHARACTERISTICS OF A RIGHT BRAIN DELAY

- Poor math reasoning (word problems, geometry, algebra)
- Poor reading comprehension and pragmatic skills
- Misses the big picture
- Very analytical
- Likes "slapstick" or obvious physical humor
- Is very good at finding mistakes (spelling)
- Takes everything literally
- Doesn't always reach a conclusion when speaking
- Started speaking early
- Has tested for a high IQ, but scores run the whole spectrum; or IQ is above normal in verbal abilities and below average in performance abilities
- Was an early word reader
- Is interested in unusual topics

PLEASE TURN OVER AND COMPLETE BACK SIDE

- Learns in a rote (memorizing) manner
- Learns extraordinary amounts of specific facts about a subject
- Is impatient
- Speaks in a monotone; has little voice inflection
- Is a poor nonverbal communicator
- Doesn't like loud noises (like fireworks)
- Speaks out loud regarding what he or she is thinking
- Talks "in your face" – is a space invader
- Good reader but does not enjoy reading
- Analytical; led 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 was often the first academic subject that became a problem

_____ TOTAL

ACADEMIC CHARACTERISTICS OF A LEFT BRAIN DELAY

- Very good at big picture skills
- Is an intuitive thinker and is led by feelings
- Good at abstract "free" association
- Poor analytical skills
- Very visual; loves images and patterns
- Constantly questions why you're doing something or why rules exist
- Has poor sense of time
- Enjoys touching and feeling actual objects
- Has trouble prioritizing
- Is unlikely to read instructions before trying something new
- Is naturally creative, but needs to work hard to develop full potential
- Would rather do things instead of observe
- Uses good voice inflection when speaking
- Misreads or omits common small words
- Has difficulty saying long words
- Reads very slowly and laboriously
- Had 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
- Was a late talker
- Has difficulty pronouncing words (poor with phonics)
- Had difficulty learning the alphabet, nursery rhymes, or songs when young
- Has difficulty finishing homework or finishing a conversation
- Acts before thinking and makes careless mistakes
- Daydreams a lot
- Has difficulty sequencing events in the proper order
- Often writes letters backward
- Is poor at basic math skills
- Has poor memorization skills
- Has poor academic ability
- Has an IQ lower than expected and verbal scores are lower than nonverbal scores
- Performs poorly on verbal tests
- Needs to be told to do something several times before acting on it
- Stutters or stuttered when younger
- Is a poor speller
- Doesn't read directions well

_____ TOTAL

COMMON IMMUNE CHARACTERISTICS OF A RIGHT BRAIN DELAY

- Has a lot of allergies
- Rarely gets colds and infections
- Has had or has eczema or asthma
- Skin has little white bumps, especially on the back of the arms
- Displays erratic behavior -- good one day, bad the next
- Craves certain foods, especially dairy and wheat products

_____ TOTAL

COMMON IMMUNE CHARACTERISTICS OF A LEFT BRAIN DELAY

- Gets chronic ear infections
- Prone to benign tumors or cysts
- Has taken antibiotics more than ten to fifteen times before the age of ten
- Has had tubes put in the ears
- Catches colds frequently
- No allergies

_____ TOTAL

AUTONOMIC CHARACTERISTICS OF A RIGHT BRAIN DELAY

- Problems with bowels, such as constipation and diarrhea
- Has a 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

AUTONOMIC CHARACTERISTICS OF A LEFT BRAIN DELAY

- Has a bedwetting problem
- Has or had an irregular heartbeat, such as an arrhythmia or a heart murmur

_____ TOTAL

TAKING THE TOTAL

Here count up the total checks you've made for left brain and right brain symptoms.

Right brain total _____

Left brain total _____

Grand Total _____

Child Neurotransmitter & Nutrition Questionnaire (CNNQ)

Name: _____ Age: _____ Sex: _____ Date: _____

* Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

SECTION: GENERAL

- Does your child have any food sensitivities or allergies? (please list)

- List your child's 4 healthiest foods eaten regularly.
_____, _____, _____, _____
- List your child's 4 unhealthiest foods eaten regularly.
_____, _____, _____, _____
- How many times a week does your child eat candy? _____
- How many times a week does your child drink soda pop? _____
- Please list the top 4 foods your child craves regularly?
_____, _____, _____, _____
- List the medication(s) your child is currently prescribed and over the counter.

- Do you find it difficult as a parent to have your child on a special diet?

SECTION: A (K52)

- Does your child eat pasta, breads, and breaded foods? 0 1 2 3
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating wheat foods? 0 1 2 3
- Does your child eat dairy products? 0 1 2 3
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating dairy products? 0 1 2 3

SECTION: B (K53)

- Does your child eat fried fish? 0 1 2 3
- Does your child eat roasted nuts or seeds? 0 1 2 3
- Is your child missing essential fatty acid rich foods in his/her diet? (for example: avocados, flax seeds, olives) (mark "0" if present, "3" if missing) 0 1 2 3
- Does your child eat fried foods? 0 1 2 3

SECTION: C (K34)

- Is your child's mental speed slow? 0 1 2 3
- Does your child have difficulty with learning or memory? 0 1 2 3
- Does your child have difficulty with balance and coordination? 0 1 2 3

SECTION: D (K16)

- Does your child have stress? 0 1 2 3
- Does your child not have enough sleep and rest? (mark "3" if not enough) 0 1 2 3
- Does your child not have regular exercise? (mark "3" if no exercise) 0 1 2 3
- Does your child feel overly worried and scared? 0 1 2 3

SECTION: E (K16, K51)

- Does your child have temper tantrums? 0 1 2 3
- Does your child exhibit wild behavior? 0 1 2 3
- Does your child frequently yell or scream for unnecessary reasons? 0 1 2 3

- Does your child have an inability to nap or sleep when physically exhausted? (mark "3" if unable) 0 1 2 3
- Is your child overly talkative? 0 1 2 3
- Does your child fidget and squirm when seated? 0 1 2 3
- Does your child run and climb excessively when it is inappropriate? 0 1 2 3
- Does your child have difficulty playing quietly or engaging in leisure activities? 0 1 2 3

SECTION: F (K51)

- Does your child get excited easily? 0 1 2 3
- Does your child have anxiousness and panic for minor reasons? 0 1 2 3
- Does your child feel overwhelmed for minor reasons? 0 1 2 3
- Does your child find it difficult to relax when she/he is awake? 0 1 2 3
- Does your child have disorganized attention? 0 1 2 3

SECTION: G (K50)

- Does your child seem depressed? 0 1 2 3
- Does your child have mood changes with overcast weather? 0 1 2 3
- Does your child have symptoms of inner rage? 0 1 2 3
- Does your child seem uninterested in games or hobbies? 0 1 2 3
- Does your child have difficulty falling into deep restful sleep? 0 1 2 3
- Does your child seem uninterested in friendships? 0 1 2 3
- Does your child have symptoms of unprovoked anger? 0 1 2 3
- Does your child seem uninterested in eating? 0 1 2 3

SECTION: H (K49)

- Does your child have difficulty handling stress? 0 1 2 3
- Does your child have anger and aggression while being challenged? 0 1 2 3
- Does your child feel tired even after long sleeps? 0 1 2 3
- Does your child tend to isolate from others? 0 1 2 3
- Does your child get distracted easily? 0 1 2 3
- Does your child have constant need and desire for candy and sugar? 0 1 2 3
- Does your child have disorganized attention? 0 1 2 3

SECTION: I (K48)

- Does your child have difficulty with visual memory? 0 1 2 3
- Does your child have difficulty remembering locations? 0 1 2 3
- Does your child have fatigue or low endurance for learning activities? 0 1 2 3
- Does your child have difficulty with attention or low attention span or endurance? 0 1 2 3
- Does your child have slow or difficult speech? 0 1 2 3
- Does your child have uncoordinated or slow movement? 0 1 2 3

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition. For nutritional purposes only

Assignment and Instruction for Direct Payment to the Doctor
Private and Group, Accident and Health Insurance

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Chiropractic Memphis
Summer Avenue Office
3675 Summer Avenue
Memphis, Tennessee 38122

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a Current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or Attorney involved in this case.

Dated at Chiropractic Memphis this _____ day of _____, _____

Signature of Policy Holder

Signature of Claimant, if other than Policy Holder

Chiropractic Memphis
3675 Summer Avenue
Memphis, Tennessee 38122

Privacy Authorization for Chiropractic Memphis

Chiropractic Memphis and members of the practice staff may need to use your name, address, phone number and clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine or with a family member.

You can restrict the individuals to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments in an open room style, with other patients in the same room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed at your office visits. Private rooms are available for any other needed consultations.

You may inspect or request a copy, for a fee, the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time (#164.524)

This Notice is effective as of April 14, 2003. This authorization will expire seven years after the date in which you last received services from us. You may receive a copy of this form when needed.

I authorize you to use or disclose my health information in the manner described. I also acknowledge that I have read and received a copy of Chiropractic Memphis Privacy Policy.

Patient Signature _____ Date _____