

The Human Tune-Up™

Brainstem Balancing Upper Cervical Care works
by correcting our bodies self-regulation and healing

Terms of Acceptance

Below are the goals of **The Human Tune-Up™ & Brainstem Balancing™**
We welcome you to this life changing form of Upper Cervical care.

Please initial each space provided if you agree to the terms.

1. **Brainstem Balancing** keeps individuals and families free of nerve interference located in the Upper Cervical region.
2. Once the Brainstem and Upper Cervical area are free of nerve interference, our bodies can start healing every body system that was compromised. This is why Upper Cervical Care has spectacular results with such a vast array of problems and conditions.
- _____ 3. **Brainstem Balancing** does not include any diagnosis or treatment of any mental, physical, or emotional disorder - therefore, we do not participate in any insurance program or legal case. If you desire advice, diagnosis, or treatment for specific symptoms or ailments, we recommend that you seek the services of a health care provider who specializes in that area.
- _____ 4. **Brainstem Balancing** is not a duplication of, or alternative to any other health system. Only Upper Cervical Care has the exclusive goal of removing Upper Cervical Nerve Interference from your Brainstem, allowing your body to do what it was designed to do - heal itself.
- _____ 5. **Brainstem Balancing** consists of, and is limited to:
 - a) analyzing the Upper Cervical Region to locate any Nerve Interference
 - b) applying gentle contacts and movements to remove the Nerve Interference
- _____ 6. Once you receive your **Brainstem Balancing** sessions on day 1 or on any other day after day 1, you may not receive a refund for any service provided (Brainstem Balancing sessions, Nerve System education, and post adjustment training). This policy is for Square, Credit Card, check, and cash payments.

I have read the above and agree to become a practice member by its terms. I understand you wish me to view your website: www.BrainstemBalancing.com for important information about this practice and the power of **The Human Tune-Up™ & Brainstem Balancing™**

Print Name: _____ Sign Name: _____

Date: _____ E-mail: _____ Best Phone # _____

Complete below if practice member is a minor or legal guardianship.

Print Child's Name: _____ Age: _____

I, _____ being the parent or legal guardian of the
aforementioned child have read and fully understand the above terms of acceptance
and hereby grant permission for this child to receive **Brainstem Balancing** sessions.

Signed: _____ Date: _____

The Human Tune-Up™ History Form

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Second Phone: _____

E-mail: (please PRINT CLEARLY) _____

Date of birth: _____ Age: _____ M F Occupation: _____

Marital Status: S M D Spouse/Partner : _____ Occupation: _____

of Children: _____ Name & age: _____

How did you find us? (NAME if referred): _____

Have you ever received Upper Cervical Care before? What system did they use?

Symptoms and Present State of Health

Reason for Seeking Care in this Office: _____

Is this condition interfering with: Work Sleep Sports/Hobby Whole Life

Are you under medical care for any condition? _____

Brainstem Insult Traumas you've experienced...

Please check the following Brainstem Traumas/Insults that you can remember:

Early Life Traumas / Insults:

- | | | |
|--|---|--|
| <input type="checkbox"/> Compromised birth | <input type="checkbox"/> Cord around neck | <input type="checkbox"/> Breech birth |
| <input type="checkbox"/> Cesarean section | <input type="checkbox"/> Dropped as a baby | <input type="checkbox"/> Frozen Neck (torticollis) |
| <input type="checkbox"/> Forceps or Vacuum Birth | <input type="checkbox"/> Rejected by parent | <input type="checkbox"/> Rejected Mom's milk |

Possible outcomes:

- | | | |
|--|---|---|
| <input type="checkbox"/> becoming "inconsolable" | <input type="checkbox"/> Failure to thrive | <input type="checkbox"/> Colicky |
| <input type="checkbox"/> refusing to breast feed | <input type="checkbox"/> Lazy eye/Vision issues | <input type="checkbox"/> Sleeping issues |
| <input type="checkbox"/> Slow to crawl / walk | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Digestion issues |

Childhood Traumas / Insults:

- | | | |
|---|---|---|
| <input type="checkbox"/> Vaccinations | <input type="checkbox"/> Playground accidents | <input type="checkbox"/> Sports injuries to head/neck |
| <input type="checkbox"/> Falls | <input type="checkbox"/> Automobile accidents | <input type="checkbox"/> Surfer? <input type="checkbox"/> Skateboarder? |
| <input type="checkbox"/> Did you do martial arts? | <input type="checkbox"/> Play(ed) team sports | <input type="checkbox"/> Chemical / Mold exposure |
| <input type="checkbox"/> Emotional traumas | <input type="checkbox"/> Dance / Ballet | <input type="checkbox"/> Repetitive motion traumas |

Possible outcomes:

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hormonal Issues | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Digestion issues | <input type="checkbox"/> Headaches | <input type="checkbox"/> Skin issues |
| <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety | <input type="checkbox"/> Learning disability | <input type="checkbox"/> Vision issues |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Socialization issues | <input type="checkbox"/> Anger issues |

Specific Sport traumas:

- | | | |
|--|--|--|
| <input type="checkbox"/> Surfing accidents | <input type="checkbox"/> Rock climbing | <input type="checkbox"/> Soccer |
| <input type="checkbox"/> Yoga head / shoulder stands | <input type="checkbox"/> Wrestling | <input type="checkbox"/> Boxing |
| <input type="checkbox"/> Any martial art | <input type="checkbox"/> Dancing / Ballet | <input type="checkbox"/> Basketball |
| <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Diving | <input type="checkbox"/> Skateboarding |
| <input type="checkbox"/> Thrown/fell from a horse | <input type="checkbox"/> Football | <input type="checkbox"/> Skiing / boarding |
| <input type="checkbox"/> Water skiing | <input type="checkbox"/> Motorcycle accidents | <input type="checkbox"/> Golf |
| <input type="checkbox"/> Baseball bat to head | <input type="checkbox"/> Baseball to head | <input type="checkbox"/> Volleyball |
| <input type="checkbox"/> Biking / Mtn. Biking | <input type="checkbox"/> Hockey / Field Hockey | <input type="checkbox"/> Cheerleading |

Specific Life traumas:

- | | | |
|--|---|---|
| <input type="checkbox"/> Surgeries _____ | | |
| <input type="checkbox"/> Medications _____ | | |
| <input type="checkbox"/> Dental issues _____ | | |
| <input type="checkbox"/> Physical Assault _____ | | |
| <input type="checkbox"/> Emotional traumas | <input type="checkbox"/> Chemical / Mold exposure | <input type="checkbox"/> Falls |
| <input type="checkbox"/> Repetitive motion traumas | <input type="checkbox"/> Improper work ergonomics | <input type="checkbox"/> Auto accidents |

Possible outcomes:

- | | | |
|--|---|---|
| <input type="checkbox"/> Migraines | <input type="checkbox"/> High <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Asthma <input type="checkbox"/> Allergies | <input type="checkbox"/> Compromised Immune System | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Digestion issues / diseases | <input type="checkbox"/> Heart issues | <input type="checkbox"/> Ringing in ears |

Mark any of the following conditions / symptoms that you have now, or have experienced:

- | | | |
|-----|-----|-----|
| H H | H H | H H |
| A A | A A | A A |
| D V | D V | D V |
| E | E | E |
- | | | |
|--|--|---|
| <input type="checkbox"/> <input type="checkbox"/> Tramatic Brain Injury | <input type="checkbox"/> <input type="checkbox"/> Neck - reduced ROM | <input type="checkbox"/> <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> <input type="checkbox"/> Concussion | <input type="checkbox"/> <input type="checkbox"/> Neck Pain | <input type="checkbox"/> <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> <input type="checkbox"/> Sub-concussive event | <input type="checkbox"/> <input type="checkbox"/> TMJ / Jaw Issues | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> <input type="checkbox"/> Numbness Hands or Arms | <input type="checkbox"/> <input type="checkbox"/> Pressure in head/neck |
| <input type="checkbox"/> <input type="checkbox"/> Migraines | <input type="checkbox"/> <input type="checkbox"/> Numbness in Legs or Feet | <input type="checkbox"/> <input type="checkbox"/> Cancer |
| <input type="checkbox"/> <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> <input type="checkbox"/> Pain in Legs or Feet | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> <input type="checkbox"/> Pain in Arms or Hands | <input type="checkbox"/> <input type="checkbox"/> Sudden Weight Loss |
| <input type="checkbox"/> <input type="checkbox"/> Loss of Smell or Taste | <input type="checkbox"/> <input type="checkbox"/> Cold Hands | <input type="checkbox"/> <input type="checkbox"/> Sudden Weight Gain |
| <input type="checkbox"/> <input type="checkbox"/> Dizziness / Vertigo | <input type="checkbox"/> <input type="checkbox"/> Cold Feet | <input type="checkbox"/> <input type="checkbox"/> Diabetes Type 1 |
| <input type="checkbox"/> <input type="checkbox"/> Brain Fog | <input type="checkbox"/> <input type="checkbox"/> Joint Swelling / Arthritis | <input type="checkbox"/> <input type="checkbox"/> Diabetes Type 2 |
| <input type="checkbox"/> <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> <input type="checkbox"/> Rhumatoid Arthritis | <input type="checkbox"/> <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> <input type="checkbox"/> Heartburn/Reflux |
| <input type="checkbox"/> <input type="checkbox"/> Irritability | <input type="checkbox"/> <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> <input type="checkbox"/> Tension | <input type="checkbox"/> <input type="checkbox"/> Asthma |
| <input type="checkbox"/> <input type="checkbox"/> Light bothers Eyes | <input type="checkbox"/> <input type="checkbox"/> Allergies | <input type="checkbox"/> <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> <input type="checkbox"/> Dry Eyes / Dry Skin | <input type="checkbox"/> <input type="checkbox"/> Menstrual Cramps / PMS | <input type="checkbox"/> <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> <input type="checkbox"/> Tri-geminal Neuralgia | <input type="checkbox"/> <input type="checkbox"/> Menopause Issues | <input type="checkbox"/> <input type="checkbox"/> Constipation |
| <input type="checkbox"/> <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> <input type="checkbox"/> Depression | <input type="checkbox"/> <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> <input type="checkbox"/> Sinus | <input type="checkbox"/> <input type="checkbox"/> Digestion Issues |
| <input type="checkbox"/> <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> <input type="checkbox"/> _____ | <input type="checkbox"/> <input type="checkbox"/> _____ |
| <input type="checkbox"/> <input type="checkbox"/> OCD issues | <input type="checkbox"/> <input type="checkbox"/> _____ | <input type="checkbox"/> <input type="checkbox"/> _____ |

Sports / Hobbies not listed on Brainstem trauma page: _____

Anything else you wish me to know about you: _____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

Patient Signature _____ Date _____