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? _________________________________

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____

____

____

Brainstem Insult Traumas you've experienced...

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

Early Life Traumas / Insults:

❑ Compromised birth
❑ Cord around neck
❑ Breech birth
❑ Cesarean section
❑ Dropped as a baby
❑ Frozen Neck (torticollis)
❑ Forceps or Vacuum Birth
❑ Rejected by parent
❑ Rejected Mom's milk

Possible outcomes:

❑ becoming "inconsolable"
❑ Failure to thrive
❑ Colicky
❑ refusing to breast feed
❑ Lazy eye /Vision issues
❑ Sleeping issues
❑ Slow to crawl / walk
❑ ADD/ADHD
❑ Digestion issues

Childhood Traumas / Insults:

❑ Vacinations
❑ Playground accidents
❑ Sports injuries to head/neck
❑ Falls
❑ Automobile accidents
❑ Surfer ❑ Skateboarder
❑ Martial arts
❑ Play(ed) team sports
❑ Chemical / Mold exposure
❑ Emotional traumas
❑ Dance / Ballet
❑ Repetitive motion traumas

Possible outcomes:

❑ Allergies
❑ Hormonal Issues
❑ Migraines
❑ Digestion issues
❑ Headaches
❑ Skin issues
❑ Depression ❑ Anxiety
❑ Learning disability
❑ Vision isssues
❑ Asthma
❑ Socialization issues
❑ Anger issues

Specific Sport traumas:

❑ Surfing accidents
❑ Rock climbing
❑ Soccer
❑ Yoga head / shoulder stands
❑ Wrestling
❑ Boxing
❑ Martial Arts
❑ Dancing / Ballet
❑ Basketball
❑ Gymnastics
❑ Diving
❑ Skateboarding
❑ Thrown/fell from a horse
❑ Football
❑ Skiing / boarding
❑ Water skiing
❑ Motorcycle accidents
❑ Golf
❑ Baseball bat to head
❑ Baseball to head
❑ Volleyball
❑ Biking / Mtn. Biking
❑ Hockey / Field Hockey
❑ Cheerleading

Specific Life traumas:

❑ Surgeries ______________________________
❑ Medications ______________________________
❑ Dental issues ______________________________
❑ Physical Assault ______________________________
❑ Emotional traumas
❑ Chemical / Mold exposure
❑ Falls
❑ Repetitive motion traumas
❑ Improper work ergonomics
❑ Auto accidents

Possible outcomes:

❑ Migraines
❑ High ❑ Low blood pressure
❑ Parkinson's
❑ Asthma ❑ Allergies
❑ Compromised Immune System
❑ Multiple Sclorisis
❑ Digestion issues / diseases
❑ Heart issues
❑ Ringing in ears

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

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

Total number of COVID-19 Shots (Vaccinations + boosters) : ______

Number of times you've had COVID-19 : ______

Any Long COVID symptoms? ____

____

Sports / Hobbies not listed on Brainstem trauma page:__________________________________

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Anything else you wish me to know about you: _______________________________________

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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______________________