



Dr. David E. Kemp, DC, DACNB, FABBIR
4169 University Blvd. S.
Jacksonville, FL 32216

Patient Name: _____ ID # _____

1. Request and Consent for Treatment

I hereby request and consent to the performance of functional neurology assessments, chiropractic adjustments (spinal and extra-spinal), and various neurological rehabilitation procedures on me (or on the patient named above, for whom I am legally responsible). These services may be performed by Dr. Kemp and/or other licensed providers who now or in the future work at Kemp Chiropractic PA dba Kemp Functional Neurology or its affiliated locations.

The procedures may include, but are not limited to:

- Manual or instrument-assisted chiropractic adjustments.
- Vestibular rehabilitation and ocular-motor training.
- Neuromuscular re-education and physical therapy modalities.
- Diagnostic imaging (X-rays) and functional neurological testing.

2. Nature and Purpose of Care

I understand that Functional Neurology is a specialized branch of healthcare focused on the assessment and rehabilitation of the nervous system. I have had the opportunity to discuss the nature and purpose of these treatments with clinic personnel. I understand that while these procedures are designed to optimize neurological function, **results are not guaranteed.**

3. Understanding Risks

I am informed that, as in the practice of any healthcare discipline, there are certain risks associated with treatment. These risks include, but are not limited to:

- **Chiropractic/Manual Therapy:** Fractures, disc injuries, dislocations, sprains, or, in rare instances, cerebrovascular injury (stroke).
- **Neurological Rehabilitation:** Temporary dizziness, nausea, fatigue, or a short-term exacerbation of current symptoms as the nervous system adapts to therapy.

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise professional judgment during the course of treatment, based on the facts then known, to act in my best interest.

4. Voluntary Participation and Communication

I understand that I have the right to ask questions about my care at any time. I am encouraged to report any new symptoms or concerns immediately. I understand that I may withdraw my consent and discontinue treatment at any time.

5. Financial Policy and Insurance Disclaimer

I understand and acknowledge that Kemp Chiropractic PA dba Kemp Functional Neurology is not a provider for any insurance company and does not accept or participate in any private insurance, Medicare, or Medicaid programs.

- **Payment Responsibility:** I understand that I am fully responsible for the total cost of all services at the time they are rendered. The clinic will not bill my insurance company on my behalf.
- **Third-Party Reimbursement:** Upon request, the clinic will provide me with a specialized receipt (often called a "superbill") containing the necessary codes and information. I may choose to submit this document to my insurance carrier to seek out-of-network reimbursement.
- **No Guarantee of Coverage:** I understand that the clinic makes no representations or guarantees that my insurance company will provide any reimbursement for the services provided.

6. Acknowledgement and Signature

I have read, or have had read to me, the above consent. I have had the opportunity to ask questions and have had them answered to my satisfaction. By signing below, I agree to the procedures named above and accept the financial terms stated in Section 5. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at this clinic.

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____



1. Please list/describe any traumatic events you have suffered even if you feel it was small, I.E. Loss of consciousness, if so how long and was there any ringing in ears, seeing stars, light sensitivity, double vision, etc.

2. Please list/describe any surgeries you have had in your life.

3. Please list/describe any medical conditions you have been diagnosed with.

4. Please list any medications, vitamins, minerals, herbal supplements you are taking and what they are taken for.

5. Please list if you had any birth traumas, I.E. C-Section, Forceps usage, suction cup use, cord wrapped around neck, long or difficult birth, etc.

6. Please list any family history of neurological disorders, I.E. Multiple Sclerosis, Parkinsons, Lou Gehrig's disease, etc.

7. Please list any family history of major medical conditions, I.E. Diabetes, Stroke, Heart Attack, etc.

2. What are your habits?

- Smoking
- Alcohol
- Recreational Drugs
- Exercise

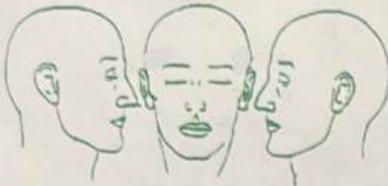
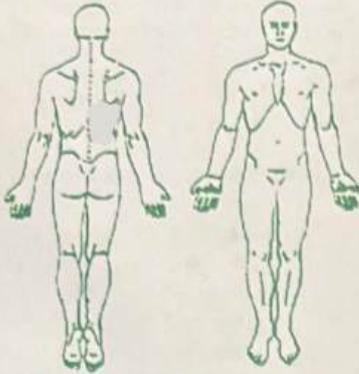
	Never	Occasionally	Moderately	Excessively
Smoking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Recreational Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. FAMILY HISTORY

	Cancer	Diabetes	Heart Trouble	High Blood Pressure	Stroke	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis	Bad Posture
Father	<input type="radio"/>															
Mother	<input type="radio"/>															
Brothers	<input type="radio"/>															
Sisters	<input type="radio"/>															
Children	<input type="radio"/>															

C. PAIN DIAGRAMMS

Please mark the location of your pain on these figures



D. MEDICAL HISTORY

1. HEALTH CARE

	Yes	No
a. Have you been to a chiropractor	<input type="radio"/>	<input type="radio"/>
b. Do you have a family physician	<input type="radio"/>	<input type="radio"/>
c. WOMEN:		
To the best of your knowledge are you pregnant	<input type="radio"/>	<input type="radio"/>
Are you under the regular care of an OB-GYN . . .	<input type="radio"/>	<input type="radio"/>
d. Have you been hospitalized in the past five years	<input type="radio"/>	<input type="radio"/>
e. Are you currently taking any medication	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Anti-inflammatory (Aspirin, Motrin, etc.)		
<input type="radio"/> Muscle Relaxants	<input type="radio"/> Pain Medication/Analgesic	
<input type="radio"/> Tranquilizers	<input type="radio"/> Birth Control Pills	
<input type="radio"/> Other		

2. Which of the following illnesses have you had?

- No Previous Conditions/Illnesses
- Arthritis
- Asthma
- Sinus Trouble
- Hay Fever
- Allergies
- Tuberculosis
- Diabetes
- Epilepsy
- Thyroid Trouble
- High Blood Pressure
- Low Blood Pressure
- Heart Trouble
- HIV/ARC
- AIDS
- Sexually Transmitted Disease
- Ulcer
- Cancer
- Polio
- Rheumatic Fever
- Serious Injury
- Bone Fracture
- Dislocated Joints
- Spinal Disc Disease
- Multiple Sclerosis
- Scoliosis
- Mental/Emotional Difficulty
- Prostate Trouble
- Kidney Trouble
- Other

E. INSURANCE INFORMATION

	Yes	No
1. Is your condition due to an automobile accident	<input type="radio"/>	<input type="radio"/>
Date of Accident	<input type="text"/>	
Have You filed an accident report	<input type="radio"/>	<input type="radio"/>
2. Is your condition due to a job injury	<input type="radio"/>	<input type="radio"/>
Date of Injury	<input type="text"/>	
Have You filed an injury report	<input type="radio"/>	<input type="radio"/>
3. Do you have health insurance	<input type="radio"/>	<input type="radio"/>
Company	<input type="text"/>	
Policy #	<input type="text"/>	
4. Are you covered by Medicare	<input type="radio"/>	<input type="radio"/>
Medicare #	<input type="text"/>	

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will 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 this Office will be credited to my account upon receipt. However, I clearly understand and agree that all services 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 treatment, any fees for professional services rendered me will be immediately due and payable.

F. PAYMENT

I WILL BE PAYING TODAY BY:

Cash Check Credit Card

MasterCard Visa American Express

Account # Exp. Date

All accounts not paid within 90 days will automatically be put through on your credit card.

Patient's Signature Date

Guardian or Spouse's Signature Date

Doctor's Signature Date

Health Questionnaire (NTAF)

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 A

- Is your memory noticeably declining? 0 1 2 3
- Are you having a hard time remembering names and phone numbers? 0 1 2 3
- Is your ability to focus noticeably declining? 0 1 2 3
- Has it become harder for you to learn things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament getting worse in general? 0 1 2 3
- Are you losing your attention span endurance? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you fatigue when driving compared to the past? 0 1 2 3
- How often do you fatigue when reading compared to the past? 0 1 2 3
- How often do you walk into rooms and forget why? 0 1 2 3
- How often do you pick up your cell phone and forget why? 0 1 2 3

SECTION B

- How high is your stress level? 0 1 2 3
- How often do you feel that you have something that must be done? 0 1 2 3
- Do you feel you never have time for yourself? 0 1 2 3
- How often do you feel you are not getting enough sleep or rest? 0 1 2 3
- Do you have the time to get regular exercise? 0 1 2 3
- How often do you not feel cared about by the people in your life? 0 1 2 3
- How often do you not feel you are accomplishing your life purpose? 0 1 2 3
- How often do you share your problems with someone? 0 1 2 3

SECTION C

SECTION C1

- How often do you get irritable, shaky, or have lightheadedness between meals? 0 1 2 3
- How often do you feel energized after eating? 0 1 2 3
- How often do you have difficulty eating large meals in the morning? 0 1 2 3
- How often does your energy level drop in the afternoon? 0 1 2 3
- How often do you crave sugar and sweets in the afternoon? 0 1 2 3
- How often do you wake up in the middle of the night? 0 1 2 3
- How often do you have difficulty concentrating before eating? 0 1 2 3
- How often do you depend on coffee to keep yourself going? 0 1 2 3
- How often do you feel agitated, easily upset, and nervous between meals? 0 1 2 3

SECTION C2

- Do you get fatigued after meals? 0 1 2 3
- Do you crave sugar and sweets after meals? 0 1 2 3
- Do you feel you need stimulants such as coffee after meals? 0 1 2 3
- Do you have difficulty losing weight? 0 1 2 3
- How much larger is your waist girth compared to your hip girth? 0 1 2 3
- How often do you urinate? 0 1 2 3
- Have your thirst and appetite been increased? 0 1 2 3
- Do you have weight gain when under stress? 0 1 2 3
- Do you have difficulty falling asleep? 0 1 2 3

SECTION 1 - S

- Are you losing your pleasure in hobbies and interests? 0 1 2 3
- How often do you feel overwhelmed with ideas to manage? 0 1 2 3
- How often do you have feelings of inner rage (anger)? 0 1 2 3
- How often do you have feelings of paranoia? 0 1 2 3
- How often do you feel sad or down for no reason? 0 1 2 3

- How often do you feel like you are not enjoying life? 0 1 2 3
- How often do you feel you lack artistic appreciation? 0 1 2 3
- How often do you feel depressed in overcast weather? 0 1 2 3
- How much are you losing your enthusiasm for your favorite activities? 0 1 2 3
- How much are you losing enjoyment for your favorite foods? 0 1 2 3
- How much are you losing your enjoyment of friendships and relationships? 0 1 2 3
- How often do you have difficulty falling into deep restful sleep? 0 1 2 3
- How often do you have feelings of dependency on others? 0 1 2 3
- How often do you feel more susceptible to pain? 0 1 2 3
- How often do you have feelings of unprovoked anger? 0 1 2 3
- How much are you losing interest in life? 0 1 2 3

SECTION 2 - D

- How often do you have feelings of hopelessness? 0 1 2 3
- How often do you have self-destructive thoughts? 0 1 2 3
- How often do you have an inability to handle stress? 0 1 2 3
- How often do you have anger and aggression while under stress? 0 1 2 3
- How often do you feel you are not rested even after long hours of sleep? 0 1 2 3
- How often do you prefer to isolate yourself from others? 0 1 2 3
- How often do you have unexplained lack of concern for family and friends? 0 1 2 3
- How easily are you distracted from your tasks? 0 1 2 3
- How often do you have an inability to finish tasks? 0 1 2 3
- How often do you feel the need to consume caffeine to stay alert? 0 1 2 3
- How often do you feel your libido has been decreased? 0 1 2 3
- How often do you lose your temper for minor reasons? 0 1 2 3
- How often do you have feelings of worthlessness? 0 1 2 3

SECTION 3 - G

- How often do you feel anxious or panic for no reason? 0 1 2 3
- How often do you have feelings of dread or impending doom? 0 1 2 3
- How often do you feel knots in your stomach? 0 1 2 3
- How often do you have feelings of being overwhelmed for no reason? 0 1 2 3
- How often do you have feelings of guilt about everyday decisions? 0 1 2 3
- How often does your mind feel restless? 0 1 2 3
- How difficult is it to turn your mind off when you want to relax? 0 1 2 3
- How often do you have disorganized attention? 0 1 2 3
- How often do you worry about things you were not worried about before? 0 1 2 3
- How often do you have feelings of inner tension and inner excitability? 0 1 2 3

SECTION 4 - ACH

- Do you feel your visual memory (shapes & images) is decreased? 0 1 2 3
- Do you feel your verbal memory is decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity been decreased? 0 1 2 3
- Has your comprehension been diminished? 0 1 2 3
- Do you have difficulty calculating numbers? 0 1 2 3
- Do you have difficulty recognizing objects & faces? 0 1 2 3
- Do you feel like your opinion about yourself has changed? 0 1 2 3
- Are you experiencing excessive urination? 0 1 2 3
- Are you experiencing slower mental response? 0 1 2 3

Category IX

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X

Tired, sluggish	0	1	2	3
Feel cold - hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" type headaches	0	1	2	3

Category XIV (Males only)

Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males only)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintain morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVI (Menstruating Females Only)

Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 24 days	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Females Only)

How many years have you been menopausal?				
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

How many alcohol beverages do you consume per week? _____

How many times do you eat out per week? _____

How many times a week do you eat fish? _____

List the three worst foods you eat during the average week: _____

List the three healthiest foods you eat during the average week: _____

Do you smoke? _____ If yes, how many times a day _____

Rate your stress levels on a scale of 1-10 during the average week: _____

Please list any medications you currently take and for what conditions: _____

Please list any natural supplements you currently take and for what conditions: _____