

WELCOME TO ADVANCED CHIROPRACTIC AND NEUROLOGY, PC

Outline Procedures for New Patients

Step One	All new patients are requested to fill out a personal health questionnaire prior to their appointment.
Step Two	Your consultation with a doctor to discuss your health problems.
Step Three	Diagnostic chiropractic, orthopedic, and neurological examination procedures to determine if chiropractic care is appropriate for your condition.
Step Four	You will be advised if there is the need of any additional procedures such as X-rays, MRI, or Cat Scan.
Step Five	If your case requires immediate attention, treatment will be administered.
Step Six	You will be advised as to a time you can return for your "report of finding" so that the Doctor will inform you as to your examination results and whether or not your case has been accepted. You will be informed of specific recommendations in regards to your condition

Confidential Patient Information

Name		Date	
Street Address		City/State	Zip Code
Home Phone ()	Work Phone ()	Cell Phone/Pager ()	
Email Address	Date of Birth	Current Age	
Social Security #		Method of Payment	

Insurance Information:

Please provide us with your insurance card so that we may make a copy for our records. This will help us to submit billing to your insurance company.

Referred by:

<input type="checkbox"/> Patient Name:	<input type="checkbox"/> Physician Name	<input type="checkbox"/> Other
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Work Status: Employed Retired Disabled Full-time Student Part-time Student

Employer	Occupation and Job Responsibilities	
Employer Address	City/State	Zip Code

Marital Status: Married Single Divorced Widow Spouse's Name _____

Why Chiropractic? People go to Chiropractor for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Other are interested in having the cause of the problem as well as the symptoms corrected and relieved to avoid future relapses (Corrective Care). Still other want whatever is malfunctioning in their bodies brought to the highest state of health possible in order to optimize their physical and emotional well-being (Comprehensive Care). Chiropractic Neurology offers some of the latest advanced procedures for optimizing your nervous system function.

Advanced Chiropractic and Neurology, P.C. stresses that it is always YOUR CHOICE to choose which care you desire. We will honor and support your choice and your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care you wish to receive.

Relief Care Corrective Care Comprehensive Care Would like to discuss options with the doctor

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. The practitioners at Advanced Chiropractic and Neurology, PC participate in SecureCare PPO through Blue Cross/Blue Shield, Midlands Choice, United Health Care, First Health Network/Mail Handlers, and Mutual of Omaha. Advanced Chiropractic and Neurology, P.C. is considered out of network for any other HMO/PPO. I understand that the Doctor's Office will prepare any necessary forms to assist me in making collection from the insurance company. 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 at the time of services unless participating with SecureCare, Blue Cross/Blue Shield, Midlands Choice, United Health Care, First Health Network, Coventry, or Mutual of Omaha. If you have been in an auto accident, please furnish us with your medical payment information as included in your auto insurance policy unless other arrangements have been made.

Patient's Signature _____ Date: _____

FEMALES ONLY

I, _____, To the best of my knowledge confirm that I am not pregnant and waive all responsibility to the Doctor.

Signature:

Date:

CONSENT OF TREATMENT OF A MINOR

I hereby authorize John W. McClaren, DC, and whomever they may so designate as assistant or associate, to administer chiropractic care as they deem necessary to my son/daughter, _____, dated at LaVista, NE this _____ day of _____, 20____.

Signature:

Witnessed:

RELEASE TO PAY ADVANCED CHIROPRACTIC AND NEUROLOGY, P.C., DIRECTLY FROM INSURANCE

I hereby authorize my insurance carrier _____ to directly pay Advanced Chiropractic and Neurology, P.C. for services provided in this office.

Signature:

IN CASE OF EMERGENCY

Name of relative or close friend not living in your home:

Home Phone

Work Phone

Cell Phone

Past Medical History

Please include any of your previous conditions.

If possible include: Dates, Diagnosis, Treatment received and any Residuals you still suffer from.

Was your mother healthy when you were in utero? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain					
Did she smoke or consume alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain					
Where were you born? City _____ State _____ Hospital _____					
Were you delivered <input type="checkbox"/> vaginally or through <input type="checkbox"/> cesarean section?					
Were there any complications during your birth process? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain:					
Were you vaccinated? <input type="checkbox"/> No <input type="checkbox"/> Yes					
Did you have normal neurological, structural, emotional, and social development? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain					
Academics	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Athletics	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Emotional	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Dietary Habits	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Overall Health	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Mental Abilities	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Exercise Level	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Motor Vehicle Accidents <input type="checkbox"/> No <input type="checkbox"/> Yes Explain: _____					
Year: _____ Type: _____					
Year: _____ Type: _____					
Work Injuries <input type="checkbox"/> No <input type="checkbox"/> Yes Explain					
Illnesses/Hospitalizations: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain					
Injuries, Accidents, Falls, or Traumas <input type="checkbox"/> No <input type="checkbox"/> Yes Explain					
Surgeries: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain					
Females Only: What age did you start your menses? _____ <input type="checkbox"/> Regular <input type="checkbox"/> Irregular					
Medications Please list your current medications and what they are taken for.					
Vitamins, Minerals, and Supplements Please list your current supplements and by whom prescribed.					

Family History

Mother <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Health Conditions? _____
Father <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Health Conditions? _____
Brother <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Health Conditions? _____
Brother <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Health Conditions? _____
Sister <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Health Conditions? _____
Sister <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Health Conditions? _____
Children: Ages and health conditions? _____ _____
Maternal Grandmother <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Health Conditions? _____
Maternal Grandfather <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Health Conditions? _____
Paternal Grandmother <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Health Conditions? _____
Paternal Grandfather <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Health Conditions? _____

Have any of your family members ever suffered from any of the following conditions?

<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Neurological Disorders (type) _____ <input type="checkbox"/> Autoimmune Disorders (type) _____ <input type="checkbox"/> Cancer (type) _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
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Habits

Cigarettes	<input type="checkbox"/> None <input type="checkbox"/> Yes How much per week?
Cigars	<input type="checkbox"/> None <input type="checkbox"/> Yes How many per week?
Alcohol	<input type="checkbox"/> None <input type="checkbox"/> Yes How many drinks per week? What type of Alcohol?
Coffee	<input type="checkbox"/> None <input type="checkbox"/> Yes How many cups per week?
Recreational Drugs	<input type="checkbox"/> None <input type="checkbox"/> Yes Types? Frequency? Years of Usage?
Exercise	<input type="checkbox"/> None <input type="checkbox"/> Yes Hours/Days per week? Types?
Water	<input type="checkbox"/> None <input type="checkbox"/> Yes Glasses per day?
Soft Drinks	<input type="checkbox"/> None <input type="checkbox"/> Yes Amount per week? Types?
Sleep	<input type="checkbox"/> None <input type="checkbox"/> Yes Average hours per night?____ Do you have difficulty falling asleep or staying asleep? <input type="checkbox"/> None <input type="checkbox"/> Yes #times up at night____ Hours sleep desired per night?
Eating	Meals per day? What types of food do you eat? Do you consider your diet healthy? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain

DATE OF LAST:

Physical Examination	By Whom?	Results?
Blood Work	By Whom?	Results
Bone Density Study	By Whom?	Results?
Mammogram	By Whom?	Results?
Pelvic Exam	By Whom?	Results?
Self Breast Exam	Regularity	
Digital Prostate Exam	Results	
EKG	Results	
PSA Level	Results	
Chest X-rays	Results	
Echocardiogram	Results	
Spinal X-rays	By Whom?	Where are they located?
MRI/Cat Scan	Results	Where are they located?
Other Tests	Results	Where are they located?

Check the first box of any of the following conditions you have HAD, and check the second box of anything you HAVE.

<input type="checkbox"/> <input type="checkbox"/> Mental Disorders	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Pneumonia	<input type="checkbox"/> <input type="checkbox"/> Infective Disease
<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Fungal Infection
<input type="checkbox"/> <input type="checkbox"/> Tumors	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Hepatitis Type____	<input type="checkbox"/> <input type="checkbox"/> Herpes
<input type="checkbox"/> <input type="checkbox"/> Alcoholism	<input type="checkbox"/> <input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> <input type="checkbox"/> Arthritis
<input type="checkbox"/> <input type="checkbox"/> Drug Addiction	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Parasites	<input type="checkbox"/> <input type="checkbox"/> Autoimmune Disease
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> <input type="checkbox"/> Venereal Infection	<input type="checkbox"/> <input type="checkbox"/> Chicken Pox

NERVOUS SYSTEM

EENT

GI

MUSCULOSKELETAL

<input type="checkbox"/> <input type="checkbox"/> Depression	<input type="checkbox"/> <input type="checkbox"/> Vision Problems	<input type="checkbox"/> <input type="checkbox"/> Poor/Excess Appetite	<input type="checkbox"/> <input type="checkbox"/> Jaw Pain
<input type="checkbox"/> <input type="checkbox"/> Memory Loss	<input type="checkbox"/> <input type="checkbox"/> Flashing Lights	<input type="checkbox"/> <input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> <input type="checkbox"/> Difficulty Chewing
<input type="checkbox"/> <input type="checkbox"/> Confusion	<input type="checkbox"/> <input type="checkbox"/> Black Spots	<input type="checkbox"/> <input type="checkbox"/> Frequent Nausea	<input type="checkbox"/> <input type="checkbox"/> Face Pain
<input type="checkbox"/> <input type="checkbox"/> Dizziness	<input type="checkbox"/> <input type="checkbox"/> Blurriness	<input type="checkbox"/> <input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> <input type="checkbox"/> Neck Pain
<input type="checkbox"/> <input type="checkbox"/> Fainting	<input type="checkbox"/> <input type="checkbox"/> Hearing Loss	<input type="checkbox"/> <input type="checkbox"/> Black/Bloody Stools	<input type="checkbox"/> <input type="checkbox"/> Arm/Elbow Pain
<input type="checkbox"/> <input type="checkbox"/> Convulsions	<input type="checkbox"/> <input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> <input type="checkbox"/> Digestive Problems	<input type="checkbox"/> <input type="checkbox"/> Wrist/Hand Pain
<input type="checkbox"/> <input type="checkbox"/> Weakness	<input type="checkbox"/> <input type="checkbox"/> Swallowing Difficulty	<input type="checkbox"/> <input type="checkbox"/> Abdominal Cramping	<input type="checkbox"/> <input type="checkbox"/> Mid Back Pain
<input type="checkbox"/> <input type="checkbox"/> Poor Balance		<input type="checkbox"/> <input type="checkbox"/> Gas/Bloating after meals	<input type="checkbox"/> <input type="checkbox"/> Lower Back Pain
<input type="checkbox"/> <input type="checkbox"/> Twitches/Tremor		<input type="checkbox"/> <input type="checkbox"/> Heartburn	<input type="checkbox"/> <input type="checkbox"/> Thigh/Knee Pain
<input type="checkbox"/> <input type="checkbox"/> Cold/Tingle Extremities	<input type="checkbox"/> <input type="checkbox"/> Bladder Trouble	<input type="checkbox"/> <input type="checkbox"/> Weight Problems	<input type="checkbox"/> <input type="checkbox"/> Ankle/Foot Pain
<input type="checkbox"/> <input type="checkbox"/> Sleeping Difficulties	<input type="checkbox"/> <input type="checkbox"/> Painful Urination	<input type="checkbox"/> <input type="checkbox"/> Gall Bladder Problems	<input type="checkbox"/> <input type="checkbox"/> Difficulty Walking
<input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> Incontinence	<input type="checkbox"/> <input type="checkbox"/> Liver Problems	<input type="checkbox"/> <input type="checkbox"/> Leg/Arm Fatigue
<input type="checkbox"/> <input type="checkbox"/> C-V	<input type="checkbox"/> <input type="checkbox"/> Discolored Urine		
<input type="checkbox"/> <input type="checkbox"/> Chest Pain			MISC.
<input type="checkbox"/> <input type="checkbox"/> Irregular Heartbeat			<input type="checkbox"/> <input type="checkbox"/> Right Handed
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Erectile Difficulties		<input type="checkbox"/> <input type="checkbox"/> Left Handed
<input type="checkbox"/> <input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> <input type="checkbox"/> Sexual Dysfunction		
<input type="checkbox"/> <input type="checkbox"/> Lung/Congestion Prob	<input type="checkbox"/> <input type="checkbox"/> Menstrual Irregularity		
<input type="checkbox"/> <input type="checkbox"/> Varicose Veins	<input type="checkbox"/> <input type="checkbox"/> Menstrual Cramping		
<input type="checkbox"/> <input type="checkbox"/> Ankle Swelling			

How often do you have a bowel movement?	Are your movements consistent? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do your stools <input type="checkbox"/> Float or <input type="checkbox"/> Sink?	Do you experience any urgency, dribbling, or incontinence?
How many times a day do you urinate?	Is this consistent? <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient Signature _____	

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payors
- Conduct normal healthcare operations such as quality assessments and physician certifications

I understand this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature of Patient or Parent/Guardian (if under 19): _____
Date: _____

Informed Consent to Chiropractic Treatment

The Nature of the Chiropractic Adjustment

We will use our hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you crack your knuckles. You may feel or sense movement.

The Material Risks Inherent in Chiropractic Adjustment

As with any health care procedure, there are certain complications that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy and costovertebral strains and separations. Some patients will feel some stiffness and soreness following the first few days of treatment.

The Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone or bone disease, which we check for during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as “rare.”

The Availability and Nature of Other Treatment Options

Other treatment options for your condition include:

- Self-administered, over-the-counter analgesics and rest
- Medical care with prescription drugs such as anti-inflammatory, muscle relaxants and pain relievers
- Hospitalization with traction
- Surgery

The Material Risks Inherent in Such Options and the Probability of Such Risks Occurring Include:

Overuse of the over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the

patient's general health, severity of the patient's discomfort, his/her pain tolerance, and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain relievers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the

patient's general health, severity of the patient's discomfort, his/her pain tolerance, and self-discipline in not abusing the medicine, and proper professional supervision. Such medications generally entail very significant risks – some with rather high probabilities.

Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor injured) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain, and exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, all those of hospitalizations and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility. In addition, compromise to your neurophysiological integrity and health of your nervous system will continue. Over time these processes may complicate treatment, making the treatment more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT Sign Until You Have Read and Understand The Above.

Please check the appropriate block and sign below:

I have read [] or have had read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to Advanced Chiropractic and Neurology, John McClaren, D.C., and Colby J. Carter, D.C. to perform the treatment and acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given to me.

Date

Patient Printed Name

Patient Signature

Signature of Parent or Guardian if Minor

Advanced Chiropractic and Neurology, P.C.

8825 S. 117th Street
La Vista, NE 68128
Telephone: (402) 597-2869
Fax: (402) 597-2536

Please take home the remaining portion of this paperwork as it is information for you.

Insurance information. For those of you fortunate enough to have chiropractic benefits on your insurance policy, we will file those claims as a service to you. Many times we will call to verify coverage by the time your first appointment is over or the same day as your first appointment. Many times the insurance companies do not give us details of your coverage in a complete and/or proper disclosure. We don't understand the reason for it, that is just the way they operate. Therefore after your first billing more or, as is more often the case, less than the total that you and we had thought covered will be. Please do not become alarmed when you receive an explanation of benefits (EOB) from the insurance company as many times we have not had any prior knowledge of what was covered. Every insurance plan is different so it is difficult to say that United Health Care, for example, will pay for all, part, or none of certain services that we provide. Please feel free to call the office at any time to discuss this. Dr. McClaren and staff are more than willing to accommodate any financial arrangements that need to be made in order that care will be maintained as appropriate for your case in the event that coverage is not adequate for your needs. Communication about your health care is very important to us and we wish to serve you as best as possible.

Here are codes that we commonly will bill for an office visit:

99203- a new patient examination- this is a one time charge.

98940, 98941, 98942- these are codes that show you have had your spine adjusted on this office visit.

98943- this is a code that is used whenever the rib cage, TMJ, clavicle, 1st rib, knees, wrists, and elbows are adjusted.

97112- this is a therapy code that refers to muscle work that is performed during an office visit

97140- a different code for muscle work and for trigger point therapy performed.

97110- this code is used for neurological rehab, flexion distraction therapy, or others not included in the above services

97014, 97035, 97032, 97010- these are used to cover modalities like hot packs, ultrasound, or electrical current therapy.

If you wonder during a visit which service Dr. McClaren is performing, please feel free to ask as it is fully within your rights to do so. Remember, Dr. McClaren prides himself on being able to spend more time with you during your office visits. The average chiropractic visit within the Omaha area lasts 3-5 minutes. Dr. McClaren will typically spend at least 15 minutes with you each visit. This is how he is able to serve and help those of you who have had other health care providers that may not have been able to do so. Dr. McClaren will openly discuss any procedure you are having performed and his reason for feeling it is necessary to your case.

Treatment Information.

Chiropractic

Chiropractic was founded in 1895 by D.D. Palmer. Since then it has grown and evolved. Conventional chiropractic uses adjusting the spine to allow the individual receiving the adjustment to better cope with their environment. D.D. believed that when the spine was correct in alignment, the body would be correct in the environment. Chiropractic has had great success in the last 108 years with many problems that have had no other source of treatment or cure.

The Chiropractic Education

Chiropractic physicians attend an undergraduate program with the same prerequisites as medical schools require. This includes 90 hours of undergraduate credit, specifically a minimum of 8 hours biology, 12 hours chemistry, 14 hours physics, 8 hours psychology, and other varied political science and liberal arts hours.

Chiropractic College is a four-year program that is comparable to medical school. The number of hours the chiropractic physician has spent in physiology, anatomy, biochemistry, and histology is higher than the number of hours the medical doctor has. Chiropractic physicians also have a full year of internship before they graduate from Chiropractic College in order to gain clinical experience.

Chiropractic Neurology

Dr. Ted Carrick founded the Chiropractic Neurology program with the idea that a higher clinical understanding of the human body and all of its systems could be gained through windows in the nervous system. Since the nervous system is the master system of the

body, as defined by *Gray's Anatomy*, one who successfully treats the nervous system can have success with disorders of the entire body. The nervous system controls all and therefore has a hand in all. Treatment of the nervous system is the key to chiropractic neurology.

Chiropractic Neurology and Your Treatment

The nervous system works via three mechanisms: feedback, feedforward, and efferent copy.

As said above, conventional chiropractic adjusts the spine in order to help the individual better adapt to their environment. This is the use of a feedback mechanism. Feedback uses input from the body into the nervous system. This includes adjusting the spine and extremities, stretching muscles and massage, most electrotherapies, and head tilts and so on. All of these modalities are used in this office.

Feedforward utilizes input to the cerebral cortex from the cerebellum. These structures regulate virtually every function in your entire body and so utilizing these in treatment can have a profound effect on the outcome of your condition. An example of feedforward is eye exercises appropriate to your case. Feedforward modalities are also a cornerstone of treatment in this office.

Efferent copy utilizes input from the cerebral cortex to the cerebellum and, thus, the body. This is another very powerful mechanism by which the nervous system works. Citations for this have even begun to work their way into mainstream media. The March issue of *Self* magazine has even cited efferent copy as effective in an individual's health. An example of efferent copy would be cognitive exercises.

Chiropractic Neurology and Head Injuries

Chiropractic Neurologists are qualified on the same level as medical neurologists for the diagnosis of head injuries and the level of impairment they may cause the individual. The difference lies in treatment. Neurosurgery has a very high risk to outcome ratio. Few medications truly work in the treatment of head injuries as most popular medications such as Prozac and Paxil actually result in a decrease in brain activity. The Chiropractic Neurologist via feedback, feedforward, and efferent copy mechanisms increases brain activity, an element essential to the successful outcome in management of head injuries. The diagnostic skills the Chiropractic Neurologist acquires provide knowledge of what level of stimulation is appropriate for the individual to further increase the likelihood of a full recovery.

Chiropractic Neurology and Musculoskeletal Injuries

Since Chiropractic Neurology allows more diagnostic and treatment options, the outcome of musculoskeletal injuries is also increased in that more progress is made during each visit. This includes back and neck injuries as well as injuries to the extremities.

Rehabilitative procedures that take into account the presentation of the entire patient, rather than treating the site of injury segmentally are essential to the smooth and efficient recovery of musculoskeletal injuries. Since the nervous system is intimately related to the musculoskeletal system, Chiropractic Neurology excels in the treatment of musculoskeletal injuries.

Chiropractic Neurology and Pain

The perception of pain is a very intimate experience. No two people experience or react to pain in the same way. Therefore tracking pain is not a good way to follow the progress of your case. It is very possible you will be out of pain very quickly. Until the proper neuroplasticity is built within your nervous system treatment should continue, no matter your level of pain or lack thereof. It is absolutely essential to your health to continue with the recommended course of care no matter how good or bad you feel. The neurological exam is paramount to gauging your progress and you will continue to be evaluated on every office visit to make sure your case is progressing appropriately and that the care of a Chiropractic Neurologist is right for you.

Concept of Neuroplasticity

This concept is very similar to strength of a muscle. The more one works out, say for example their biceps, the bigger and stronger the biceps will be. The same can be said for neurons and neuronal tissues. This concept explains why chiropractic requires more than one visit in most cases to resolve a patient's problems. Since chiropractic neurology utilizes feedback, feedforward, and efferent copy mechanisms, the neuroplasticity in systems gained from treatment is higher than the use of only one mechanism.

Missed appointments

Missed appointments are much the same as missed workouts in that if one misses workouts, say for example again the biceps, the biceps will become weaker and smaller and not function as well. The same occurs with the nervous system. If a patient misses appointments, they are jeopardizing their opportunity to develop neuroplasticity and resolve their condition.