New Member Intake and Financial Policies
Dr. Brandon Crawford, DC
&
Associates

Today's Date: _____

Name: _____ DOB: _____ Age: _____

Address: _____ State, zip code :_____

Best phone #: _____ Can we text you at this #? ☐ Yes / ☐ No

Best email: _____ Can we email you? ☐ Yes / ☐ No

From herein the collective term of "Dr. Brandon Crawford, DC & Associates" refers to Dr. Brandon Crawford, DC and any staff member that is employed or contracted to help with patient care.

Initial:_____ I authorize Dr. Brandon Crawford, DC & Associates to contact me via phone, text, or email. Contact purposes are typically, but not limited to being informative in nature – appointment reminders and/or info about closings and important dates. On occasion I may send notification about current research or goings on in the field of Chiropractic, Functional Neurology, Functional Endocrinology, or health in general. Dr. Crawford will also use these contacts to follow up when that is necessary. Your contact info will never be sold or solicited. I authorize Dr. Crawford & Associates to utilize his email bcrawforddc@gmail.com and / or austinbraindc@gmail.com, and/or his phone (512) 659-7449 to call or text, to contact me when needed.

Initial:_____ I understand that Dr. Brandon Crawford, DC & Associates will not in any way bill my insurance, *nor will they give billing codes for reimbursement from insurance*. I understand that I am responsible for full payment for any service at the time of service, unless otherwise agreed upon. I agree that if an invoice is emailed or mailed after the service that I will submit payment in full within 7 days of receiving the invoice, unless otherwise agreed upon. If payment is not received within 7 days Dr. Brandon Crawford, DC & Associates may begin collection procedures if deemed necessary and / or begin to add 5% interest to the uncollected balance per month from the date of service.

Initial:_____ I fully acknowledge that Dr. Brandon Crawford, DC & Associates will enforce a cancellation policy if I fail to cancel my appointment **less** than 14 days in advance. The policy is as detailed below:

- If appointment is canceled between days 8-14 days before the appointment a 50% cancellation fee may be collected.
- If appointment is canceled between days 0-7 days before the appointment a 100% cancellation fee may be collected.
- If you do not show up at your scheduled appointment, your card will be charged for 100% of the scheduled appointment fee.

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Initial:_____ Based on the details noted above, I authorize Dr. Brandon Crawford, DC & Associates to charge the credit card given below for the amount dictated per the guidelines above.

Credit Card info:

Type of card:

Card Number: _____

Card Expiration Date: _____ Security Code: _____

Address for card: _____

Name as appears on card: _____

Initial:_____ I have read or been given the chance to read over the HIPPA guidelines (posted on the website).

Initial:_____ I agree to allow Dr. Brandon Crawford, DC & Associates to obtain and/or send medical information as deemed medically necessary for my care. I also agree to allow Dr. Brandon Crawford, DC & Associates to consult with providers that I am seeing or have seen as needed for my care.

Media Release:

Initial:_____ I authorize Dr. Brandon Crawford, DC & Associates to use various photos and videos as deemed necessary for educational and academic purposes. Mediums that these photos and videos may be used on include but may not be limited to: lectures and social media (Brandon Crawford's Face Book page & @bcrawforddc Instagram page). Due to the nature of what we do in the office it is important that people see and understand this new form of healthcare. Our goal with any information shared is to further the understanding of functional neurology, laser therapy, chiropractic, and other modalities or methods utilized. All photos and videos will be tactful.

By signing below you agree that you have read and agree to all terms stated within this document. You agree that you have been given time to review and ask questions regarding this information.

Signature: _____ **Date:** _____

Informed Consent
Dr. Brandon Crawford, DC
&
Associates

This document serves to inform you about potential risks that can be associated with care in our office. Please read and ask questions as needed. Dr. Brandon Crawford, DC is licensed as a Chiropractor in the state of Texas and in the United Arab Emirates. Dr. Crawford has pursued post graduate courses in neuroscience from the Carrick Institute of Graduate Studies, the International Association of Functional Neurology and Rehab, and other educational platforms. Dr. Crawford is currently a board eligible Functional Neurologist with a focus in Developmental Functional Neurology. Dr. Crawford currently teaches Developmental Functional Neurology to various groups around the world. Dr. Crawford is considered a leading expert in the field of photobiomodulation (the use of laser and light therapy to improve one's health). With that being said, please read each statement accordingly:

Dr. Brandon Crawford, DC & Associates will not claim to treat or cure any medical conditions, but rather will attempt to restore balance and function to your health and wellness. This process may include: Examinations, Chiropractic adjustments, functional neurology assessments and therapies, music / acoustic therapy, color / light therapy, vestibular rehab, physical therapy exercises, muscle work (muscle stripping, massage, stretching, rehab), supplemental recommendations, diet alteration, blood chemistries, stool samples, saliva samples, various intake forms, and other methods and modalities may be used as well.

If any dietary or supplemental recommendations are made by Dr. Brandon Crawford, DC & Associates we do recommend that you bring these recommendations to your medical providers before beginning. Any recommendations made are not intended to diagnose, treat, cure or manage any medical condition.

Chiropractic and Functional Neurology comprise various methods of establishing balance within one's body. The methods that Dr. Brandon Crawford, DC & Associates utilizes should not replace that of traditional medical approaches, and it is always advised that anyone under our care should follow up with their medical providers to discuss any care recommendations. At times, an adjustment/manipulation/fast stretch may be performed to help improve your function and eliminate the effects of vertebral subluxation. Risks associated with this type of care can include but is not limited to: sprain/strain injury, fracture, headache, or dizziness. There are very rare occurrences when stroke has been linked to an adjustment - many studies have been performed on this topic, some try to demonstrate a very weak association, but most studies show that chiropractic manipulations are not directly linked to this type of injury. The methods that Dr. Crawford utilizes minimize all the above mentioned risks. Historically Chiropractic is a very safe and effective means to achieve a more optimal state of health and wellness. In this practice Dr. Crawford will need to perform an exam prior to commenting on the state of your health and prior to making any recommendations.

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Dr. Brandon Crawford, DC & Associates may use various types of photobiomodulation during your appointments. This will involve the use of a laser / light. Laser therapy has been heavily researched and proven safe and effective for many different conditions over the past several decades. We do not claim to treat, cure, manage, or diagnose any medical condition with photobiomodulation. We are simply improving the overall function of your body via the various proven effects of the laser / light therapy.

Dr. Brandon Crawford, DC & Associates acknowledges the scope of Chiropractic in the state of Texas is very limited and we will stay within this scope of practice. All therapies and procedures performed will be geared toward the following goals: to reduce the effects of the vertebral subluxation complex via various reflexogenic systems, to establish balance within your body, and to improve your overall health and wellness.

If you have any concerns or reservations prior to care with Dr. Brandon Crawford, DC & Associates please do not hesitate to ask. If you ever experience something that causes any concern please discuss the matter with us immediately.

By signing below you acknowledge that you have fully read or have had the chance to read all information contained within this document and have had an opportunity to ask any about any questions or concerns and are in agreement with these terms and information.

Signature: _____ Date: _____

Child's Name: _____ Age: _____ Gender: _____
Date of Birth: _____
Mother's & Father's Name: _____

HISTORY

1. Formal Diagnosis?
   _____
   _____
   _____

2. Chief complaints in order of importance (1-5)
   1) _____
   2) _____
   3) _____
   4) _____
   5) _____

3. Pregnancy and Delivery Complications?
   _____
   _____

4. Breast feeding in hospital was formula supplemented?
   Any issues early on ☐sucking ☐illness ☐eczema ☐other? _____
   _____
   _____
   _____
   _____

5. Development at home, breast fed? When was food supplemented? Any dairy based products introduced? And problems with feeding, reflux etc.?
   _____
   _____
   _____

6. Any immune issues, first or now? ☐Eczema ☐asthma ☐allergies ☐infections?
   _____
   _____

7. Any sleeping issues first or now? _____

8. Parents relationship, married, live together? _____

9. Developmental milestones? When did they walk alone? When did they talk?
   How many words do they speak now?
   _____
   _____
   _____

10. Verbal vs. Non-verbal communication? Eye contact, joint attention?
    Do they look in a mirror? Recognize or know body parts? Do they care about their appearance, clothes etc.?
    _____
    _____
    _____

11. Do they have friends, do they play with other kids? _____
    Where are they in school, what grade? _____

12. Do they know ☐letters ☐numbers ☐colors ☐shapes? _____

13. Do they read at all? Can they do Math? Do they ☐write ☐color or ☐draw?
    _____
    _____

14. Is there any learning disability in school? What are the most difficult subjects?
    _____
    _____

15. What are the best subjects for the child? _____

16. Any emotional issues, tantrums etc.? _____

17. Any major sensory issues, hyper, hyposensitivities? _____

18. Do they feel pain? _____

19. Are they a picky eater? Any food preferences? What do they drink?
    ☐Gluten Free ☐Dairy Free ☐Soy Free ☐Other _____
    _____
    _____

20. Do they have a sense of smell or taste? _____

21. What does muscle tone and motor activity look like? What is hand, foot dominance? When? _____
    _____

22. Any obvious balance issues, motion sickness, afraid of high places? Does she spin herself, get dizzy? _____
    _____

23 Any stims or tics? Any OCD behaviors? _____

24. Any unusually strong skills? ☐Early reading ☐memorizing songs ☐memory for details or ☐locations ☐other? _____
    _____
    _____
    _____

25. Bowel movements, toileting issues Before and Now? _____
_____

26. Parents jobs, personalities ☐extrovert ☐Introvert ☐creative ☐logical ☐linear ☐other _____
Parents' health and development? Parents' dominance profile?
_____
_____
_____

27. Any family or genetic history of Physical or mental health issues, learning challenges
What does the child like to do during the day for playtime? How much computer screen time? _____
_____
_____

28. Do they prefer to be ☐outdoor or ☐indoors? _____

29. What treatments or tests?
☐Blood Tests ☐MRI ☐Genetic ☐Metabolic ☐EEG ☐IQ ☐Allergy?
_____
_____

30. Has any treatments helped? What has been the most effective?
_____
_____

31. How did they come aware of my work? Have they read Disconnected Kids? Have they tried any of the treatments or therapies and if so, describe?
_____
_____
_____
_____

32. What are your goals you wish to accomplish for your child?
_____
_____
_____

33. What type of vaccine schedule has been used?
_____
_____

34. Were there any vaccines given during the pregnancy? Yes/No, if so which ones?
_____
_____

35. When/what was the most recent vaccination?
_____
_____

36. Have you ever witnessed a vaccine reaction that you know of? ☐ yes / ☐ no

37. Has there been a routine medical check-up in the last 12 months? ☐ yes / ☐ no

38. Has there been any psychological or educational testing done? ☐ yes / ☐ no