MEDTRAK DIAGNOSTICS AT
HENDERSON, NEVADA
400 N. STEPHANIE ST SUITE 225 HENDERSON NV 89014

PATIENT: _____ DATE: _____
PRINT NAME

ADDRESS: _____ _____ _____ _____
NUMBER CITY STATE ZIP

PHONE: _____ Email:___ _____

GENDER: _____ HEIGHT: _____ WEIGHT: _____ AGE: _____

DATE OF ACCIDENT: _____ DATE OF BIRTH: _____
aka: DOL aka: DOB

ATTORNEY OR CASE MANAGER NAME:_____PHONE #:_____

ATTORNEY LAW FIRM NAME:_____FAX #:_____

ATTORNEY/LAW FIRM ADDRESS:_____

For this incident, did you lose consciousness? Definitely Yes _____ Not sure _____

For this incident, did you go to a hospital? Yes immediately _____ Yes later _____ No____

For this incident, who was the first doctor you saw:

Doctor's Name:_____ Doctor's phone:_____

For this incident, name any other doctor you have seen:

Doctor's Name:_____ Doctor's phone_____
Print

Doctor's Name:_____ Doctor's phone_____
Print

For this incident, have you had any treatment from a chiropractor: Yes_____ No _____

Chiropractor's Name:_____ Chiropractors phone_____
Print

For this incident, have you had any treatment from a physical therapist: Yes_____ No _____

Therapist's Name:_____ Therapist's phone:_____
Print

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HAS ANY HEALTHCARE PROVIDER EVER DIAGNOSED YOU AS HAVING HAD ACONCUSSION **PRIOR** TO THIS INCIDENT? _____ YES _____ NO

IF YES, IN THE PAST 12 MONTHS, WERE YOU SEEKING ANY MEDICAL ADVICE OR ANY TREATMENT FOR THAT PRIOR CONCUSSION? _____ YES _____ NO

IF YES, PLEASE FULLY DESCRIBE:_____

_____

HAVE YOU TAKEN ANY MEDICATIONS IN THE **LAST 24 HOURS**? _____ YES _____ NO

IF YES, WHAT DID YOU TAKE? _____

HAVE YOU HAD ANY ALCOHOL IN THE **LAST 24 HOURS**? _____ YES _____ NO

IF YES: HOW MUCH? _____

HAVE YOU EATEN A BIG MEAL IN THE **LAST 2 HOURS**? _____ YES _____ NO

HAVE YOU HAD ANY FORM OF MARIJUNA IN THE **LAST 24 HOURS**? _____ YES _____ NO

HAVE YOU EVER HAD A TORN EAR DRUM? _____ YES _____ NO

IF YES: LEFT ____ RIGHT ____ BOTH ____ HAS IT HEALED? _____ YES _____ NO

For this incident:

TYPE OF ACCIDENT: ____ _____ _____ _____ _____ _____
Check all of the appropriate: CAR I was DRIVER or PASSENGER or PEDESTRIAN WORK OTHER

DESCRIBE THE INCIDENT_____

_____

DESCRIBE YOUR INJURIES_____

_____

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SUBJECTIVE COMPLAINTS

Patient_____ Date:_____
Print Name

Have you developed any of the following symptoms or complaints at any time since this incident?

	Yes	No
Anxiety	_____	_____
Balance problems	_____	_____
Being easily distracted	_____	_____
Blurred vision	_____	_____
Cervical (neck) pain and muscle spasm	_____	_____
Confusion	_____	_____
Depression	_____	_____
Difficulty multi-tasking	_____	_____
Difficulty reading	_____	_____
Difficulty with maintaining focus	_____	_____
Diminished attention span	_____	_____
Diminished ability to concentrate	_____	_____
Difficulty carrying on conversations and tasks	_____	_____
Diminished smell	_____	_____
Diminished taste	_____	_____
Dizziness	_____	_____

SUBJECTIVE COMPLAINTS

Patient Name:_____Date:_____
_

	Yes	No
Facial muscle weakness	_____	_____
Fatigue	_____	_____
Fear of falling	_____	_____
Feeling frustrated	_____	_____
Feeling off balance in the shower	_____	_____
Headaches	_____	_____
Hearing loss	_____	_____
Interrupted sleep	_____	_____
Lightheadedness	_____	_____
Memory problems	_____	_____
Mood swings	_____	_____
Multiple musculoskeletal issues	_____	_____
Multiple neurological issues	_____	_____
Nausea	_____	_____
Positional transfer difficulties	_____	_____
Restlessness	_____	_____
Ringing in the ears	_____	_____
Sensitivity to light	_____	_____
Sensitivity to sound	_____	_____
Taking longer to think	_____	_____
Word finding issues	_____	_____

Patient/Surrogate Signature: _____ Patient **Date of Birth**_____
DOB

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Patient Consent for Videonystagmography (VNG) Balance Plate and Neurocognitive Testing & Authorization to Release/Receive Medical or Other Information

Patient: _____Date:_____

I hereby authorize representatives of MedTrak Diagnostics, Inc. to perform VNG testing, balance plate testing and neurocognitive testing on me.

My physician has explained to me that these procedures are necessary to assist my physician in diagnosing my condition and I understand the nature of the testing procedures.

For the VNG test:
In order to monitor the motions of my eyes in response to various types of stimulation, (following visual cues, tilting, turning of head and body, placement in different body positions, and the response to warm and cold air or water instilled in either ear) infrared goggles are placed around the eyes.

For the Balance Plate test:
In order to measure my balance and coordination, I will stand on a balance plate and/or pad and perform specific standing and movement activities.

For the neurocognitive test:
In order to measure my general cognitive abilities, I will perform certain neuropsychological tests on a computer or i-pad (such as memory tests, executive function/stimulus control, selective attention, sustained attention and symbol recall…)

I understand that VNG tests, balance plate testing and the neurocognitive testing are all non-invasive, and only minor discomfort may be experienced during the VNG testing as a result of wearing goggles.

I understand that I may experience temporary dizziness, vertigo, and in rare cases nausea or vomiting.

I have made my doctor aware of any medical condition that may affect or even interfere with certain aspects of the testing procedure.

Additionally, I hereby authorize MedTrak Diagnostics, Inc. and its affiliates to release and/or receive any and all documentation, including but not limited to, medical history and reports and coverage information pertaining to applicable health insurance.

Patient
Patient/Surrogate Signature: _____Date of Birth: _____

Tester Technician: _____

PATIENT LIEN / ATTORNEY LETTER OF PROTECTION / ASSIGNMENT OF BENEFITS AGREEMENT

PROVIDER: **MEDTRAK DIAGNOSTICS, INC. 1372 River Spey Ave, Henderson, NV 89012 347-742-4100**

*PATIENT NAME*_____ *DOL*_____ *DOB*_____
Date of this injury Date of Birth

*PATIENT ADDRESS*_____ Phone_____

Attorney Name_____ *Attorney Phone*_____

Attorney Address_____ Fax_____

I do hereby authorize and direct the above named provider to furnish my attorney with all reports, findings, interpretations, impression, diagnosis, etc. of any and all diagnostic studies that you may perform on me, including those studies performed in connection with any accident in which I was involved.

I hereby authorize and direct my attorney, who is identified above, as well as any subsequent attorney I may obtain in addition to or replacement of my above identified attorney, to pay directly to the above named provider all amounts that may be due and owing for medical services rendered to me both in connection with the accident in which I was involved and amounts owed by me for services unrelated to the accident. I hereby authorize and direct my attorney (as well as any future attorneys) to withhold from any settlement, judgment, verdict, or other economic recovery I may receive such amounts as are necessary to adequately protect the above named provider. I understand that, by this agreement, I am giving the above named provider a lien on any settlement, judgment, verdict, or other economic recovery I may obtain in my case, including any amounts held by my attorney that are payable to me.

I fully understand that, notwithstanding this agreement, I am directly and fully responsible to the above named provider for all medical bills associated with the services provided to me and this agreement is made solely for additional protection and in consideration of the provider agreeing to awaiting payment. I understand that this agreement tolls any laws that limit the time for the provider to take action to collect amounts I may owe for the services provided and that my obligations to pay the same are not contingent on my receiving any recovery in my case. I further understand and agree this agreement is not a payment arrangement with respect to the satisfaction of my account whatsoever.

I do hereby authorize my attorney to communicate with the above named provider (or provider's assignee) concerning the status of me and my case and direct my attorney to answer all questions that may be asked concerning me or my case. I agree to notify, and hereby direct my attorney to notify, the above named provider (or provider's assignee) if I change attorney representation. I agree to notify, and hereby direct my attorney to notify, the provider (or provider's assignee) in writing within 2 weeks of the settlement of my case. Further, if my case settles for less than the anticipated amount and/or my attorney determines that it will be impossible to pay provider in full for all medical services rendered, I hereby authorize my attorney to provide to provider (or provider's assignee) a breakdown of the total settlement amount, along with all costs, fees, or other expenses to be paid from the settlement proceeds, to allow provider (and/or provider's assignee) to make an informed decision on whether to accept less than the total charges billed for my services.

I had a chance to inquire into the provider's fees and I acknowledge that the provider's charges for its services are fair and reasonable and that the same appropriately reflect the provider's risk of waiting for its payment until my case is resolved. I further acknowledge that this agreement is an agreement that provides collateral for the amounts I owe with respect to the services rendered to me and does not constitute a payment arrangement or other agreement regarding the payment of any amounts I may owe with respect to services rendered to me. I hereby authorize the provider to assign my account receivable and to provide copies of all my records relating to the assigned portion of my account receivable to the assignee. I understand and agree that any assignee of the provider is entitled to all of the rights and privileges provided to the provider by this agreement. I understand that such an assignment will not affect my obligations or my attorney's obligations under, or the consents I am giving in, this agreement.

If there is a controversy or claim (each a "Dispute") arising from or otherwise relating to the terms of this agreement, I hereby consent and agree that such Dispute will be resolved through binding arbitration in the county and state where provider is located, with the American Arbitration Association ("AAA") before a single arbitrator. Such arbitrator shall award attorneys' fees and costs to the prevailing party.

_____ _____ _____
DATE PATIENT'S SIGNATURE PRINT NAME

The undersigned being the attorney of record for the above patient does hereby agree to honor the above lien, and agrees to withhold such sums for any settlement, judgment or verdict as may be necessary to adequately protect the above provider.

_____ _____ _____
DATE ATTORNEY'S SIGNATURE PRINT NAME

Attorney: Please date, sign and return one copy to the healthcare provider. Keep one copy for your own records.

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Patient Name:_____ Date:_____

Fukuda Test: **Pass _____** **Fail _____**

For Fail: Turns Left _____ Turns Right _____Moves Forward _____

Romberg Test: **Pass _____** **Fail _____**

For Fail: off balance: Left _____ Right _____ Forward _____ Backward _____

Eye dysconjugacy: **Observed _____** **Not observed _____**

Near Point Convergence Test: **Normal _____** **Abnormal _____**

Convergence insufficiency is considered abnormal when double vison occurs with the object at 10cm or greater from the patients nose.

Grip Strength: R: Strong___ Avg___ Weak___

L: Strong___ Avg___ Weak___

INVOLVED SIDE _____ **PREFERRED SIDE _____**