BrainCARE

Concussion ◆ Assessment ◆ Recovery ◆ Education

(MICHAEL LEWIS MD LLC)

Required*

PATIENT CONTACT INFORMATION

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐

First Name*

Middle Name/Initial

Last Name*

Date of Birth*

Gender* Male ☐ Female ☐

Marital Status

Single ☐ Married ☐ Divorced ☐ Other ☐

HOME ADDRESS

Address

City

State

Zip Code

Home Phone

Mobile Phone*

Email*

EMERGENCY CONTACT INFORMATION

Name

Relationship

Phone

Email

Occupation

Company/School/Grade

Referred By

PREFERRED PHARMACY

Pharmacy Name*

Phone*

Address

City

State

Zip Code

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braincareclinic@gmail.com

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MICHAEL LEWIS MD LLC

CONSENT TO TREATMENT

I hereby consent to receive and take part in the treatment provided by Dr. Michael Lewis. I understand that developing a treatment plan with this physician and regularly reviewing our work toward meeting the treatment goals is in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this physician. I understand that Dr. Lewis may prescribe or recommend treatments and/or therapies that are not considered standard of practice as recognized by state or federal medical guidelines and, subsequently, are likely not to be reimbursable by insurance plans. Treatment recommendations may be considered off label use of products.

I am aware that this consent is voluntary and I may stop my treatment with this physician at any time. The only thing I will still be responsible for is paying for the services I have already received.

YOUR HEALTH INFORMATION RIGHTS: Unless otherwise required by law your health record is the physical property of the healthcare practitioner or facility that compiled it; the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect, and obtain a copy of your health record. You may obtain an accounting of disclosures of your health information, request communications of your health information by alternative means or at alternative locations, revoke your authorization to use or disclose health information except to the extent that actions has already been taken.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I understand that payment for services is due, in full, at the time of service. I understand the fee structure, and accept responsibility for payment.

My signature below shows that I understand and agree with all of the aforementioned statements.

_____ _____

Signature of patient (or patient representative/guardian) Date

_____

Printed name (Relationship to patient if applicable)

I, the physician, have discussed the issues above with the patient (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of Michael Lewis, MD Date

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CONCUSSION PATIENT – INITIAL VISIT

NAME: _____DATE OF BIRTH:_____ CURRENT DATE:_____

*****PLEASE COMPLETE THE 22 QUESTION BRAIN HEALTH SYMPTOM INVENTORY*****

DATE/TIME OF HEAD INJURY:

PLEASE DESCRIBE IN DETAIL HOW THE HEAD INJURY OCCURRED.

(CIRCLE YES / NO) DID YOU LOSE CONSCIOUSNESS, IF SO, FOR HOW LONG?

WHAT WERE YOUR INITIAL SYMPTOMS:

(CIRCLE YES / NO) WERE YOU SEEN AT URGENT CARE, EMERGENCY ROOM, OR HOSPITAL? IF YES, WHERE? WHAT WAS DONE THERE? WERE YOU HOSPITALIZED OVERNIGHT/HOW LONG?

WHAT SYMPTOMS/PROBLEMS HAVE YOU BEEN HAVING SINCE THE INITIAL INJURY?

WHAT IS YOUR MAIN COMPLAINT(S) TODAY?

COMPARED TO BEFORE THE INJURY, HOW ARE YOU DOING TODAY: _____% OUT OF 100%

HOW MUCH BETTER SINCE THE INITIAL INJURY: _____%

(CIRCLE YES / NO) HAVE YOU EVER SUFFERED ANY OTHER HEAD INJURIES PRIOR TO THE CURRENT INJURY? IF YES, WHEN DID THIS HAPPEN? WAS IT SPORTS RELATED? WHAT TYPE OF TREATMENT, IF ANY, WAS DONE?

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NAME: _____ CURRENT DATE:_____

(CIRCLE YES / NO) DO YOU NOW OR HAVE YOU EVER PLAYED A CONTACT SPORT SUCH AS IN HIGH SCHOOL, COLLEGE, ETC? IF SO, WHAT TYPE OF SPORT? WHAT POSITION DID YOU PLAY? WERE YOU EVER TREATED FOR A CONCUSSION?

(CIRCLE YES / NO) ARE YOU A MILITARY VETERAN: WHICH BRANCH; ENTRY DATE; SIGNIFICANT TRAINING (AIRBORNE, BUDS/SEAL, SF-Q) DEPLOYMENTS TO ACTIVE WARZONES IN WHAT CAPACITY; ANY INJURIES NOT COVERED ABOVE; ETS/LOS RETIREMENT/MEDICALLY RETIRED? % DISABILITY RATING (DOD OR VA)?

WHAT IS YOUR CURRENT VOCATION/PROFESSION/GRADE IN SCHOOL?

HAS THIS HEAD INJURY AFFECTED YOUR ABILITY TO FUNCTION AT WORK/SCHOOL?

WHAT ARE YOUR CURRENT STRESS LEVELS AT HOME/WORK/SCHOOL?

PLEASE LIST ALL PAST MEDICAL HISTORY. □ NONE

SURGICAL HISTORY (LIST OPERATIONS) □ NONE

PLEASE LIST MEDICATIONS CURRENTLY TAKING: □ NONE

PLEASE LIST SUPPLEMENTS CURRENTLY TAKING: □ NONE

PLEASE LIST ANY THERAPY, TREATMENTS, MEDICATIONS, SUPPLEMENTS YOU HAVE TRIED AND STOPPED. PLEASE EXPLAIN THE REASON FOR STOPPING.

NAME: _____ CURRENT DATE:_____

(CIRCLE YES / NO) TOBACCO USE (IF SO, HOW MUCH?)

(CIRCLE YES / NO) ALCOHOL USE (IF SO, HOW MUCH?)

(CIRCLE YES / NO) CANNABIS USE (IF SO, HOW MUCH?)

HOW WOULD YOU DESCRIBE YOUR DIET/DAILY EATING HABITS?:

HOW WOULD YOU DESCRIBE YOUR DAILY EXERCISE HABITS (HOW MUCH/HOW OFTEN/WHAT INTENSITY):

WHAT DO YOU LIKE TO DO TO KEEP YOUR BRAIN COGNITIVELY ACTIVE?

ANY OTHER INFORMATION YOU BELIEVE I SHOULD KNOW THAT WILL HELP ME BE A BETTER PARTNER WITH YOU IN YOUR HEALTHCARE AND RECOVERY.

MOST IMPORTANTLY, WHAT ARE YOUR GOALS? WHAT DOES SUCCESS LOOK LIKE FOR YOU? WHAT DO YOU HOPE TO GET OUT OF OUR DOCTOR-PATIENT RELATIONSHIP?

Brain Health Symptom Inventory

Name:	Email:
Current Date:	**Date of last injury:**

Rating - Place an "X" the appropriate box for each of the 22 rows

0 None: Rarely if ever present. Not a concern.

1-2 Mild: Occasionally present, but does really not disrupt activities. A little concern for me.

3-4 Moderate: Often present, disrupts activities, but still function. Can't do complicated tasks or activities. I am concerned.

5-6 Severe: Frequently to almost always present and disrupts activities. Cannot function without help. I'm very concerned.

		None	Mild		Moderate		Severe	
		0	1	2	3	4	5	6
1	Headaches							
2	Feeling dizzy, loss of balance, coordination problems							
3	Vision problems, blurring, trouble seeing							
4	Sensitivity to light							
5	Hearing difficulty, sensitivity to noise							
6	Ringing in the ears							
7	Change in taste and/or smell							
8	Not able to think clearly, feeling mentally "foggy"							
9	Problems with confusion, easily confused							
10	Feeling depressed or sad							
11	Emotional withdrawal							
12	Feeling anxious or tense, nervousness							
13	Irritability, easily annoyed, temper outbursts, hostility							
14	Feeling easily overwhelmed by things							
15	Feeling more emotional							
16	Fatigue, loss of energy, getting tired easily, drowsiness							
17	Difficulty concentrating, can't pay attention, easily distracted							
18	Difficulty remembering things, forgetfulness, memory concerns							
19	Difficulty making decisions							
20	Difficulty reading							
21	Insomnia; difficulty falling or staying asleep							
22	Libido issues/concerns with desire or functioning							
	Count the Number of Times Answered in This Column:	**0**						
	Multiply by the Number in This Column:							
	Total Score in This Column:	**0**						

TOTAL SCORE - ADDING ALL COLUMN TOTALS ABOVE:

Complete this form by checking a box for all 22 questions and follow the directions to reach a TOTAL SCORE

This form is informational only. It is not intended to diagnose or treat any condition or disease. If you have any concerns about your scores or your recovery following a concussion, TBI, or head injury, please contact your healthcare provider.

Michael D. Lewis, MD, MPH, MBA, FACPM, FACN
Colonel (Retired), U.S. Army

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