FxN FUNCTIONAL NEUROLOGY RELIEF FOUNDATION

Patient Information Sheet

***Attention*: Please fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.**

Social Security#

First Name: **Last Name:** **Middle Initial:**

Date of Birth: (MM/DD/YYYY) _____ / _____ / _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address: **Apt.#:** **City:** **State:** **Zip:**

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Emergency Contact:

Emergency Telephone#: (_____) _____

Employer Name: **Occupation:**

Ref Dr: **Ref Dr's Add / City / State / Zip** **Ref Dr NPI #**

Primary Care Physician: **PCP Add / City / State / Zip** **PCP NPI #**

PHYSICIAN'S USE ONLY Medical Diagnosis

Select all that apply:

- ☐ Autism Spectrum Disorder (ASD)
- ☐ Attention Deficit Disorder (ADHD)
- ☐ Learning Disabilities
- ☐ Concussion
- ☐ Chronic Pain
- ☐ Migraines
- ☐ Movement Disorders

Can the patient walk on their own?

☐ Yes ☐ No ☐ Very Little

Can the patient talk and form clear and consise sentences and thoughts?

☐ Yes ☐ No ☐ Very Little

Physician Signature: _____ Date: _____

PHYSICIAN'S USE ONLY Medical History

Select all that apply:

When was the primary inncident that caused the injury to the patient?

Date: _____ / _____ / _____

Did the injury happen during birth or was caused by any type of congenital birth defect?

☐ Yes ☐ No

What was the primary type of trauma? Select all that apply:

- ☐ Acute Trauma
- ☐ Chronic Trauma
- ☐ Complex Trauma

Physician Signature: _____ Date: _____

PHYSICIAN'S USE ONLY

PHYSICIAN'S USE ONLY

Responsible Party Information – *Please complete if the responsible is not the Patient requesting services, and/or the Patient is under 18 years of age.*

Responsible Party's Name (Last / First):

Responsible Party's SSN: _____-_____-_____

Relationship to Responsible Party: ☐Self ☐Spouse ☐Child ☐Other

Responsible Party's Address / City / State / Zip:

FINANCIAL POLICY

I hereby authorize the release of any medical information necessary to process this claim.

By signing below, I acknowledge and agree to abide by all FXN policies and procedures. I also acknowledge that financial services are only granted to applicants who are eligible and I may not receive financial services from FXN.

Today's Date:_____ Patient's Signature (or parents if under 18 years of age): _____

FxN FUNCTIONAL NEUROLOGY RELIEF FOUNDATION

Sliding Fee Application

Head of Household Information / Responsible Party

Last Name	First Name:		Date of birth

Address:	City:	State:	Zip Code:	Phone:

Place of Employment:	Phone:	Self Employed?	
		Yes (☐)	No (☐)

Please list spouse and dependents under age 18 (including yourself)

Name		DOB	Income? (Circle one)
Self			yes ☐ no ☐
Spouse			yes ☐ no ☐
Dependent			yes ☐ no ☐
Dependent			yes ☐ no ☐
Dependent			yes ☐ no ☐
Dependent			yes ☐ no ☐
Dependent			yes ☐ no ☐
Dependent			yes ☐ no ☐
Dependent			yes ☐ no ☐
Dependent			yes ☐ no ☐

Household Income

Documentation of you and your household's income must be attached to this application pursuant to our sliding fee scale policy. Please check with a member of our staff if you have questions regarding what documentation is necessary. Our staff will calculate the annual household income from the documentation you provide and will tell you which slide you qualify for, if any. If you have any questions regarding your annual household income please check with a member of our staff. By signing this application you are certifying that you have provided **all** income information relevant to this application and your household's annual income and are attesting to its authenticity.

Verification Checklist (attach copies) – For Office Staff Use Only	Yes	No
Identification/Address: Driver's License, Birth Certificate, Employment ID, Valid Florida ID, or Other Photo ID	☐	☐
Income: Prior Year Tax Return, four weekly or two bi-weekly most recent pay stubs, letter of support, letter of attestation	☐	☐
Is patient applying due to Health Insurance Non-Covered Services or Out of Network Services?	☐	☐

I certify that I have received and verified all the information and documents provided that are required to complete this application.

Annual Income: $			
Processed by(Athena/Denticon Login):	Pay Scale Approved:	Effective:	Expires:
Verified by:	Initials:	Date:	

Attestation/Signature

I/We hereby apply for financial assistance for services rendered by the Functional Neurology Relief Foundation, Inc and certify that the information provided by me/us and contained herein is true and accurate t the best of myour knowledge. I/We hereby give consent to FXN to verify all statements made on this application and documentation contained herein. I/We understand that intentionally making a false statement on this form is a crime punishable under Florida law. I/We accept and understand the requirement to re-determine eligibility before expiration date and/or if the information provided changes. I/We agree to payment responsibilities, and that minimum fees vary depending on the type of services I/We receive from FXN.

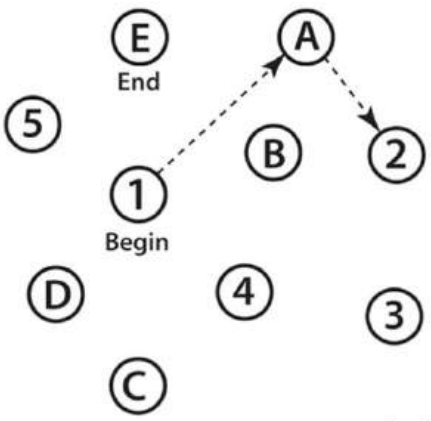
Name (Print) _____ Signature _____ Date _____

MONTREAL COGNITIVE ASSESSMENT (MOCA®)

Version 8.1 English

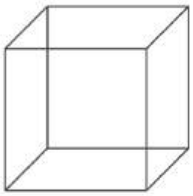
Name:
Education: Date of birth:
Sex: DATE:

VISUOSPATIAL / EXECUTIVE



[ ] [ ]

Copy cube

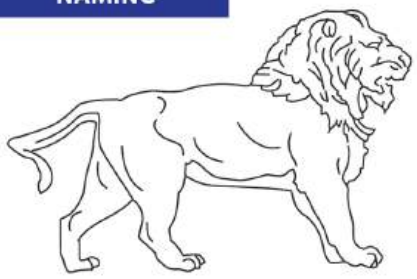


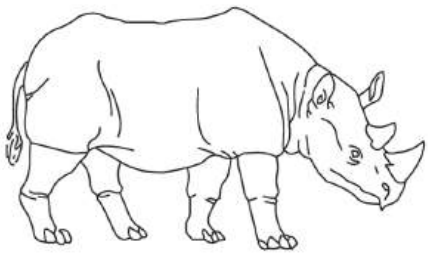
Draw CLOCK (Ten past eleven)
(3 points)

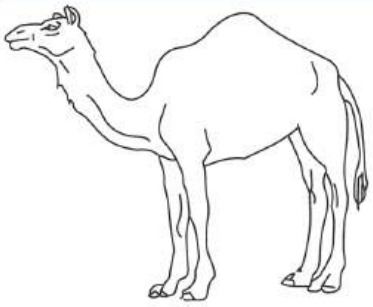
[ ] Contour [ ] Numbers [ ] Hands

POINTS __/5

NAMING







[ ] [ ] [ ]

__/3

MEMORY

Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1ST TRIAL					
2ND TRIAL					

NO POINTS

ATTENTION

Read list of digits (1 digit/ sec.). Subject has to repeat them in the forward order. [ ] 2 1 8 5 4

Subject has to repeat them in the backward order. [ ] 7 4 2

__/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors

[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

__/1

Serial 7 subtraction starting at 100. [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65

4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0**

__/3

LANGUAGE

Repeat: I only know that John is the one to help today. [ ]

The cat always hid under the couch when dogs were in the room. [ ]

__/2

Fluency: Name maximum number of words in one minute that begin with the letter F. [ ] _____ (N ≥ 11 words)

__/1

ABSTRACTION

Similarity between e.g. banana - orange = fruit [ ] train - bicycle [ ] watch - ruler

__/2

DELAYED RECALL

Memory Index Score (MIS)

(MIS)	Has to recall words WITH NO CUE	FACE	VELVET	CHURCH	DAISY	RED	Points for UNCUED recall only
X3		[ ]	[ ]	[ ]	[ ]	[ ]	
X2	Category cue						MIS = ____ /15
X1	Multiple choice cue						

__/5

ORIENTATION

[ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City

__/6

MIS: /15
(Normal ≥ 26/30)
Add 1 point if ≤ 12 yr edu

TOTAL __/30

Administered by: _____

Training and Certification are required to ensure accuracy

FxN FUNCTIONAL NEUROLOGY RELIEF FOUNDATION

Social Security#

_____

First Name:

_____

Middle Initial:

_____

Last Name:

_____

Date of Birth: (MM/DD/YYYY)

_____ / _____ / _____

Gender:

☐ Male ☐ Female

INSTRUCTIONS: Check all disorders and symptoms that apply:

Asymmetrical Tonic Neck Reflex (ATNR)

- ❑Hand-eye coordination problems
- ❑Awkward walk or gait
- ❑Difficulty in school
- ❑Immature handwriting
- ❑Difficulty in sports
- ❑Math and reading issues
- ❑Poor balance
- ❑Eye, ear, foot and hand dominance will not be on the same side
- ❑Poor depth perception
- ❑Shoulder, neck, and hip problems
- ❑Tension down the neck, back, and hips
- ❑Difficulty in things that require crossing over the midline of the body

Landau Reflex

- ❑Low muscle tone
- ❑Poor posture
- ❑Poor motor development
- ❑Short Term Memory difficulty
- ❑Tension in the back of the legs, walks on toes
- ❑Lack of stimulation in the pre-frontal cortex causing attention, organization and concentration problems
- ❑Weak upper body
- ❑Difficulty swimming the breast stroke
- ❑Struggles to do a summersault, knees buckle when head turns under
- ❑May prevent the Spinal Galant Reflex from integrating
- ❑Difficulty coordinating body movements that use the upper and lower part of the body together
- ❑The low muscle tone in the neck can inhibit proper stimulation to the pre-frontal cortex, causing attention problems.
- ❑ADD and ADHD

Spinal Galant Reflex

- ❑Hyper activity and restlessness, especially if clothes or chair brush their back
- ❑If active down only one side of the body, can cause scoliosis, rotates pelvis, and lower back pain
- ❑Poor concentration
- ❑Attention problems
- ❑Bedwetting long after potty training
- ❑Short term memory issues
- ❑Fidgeting and wiggly "ants in the pants"
- ❑Posture problems
- ❑Hip rotation on one side
- ❑Low endurance
- ❑Chronic digestion problems
- ❑Tension in the legs
- ❑Lower body clumsiness

Rooting Reflex

- ❑Tongue lies too far forward
- ❑Hyper sensitive around mouth
- ❑Difficulty with textures and solid foods
- ❑Thumb sucking
- ❑Speech and articulation problems
- ❑Difficulty swallowing and chewing
- ❑Dribbling
- ❑Hormone imbalance
- ❑Thyroid problems and autoimmune tendency
- ❑Dexterity problems when talking
- ❑Overeats

Symmetrical Tonic Neck Reflex (STNR)

- ❑Poor posture standing
- ❑Sits with slumpy posture
- ❑Low muscle tone
- ❑Ape-like walk
- ❑Problems with attention especially in stressful situations
- ❑Vision accommodation and tracking problems
- ❑Difficulty learning to swim
- ❑Difficulty reading
- ❑Usually skips crawling as an infant
- ❑Sits with legs in a W position
- ❑ADD
- ❑ADHD
- ❑Hyper activity or fidgety
- ❑Poor hand eye coordination
- ❑Problems looking between near and far sighted objects, like copying from a chalkboard
- ❑Sloppy eaters
- ❑Rotates pelvis

Palmar Reflex

- ❑Poor handwriting
- ❑Poor pencil grip
- ❑Poor fine muscle control
- ❑Poor dexterity
- ❑Poor fine motor skills
- ❑Poor vision coordination
- ❑Slumpy posture when using hands
- ❑Back aches when sitting
- ❑Sticks tongue out when using hands
- ❑Poor pencil grip
- ❑Poor ability to put thoughts to paper
- ❑Dysgraphia
- ❑Speech and language problems
- ❑Anger control issues

Moro Reflex

- ❑Easily distracted
- ❑Hypersensitive to sensory stimuli like light, sound and touch
- ❑Over sensitivity to motion causing car sickness
- ❑Overreacts
- ❑Impulsive and aggressive
- ❑Emotional immaturity
- ❑Withdrawn
- ❑ADD
- ❑ADHD
- ❑Autism Spectrum
- ❑Asperger's
- ❑Difficulty making friends
- ❑Depression
- ❑Anger or emotional outbursts
- ❑Poor balance and coordination
- ❑Poor digestion and food sensitivities
- ❑Health issues such as Allergies, Asthma, and Adrenal Fatigue

Tonic Labyrinthine Reflex (TLR)

- ❑Poor balance and spatial awareness
- ❑Tense muscles down the back of the body
- ❑Toe walker
- ❑Over flexible joints and weak muscles
- ❑Difficulty holding still and concentrating
- ❑Poor posture and weak neck
- ❑Difficulty paying attention, especially when head is down (at a desk or reading)
- ❑Poor sense of rhythm
- ❑Gets motion sickness easily
- ❑Speech problems due to forward tongue
- ❑Spatial issues
- ❑Bumps into things and people more than normal
- ❑Tends to cross eyes
- ❑Difficulty climbing up things
- ❑Causes inefficient stimulation to the pre frontal cortex
- ❑Usually active in kids with ADD and ADHD
- ❑Holds head forward or to the side
- ❑Problems with balance when looking up or down

Physician Signature: _____ Date: _____