# Welcome to OrthoNeuro

## Martin T. Taylor, DO, PHD

Your appointment is for a neurologic consultation with Dr. Martin Taylor. He is board certified in both Neurology and Headache Medicine. His residency training in neurology was completed at the University of Rochester in Rochester, New York. He is originally from Texas and earned his medical degree from the University of North Texas Health Science Center in Fort Worth. He also holds a Ph.D. in Biomedical Science from the same institution.

A neurologist is a fully licensed physician (D.O. or M.D.) with special training in disorders of the nervous system including the brain, spinal cord, and peripheral nerves. Neurologists do not perform surgery but they work closely with neurosurgeons and orthopedic surgeons in cases that require a surgical consultation. As a general neurologist, Dr. Taylor diagnoses and/or treats all of the conditions listed on the back of this letter. His special interests and areas of expertise are listed below.

### Botulinum Toxin Therapy (Botox/Dysport/Myobloc/Xeomin)

Dr. Taylor has extensive training and experience in the use of Botulinum toxin to treat multiple medical conditions. These medications can be used to treat many conditions of muscle dysfunction. Botulinum toxin is used to treat conditions such as neck and back pain, headaches/migraines, dystonia/torticollis, facial spasm, spasticity associated with stroke, cerebral palsy or multiple sclerosis, hyperhidrosis (excessive sweating) and jaw pain. He also trains other physicians throughout Ohio and the nation on the proper use of this treatment.

### Non-Surgical Treatment of Neck, Head and Neuropathic Pain

Multiple minimally invasive techniques are used along with medications to reduce symptoms of pain and to improve quality of life and sleep patterns, which are commonly disrupted in chronic pain. Treatments include the use of physical therapy, counseling/ biofeedback, muscle injections such as trigger point injections or Botulinum Toxin, nerve block or spinal electrical stimulation as appropriate. Narcotic medications are used in select patients for occasional use only. Dr. Taylor is the author of the Johns Hopkins Press Health Book, My Neck Hurts! Nonsurgical Treatments for Neck and Upper Back Pain.

**Please feel free to ask for more information regarding these services and treatments for yourself or for family/friends.**

**(614) 890-6555 | orthoneuro.com**

OrthoNeuro
For every motion in life.


## What is Our Philosophy of Care?

We are dedicated to providing the highest quality of neurological care. We pride ourselves on being up to date on the latest developments in diagnostic testing, treatments and techniques for neurological conditions. Our knowledge is passed on to our patients through educational discussions and various reading materials. It is very important that our patients understand their neurological diagnosis and that they feel comfortable with the treatment plan. We encourage questions during your visit or at any time a concern may arise.

As osteopathic physicians, we believe in the body's innate ability to heal itself. We realize that our role is to facilitate this process. The patient's role in maintaining or restoring health is pivotal. This participation may involve such things as discontinuing the use of tobacco products, altering dietary habits, exercising and maintaining awareness of your body symptoms or simply taking medications as directed on a regular basis. Therapeutic decisions are made through a mutual agreement between the patient and physician. Based on their individual needs, patients may be referred for testing or for consultation with other physicians or health care professionals. Neurological conditions frequently require working with specialists in areas such as physical therapy, health psychology and sleep medicine. Our practice encourages patients to work toward achieving wellness utilizing the best that both drug and non-pharmacologic treatment can offer through a multidisciplinary approach.

The physicians and staff realize that the patient is not the only one affected by illness. Often the entire family is affected and needs to be involved in maximizing the patient's health. Family members are encouraged to attend office visits and ask questions. As appropriate, we will put you in touch with support groups and other organizations to help you live with and understand your illness.

### What Conditions are Diagnosed and Treated by a Neurologist?

ALS (Lou Gehrig's Disease)
Balance Problems
Bell's Palsy
Brain Tumors
Carpal Tunnel Syndrome
Cerebral Palsy
Dementia (i.e. Alzheimer's Disease)
Dizziness
Guillan-Barre Syndrome
Head Trauma
Hydrocephalus
Movement Disorders
-Dystonia
-Huntington's Disease
-Parkinson's Disease
-Tourette's Syndrome/Tics
-Torticollis
-Tremor
-Writer's Cramp
Multiple Sclerosis
Muscular Dystrophy
Myasthenia Gravis
Myopathy (muscle weakness)
Neuropathy (disease of the peripheral nerves)
Numbness/Tingling
Pain Syndromes
-Back pain
-Headache
-Migraine
-Neck pain
-Neuropathic Pain
-Trigeminal Neuralgia
Pseudotumor Cerebri
Radiculopathy (pinched nerve in the neck or back)
Restless Legs Syndrome
Seizures/Epilepsy
Sleep Disorders
Stroke
Spasticity
Syncope (passing out spells)
TIA (Transient Ischemic Attack)
Transverse Myelitis

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For every motion in life.

***Scheduling an appointment is fast and easy. Contact us today.***

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*OrthoNeuro*

***Please fill out the following except for sections marked "physician comments". Please fill out all 3 pages.***

Name: _____ Date Seen: _____ Social Security # _____

Age: _____ Birth Date: _____ Sex: M F Right or Left handed

Please comment briefly on the nature of today's visit (1 to 2 sentences only):

(*Physician Comments*)

| **Review of Systems** | **Yes** | **No** |
|---|---|---|
| Do you have a fever? | | |
| Do you have a skin rash? | | |
| Any changes in skin, hair, or nails? | | |
| Do you sweat heavily at night? | | |
| Do you have any visual problems? | | |
| Do you experience dizziness or lightheadedness? | | |
| Have you recently passed out? | | |
| Do you have problems with balance? | | |
| Do you have ear pain or fullness? | | |
| Do you have hearing problems? | | |
| Do you have ringing in your ears? | | |
| Do you have chest pain? | | |
| Does your heart race or skip beats? | | |
| Do you have shortness of breath? | | |
| Do your ankles swell? | | |
| Do you cough up phlegm or blood? | | |

Name _____ Date _____

| **Review of Systems Continued** | **Yes** | **No** |
|---|---|---|
| Any pain in your abdomen? | | |
| Do you have nausea or vomiting? | | |
| Do you suffer from constipation or diarrhea? | | |
| Do you have burning or pain on urination? | | |
| Do you urinate frequently? | | |
| Do you have sexual dysfunction? | | |
| Do you have weakness in the arms or legs? | | |
| Do you have tingling/numbness of the arms or legs? | | |
| Do you suffer from headaches or facial pain? | | |
| Do you suffer from neck or back pain? | | |
| Do you have joint pain or swelling? | | |
| Do you often feel depressed? | | |
| Do you often feel anxious or nervous? | | |
| Do you have problems falling or staying asleep? | | |
| Do you have problems with your memory? | | |

(*Physician Comments*)

_____

_____

**Past Medical History**

Do you suffer from any of the following conditions?

| | | |
|---|---|---|
| _____ High blood pressure | _____ High cholesterol | _____ Cancer |
| _____ Diabetes | _____ Stroke | _____ Heart disease |
| _____ Depression | _____ Thyroid disease | _____ Blood clots |
| _____ Anxiety | _____ Arthritis | _____ Ulcers/GI reflux |
| _____ Migraines | _____ Seizure | _____ Lung Disease |

Please list any other medical conditions.

_____

_____

_____

_____

**If you are a women age 65 or older…**

Have you been screened (DXA scan) for osteoporosis since you turned 60 years old? □ Y □ N

If yes, what was the result of the testing? _____

Have you been prescribed medication to prevent or treat osteoporosis? □ Y □ N

If yes, what medication are you taking? _____

**Family History**

Please comment on any close relatives with the following illnesses.

Include which side of the family (i.e.. Mother's Brother, Father's Mother)

| **Condition** | **Relation** | **Condition** | **Relation** |
|---|---|---|---|
| _____ Headaches | | _____ Cerebral aneurysm | |
| _____ Stroke | | _____ Cancer | |
| _____ High Blood Pressure | | _____ Diabetes | |
| _____ Lung Disease | | _____ Seizures | |
| _____ Depression | | _____ Anxiety | |
| _____ Blood Clots | | _____ High Cholesterol | |
| _____ Arthritis | | _____ Other _____ | |
| _____ Other _____ | | _____ Other _____ | |

Name _____ Date _____

**Social History**

_____ Single _____ Married _____ Divorced _____ Separated _____ Widowed

_____ Children Ages: _____

I have smoked about _____ packs of cigarettes per day for the last _____ years.

I consume about _____ alcoholic drinks per DAY / WEEK / or MONTH.

I drink about _____ cups of coffee or tea and _____ sodas per day.

Please list all prescription medications that you are currently taking and for what medical problem.

| Medication | Dose (mg) | How often? | Medical problem |
|---|---|---|---|
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Please list over the counter medications that you are currently taking and for what medical problem.

| Medication | Dose (mg) | How often? | Medical problem |
|---|---|---|---|
| | | | |
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| | | | |
| | | | |
| | | | |

Do you have any **allergies** to medication? (Please list)

_____

_____

**Data**

Please list any tests related to your visit previously performed. (indicate where and when)

_____ MRI (Head / Neck / Low back) _____

_____ Cat Scan (Head / Neck / Low back) _____

_____ EEG _____

_____ EMG _____

_____ Other _____

_____ Other _____

**Patient Signature** _____ **Date** _____

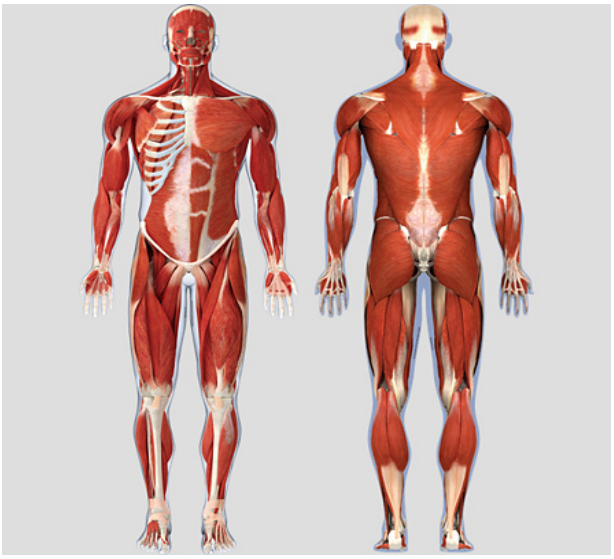
Name _____ Date _____

**General Exam**

Blood Pressure: Supine _____ Pulse _____ RR _____

Sitting _____ Pulse _____

Standing _____ Pulse _____



Carotids: _____ Heart: _____ Extremities: _____

**Neurologic Exam**

Mental status: Alert/Oriented _____ Follows simple/complex commands _____

Naming _____ Language _____

MMSE _____ /30

Cranial Nerves:

Motor:

Sensory:

Reflexes:

Coordination:

Gait:

**Impression/Plan**

Martin Taylor, D.O., Ph.D

## OrthoNeuro Authorizations and Financial Policy

**Section 1: Appointment of Personal Representative to Receive Protected Health Information**

You may rely upon your spouse, relatives or friends to be involved in your medical care. OrthoNeuro can disclose your Protected Health Information to these people if you appoint them as your "personal representatives." To appoint an individual as your personal representative, complete this section:

**I hereby appoint the following individual as my personal representative:**

**Name: _____ Relationship to me: _____**

**I hereby authorize OrthoNeuro to disclose the following Protected Health Information to my personal representative:**

☐ All Protected Health Information

*OR One or more of these choices:*

☐ Times of Appointments
☐ Prescriptions & Ancillary Equipment
☐ Other _____
☐ Test Results
☐ Copies of Medical Records

I may revoke my appointment of a personal representative at any time in writing. I understand that revocation of my appointment will NOT affect any action OrthoNeuro took in reliance on my appointment before it received written notice of my revocation. **Please initial: _____**

**Section 2: Receipt of Notice of Privacy Practices**

I hereby acknowledge receiving a copy of OrthoNeuro's Notice of Privacy Practices that outlines my privacy rights and explains how OrthoNeuro is permitted to use and disclose my Protected Health Information. I should call OrthoNeuro's Privacy Officer at (614) 890-6555 if I have a question or concern about my privacy rights. **Please initial: _____**

**Section 3: Patient Information**

Race: _____ Ethnicity: _____ Date of Birth: _____

Language: _____ Social Security Number: _____

Emergency Contact: _____ Phone Number: _____

**Section 4: Photography and Recording Policy**

Patients, family members, and other visitors shall not take photographs and shall not record video or audio in OrthoNeuro's offices.

This policy includes recording an individual's voice using technology capable of capturing audio and recording an individual's likeness using photography, video recording or any technology capable of capturing an image. **Please initial: _____**

**Section 5: Financial Policy**

**I have reviewed OrthoNeuro's Financial Policy and Authorizations (collectively, the "Financial Policy"), hereby acknowledge my responsibilities set forth in the Financial Policy, and hereby make the authorizations set forth in the Financial Policy. Please initial: _____**

**By signing below, I am acknowledging that I have read and understand the financial policy and authorizations of OrthoNeuro**

| Patient Name (please print) | Patient Signature | Date |
|---|---|---|
| If applicable, Parent/Guardian Name | If applicable, Parent/Guardian Signature | Date |