



## Adolescent Patient Information

Today's Date (Month/Day/Year): \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Birth (Month/Day/Year): \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Name: \_\_\_\_\_ Sex:  M  F

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Name of Parents/Guardians: \_\_\_\_\_

Parent/Guardian Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

## Daily Habits

Describe your *stress* on a scale of 1-10 (1=none, 10= extreme) School \_\_\_\_\_ Personal \_\_\_\_\_

Do you smoke? If yes, how many packs/day: \_\_\_\_\_ Alcoholic Drinks/week: \_\_\_\_\_

Cups of coffee/tea: \_\_\_\_\_ Soft drinks/day: \_\_\_\_\_ Energy drinks/day? \_\_\_\_\_ Glasses/Bottles of water/day: \_\_\_\_\_

Diet:  Vegetarian  Specialty (Weight Watchers, Atkins, etc.)  Take Out (including cafeteria) >3x/wk  Fruits & Vegetables

Rate your Exercise Level:  Non-existent  Minimal  Moderate  Intense

Type of Exercise:  Walking  Running  Biking  Weight Training  Aerobic  Pilates/Yoga  Golfing  Other \_\_\_\_\_

How many hours of sleep/night?  5  6  7  8  9+ Rate the Quality of Sleep:  Poor  Fair  Good  Excellent

How many hours of TV? \_\_\_\_\_ How many hours of computer time? \_\_\_\_\_ How many hours of gaming (Xbox, etc)? \_\_\_\_\_

Do you take Probiotics daily?  Y  N Do you take Omega-3 (fish oil) daily?  Y  N

Please list any other supplements/vitamins you take:

1. \_\_\_\_\_ 2. \_\_\_\_\_

Please list the Prescribed and Over-the-Counter medications you currently take:

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

## List of Health Concerns

Primary: \_\_\_\_\_

Secondary: \_\_\_\_\_



## Primary Health Concern

Is the condition due to injury or sickness arising out of: Employment? Y N Accident? Y N

What is the exact location of your symptom? \_\_\_\_\_

What do you think caused this? \_\_\_\_\_

What Month/Year did you first notice this? \_\_\_\_\_/\_\_\_\_\_

Did it come on: Suddenly Gradually? Briefly describe: \_\_\_\_\_

Overall, the presentation is Improving Slightly Improving Dramatically Worsening Unchanged

Is the presentation: Sharp Dull Aching Stabbing Burning Shooting Tingling Numb Weakness

Rate your pain/complaint on a scale of 1-10 (1=nuisance and 10= debilitating): 1 2 3 4 5 6 7 8 9 10

How often does this occur? Constant (100% of day) Frequent (75%) Often (50%) Seldom (25%) Rarely (less than 25%)

Is the intensity: Mild (nuisance) Moderate (having trouble coping with it) Severe (ruining the quality of my life)?

When are your symptoms most noticeable? Morning Afternoon Evening When sleeping

Which aggravate your condition? Sitting Standing Laying Down Shifting/Changing Positions Lifting Carrying Pushing

Pulling Bending/Extending Walking Running Exercising Coughing/Sneezing Driving Typing Cooking/Cleaning

Stress Bright light Sound Other \_\_\_\_\_

Which improve your condition? Adjustments Massage Medication Heat Ice Laying Down Sitting Standing

Walking Exercising Cooking/Cleaning Dark Room Quiet Room

Other \_\_\_\_\_

Please list all other chiropractors/physicians/physical therapists/massage therapists that you have seen for this complaint:

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_

For this complaint, have you had X-rays CT Scan MRI Electrodiagnostic studies (EMG/NCV) performed?

I, the undersigned, understand that ***I am financially responsible for all charges*** whether or not paid by insurance. I hereby authorize the use of this signature on all my insurance submission whether manual or electronic. I consent to proceed with the interview and examination. I understand that any treatment will be explained to me and my verbal consent will be requested before any care is rendered.

Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Consent to Treatment of a Minor (Under 17)

I hereby authorize Chiropractic Neurology & Wellness Center to administer chiropractic care as necessary to my son/daughter, \_\_\_\_\_, dated \_\_\_\_\_, 20\_\_\_\_.

Signature: \_\_\_\_\_

Witnessed: \_\_\_\_\_

# CHIROPRACTIC NEUROLOGY & WELLNESS CENTER



## Medical History

Have you benefitted from previous Chiropractic Care?  Y  N When were you last adjusted? \_\_\_\_\_

Do you ever "crack" or "pop" your own neck ( Y  N) or back? ( Y  N) Why? \_\_\_\_\_

Who is your family physician? \_\_\_\_\_ **May we send OUR REPORT to your doctor?**  Y  N

Date of your last: Physical Examination? \_\_\_\_\_ Blood Work? \_\_\_\_\_ Urine Test? \_\_\_\_\_

Please list and date your significant hospitalizations, surgeries, infections, traumas, and accidents.

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

Please **CIRCLE** the conditions you **CURRENTLY** have.  
Please underline the conditions you have had in the PAST YEAR.

### GENERAL/CONSTITUTIONAL:

Dizziness Lightheaded  
Headaches Unsteady  
Fatigue Fever/Chills  
Night sweats Anemia  
Bleeding Diabetes  
Thyroid Fainting  
Weight loss/gain Cancer  
Problems falling asleep

### GASTROINTESTINAL:

belching/gas heartburn  
ulcers vomiting  
bloody stools hernia  
constipation diarrhea  
abdominal pain nausea  
liver problems

### RESPIRATORY:

breathing problems allergies  
spitting phlegm/blood asthma  
shortness of breath  
chronic cough pneumonia  
other:

### CARDIOVASCULAR:

racing heart chest pain  
high blood pressure pacemaker  
high cholesterol  
swelling feet/legs/hands  
prior heart problem  
irregular heartbeat stroke  
other:

### MUSCULOSKELETAL:

Stiffness pain  
Swelling spinal curve  
Arthritis weakness  
Twitching tremors  
Numbness other:

### SKIN:

Rashes mole changes  
Itching nail changes  
Redness other:

### EYES, EARS, NOSE, THROAT:

blurry vision double vision  
eye pain glaucoma  
hearing loss ringing in ears  
ear infection sinus problems  
nosebleeds throat problems  
jaw pain speech problems

### GENITOURINARY:

frequent/painful urination  
incontinence/dribbling  
blood in urine  
urinary infection  
venereal infection  
kidney/bladder disease  
other:

### NEUROLOGIC/PSYCHIATRIC:

Seizures convulsions  
Tremors Paralysis  
Depression Anxiety  
Memory Loss Confusion  
Phobias Addiction

### FEMALES ONLY:

**ARE YOU PREGNANT?**  Y  N  
difficult periods hot flashes  
irregular cycles breast pain  
lump in breast  
difficulty becoming pregnant  
complications of pregnancy  
Date last period ended: \_\_\_\_\_  
Last gynecologic exam:

### MALES ONLY:

testicular pain prostate problems  
difficult erection low sperm count

### Who in your family suffers with the following?:

Dizziness \_\_\_\_\_  
ADHD \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Stroke \_\_\_\_\_  
High Blood Pressure \_\_\_\_\_  
High Cholesterol \_\_\_\_\_  
Cancer \_\_\_\_\_  
Seizures \_\_\_\_\_  
Tremors \_\_\_\_\_  
Brain disorder \_\_\_\_\_  
Neurological Disorder \_\_\_\_\_  
Heart disease \_\_\_\_\_  
Lung disease \_\_\_\_\_  
Arthritis \_\_\_\_\_  
Scoliosis \_\_\_\_\_  
Is your mother alive?  Y  N  
Is your father alive?  Y  N  
Are your siblings alive?  Y  N



## AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

I, (Patient Name) \_\_\_\_\_, hereby authorize (Doctor/Clinic/Hospital name)

\_\_\_\_\_ to disclose the following protected health information (including, but not limited to: patient notes, narratives, examinations and findings, laboratory work, radiological studies, etc.) to Chiropractic Neurology & Wellness Center.

I specifically authorize the release of data and information relating to: (mark the appropriate box)

1.  Substance abuse
2.  Mental Health (includes psychological testing)
3.  HIV-related Information

This protected health information may be used or disclosed to carry out treatment, payment and/or health care operation at Chiropractic Neurology & Wellness Center.

This authorization shall be in force and effect as long as copies may reside in my patient records at Chiropractic Neurology & Wellness Center or until records necessitate return.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification. I understand that a revocation is not effective to the extent that Chiropractic Neurology & Wellness Center has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Chiropractic Neurology & Wellness Center will not condition my: treatment; payment in a health plan; or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Printed Name of Patient or Personal Representative



## Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

**Chiropractic** is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

\_\_\_\_\_

Print Name

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

## Consent to Evaluate and Adjust a Minor Child

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_

Print Name

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

## Pregnancy Release

This is to certify that , to the best of my knowledge, **I am not pregnant** and the above doctor and his/her associates have my permission to perform an x-ray evaluation. **I have been advised that x-ray can be hazardous to an unborn child.**

Date of last menstrual cycle: \_\_\_\_\_

\_\_\_\_\_

Print Name

\_\_\_\_\_

Signature

\_\_\_\_\_

Date



## ACKNOWLEDGEMENT OF NOTICE

I, \_\_\_\_\_ acknowledge that the Notice of Privacy Practices (aka Notice) for Chiropractic Neurology & Wellness Center has been made available to me.

I understand that I have the right to review the Notice prior to signing this document. The Notice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, and/or the performance of healthcare operations at Chiropractic Neurology & Wellness Center.

Chiropractic Neurology & Wellness Center reserves the right to change the privacy practices that are described in the Notice. I understand that I may obtain a revised Notice at [www.cnwcenter.com](http://www.cnwcenter.com) by calling and requesting a copy by mail, or by picking one up at one of the offices.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

## ASSIGNMENT OF BENEFITS

I understand that I will provide all current insurance, benefit, and/or worker compensation coverage and as a courtesy to me, Chiropractic Neurology & Wellness Center will file my insurance electronically. I understand and appreciate this benefit and will provide all the information necessary to help file claims promptly and accurately.

I direct Chiropractic Neurology & Wellness Center to accept payment directly from my insurance company, if they allow. If my insurance company does not allow payment directly, I will make payment in full at the time of service.

I understand that my co-payment is due at the time of service. Cash and checks are accepted. If my care is not covered by insurance, payment is due at the time of service. There will be a 2.0% monthly service charge on all balances past 30 days.

I understand that Chiropractic Neurology & Wellness Center CANNOT GUARANTY PAYMENT OF CHIROPRACTIC SERVICE. If there is a dispute with my insurance company regarding benefits, I understand that it is my responsibility to resolve the matter. I understand that I am responsible for payment of all services rendered regardless of insurance coverage, and that all balances regardless of insurance status are subject to a 2.0% monthly service charge.

I have read and understood the above that it is my responsibility to find out the details of my insurance coverage and I will see that my charges will be taken care of. I understand also that I have the right to refuse to sign. I also understand that by refusing to sign, Chiropractic Neurology & Wellness Center may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

Signature \_\_\_\_\_

Date \_\_\_\_\_

## CONFIDENTIALITY

In the event this office needs to contact you:

May we leave a message for you with someone at your home phone number?  Yes  No

May we leave a message for you on your home voicemail?  Yes  No

# Metabolic Assessment Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

## **PART I**

**Please list the 5 major health concerns in your order of importance:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

## **PART II** Please circle the appropriate number “0 - 3” on all questions below. **0 as the least/never to 3 as the most/always.**

<b>Category I</b>				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue of “fuzzy” debris on tongue	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
<b>Category II</b>				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3
<b>Category III</b>				
Stomach pain, burning, or aching 1- 4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
<b>Category IV</b>				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

<b>Category V</b>				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed	Yes	No		
<b>Category VI</b>				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3
<b>Category VII</b>				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3
<b>Category VIII</b>				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

*Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.  
For nutritional purposes only.*

**Category IX**

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

**Category X**

Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

**Category XI**

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

**Category XII**

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

**Category XIII**

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

**Category XIV (Males Only)**

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

**Category XV (Males Only)**

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

**Category XVI (Menstruating Females Only)**

Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 24 days	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

**Category XVII (Menopausal Females Only)**

How many years have you been menopausal?	_____			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

**PART III**

How many alcoholic beverages do you consume per week? \_\_\_\_\_ How many caffeinated beverages do you consume per day? \_\_\_\_\_

How many times do you eat out per week? \_\_\_\_\_ How many times a week do you eat raw nuts or seeds? \_\_\_\_\_

How many times a week do you eat fish? \_\_\_\_\_ How many times a week do you workout? \_\_\_\_\_

List the three worst foods you eat during the average week: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

List the three healthiest foods you eat during the average week: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If yes, how many times a day: \_\_\_\_\_

Rate your stress levels on a scale of 1-10 during the average week: \_\_\_\_\_

**Please list any medications you currently take and for what conditions:**

**Please list any natural supplements you currently take and for what conditions:**

# Health Questionnaire (NTAF)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

\* Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

## SECTION A

- Is your memory noticeably declining? 0 1 2 3
- Are you having a hard time remembering names and phone numbers? 0 1 2 3
- Is your ability to focus noticeably declining? 0 1 2 3
- Has it become harder for you to learn things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament getting worse in general? 0 1 2 3
- Are you losing your attention span endurance? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you fatigue when driving compared to the past? 0 1 2 3
- How often do you fatigue when reading compared to the past? 0 1 2 3
- How often do you walk into rooms and forget why? 0 1 2 3
- How often do you pick up your cell phone and forget why? 0 1 2 3

## SECTION B

- How high is your stress level? 0 1 2 3
- How often do you feel that you have something that must be done? 0 1 2 3
- Do you feel you never have time for yourself? 0 1 2 3
- How often do you feel you are not getting enough sleep or rest? 0 1 2 3
- Do you find it difficult to get regular exercise? 0 1 2 3
- Do you feel uncared for by the people in your life? 0 1 2 3
- Do you feel you are not accomplishing your life's purpose? 0 1 2 3
- Is sharing your problems with someone difficult for you? 0 1 2 3

## SECTION C

### SECTION C1

- How often do you get irritable, shaky, or have lightheadedness between meals? 0 1 2 3
- How often do you feel energized after eating? 0 1 2 3
- How often do you have difficulty eating large meals in the morning? 0 1 2 3
- How often does your energy level drop in the afternoon? 0 1 2 3
- How often do you crave sugar and sweets in the afternoon? 0 1 2 3
- How often do you wake up in the middle of the night? 0 1 2 3
- How often do you have difficulty concentrating before eating? 0 1 2 3
- How often do you depend on coffee to keep yourself going? 0 1 2 3
- How often do you feel agitated, easily upset, and nervous between meals? 0 1 2 3

### SECTION C2

- Do you get fatigued after meals? 0 1 2 3
- Do you crave sugar and sweets after meals? 0 1 2 3
- Do you feel you need stimulants such as coffee after meals? 0 1 2 3
- Do you have difficulty losing weight? 0 1 2 3
- How much larger is your waist girth compared to your hip girth? 0 1 2 3
- How often do you urinate? 0 1 2 3
- Have your thirst and appetite been increased? 0 1 2 3
- Do you have weight gain when under stress? 0 1 2 3
- Do you have difficulty falling asleep? 0 1 2 3

## SECTION 1 - S

- Are you losing your pleasure in hobbies and interests? 0 1 2 3
- How often do you feel overwhelmed with ideas to manage? 0 1 2 3
- How often do you have feelings of inner rage (anger)? 0 1 2 3
- How often do you have feelings of paranoia? 0 1 2 3
- How often do you feel sad or down for no reason? 0 1 2 3
- How often do you feel like you are **not** enjoying life? 0 1 2 3

- How often do you feel you lack artistic appreciation? 0 1 2 3
- How often do you feel depressed in overcast weather? 0 1 2 3
- How much are you losing your enthusiasm for your favorite activities? 0 1 2 3
- How much are you losing enjoyment for your favorite foods? 0 1 2 3
- How much are you losing your enjoyment of friendships and relationships? 0 1 2 3
- How often do you have difficulty falling into deep restful sleep? 0 1 2 3
- How often do you have feelings of dependency on others? 0 1 2 3
- How often do you feel more susceptible to pain? 0 1 2 3
- How often do you have feelings of unprovoked anger? 0 1 2 3
- How much are you losing interest in life? 0 1 2 3

## SECTION 2 - D

- How often do you have feelings of hopelessness? 0 1 2 3
- How often do you have self-destructive thoughts? 0 1 2 3
- How often do you have an inability to handle stress? 0 1 2 3
- How often do you have anger and aggression while under stress? 0 1 2 3
- How often do you feel you are not rested even after long hours of sleep? 0 1 2 3
- How often do you prefer to isolate yourself from others? 0 1 2 3
- How often do you have unexplained lack of concern for family and friends? 0 1 2 3
- How easily are you distracted from your tasks? 0 1 2 3
- How often do you have an inability to finish tasks? 0 1 2 3
- How often do you feel the need to consume caffeine to stay alert? 0 1 2 3
- How often do you feel your libido has been decreased? 0 1 2 3
- How often do you lose your temper for minor reasons? 0 1 2 3
- How often do you have feelings of worthlessness? 0 1 2 3

## SECTION 3 - G

- How often do you feel anxious or panic for no reason? 0 1 2 3
- How often do you have feelings of dread or impending doom? 0 1 2 3
- How often do you feel knots in your stomach? 0 1 2 3
- How often do you have feelings of being overwhelmed for no reason? 0 1 2 3
- How often do you have feelings of guilt about everyday decisions? 0 1 2 3
- How often does your mind feel restless? 0 1 2 3
- How difficult is it to turn your mind off when you want to relax? 0 1 2 3
- How often do you have disorganized attention? 0 1 2 3
- How often do you worry about things you were not worried about before? 0 1 2 3
- How often do you have feelings of inner tension and inner excitability? 0 1 2 3

## SECTION 4 - ACH

- Do you feel your visual memory (shapes & images) is decreased? 0 1 2 3
- Do you feel your verbal memory is decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity been decreased? 0 1 2 3
- Has your comprehension been diminished? 0 1 2 3
- Do you have difficulty calculating numbers? 0 1 2 3
- Do you have difficulty recognizing objects & faces? 0 1 2 3
- Do you feel like your opinion about yourself has changed? 0 1 2 3
- Are you experiencing excessive urination? 0 1 2 3
- Are you experiencing slower mental response? 0 1 2 3

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.  
For nutritional purposes only.

# Medication History

Please circle any of the following medication you have been or are currently taking.

## Acetylcholine Receptor Antagonist – Antimuscarinic Agents

Atropine, Ipratropium, Scopolamine, Tiotropium

## Acetylcholine Receptor Antagonist - Ganglionic Blockers

Mecamylamine, Hexamethonium, Nicotine (high doses), Trimethaphan

## Acetylcholinesterase Reactivators

Pralidoxime

## Acetylcholine Receptor Antagonist - Neuromuscular Blockers

Atracurium, Cisatracurium, Doxacurium, Metocurine, Mivacurium, Pancuronium, Rocuronium, Uccinylcholine, Tubocurarine, Vecuronium, Hemicholine

## Agonist Modulator of GABA Receptor (benzodiazepines)

Xanax, Lexotanil, Lexotan, Librium, Klonopin, Valium, ProSom, Rohypnol, Dalmane, Ativan, Loramet, Sedoxil, Dormicum, Megadon, Serax, Restoril, Halcion

## Agonist Modulator of GABA Receptors (nonbenzodiazepines)

Ambien, Sonata, Lunesta, Imovane

## Cholinesterase Inhibitors (irreversible)

Echotiophate, Isoflurophate, Organophosphate Insecticides, Organophosphate-containing nerve agents

## Cholinesterase Inhibitors (reversible)

Donepezil, Galatamine, Rivastigmine, Tacrine, THC, Erophonium, Neostigmine, Phystigimine, Pyridostigmine, Carbamate Insecticides

## Dopamine Reuptake Inhibitors

Wellbutrin (Bupropion)

## Dopamine Receptor Agonists

Mirapex, Sifrol, Requip

## D2 Dopamine Receptor Blockers (antipsychotics)

Thorazine, Prolixin, Trilafon, Compazine, Mellaril, Stelazine, Vesprin, Nozinan, Depixol, Navane, Iuanxol, Clopixol, Acuphase, Haldol, Orap, Clozaril, Zyprexa, Zydis, Seroquel, Geodon, Solian, Invega, Abilify

## GABA Antagonist Competitive binder

Flumazenil

## Monoamine Oxidase Inhibitor (MAOI)

Marplan, Aurorix, Maneric, Moclodura, Nardil, Adlegiine, Elepryl, Azilect, Marsilid, Iprozid, Ipronid, Rivivol, Popilniazida, Zyvox, Zyvoxid

## Noradrenergic and Specific Serotonergic Antidepressants (NaSSa)

Remeron, Zispin, Avanza, Norset, Remergil, Axit

## Selective Serotonin Reuptake Inhibitor

Paxil, Zoloft, Prozac, Celexa, Lexapro, Luvox, Cipramil, Emocal, Serpam, Seropram, Ciprallex, Esteria, Fontex, Seromex, Seronil, Sarafem, Fluctin, Faverin, Seroxat, Aropax, Deroxat, Rexetin, Xentor, Paroxat, Lustral, Serlain, Dapoxetine

## Selective Serotonin Reuptake Enhancers

Stablon, Coaxil, Tatinol

## Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

Effexor, Pristiq, Meridia, Serzone, Dalcipran, Despramine, Duloxetine

## Tricyclic Antidepressants (TCAs)

Elavil, Endep, Tryptanol, Trepiline, Asendin, Asendis, Defanyl, Demolox, Moxadil, Anafranil, Norpramin, Pertofrane, Prothiadin, Thanden, Adapin, Sinequan, Trofranil, Janamine, Gamanil, Aventyl, Pamelor, Opipramol, Vivactil, Rhotrimine, Surmontil