



Pediatric 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: _____

Who referred you to our office? _____

Prenatal History

Name of Obstetrician/Midwife: _____

Complications during pregnancy?: _____

Medications during pregnancy?: _____ Cigarette/Alcohol use during pregnancy? Y N

Birth History

Birth Place: Hospital Home Birthing Center

Birth Intervention: Forceps Vacuum Extraction C-Section

Complications during delivery?: _____

Birth Weight: _____ Length: _____ APGAR: _____ Genetic Disorder/Disability?: _____

Feeding History

Breast Fed? Y N If yes, how long? _____ Formula Fed? Y N If yes, how long? _____

Food/Fluid Intolerance? _____

Food Allergies? _____

Vaccination History

Vaccine Exempt:	<input type="checkbox"/> Y <input type="checkbox"/> N			
Hepatitis B	<input type="checkbox"/> Y <input type="checkbox"/> N	Rotavirus	<input type="checkbox"/> Y <input type="checkbox"/> N	DPT <input type="checkbox"/> Y <input type="checkbox"/> N
Varicella	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis A	<input type="checkbox"/> Y <input type="checkbox"/> N	Influenza <input type="checkbox"/> Y <input type="checkbox"/> N
Meningococcal	<input type="checkbox"/> Y <input type="checkbox"/> N	Pneumococcal	<input type="checkbox"/> Y <input type="checkbox"/> N	MMR (Measles, Mumps, Rubella) <input type="checkbox"/> Y <input type="checkbox"/> N
Influenzae type B	<input type="checkbox"/> Y <input type="checkbox"/> N			Inactivated Polio Virus <input type="checkbox"/> Y <input type="checkbox"/> N

Did your child suffer from **ANY** of the following **Adverse Reactions** following the vaccinations?

Fever Vomit Seizure Swelling Lethargy Paralysis Other: _____



Developmental History

It is important to know if your child reached his/her milestones on time. Give the approximate age that your child:
 Responded to Sound: _____ Responded to Visual Stimuli: _____ Held Head Up: _____ Sat Independently: _____
 Crawled: _____ Stood Independently: _____ Walked: _____

According to the National Safety Council, approximately 50% of children fall from a high place (bed, changing table, stairs, etc.) during their first year of life. Was this the case with your child? Y N If yes, please describe: _____

Has your child been involved in any impact sports (soccer, football, wrestling, gymnastics, karate, etc.)? Y N

Has your child ever been involved in ANY motor vehicle accident (auto, 4-wheeler, riding lawnmower)? Y N What happened and when? _____

Has your child been seen on an emergency visit? Y N For what? _____

Has your child undergone any surgery? Y N For what? _____

Daily Habits

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

Does your child take Probiotics daily? Y N Does your child take Omega-3 (fish oil) daily? Y N

Please list any other supplements/vitamins your child takes:

1. _____ 2. _____

Please list any medications your child currently takes:

1. _____ 2. _____

3. _____ 4. _____

Purpose of Visit

Why is your child here today? _____

When did the condition begin? _____ Does anything improve the condition? _____

What makes the condition worse? _____ Has your child seen his/her pediatrician for this complaint? Y N

Name of Pediatrician: _____ Are you satisfied with his/her care? Y N

Other practitioners (specialists, chiropractors, massage therapists, etc.) your child has seen for this complaint:

1. _____ 2. _____

3. _____ 4. _____

Other Health Concerns

Check any of the conditions your child has suffered from in the past 6 months:

Ear Infections Seizures Cold/Flu Asthma Allergies Digestive Problems

Colic ADD Bed Wetting Recurring Fevers Other: _____

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 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

Child Neurotransmitter & Nutrition Questionnaire (CNNQ)

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: GENERAL

- Does your child have any food sensitivities or allergies? (please list)

- List your child's 4 healthiest foods eaten regularly.

_____, _____,

- List your child's 4 unhealthiest foods eaten regularly.

_____, _____,

- How many times a week does your child eat candy? _____

- How many times a week does your child drink soda pop? _____

- Please list the top 4 foods your child craves regularly?

_____, _____,

- List the medication(s) your child is currently prescribed and over the counter.

- Do you find it difficult as a parent to have your child on a special diet?

SECTION: A (K52)

- Does your child eat pasta, breads, and breaded foods? 0 1 2 3

- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating wheat foods? 0 1 2 3

- Does your child eat dairy products? 0 1 2 3

- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating dairy products? 0 1 2 3

SECTION: B (K53)

- Does your child eat fried fish? 0 1 2 3

- Does your child eat roasted nuts or seeds? 0 1 2 3

- Is your child **missing** essential fatty acid rich foods in his/her diet? (for example: avocados, flax seeds, olives) (mark "0" if present, "3" if missing) 0 1 2 3

- Does your child eat *fried* foods? 0 1 2 3

SECTION: C (K34)

- Is your child's mental speed slow? 0 1 2 3

- Does your child have difficulty with learning or memory? 0 1 2 3

- Does your child have difficulty with balance and coordination? 0 1 2 3

SECTION: D (K16)

- Does your child have stress? 0 1 2 3

- Does your child **not** have enough sleep and rest? (mark "3" if not enough) 0 1 2 3

- Does your child **not** have regular exercise? (mark "3" if no exercise) 0 1 2 3

- Does your child feel overly worried and scared? 0 1 2 3

SECTION: E (K16, K51)

- Does your child have temper tantrums? 0 1 2 3

- Does your child exhibit wild behavior? 0 1 2 3

- Does your child frequently yell or scream for unnecessary reasons? 0 1 2 3

- Does your child have an **inability** to nap or sleep when physically exhausted? (mark "3" if unable) 0 1 2 3

- Is your child overly talkative? 0 1 2 3

- Does your child fidget and squirm when seated? 0 1 2 3

- Does your child run and climb excessively when it is inappropriate? 0 1 2 3

- Does your child have difficulty playing quietly or engaging in leisure activities? 0 1 2 3

SECTION: F (K51)

- Does your child get excited easily? 0 1 2 3

- Does your child have anxiousness and panic for minor reasons? 0 1 2 3

- Does your child feel overwhelmed for minor reasons? 0 1 2 3

- Does your child find it difficult to relax when she/he is awake? 0 1 2 3

- Does your child have disorganized attention? 0 1 2 3

SECTION: G (K50)

- Does your child seem depressed? 0 1 2 3

- Does your child have mood changes with overcast weather? 0 1 2 3

- Does your child have symptoms of inner rage? 0 1 2 3

- Does your child seem uninterested in games or hobbies? 0 1 2 3

- Does your child have difficulty falling into deep restful sleep? 0 1 2 3

- Does your child seem uninterested in friendships? 0 1 2 3

- Does your child have symptoms of unprovoked anger? 0 1 2 3

- Does your child seem uninterested in eating? 0 1 2 3

SECTION: H (K49)

- Does your child have difficulty handling stress? 0 1 2 3

- Does your child have anger and aggression while being challenged? 0 1 2 3

- Does your child feel tired even after long sleeps? 0 1 2 3

- Does your child tend to isolate from others? 0 1 2 3

- Does your child get distracted easily? 0 1 2 3

- Does your child have constant need and desire for candy and sugar? 0 1 2 3

- Does your child have disorganized attention? 0 1 2 3

SECTION: I (K48)

- Does your child have difficulty with visual memory? 0 1 2 3

- Does your child have difficulty remembering locations? 0 1 2 3

- Does your child have fatigue or low endurance for learning activities? 0 1 2 3

- Does your child have difficulty with attention or low attention span or endurance? 0 1 2 3

- Does your child have slow or difficult speech? 0 1 2 3

- Does your child have uncoordinated or slow movement? 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

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

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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