

**In addition to the comprehensive Case History that follows, please answer the following CASE REVIEW QUESTIONS.**

- **Some of the questions will be duplicated in the Case History, so don't worry.**
- **Please type out your answers and with as much detail as possible.**
- **These must be returned with your Case History forms before your appointment.**

HEALTH HISTORY QUESTIONS

1. Please list your education, profession, sports and hobbies
2. List your chief complaints in order of your importance
3. Provide a detailed narrative (story) of your health history in a timeline sequence
4. List all diagnoses given to you in a timeline sequence and your personal opinions about the diagnosis
5. List your opinion on what you think has happened to your health
6. List of all healthcare providers you have consulted and their opinions and treatments about your case
7. List any treatments, medications, or supplements that have improved your health
8. List any treatments, medications, or supplements that have caused reactions or decreased your health
9. List in a timeline sequence and medications you have taken
10. List in a timeline sequence any medical procedures or surgeries you have had
11. List in a timeline sequence any significant laboratory or imaging results
12. List in a timeline sequence any exposure to environmental, industrial, or toxic compounds.
13. List any history of infections (excluding common colds).

PERSONAL OPINION QUESTIONS

*Please do not answer, "I don't know" to any of these questions*

1. Why do you think healthcare practitioners have failed with your case?
2. Do you think your condition can be cured, or improved?
3. What do you consider a realistic time frame to see changes in your health under our care?
4. What are your expectations from us?
5. Is there anyone you blame for your health condition?
6. What specific improvements in your health would you consider a successful outcome in your case?
7. Are you emotionally and spiritually able to handle further investigation and management of your case?
8. Is there anything you feel you should tell us about yourself or your case?
9. Is there anything in what you believe about health and the body that you may think is holding back your health?
10. Are you willing to change what you believe about health and the body to gain more health?
11. Are there any emotional experiences that can be affecting to your health condition?
12. Do you have a distinct purpose in life?
13. Are there any patterns in childhood or adulthood that has contributed to your health problems?
14. Is your spouse and/or family unit supportive of you with your health condition?
15. Are your spouse and/or family unit supportive of you seeking care at our office?
16. How did you feel about answering all of these questions and the case review process?

# CHRONIC NEUROLOGICAL & METABOLIC CASE HISTORY

Name \_\_\_\_\_

**How do you wish to be addressed in our office?**  First name  Mr  Mrs  Ms  Miss  Dr

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SSN# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status: Single Married Widowed Divorced

Home Telephone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Email address: \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Spouse/Partner's Name \_\_\_\_\_ Employer \_\_\_\_\_

Spouse/Partner's Work Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_

Name of person to contact in case of emergency: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone \_\_\_\_\_

**How did you choose our office? (e.g. Referral, internet, advertisement etc.)**

\_\_\_\_\_

**What is the main problem or symptom that made you come here today?:**

\_\_\_\_\_

**When and How did this begin?** \_\_\_\_\_

**Have you had this or similar conditions in the past?**  Yes  No If yes, when? \_\_\_\_\_

**What aggravates your condition?** \_\_\_\_\_

**What makes it better?** \_\_\_\_\_

**Describe what you are feeling?** \_\_\_\_\_

**Do you experience Numbness or Tingling?**  No  Yes If yes, where? \_\_\_\_\_

**SYMPTOM INTENSITY:** Please circle the number describing the intensity of your symptoms.

None → 0 1 2 3 4 5 6 7 8 9 10 ← Unbearable

**When you're awake, how often are you feeling these symptoms?( 0-100%)** \_\_\_\_\_%

**Is this getting progressively worse?**  Yes  No **Is your condition:**  Constant  Comes & goes

**Is this condition interfering with your:**  Work  Sleep  Daily routine  Other \_\_\_\_\_

**Has there been any medical diagnosis of your complaint?**  Yes  No If yes, list the Dr.'s name and the Diagnosis \_\_\_\_\_

**How have you tried to take care of this problem in the past? Circle all that apply**

Medications • Emergency Room • Surgery • Routine Medical • Exercise • Supplements • Regular Chiropractic

Other (please specify) \_\_\_\_\_

**How did the previous method(s) work out for you? Circle all that apply**

Bad results • Some Results • Great Results • Nothing Changed • Didn't get worse • Didn't work very long

**What are you afraid this might be?** \_\_\_\_\_



## Past Evaluations

**Here is a list of possible testing and evaluations you may have. If you have any of these please make sure to send copies of these results and reports with this questionnaire. (We do not need daily office notes).**

- MRI, CT, EEG
- Psychological / Neuropsychological Evaluations
- Psychiatric
- Neurological Evaluations
- Gastroenterology Evaluations
- Rheumatology Evaluations
- Internal Medicine Evaluations
- Genetic Evaluations
- Celiac/Gluten testing

## Hospitalizations

Age	Reason for Hospitalization	Discharge Summary Attached?

Age	Operations	
	Appendix	
	Hernia	
	Tonsils	
	Adenoids	
	Tubes in Ears	
	Other Surgery:	
	Other Surgery:	

Please describe any head injuries, broken bones or other injuries/traumas	Age

**Please mark the following in each category by ranking each one 0-4.  
0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently**

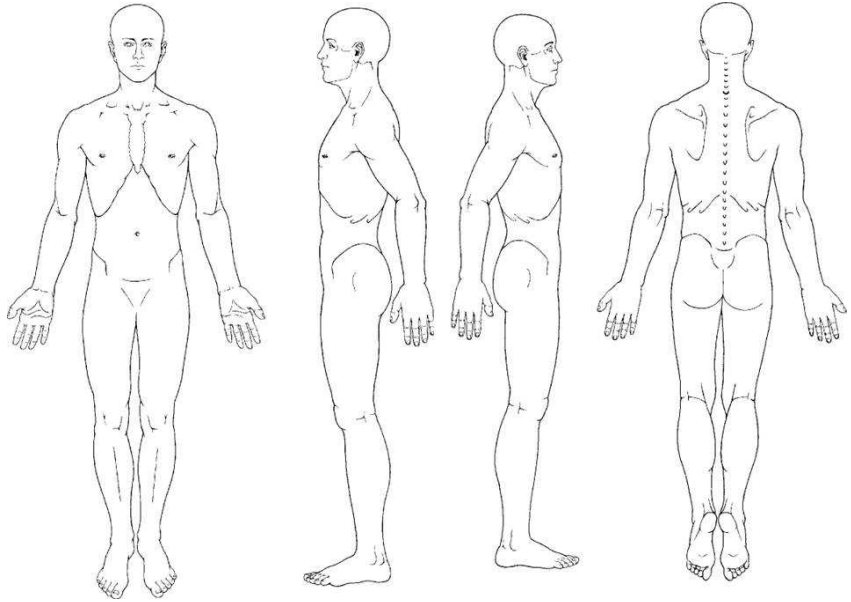
	0	1	2	3	4	Past ONLY	Comments
Sensitive to odors, perfumes, smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sensitive to pollens, molds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Extreme sugar cravings (child seeks out sugary foods)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Genital rash (vaginal, "jock itch")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ringworm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fungus on toenails or fingernails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Repeated use of antibiotics (even in distant past)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Repeated use of steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth thrush (yeast infection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dark skin under eyes; looks like you might have a mild 'black eye'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Belching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Intestinal gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Esophageal reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Itching, tingling or burning (child may scratch a lot, or tell you)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hives, psoriasis or dandruff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic infections (repeated infections)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Your symptoms/behaviors worse in the following weather:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Damp, hot, misty, moldy, musty							
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Congestion with changing seasons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sighing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus fullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

List surgical operations and years: \_\_\_\_\_

Other Medical or Physical conditions you have been diagnosed with (e.g. diabetes, heart conditions, arthritis, osteoporosis, low thyroid, hormone imbalance, food allergies, anxiety or panic attacks etc.) \_\_\_\_\_

**Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the diagram to accurately describe your problem.**

- |     |           |
|-----|-----------|
| PPP | PAIN      |
| WWW | WEAKNESS  |
| NNN | NUMBNESS  |
| HHH | HEAT      |
| TTT | TINGLING  |
| BBB | BURNING   |
| CCC | CRAMPING  |
| FFF | STIFFNESS |



**Write "YES" or "NO" in the box next to each of the questions.**

Weakness	Fatigue
Pins & Needles feelings, electric shock feelings	Racing heart beat
Trouble controlling bowels or bladder	Angina—chest pain or shortness of breath
Hair loss on the arms or legs	Left arm pain
Balance problems	Swelling in the lower legs
Fingernails are brittle or have ridges or look different	Extreme shortness of breath; feel like drowning / suffocating
Symptom changes with arm, leg or neck movement	Blackouts
Twitching muscles	Light headedness
Decrease in size or tone of your arms or legs	Cramping pains in the legs that start after walking
Uncoordinated	Poor exercise tolerance
Muscle cramping	Erectile dysfunction

Double vision?	Sensitivity to light
Difficulty talking?	Sweat more on one side (armpit, face etc.)
You feel unsteady or you fall	Dry mouth
Vomiting, sick to stomach	Dry eyes
Abnormal jerking of the eyes	Cold arms, legs, hands, feet
Numbness? Where?	

**Please mark the following in each category by ranking each one 0-4.  
 0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently, 5=Always**

	0	1	2	3	4	5	Past ONLY	Comments
Teeth grinding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Where?</b> _____
Restless legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Where?</b> _____
Bites or chews fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Obsessive thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gets stuck on a behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gets song stuck in head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor handwriting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Low motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Quick startle reaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Persistent phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Easily embarrassed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Easily sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hot or cold flashes / hot or cold hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Feelings of nervousness or anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tremors / Shakiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart pounding, rapid heart rate, chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Troubled breathing or feelings of being smothered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Avoidance of public places from fear of anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Periods of nausea and stomach upset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tendency to predict the worst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fear of being judged or scrutinized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive worrying about what others think	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tendency to freeze in anxiety provoking situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Please mark the following in each category by ranking each one 0-4.  
0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently, 5=Always**

	0	1	2	3	4	5	Past ONLY	Comments
Feelings of Sadness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Moodiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Negativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Low Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suicidal Feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Low Self Esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Face, lip movements or noises.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Feelings of hopelessness about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Feelings of helplessness or powerlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Feeling dissatisfied or bored	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crying easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lowered Interest in things considered fun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appetite changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Very sensitive to smells and odors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mild paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Memory problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Periods of forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spaciness or confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Periods of panic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent misinterpretation of comments as negative when they are not	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Auditory or visual hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Sudden</b> fear, anger or sexual feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of family violence or explosiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Short fuse or periods of extreme irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Periods of rage without provocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dark thoughts or thoughts of suicide, homicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Preoccupation with moral or religious ideas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reading comprehension problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irritability that tends to build, then explode	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ringling in the ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Please mark the following in each category by ranking each one 0-4.  
0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently**

RB		
	Difficulty remaining seated when expected	Trouble sustaining attention in routine situations
	Difficulty remembering where things are	Trouble recognizing the emotion in someone's voice
	Bad memory for directions	Don't respond well to new situations
	Difficulty understanding body language	Don't understand the 'big picture' of words / phrases
	Often don't get humor and metaphors	Not Able to "read between the lines"
	Act compulsively	Inappropriate social behavior and responses
	Difficulty with word problems	Not Able to focus
	Difficulty following through or finishing things	Not Able to 'tune out' irrelevant stimuli
	Trouble imagining or visualizing an activity or physical action	Not Able to speak without sounding monotone
	Trouble with reading comprehension	Blurting out of answers before question is completed
	Hyperactive-move excessively	Trouble understanding symbolism in words and art
	Not Able to control what you say	Not Able to cry or be spontaneous
	Not Able to predict what others will do	Irregular heart rate (fast or slow)
	Feel fearful and anxious	Easily distracted by ordinary insignificant things

LB		
	Not Able to remember facts and figures	Trouble understanding when spoken to
	Not Able to speak clearly	Not Able to identify objects by name
	Can't find words when talking	Trouble with fine motor skills (small objects, handwriting, buttons)
	Not Able to draw pictures accurately	Not able to focus on smaller details
	Difficulty with calculations/math	Depression (even if in the past)
	Trouble reading (dyslexic)-even if past only	Trouble following multiple step directions
	Upset if routine or plan changes	Irregular heart rhythm (skipped beats, fluttering)
	Have repetitive thoughts	Excessively motivated
	Start things, but don't finish	Very good at finding mistakes
	Can't turn thoughts off at night	Tend to write very small

**Please mark the following in each category by ranking each one 0-4.  
 0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently, 5=Always**

	0	1	2	3	4	5	Past ONLY	Comments
Letters seen backwards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty counting, calculating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
You have difficulty understanding how you feel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Without looking, have difficulty knowing "where" in space foot or hand is.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feel odd sensations (bugs crawling, tingling, burning etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Where?</b>
Get claustrophobic, tunnel vision, or feeling that the world is closing in	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have difficulty understanding how others feel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gets surprised by things coming from the left side (more than from opposite side)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with "spatial" skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with word problems in math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty getting dressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty reading people's facial expressions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty interpreting emotional content of a verbal conversation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Confusion between right and left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dry eyes, nose, mouth or tearing of eyes and running of nose, excess saliva.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with arousal (i.e. waking up), seem to be half asleep all the time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Speech is slurred	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Movement does not look coordinated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fall, get hurt running climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have trouble maintaining balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Knock over things when reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drop things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

# NT Assessment Form

Please circle mark the appropriate number "0 - 3" on all questions below.

0 as the least/never to 3 as the most/always.

<b>SECTION A</b>				How often do you feel like you are not enjoying life?	0	1	2	3	
Is your memory noticeably declining?	0	1	2	3	How often do you feel you lack artistic appreciation?	0	1	2	3
Are you having a hard time remembering names and phone numbers	0	1	2	3	How often do you feel depressed in overcast weather?	0	1	2	3
Is your ability to focus noticeably declining?	0	1	2	3	How much are you losing your enthusiasm for your favorite activities?	0	1	2	3
Has it become harder for you to learn things?	0	1	2	3	How much are you losing enjoyment for your favorite foods?	0	1	2	3
How often do you have a hard time remembering your appointments?	0	1	2	3	How much are you losing your enjoyment of friendships and relationships?	0	1	2	3
Is your temperament getting worse in general?	0	1	2	3	How often do you have difficulty falling into deep restful sleep?	0	1	2	3
Are you losing your attention span endurance?	0	1	2	3	How often do you have feelings of dependency on others?	0	1	2	3
How often do you find yourself down or sad?	0	1	2	3	How often do you feel more susceptible to pain?	0	1	2	3
How often do you fatigue when driving compared to the past?	0	1	2	3	How often do you have feelings of unprovoked anger?	0	1	2	3
How often do you fatigue when reading compared to the past?	0	1	2	3	How much are you losing interest in life?	0	1	2	3
How often do you walk into rooms and forget why?	0	1	2	3	<b>SECTION 2 - D</b>				
How often do you pick up your cell phone and forget why?	0	1	2	3	How often do you have feelings of hopelessness?	0	1	2	3
<b>SECTION B</b>				How often do you have self-destructive thoughts?	0	1	2	3	
How high is your stress level?	0	1	2	3	How often do you have an inability to handle stress?	0	1	2	3
How often do you feel that you have something that must be done?	0	1	2	3	How often do you have anger and aggression while under stress?	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 rested even after long hours of sleep?	0	1	2	3
How often do you feel you are not getting enough sleep or rest?	0	1	2	3	How often do you prefer to isolate yourself from others?	0	1	2	3
Do you have the time to get regular exercise?	0	1	2	3	How often do you have unexplained lack of concern for family and friends?	0	1	2	3
How often do you not feel cared about by the people in your life?	0	1	2	3	How easily are you distracted from your tasks?	0	1	2	3
How often do you not feel you are accomplishing your life purpose?	0	1	2	3	How often do you have an inability to finish tasks?	0	1	2	3
How often do you share your problems with someone?	0	1	2	3	How often do you feel the need to consume caffeine to stay alert?	0	1	2	3
<b>SECTION C</b>				How often do you feel your libido has been decreased?	0	1	2	3	
SECTION C1	0	1	2	3	How often do you lose your temper for minor reasons?	0	1	2	3
How often do you get irritable, shaky, or have lightheadedness between meals?	0	1	2	3	How often do you have feelings of worthlessness?	0	1	2	3
How often do you feel energized after eating?	0	1	2	3	<b>SECTION 3 - G</b>				
How often do you have difficulty eating large meals in the morning?	0	1	2	3	How often do you feel anxious or panic for no reason?	0	1	2	3
How often does your energy level drop in the afternoon?	0	1	2	3	How often do you have feelings of dread or impending doom?	0	1	2	3
How often do you crave sugar and sweets in the afternoon?	0	1	2	3	How often do you feel knots in your stomach?	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 feelings of being overwhelmed for no reason?	0	1	2	3
How often do you have difficulty concentrating before eating?	0	1	2	3	How often do you have feelings of guilt about everyday decisions?	0	1	2	3
How often do you depend on coffee to keep yourself going?	0	1	2	3	How often does your mind feel restless?	0	1	2	3
How often do you feel agitated, easily upset, and nervous between meals?	0	1	2	3	How difficult is it to turn your mind off when you want to relax?	0	1	2	3
SECTION C2	0	1	2	3	How often do you have disorganized attention?	0	1	2	3
Do you get fatigued after meals?	0	1	2	3	How often do you worry about things you were not worried about before?	0	1	2	3
Do you crave sugar and sweets after meals?	0	1	2	3	How often do you have feelings of inner tension and inner excitability?	0	1	2	3
Do you feel you need stimulants such as coffee after meals?	0	1	2	3	<b>SECTION 4 - ACH</b>				
Do you have difficulty losing weight?	0	1	2	3	Do you feel your visual memory (shapes & images) is decreased?	0	1	2	3
How much larger is your waist girth compared to your hip girth?	0	1	2	3	Do you feel your verbal memory is decreased?	0	1	2	3
How often do you urinate?	0	1	2	3	Do you have memory lapses?	0	1	2	3
Have your thirst and appetite been increased?	0	1	2	3	Has your creativity been decreased?	0	1	2	3
Do you have weight gain when under stress?	0	1	2	3	Has your comprehension been diminished?	0	1	2	3
Do you have difficulty falling asleep?	0	1	2	3	Do you have difficulty calculating numbers?	0	1	2	3
<b>SECTION 1 - S</b>				Do you have difficulty recognizing objects & faces?	0	1	2	3	
Are you losing your pleasure in hobbies and interests?	0	1	2	3	Do you feel like your opinion about yourself has changed?	0	1	2	3
How often do you feel overwhelmed with ideas to manage?	0	1	2	3	Are you experiencing excessive urination?	0	1	2	3
How often do you have feelings of inner rage (anger)?	0	1	2	3	Are you experiencing slower mental response?	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					

# 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, Ucinylcholine, 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, Cipralex, 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

# Metabolic Assessment Form

Please check mark the appropriate number "0 - 3" on all questions below.

0 as the least/never to 3 as the most/always.

<b>Category I</b>	0	1	2	3	<b>Category V</b>	0	1	2	3
Feeling that bowels do not empty completely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Greasy or high fat foods cause distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower abdominal pain relief by passing stool or gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower bowel gas and or bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alternating constipation and diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	several hours after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bitter metallic taste in mouth,				
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	especially in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hard dry or small stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained itchy skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coated tongue or "fuzzy" debris on tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yellowish cast to eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pass large amount of foul smelling gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stool color alternates for clay colored				
More than 3 bowel movements daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	to normal brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use laxatives frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reddened skin, especially palms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Dry or flaky skin and/or hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category II</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	History of gallbladder attacks or stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive belching burping or bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had your gallbladder removed?				
Gas immediately following a meal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Offensive breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Category VI</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Difficult bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave sweets during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sense of fullness during and after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable if meals are missed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty digesting fruits and vegetables;					Depend on coffee to keep yourself going or started	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
undigested foods found in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Get lightheaded and if meals are missed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Eating relieves fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category III</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	Feel shaky, jittery, tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach pain, burning or aching 1- 4 hours after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Agitated, easily upset, nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you frequently use antacids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor memory, forgetful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling hungry an hour or two after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn when lying down or bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Temporary relief from antacids, food,					<b>Category VII</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
milk, carbonated beverages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problems subside with rest and relaxation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave sweets during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn due to spicy foods, chocolate, citrus,					Eating sweets does not relieve cravings for sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
peppers, alcohol and caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Must have sweets after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Waist girth is equal or larger than hip girth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category IV</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Roughage and fiber cause constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increased thirst & appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion and fullness lasts 2-4					Difficulty losing weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hours after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Pain, tenderness, soreness on left side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Category VIII</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Under rib cage bloated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cannot stay asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive passage of gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea and/or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow starter in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stool undigested, foul smelling,					Afternoon fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mucous -like, greasy or poorly formed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness when standing up quickly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Afternoon headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased thirst and appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches with exertion or stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty losing weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weak nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Category IX</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Cannot fall asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perspire easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Under high amounts of stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain when under stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wake up tired even after 6 or more hours of sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive perspiration or perspiration with little or no activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category X</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Tired, sluggish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel cold – hands, feet, all over .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Require excessive amounts of sleep to function properly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increase in weight gain even with low-calorie diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gain weight easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult, infrequent bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression, lack of motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morning headaches that wear off as the day progresses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outer third of eyebrow thins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinning of hair on scalp, face or genitals or excessive falling hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness of skin and/or scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental sluggishness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category XI</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inward trembling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased pulse even at rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness and emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty gaining weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category XII</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Diminished sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual disorders of lack of menstruation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased ability to eat sugars without symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category XIII</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Increased sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tolerance to sugars reduced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Splitting" type headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Category XIV (Male Only)</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Urination difficulty or dribbling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urination frequent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain inside of legs or heels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling of incomplete bowel evacuation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg nervousness at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category XV (Males Only)</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Decrease in libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decrease in spontaneous morning erections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decrease in fullness of erections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in maintain morning erections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spells of mental fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inability to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Episodes of depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decrease in physical stamina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increase in fat distribution around chest and hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweating attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More emotional than in the past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category XVI (Menstruating Females Only)</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Are you a menopausal ?		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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scanty blood flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy blood flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast pain and swelling during menses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic pain during menses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable and depressed during menses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne break outs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial hair growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss/thinning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category XVII (Menopausal Females only)</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
How many years have you been menopausal?				
Do you ever have uterine bleeding since menopause?		Yes	No	
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental fogginess	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disinterest in sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shrinking breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial hair growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased vaginal, pain, dryness or itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## PART II

How many alcohol beverages they consume per week? \_\_\_\_\_

How many times do you eat out per week? \_\_\_\_\_

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

List the three worst foods you eat during the average week: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

List the three healthiest foods you eat during the average week: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

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

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

What do you eat for the following meals on a typical day?

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

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

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

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

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific \_\_\_\_\_

What would be different/better without this problem? Please be specific \_\_\_\_\_

What do you desire most to get from working with us? \_\_\_\_\_

What is that worth to you? \_\_\_\_\_

What is your idea of the ideal doctor? \_\_\_\_\_

*We thank you for your patience and cooperation in completely filling out this form.*

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**BE SURE TO COMPLETE THE LAST 3 PAGES OF THIS HISTORY—IT IS A 3-DAY DIET RECORD. THIS MUST BE COMPLETED.**

For Doctor's Use Only

**\*\*\*Write down EVERYTHING you eat & drink for 3 days. What you're eating and when you're eating can have a HUGE NEGATIVE EFFECT on your health.\*\***

**Day 1**

Breakfast	Lunch	Dinner
Time:	Time:	Time:
Snack	Snack	Snack
Time:	Time:	Time:

**Day 2**

Breakfast	Lunch	Dinner
Time:	Time:	Time:
Snack	Snack	Snack
Time:	Time:	Time:

**Day 3**

Breakfast	Lunch	Dinner
Time:	Time:	Time:
Snack	Snack	Snack
Time:	Time:	Time:

**\*\*\*Write down EVERYTHING you eat & drink for 3 days. What you're eating and when you're eating can have a HUGE NEGATIVE EFFECT on your health.\*\***

**Day 1**

Breakfast	Lunch	Dinner
Time:	Time:	Time:
Snack	Snack	Snack
Time:	Time:	Time:

**Day 2**

Breakfast	Lunch	Dinner
Time:	Time:	Time:
Snack	Snack	Snack
Time:	Time:	Time:

**Day 3**

Breakfast	Lunch	Dinner
Time:	Time:	Time:
Snack	Snack	Snack
Time:	Time:	Time:

**\*\*\*Write down EVERYTHING you eat & drink for 3 days. What you're eating and when you're eating can have a HUGE NEGATIVE EFFECT on your health.\*\***

**Day 1**

Breakfast	Lunch	Dinner
Time:	Time:	Time:
Time: <b>Snack</b>	Time: <b>Snack</b>	Time: <b>Snack</b>

**Day 2**

Breakfast	Lunch	Dinner
Time:	Time:	Time:
Time: <b>Snack</b>	Time: <b>Snack</b>	Time: <b>Snack</b>

**Day 3**

Breakfast	Lunch	Dinner
Time:	Time:	Time:
Time: <b>Snack</b>	Time: <b>Snack</b>	Time: <b>Snack</b>