

Hoffman Chiropractic Neurology

Confidential Patient Information

Date _____ Name _____ Middle Initial _____
Address _____ City/State/Zip _____ Email _____
SSN# _____ Home Phone _____ Work _____
Cell _____ Age _____ Birth Date _____ Marital: _____ How many Children? _____
Occupation _____ Employer _____
Name of Spouse _____ Spouse's Birth Date _____ Who referred you to us? _____
Is the condition due to injury or sickness arising out of employment? _____ # days lost from work _____
Is the condition due to injury or sickness arising out of auto or other type of accident? _____ Date of accident _____
Briefly describe the reason for your visit here: _____

In the past, have you ever had the same or a similar condition? ____ yes ____ no If yes, please describe: _____

Please list all medical or chiropractic physicians you have seen related to your current concern:

1. _____ 3. _____
2. _____ 4. _____

Please describe any special tests (X-ray, MRI, EKG, blood work, etc ...) to investigate your current concern. _____

Please list any medications you have taken in the past year:

1. _____ 3. _____
2. _____ 4. _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Hoffman Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment it to be considered as valid as the original. I have read and fully understand this agreement.

Signature _____ Date _____

PLEASE DESCRIBE YOUR HEALTH CONCERNS

1. What are the major problems you are experiencing?

2. If this is a re-occurrence, when did you originally notice the problem?
What initially caused it?

3. Has it changed recently? _____ Better _____ Worse _____ Same What types of treatment have you tried?

What makes it better? _____ Worse? _____
4. How frequent is the condition? _____ How long does it last? _____
5. Is this affecting your sleep? _____ Yes _____ No If yes, please describe:

6. Is this affecting your ability to perform your job or daily activities? _____ Yes _____ No if yes, please describe:

7. Are there any other symptoms that may be related to these concerns, which you have not listed?
_____ Yes _____ No
If yes, please describe: _____

Please mark an "X" on the line to indicate the severity of your condition:

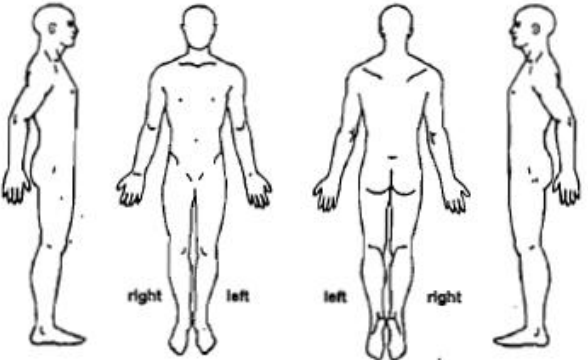
No symptoms

Extreme symptoms

Does not interfere with activities

Disabling

1 _____ 10

SHOW US WHERE IT HURTS	
Please mark area(s) of injury or discomfort. Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).	
	

Survey Your Health History

Please Circle all that apply. Indicate whether this is a current or old concern by providing an approximate date.

1. General

Fever
Night Sweats
Nervousness
Bleeding
Diabetes
Thyroid
Headache
Fainting
Depression
Memory Loss
Chills
Fatigue
Weight Loss/Gain
Anemia
Cancer
Substance Abuse
Dizziness
Seizures
Phobias
Waking in night
Problems Falling Asleep
Explain any surgeries or hospitalizations:

Any broken bones, car accidents or other injuries?

2. Gastrointestinal

Belching/gas
Vomiting
Bloody Stools
Hernia
Constipation
Diarrhea
Abdominal Pain
Nausea
Liver Problems
Other _____

3. Respiratory

Breathing Problems
Spitting Phlegm/blood
Allergies
Asthma
Shortness of breath
Chronic Cough
Pneumonia
Other _____

4. Cardiovascular

Irregular heartbeat
Racing Heart
Chest Pain
High Blood Pressure
Swelling
Prior Heart Problems
Pacemaker
Stroke
Other _____

5. Musculoskeletal

Stiffness
Pain
Swelling
Spinal Curve
Arthritis
Weakness
Twitching
Tremors
Numbness
Other _____

6. Skin

Rashes
Mole Changes
Itching
Nail Changes
Redness
Other _____

7. EENT

Blurry Vision
Double Vision
Eye Pain
Jaw Pain
Hearing Loss
Ringing in Ears
Ear Infection
Sinus Problems
Nosebleeds
Throat Problems
Speech Problems
Glasses or Contacts? _____

8. Genitourinary

Frequent/Painful urination
Incontinence
Blood in Urine or Stool
Urinary Infection
Venereal Infection
Other _____

9. Women Only

Difficult Periods
Hot Flashes
Irregular Cycles
Breast Pain
Lump in Breast
Difficulty becoming pregnant
Complications of pregnancy
Other _____
Date Last Period ended _____
Date Last Gyne Exam _____

10. Men Only

Testicular Pain
Prostate Problems
Difficult Erection
Low Sperm Count

11. Exercise

None
1-2 per week
3-4 per week
5-7 per week
What Type? _____

12. Habits

Smoke (____packs/day, years? ____)
Alcohol(____drinks per wk)
Caffeine (____cups per day)
Recreation drug use _____

13. Family

Are your parents living? _____
If so, do you consider them to be in good health? _____
Ages: Mother _____ Father _____

Circle any below that apply to your parents, siblings or children:

Diabetes
Stroke
Hypertension
Cancer
Seizures
Tremors
Brain Disorder
Heart Disease
Lung Disease
Arthritis
Scoliosis

Hoffman Chiropractic Neurology
662 N. Convent
Bourbonnais, IL 60914
815-937-0446

Metabolic Assessment Form

Name: _____ Age: _____ Sex: _____ Date: _____

Part 1: Please list your 5 major health concerns in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Part 2: Please circle the appropriate number "0-3" on all questions below. 0=the least/never 3= the most/always

Category I

	0	1	2	3
Feeling that bowels do not empty	<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"/>
Alternating constipation & Diarrhea	<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"/>
Constipation	<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"/>
Coated tongue or "fuzzy" debris on tongue	<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"/>
More than 3 bowel movements daily	<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"/>

Category II

	0	1	2	3
Excessive belching or burping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
Difficult bowel movements	<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"/>
Difficulty digesting fruits and vegetables; undigested foods in stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Category III

	0	1	2	3
Stomach pain, burning, or aching 1-4 hrs after eating	<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"/>
Feeling hungry an hour or two after eating	<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, milk, carbonated beverages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problems subside with rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Category IV

	0	1	2	3
Roughage and fiber cause constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion and fullness lasts 2-4 hrs after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain, tenderness, soreness on left side under ribcage	<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"/>
Nausea and/or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	<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"/>
Increased thirst and appetite	<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"/>

Category V

	0	1	2	3
Greasy or high fat foods cause distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower bowel gas and/or bloating several hours after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bitter metallic taste in mouth, especially in the morning	<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"/>
Yellowish cat to eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stool color alternates from clay colored to normal brown	<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"/>
History of gallbladder attacks/ stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had your gallbladder removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Category VI

	0	1	2	3
Crave sweets during the day	<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"/>
Depend on coffee to keep yourself going or started	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get lightheaded 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"/>
Feel shaky, jittery, tremors	<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"/>
Poor memory, forgetful	<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"/>

Category VII

	0	1	2	3
Fatigue after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crave sweet during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating sweets does not relieve cravings for sugar	<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/larger than hip girth	<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"/>
Increased thirst or appetite	<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"/>

Category VIII

	0	1	2	3
Cannot stay asleep	<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"/>
Slow starter in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon Fatigue	<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"/>
Afternoon headaches	<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"/>
Weak Nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Category IX

	0	1	2	3
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"/>

Category X

	0	1	2	3
Tired, sluggish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel cold 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 your 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"/>

Category XI

	0	1	2	3
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"/>

Category XII

	0	1	2	3
Diminished sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual disorders or lack of menstruation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased ability to eat sugar without symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Category XIII

	0	1	2	3
Increase sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tolerance of 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"/>

Category XIV (Male Only)

	0	1	2	3
Urinations 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 legs or heels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling of incomplete bowel evac.	<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"/>

Category IV (Male Only)

	0	1	2	3
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 maintaining 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"/>

Category XVI (Menstruating Females Only)

Are you a menopausal	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Alternating menstrual cycle lengths	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Extended menstrual cycle, greater than 32 days	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Short cycles, less than every 24	Yes <input type="checkbox"/>	No <input type="checkbox"/>

	0	1	2	3
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/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"/>

Category XVII (Menopausal Females only)

How many years have you been menopausal?	_____
Since then, have you had bleeding?	Yes <input type="checkbox"/> No <input type="checkbox"/>

	0	1	2	3
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental foginess	<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"/>
Increase vaginal pain/dryness/itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Part 3:

How many alcohol beverages do you consume per week? _____ How many caffeinated beverages per day? _____

How many times do you eat out per week? _____ How many times a week do you eat raw nuts/seeds? _____

How many times a week do you eat fish? _____ How many times a week do you work out? _____

List the three healthiest foods you eat during the average week? _____, _____, _____

Do you smoke? _____ If yes, how many times per day? _____, a week? _____

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 numbers "0-3" on all questions below. 0 as the least/never to 3 as the most/always.**

SECTION A

- | | | | | |
|--|---|---|---|---|
| | 0 | 1 | 2 | 3 |
| • 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

- | | | | | |
|--|---|---|---|---|
| | 0 | 1 | 2 | 3 |
| • 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

- | | | | | |
|---|---|---|---|---|
| | 0 | 1 | 2 | 3 |
| • 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

- | | | | | |
|---|---|---|---|---|
| | 0 | 1 | 2 | 3 |
| • 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

- | | | | | |
|---|---|---|---|---|
| | 0 | 1 | 2 | 3 |
| • 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 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

- | | | | | |
|---|---|---|---|---|
| | 0 | 1 | 2 | 3 |
| • 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 an inability to finish tasks? | 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

- | | | | | |
|---|---|---|---|---|
| | 0 | 1 | 2 | 3 |
| • 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

- | | | | | |
|--|---|---|---|---|
| | 0 | 1 | 2 | 3 |
| • 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.

Medication History*

Please check any of the following medications you have taken in the past or are currently taking.

Noradrenergic and Specific Serotonergic Antidepressants (NaSSAAs)

- | | |
|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Remeron* | <input type="checkbox"/> Norset* |
| <input type="checkbox"/> Zispin* | <input type="checkbox"/> Remergil* |
| <input type="checkbox"/> Avanza* | <input type="checkbox"/> Axit* |

Tricyclic Antidepressants (TCAs)

- | | |
|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Elavil* | <input type="checkbox"/> Prothiaden* |
| <input type="checkbox"/> Endep* | <input type="checkbox"/> Adapin* |
| <input type="checkbox"/> Tryptanol* | <input type="checkbox"/> Sinequan* |
| <input type="checkbox"/> Trepiline* | <input type="checkbox"/> Tofranil* |
| <input type="checkbox"/> Asendin* | <input type="checkbox"/> Janamine* |
| <input type="checkbox"/> Asendis* | <input type="checkbox"/> Gamanil* |
| <input type="checkbox"/> Defanyl* | <input type="checkbox"/> Aventyl* |
| <input type="checkbox"/> Demolox* | <input type="checkbox"/> Pamelor* |
| <input type="checkbox"/> Moxadil* | <input type="checkbox"/> Opipramol* |
| <input type="checkbox"/> Anafranil* | <input type="checkbox"/> Vivactil* |
| <input type="checkbox"/> Norpramin* | <input type="checkbox"/> Rhotrimine* |
| <input type="checkbox"/> Pertofrance* | <input type="checkbox"/> Surmontil* |
| <input type="checkbox"/> Thaden* | |

Selective Serotonin Reuptake Inhibitors (SSRIs)

- | | |
|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Paxil* | <input type="checkbox"/> Seromex* |
| <input type="checkbox"/> Zoloft* | <input type="checkbox"/> Seronil* |
| <input type="checkbox"/> Prozac* | <input type="checkbox"/> Sarafem* |
| <input type="checkbox"/> Celexa* | <input type="checkbox"/> Fluctin* |
| <input type="checkbox"/> Lexapro* | <input type="checkbox"/> Faverin* |
| <input type="checkbox"/> Esertia* | <input type="checkbox"/> Seroxat* |
| <input type="checkbox"/> Luvox* | <input type="checkbox"/> Aropax* |
| <input type="checkbox"/> Cipramil* | <input type="checkbox"/> Deroxat* |
| <input type="checkbox"/> Emocal* | <input type="checkbox"/> Rexetin* |
| <input type="checkbox"/> Seropram* | <input type="checkbox"/> Paroxat* |
| <input type="checkbox"/> Cipralex* | <input type="checkbox"/> Lustral* |
| <input type="checkbox"/> Fontex* | <input type="checkbox"/> Serlain* |
| <input type="checkbox"/> Priligy* | |

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

- | |
|-------------------------------------|
| <input type="checkbox"/> Effexor* |
| <input type="checkbox"/> Pristiq* |
| <input type="checkbox"/> Meridian* |
| <input type="checkbox"/> Serzone* |
| <input type="checkbox"/> Dalcipran* |
| <input type="checkbox"/> Norpramin* |
| <input type="checkbox"/> Cymbalta* |

Selective Serotonin Reuptake Enhancers (SSREs)

- | |
|-----------------------------------|
| <input type="checkbox"/> Stablon* |
| <input type="checkbox"/> Coaxil* |
| <input type="checkbox"/> Tatinol* |

Monoamine Oxidase inhibitors (MAOIs)

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Marplan* | <input type="checkbox"/> Marsilid* |
| <input type="checkbox"/> Aurorix* | <input type="checkbox"/> Iprozid* |
| <input type="checkbox"/> Manerix* | <input type="checkbox"/> Ipronid* |
| <input type="checkbox"/> Moclodura* | <input type="checkbox"/> Rivivol* |
| <input type="checkbox"/> Nardil* | <input type="checkbox"/> Propilniazide* |
| <input type="checkbox"/> Adeline* | <input type="checkbox"/> Zyvox* |
| <input type="checkbox"/> Eldepryl* | <input type="checkbox"/> Zyvoxid* |
| <input type="checkbox"/> Azilect* | |

Dopamine Receptor Agonists

- | |
|-----------------------------------|
| <input type="checkbox"/> Mirapex* |
| <input type="checkbox"/> Sifrol* |
| <input type="checkbox"/> Requip* |

Norepinephrine Reuptake Inhibitors (NDRI)

- | |
|---|
| <input type="checkbox"/> Wellbutrin XL* |
|---|

D2 Dopamine Receptor Blockers (antipsychotics)

- | | |
|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Thorazine* | <input type="checkbox"/> Acuphase* |
| <input type="checkbox"/> Prolixin* | <input type="checkbox"/> Haldol* |
| <input type="checkbox"/> Trilafon* | <input type="checkbox"/> Orap* |
| <input type="checkbox"/> Compazine* | <input type="checkbox"/> Clozaril* |
| <input type="checkbox"/> Mellaril* | <input type="checkbox"/> Zyprexa* |
| <input type="checkbox"/> Stelazine* | <input type="checkbox"/> Zydis* |
| <input type="checkbox"/> Vesprin* | <input type="checkbox"/> Seroquel XR* |
| <input type="checkbox"/> Nozinan* | <input type="checkbox"/> Geodon* |
| <input type="checkbox"/> Depixol* | <input type="checkbox"/> Solian* |
| <input type="checkbox"/> Navane* | <input type="checkbox"/> Invega* |
| <input type="checkbox"/> Fluaxol* | <input type="checkbox"/> Abilify* |
| <input type="checkbox"/> Clopixol* | |

GABA Antagonist Competitive Binder

- | |
|-------------------------------------|
| <input type="checkbox"/> Romazicon* |
|-------------------------------------|

Agonist Modulators of GABA Receptors (benzodiazepines)

- | | |
|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Xanax* | <input type="checkbox"/> Dalmane* |
| <input type="checkbox"/> Lexotanil* | <input type="checkbox"/> Ativan* |
| <input type="checkbox"/> Lexotan* | <input type="checkbox"/> Loramet* |
| <input type="checkbox"/> Librium* | <input type="checkbox"/> Sedoxil* |
| <input type="checkbox"/> Klonopin* | <input type="checkbox"/> Dormicum* |
| <input type="checkbox"/> Valium* | <input type="checkbox"/> Serax* |
| <input type="checkbox"/> ProSom* | <input type="checkbox"/> Restoril* |
| <input type="checkbox"/> Rohypnol* | <input type="checkbox"/> Halcion* |
| <input type="checkbox"/> Magadon* | |

Agonist Modulators of GABA Receptors (non-benzodiazepines)

- | |
|-------------------------------------|
| <input type="checkbox"/> Ambien CR* |
| <input type="checkbox"/> Sonata* |
| <input type="checkbox"/> Lunesta* |
| <input type="checkbox"/> Imovance* |

Acetylcholine Receptor Agonists

- | | |
|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Uncholine* | <input type="checkbox"/> Salagen* |
| <input type="checkbox"/> Evoxac* | <input type="checkbox"/> Isopto* |
| <input type="checkbox"/> Anectine* | <input type="checkbox"/> Nicotine* |

Acetylcholine Receptor Antagonists Antimuscarinic Agents

- | | |
|-----------------------------------|------------------------------------|
| <input type="checkbox"/> AtroPen* | <input type="checkbox"/> Atrovent* |
| <input type="checkbox"/> Scopace* | <input type="checkbox"/> Spiriva* |

Acetylcholine Receptor Antagonists Ganglionic Blockers

- | | |
|--|--|
| <input type="checkbox"/> Inversine* | <input type="checkbox"/> Hexamethonium |
| <input type="checkbox"/> Nicotine (high doses) | <input type="checkbox"/> Arfonad* |

Acetylcholine Receptor Antagonists Neuromuscular Blockers

- | | |
|--|--|
| <input type="checkbox"/> Atracurium | <input type="checkbox"/> Rocuronium |
| <input type="checkbox"/> Cisatracurium | <input type="checkbox"/> Anectine* |
| <input type="checkbox"/> Doxacurium | <input type="checkbox"/> Tubocurarine |
| <input type="checkbox"/> Metocurine | <input type="checkbox"/> Vecuronium |
| <input type="checkbox"/> Mivacurium | <input type="checkbox"/> Hemicholinium |
| <input type="checkbox"/> Pancuronium | |

Acetylcholinesterase Reactivators

- | |
|------------------------------------|
| <input type="checkbox"/> Protopam* |
|------------------------------------|

Cholinesterase Inhibitors (reversible)

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Aricept* | <input type="checkbox"/> Enlon* |
| <input type="checkbox"/> Razadyne* | <input type="checkbox"/> Prostigmin* |
| <input type="checkbox"/> Exclon* | <input type="checkbox"/> Antilirium* |
| <input type="checkbox"/> Cognex* | <input type="checkbox"/> Mestinon* |
| <input type="checkbox"/> THC | |
| <input type="checkbox"/> Carbamate insecticides | |

Cholinesterase Inhibitors (irreversible)

- | |
|--|
| <input type="checkbox"/> Echothiophate |
| <input type="checkbox"/> Flexyx* |
| <input type="checkbox"/> Organophosphate insecticides |
| <input type="checkbox"/> Organophosphate-containing nerve agents |