



3709 Strawberry Plains Rd. Suite D • Williamsburg, VA 23188

757-229-6069

Dr. Robert Kuhn

Vision: A Primary Healthcare Center dedicated to optimizing the health and well- being of our patients.

Mission: Add Value to your life!

Goals:

1. To do the appropriate testing on each patient to find the root cause of their condition.
2. To prevent neurological degeneration. (brain and nerve damage)
3. To return you to the most optimal state of health possible.
4. To enhance, extend, and have maximum positive impact on your life.

Platinum Chiropractic
CONFIDENTIAL PATIENT INFORMATION
(Please Print)

Date: _____ E-mail Address _____
Full Name: _____
Name of Wife, Husband, or Guardian: _____
Address: _____
City _____ State _____ Zip Code _____
Telephone Number () _____ Cell Phone Number () _____
Social Security No. _____ -- _____ -- _____
Birth Date: _____ No. of Children _____ Currently Pregnant? _____
Marital Status: S ___ M ___ D ___ W ___ Student: No ___ Part Time ___ Full Time ___
Occupation: _____
Employer's Name / Phone #: _____
Spouse's Occupation/Employer _____
Name and Phone # of Emergency Contact: _____
How did you hear about our office? _____

INSURANCE INFORMATION

Primary Insurance Co. _____
Subscriber's Name _____
Relationship Patient _____
Subscriber's Birth Date _____
Subscriber's SS# _____
Subscriber's Employer _____
Is patient covered by additional insurance? _____ Yes _____ No

Secondary Insurance Co. _____
Subscriber's Name _____
Relationship Patient _____
Subscriber's Birth Date _____
Subscriber's SS# _____
Subscriber's Employer _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Kuhn all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above name doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. In addition, I give Dr. Kuhn consent to treat utilizing chiropractic care.

Signature of patient/parent _____ **Date** _____

NOTICE OF PRIVACY PRACTICES

I have received a copy of the HIPAA Privacy Regulations and understand that my private healthcare information is protected.

Signature of patient/parent _____ **Date** _____

List Chiropractors you have seen before:

1. Name: _____ When Visited: _____
2. Name: _____ When Visited: _____

List Medical Doctors consulted within the past year:

1. Name: _____ Reason for visit? _____
2. Name: _____ Reason for visit? _____

Please list all your reasons for visiting our office:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List **ALL** medications you take. (Prescriptions and over-the-counter- use additional pages if needed)

Drug name:	Dosage:	How long have you taken this and for what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

List **ALL** medications you take. (Use additional pages if needed)

Name of Supplements:	Dosage:	How long have you taken this and for what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

List **ALL** previous hospitalizations, surgeries, accidents, fractures and illnesses (Use additional pages)
(Example: **All past** Auto, Sports, Work, Home related.)

- | | | |
|---------------|------------|----------------------------------|
| 1. Type _____ | When _____ | Hospitalized? Yes _____ No _____ |
| 2. Type _____ | When _____ | Hospitalized? Yes _____ No _____ |
| 3. Type _____ | When _____ | Hospitalized? Yes _____ No _____ |
| 4. Type _____ | When _____ | Hospitalized? Yes _____ No _____ |

Patient Name: _____

Check **ALL** "body signals" (symptoms/ pain) you may have had or do have now:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> ADD/ ADHD | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Eczema | <input type="checkbox"/> High Blood Sugar | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Irregular Periods/Cramps | <input type="checkbox"/> Raynaud's |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Kidney infections/stones | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Goiter | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinus infections |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Celiac/ Gluten Dis. | <input type="checkbox"/> Headaches | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lupus | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraine | <input type="checkbox"/> Vertigo/dizziness |

Please check all of the following conditions your family has experienced:

- | | | | | | | | |
|------------------|--------------------------------------|---------------------------------|-----------------------------------|--|--------------------------------------|-----------------------------|---------------------------------|
| Mother: | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> MS | <input type="checkbox"/> Stroke |
| Father: | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> MS | <input type="checkbox"/> Stroke |
| GrandMother (M): | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> MS | <input type="checkbox"/> Stroke |
| GrandFather (M): | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> MS | <input type="checkbox"/> Stroke |
| GrandMother (P): | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> MS | <input type="checkbox"/> Stroke |
| GrandFather (P): | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> MS | <input type="checkbox"/> Stroke |
| Sisters: | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> MS | <input type="checkbox"/> Stroke |
| Brothers: | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> MS | <input type="checkbox"/> Stroke |

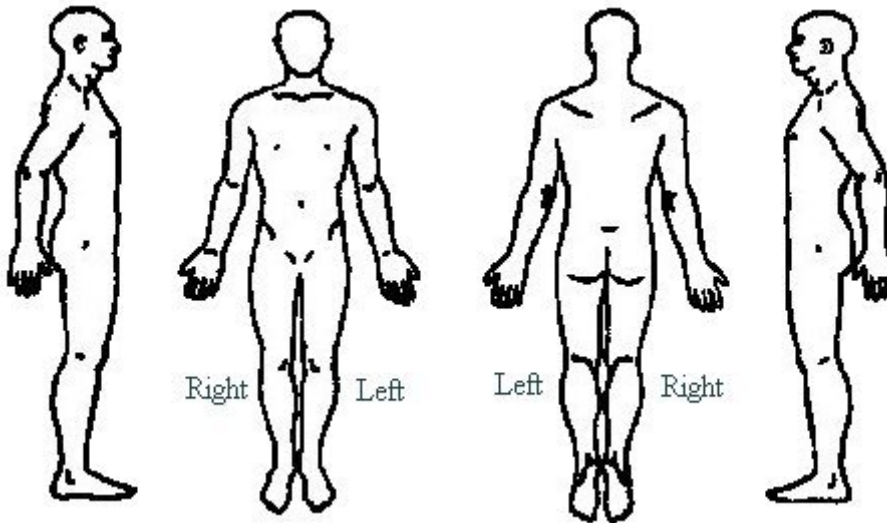
List any other health conditions that you or your family have had that are not listed: _____

Do you consume any of the following? (Leave blank what doesn't apply)

- Tobacco products (packs/day) _____ How many years? _____ Alcohol drinks/day _____ How many years? _____
Coffee/Tea cups/day _____ Regular or decaf? _____ Soft drinks # day _____ Regular or diet? _____
Do you use artificial sweeteners? _____ Yes _____ No If yes please list _____

Level of exercise? _____ None _____ Moderate (days per week) _____ Strenuous (days per week)
Have you experienced any unexplained or rapid weight changes in the last six months? _____ Yes _____ No _____ lbs

Please mark off the areas of your complaint on the diagram below. Use the following symbols:
P= pain, N= numbness, T= tingling, B= burning, C= cramping



**PLATINUM CHIROPRACTIC
NEUROLOGICAL ASSESMENT FORM**

NAME: _____

DATE: _____

- | | | | |
|--------------------------|---|-------|------|
| <input type="checkbox"/> | Are you left or right handed? _____ | Right | Left |
| <input type="checkbox"/> | Have you had a head injury? _____ | YES | NO |
| <input type="checkbox"/> | Do you currently experience or have a past history of vertigo or balance disorders? _____ | YES | NO |
| <input type="checkbox"/> | Do you have any ringing or pressure in the ears? _____ | YES | NO |
| <input type="checkbox"/> | Do you experience nausea? _____ | YES | NO |
| <input type="checkbox"/> | Do you find that your balance is getting worse? _____ | YES | NO |
| <input type="checkbox"/> | Do you have difficulties walking down stairs? _____ | YES | NO |
| <input type="checkbox"/> | Do you have difficulty with math problems, or remembering numbers? _____ | YES | NO |
| <input type="checkbox"/> | Do you find yourself searching for words frequently when you speak? _____ | YES | NO |
| <input type="checkbox"/> | Have you noticed your ability to concentrate is getting worse? _____ | YES | NO |
| <input type="checkbox"/> | Do you get lost often or have a hard time with directions? _____ | YES | NO |
| <input type="checkbox"/> | Do quick flashes of light on TV or loud noises bother you? _____ | YES | NO |
| <input type="checkbox"/> | Do you feel like you need to wear sunglasses outside? _____ | YES | NO |
| <input type="checkbox"/> | Has your handwriting changed in recent years? _____ | YES | NO |
| <input type="checkbox"/> | Do you have a hard time swallowing? _____ | YES | NO |
| <input type="checkbox"/> | Do you gag easily? _____ | YES | NO |
| <input type="checkbox"/> | Do you experience blurriness in your vision or double vision? ← (CIRCLE) _____ | YES | NO |
| <input type="checkbox"/> | Do you have any changes in smell or smell foul things that are not present? _____ | YES | NO |
| <input type="checkbox"/> | Do you have any difficulty with taste or taste things differently than what you are eating? _____ | YES | NO |
| <input type="checkbox"/> | Noticed clumsiness in hand coordination? Which hand? Right/ Left ← (CIRCLE) _____ | YES | NO |
| <input type="checkbox"/> | Do you have difficulty with short-term memory? _____ | YES | NO |
| <input type="checkbox"/> | Have you been told or noticed any memory loss of past events? _____ | YES | NO |
| <input type="checkbox"/> | Noticed uneven sweating or temperature on one side of your body? _____ | YES | NO |
| <input type="checkbox"/> | Do you have any tightness, weakness or instability in your back or neck? ← (CIRCLE) _____ | YES | NO |
| <input type="checkbox"/> | Do you have tightness, or feelings of weakness in your hands or legs? ← (CIRCLE) _____ | YES | NO |
| <input type="checkbox"/> | Do you ever have any numbness or tingling in your hands, legs, or face? ← (CIRCLE) _____ | YES | NO |
| <input type="checkbox"/> | Do you have any difficulty with falling asleep or staying asleep? _____ | YES | NO |
| <input type="checkbox"/> | Do you get motion sickness easily (car sick or sea sick)? _____ | YES | NO |
| <input type="checkbox"/> | Do you ever experience flashes of light in your visual field? _____ | YES | NO |
| <input type="checkbox"/> | Do you ever experience dry eyes or mouth? ← (CIRCLE) _____ | YES | NO |
| <input type="checkbox"/> | Do you ever experience increase tearing or salivation? ← (CIRCLE) _____ | YES | NO |
| <input type="checkbox"/> | Do you ever have slurred speech? _____ | YES | NO |
| <input type="checkbox"/> | Noticed any drooping of your eyelids or facial muscles? ← (CIRCLE) _____ | YES | NO |
| <input type="checkbox"/> | Do you ever notice increased heart rate (tachycardia) or pulse during the day? _____ | YES | NO |
| <input type="checkbox"/> | Have you ever experienced or been diagnosed with arrhythmia (fluctuating heart rate)? _____ | YES | NO |
| <input type="checkbox"/> | Do you experience Déjà vu? _____ | YES | NO |
| <input type="checkbox"/> | Does driving cause you fatigue, headaches, or other symptoms? ← (CIRCLE) _____ | YES | NO |
| <input type="checkbox"/> | Does working on a computer cause you fatigue, headaches or other symptoms? _____ | YES | NO |
| <input type="checkbox"/> | Have you lost your interest in hobbies and functions that you used to enjoy? _____ | YES | NO |
| <input type="checkbox"/> | Do you have a hard time motivating yourself to engage in activities? _____ | YES | NO |
| <input type="checkbox"/> | Do you ever have fluttering of the eye or noticed you are blinking frequently? _____ | YES | NO |
| <input type="checkbox"/> | Do you have difficulty distinguishing right and left? _____ | YES | NO |

Patient Signature: _____

Date: _____

Patient Name: _____

Complaint History

Complaint 1: _____

When did your complaint first begin? _____ Have you ever experienced this complaint before? _____

What makes your problem better? _____

What makes your problem worse? _____

Describe the type of pain/ symptom you experience? _____

Does your problem travel into any other part of your body? Where? _____

Where exactly is the complaint area? _____

Have you lost control of any body part (arms, legs, bladder, bowel, etc..)? _____

Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? _____

Complaint 2: _____

When did your complaint first begin? _____ Have you ever experienced this complaint before? _____

What makes your problem better? _____

What makes your problem worse? _____

Describe the type of pain/ symptom you experience? _____

Does your problem travel into any other part of your body? Where? _____

Where exactly is the complaint area? _____

Have you lost control of any body part (arms, legs, bladder, bowel, etc..)? _____

Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? _____

Complaint 3: _____

When did your complaint first begin? _____ Have you ever experienced this complaint before? _____

What makes your problem better? _____

What makes your problem worse? _____

Describe the type of pain/ symptom you experience? _____

Does your problem travel into any other part of your body? Where? _____

Where exactly is the complaint area? _____

Have you lost control of any body part (arms, legs, bladder, bowel, etc..)? _____

Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Platinum Chiropractic may prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Platinum Chiropractic, will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that I am responsible for all attorney fees or collection fees related to the collection of my account. I agree to pay interest at the rate of 1.5% per month (18% per annum) on any unpaid balance.

Patient Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

The Neck Disability

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1- PAIN INTENSITY

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

SECTION 2- PERSONAL CARE (Washing, Dressing, etc.)

- I can look after myself normally, without causing extra pain
- I can look after myself normally, but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help, but manage most of my personal care
- I need help every day in most aspects of my life
- I do not get dressed: I was with difficulty and stay in bed

SECTION 3- LIFTING

- I can lift heavy weights without extra pain
- I can lift heavy weights, but it gives extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example- on table
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
- I can lift very light weights
- I cannot lift or carry anything at all

SECTION 4- READING

- I can read as much as I want to, with no pain in my neck
- I can read as much as I want to, with slight pain in my neck
- I can read as much as I want to, with moderate pain in my neck
- I can read as much as I want to, because of moderate pain in my neck
- I can hardly read at all, because severe pain in my neck
- I cannot read at all

SECTION 5- HEADACHES

- I have no headaches at all
- I have slight headaches that come frequently
- I have moderate headaches that come infrequently
- I have moderate headaches that come frequently
- I have severe headaches that come frequently
- I have headaches almost all the time

SECTION 6- CONCENTRATION

- I can concentrate fully when I want to without difficulty
- I can concentrate fully when I want to with slight difficulty
- I have a fair degree of difficulty in concentrating when I want to
- I have a lot of difficulty in concentrating when I want to
- I have a great deal of difficulty in concentrating when I want to
- I cannot concentrate at all

SECTION 7- WORK

- I can do as much work as I want to
- I can do my usual work but no more
- I can do most of my usual work; but no more
- I cannot do my usual work
- I can hardly do any work at all
- I can't do any work at all

SECTION 8- DRIVING

- I can drive my car without any neck pain
- I can drive my car as long as I want, with slight neck pain
- I can drive my car as long as I want, with moderate neck pain
- I can't drive my car as long as I want, because of moderate neck pain
- I can't drive at all, because of severe neck pain
- I can't drive my car at all

SECTION 9- SLEEPING

- I have no trouble sleeping
- My sleep is slightly disturbed (less than 1 hr sleepless)
- My sleep is slightly disturbed (1-2 hrs sleepless)
- My sleep is moderately disturbed (2-3 hrs sleepless)
- My sleep is greatly disturbed (3-5 hrs sleepless)
- My sleep is completely disturbed (5-7 hrs sleepless)

SECTION 10- RECREATION

- I am able to engage in all my recreation activities, with no neck pain at all
- I am able to engage in all my recreation activities, with some neck pain
- I am able to engage in most, but not all, of my usual recreational activities because of neck pain
- I am able to engage in few of my recreation activities, because of my neck pain

PRINTED NAME

DATE

PATIENT SIGNATURE

The Revised Oswestry Disability Index (for low back pain/ dysfunction)

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1- PAIN INTENSITY

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is very severe.
- The pain is severe and does not vary much.

SECTION 2- PERSONAL CARE (Washing, Dressing, etc.)

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing, or dressing even though it causes some pain.
- Washing and dressing increases the pain, but I manage not to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3- LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on the table)
- Pain prevents me from lifting heavy objects off the floor.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

SECTION 4- WALKING

- I have no pain on walking.
- I have some pain on walking, but it does not increase with distance.
- I cannot walk more than one-mile without increasing pain.
- I cannot walk more than ½ mile without increasing pain.
- I cannot walk more than ¼ mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5- SITTING

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 min.
- I avoid sitting because of pain right away.

SECTION 6- STANDING

- I can stand as long as I want without pain.
- I have some pain on standing, but it does not increase with time.
- I cannot stand for longer than 1 hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand for longer than 10 minutes increasing pain.
- I avoid standing because there is pain right away.

SECTION 7- SLEEPING

- I get no pain in bed.
- I get pain in bed, but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than ¼
- Because of pain, my normal nights sleep is reduced by less than ½
- Because of my pain, my normal night's sleep is reduced by less than ¾
- Pain prevents me from sleeping at all.

SECTION 8- SOCIAL LIFE

- My social life is normal and gives no pain.
- My social life is normal, but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

SECTION 9- TRAVELING

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel makes it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling, which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

PRINTED NAME: _____

SIGNATURE: _____ DATE: _____

Metabolic Assessment Form

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

PART I

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

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

PART II

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

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

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

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

Category XIV (Males only)				
Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3
Category XV (Males only)				
Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3
Category XVI (Menstruating Females Only)				
Are you premenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 24 days	Yes	No		
Shortened menses, less than every 24 days	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/ thinning	0	1	2	3
Category XVII (Menopausal Females Only)				
How many years have you been menopausal?				
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consumer per day? _____

How many times a week do you work out? _____

How many times do you eat out per week? _____

How many times a week do you eat fish? _____

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

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

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

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

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

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

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

Health Questionnaire (NTAF)

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

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

SECTION A

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

SECTION B

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

SECTION C

SECTION C1

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

SECTION C2

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

SECTION 1-S

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

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

SECTION 2-D

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

SECTION 3-G

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

SECTION 4-ACH

- Do you feel your visual memory (shapes & images) is decreased? 0 1 2 3
- Do you feel your verbal memory is decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity been decreased? 0 1 2 3
- Has your comprehension been diminished? 0 1 2 3
- Do you have difficulty calculating numbers? 0 1 2 3
- Do you have difficulty recognizing objects and 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

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

Acetylcholine Receptor Reactivators

Pralidoxime

Acetylcholine Receptor Antagonist- Neuromuscular Blockers

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

Agonist Modulator of GABA Receptor (benzodiazepines)

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

Agonist Modulator of GABA Receptors (nonbenzodiazepines)

Ambien, Sonata, Lunesta, Imovane

Cholinesterase Inhibitors (irreversible)

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

Cholinesterase Inhibitors (reversible)

Donepezil, Galatamine, Rivastigmine, Tacrine, THA, Erophonium, Neostigmine, Physostigmine, Pyridostigmine,
Carbamate Insecticides

Dopamine Reuptake Inhibitors

Wellbutrin (Bupropion)

Dopamine Receptor Antagonist

Mirapex, Sifrol, Requip

Medication History Continued...

D2 Dopamine Receptor Blockers (antipsychotics)

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

GABA Antagonist Competitive binder

Flumazenil

Monoamine Oxidase Inhibitor (MAOI)

Marplan, Auroix, Maneric, Moclodura, Nardil, Adlegiine, Elepryl, Azilect, Marsilid, Iprozid, 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, Cipralext, Esteria, Fontex, Seromex, Seronil, Sarafem, Fluctin, Faverin, Seroxat, 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, Deolox, Moxadil, Anafranal, Norpramin, Pertofrane, Prothiadin, Thanden, Adapin, Sinequan, Trofranil, Janamine, Gamanil, Aventyl, Pamelor, Opipramol, Vivactil, Rholtrimine, Surmontil