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: _____
Employers Name / phone number_____
Spouses Ocupation/Employer_____
Name and phone # of Emergency Contact: _____
How did you hear about our office? _____
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*** nutritional supplements 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 ____

Patient Name: _____

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

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

Please Check all of the following conditions your family has experienced.

Mother:	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
Father:	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
GrandMother (M):	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
GrandFather (M):	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
GrandMother (P):	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
GrandFather (P):	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
Sisters:	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ Stroke	
Brothers:	___ Alzheimer's	___ Cancer	___ Diabetes	___ Heart Disease	___ Parkinson's	___ MS	___ 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? ___

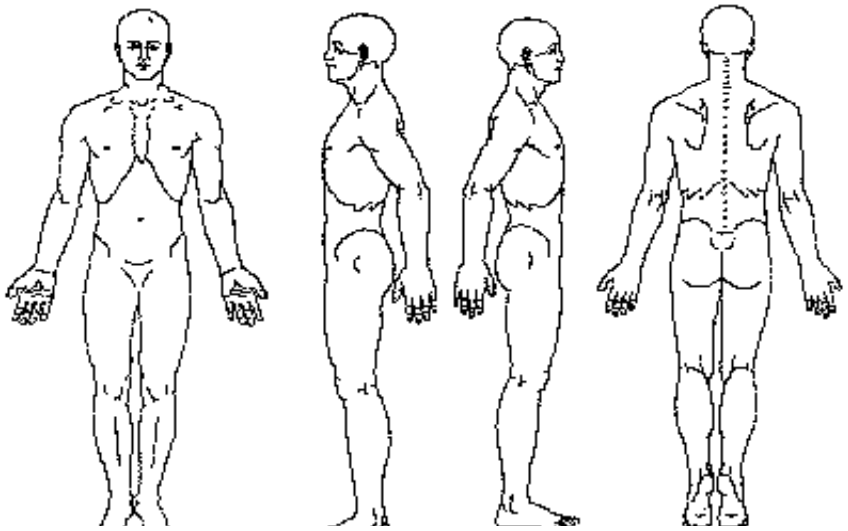
Do you use artificial sweeteners?___ Yes ___ No If yes please list? _____

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



Please use the following symbols on the pain diagram to accurately describe your condition.

NAME: _____ DATE: _____

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

Patient Signature: _____ Date: _____

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 status.

SECTION 1 – PAIN INTENSITY

- ❑ The pain comes and goes and is very mild.
- ❑ The pain is mild and does not vary much.
- ❑ The pain come 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.
- ❑ Washing and dressing increases the pain and I find it necessary 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 % mile without increasing pain.
- ❑ I cannot walk more than % 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 1/2 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 % hour without increasing pain.
- ❑ I cannot stand for longer than 10 min without 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 nights sleep is reduced by less than %.
- ❑ Because of pain, my normal nights sleep is reduced by less than %.
- ❑ Because of my pain, my normal nights sleep is reduced by less than %.
- ❑ Pain prevents me from sleeping at all.

SECTION 8 – SOCIAL LIFE

- ❑ My social life is normal and gives me 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 form of travel.
- ❑ Pain prevents all forms of travel except that done lying down.

SECTION 10 – CHANGING DEGREE OF PAIN

PRINTED NAME:_____

SIGNATURE:_____ **DATE:**_____

The Neck Disability Index

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

- ❑ 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 I 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 wash 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 a 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't read as much as I want 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
- ❑I can't do any recreational activities at all.

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 usually 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 pain in my neck
- ❑ I can drive my car as long as I want, with moderate pain in my neck
- ❑ I can't dive as long as I want because of moderate pain in my neck.
- ❑ I can't drive at all, because of severe pain in my neck.
- ❑ 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 the pain in my neck
- ❑ I am able to engage in few of my recreation activities, because of the pain in my neck

PRINT NAME _____DATE_____ PATIENTS SIGNATURE_____

Metabolic Assessment Form™

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

PART I

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

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

PART II **Please circle the appropriate number 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 relieved 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 or "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

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

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 food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of 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 by using antacids, food, milk, or 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 VI

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 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

Category VI *(Cont.)*

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

Category VII

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
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	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 VIII

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category IX

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed 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 X

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI

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 XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount 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 XIII

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight 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 hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

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

Category XV *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI *(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 emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty 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
Decreased 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 XVIII *(Menstruating Females Only)*

Perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle (greater than 32 days)	Yes	No
Shortened menstrual cycle (less than 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	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XIX *(Menopausal Females Only)*

How many years have you been menopausal? _____ years

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

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

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

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

How many times do you eat fish per week? _____

How many times do you work out per week? _____

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

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

PART IV

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

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

Neurotransmitter Assessment Form™ (NTAF)

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

Please circle the appropriate number 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 new things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament generally getting worse? 0 1 2 3
- Is your attention span decreasing? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you become fatigued when driving compared to in the past? 0 1 2 3
- How often do you become fatigued when reading compared to in 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 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 light-headedness 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

- How often do you get fatigued after meals? 0 1 2 3
- How often do you crave sugar and sweets after meals? 0 1 2 3
- How often do you feel you need stimulants, such as coffee, after meals? 0 1 2 3
- How often 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 increased? 0 1 2 3
- How often do you gain weight when under stress? 0 1 2 3
- How often do you have difficulty falling asleep? 0 1 2 3

SECTION 1

- Are you losing interest in hobbies? 0 1 2 3
- How often do you feel overwhelmed? 0 1 2 3
- How often do you have feelings of inner rage? 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 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

- 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

- How often do you feel anxious or panicked 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

- Do you feel your visual memory (shapes & images) has decreased? 0 1 2 3
- Do you feel your verbal memory has decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity decreased? 0 1 2 3
- Has your comprehension 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 a slower mental response? 0 1 2 3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Medication History*

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

Noradrenergic and Specific Sertonergic Antidepressants (NaSSAas)

- ☐ Remeron®
- ☐ Zispin®
- ☐ Avanza®
- ☐ Norset®
- ☐ Remergil®
- ☐ Axit®

Tricylic Antidepressants (TCAs)

- ☐ Elavil®
- ☐ Endep®
- ☐ Tryptanol
- ☐ Trepiline®
- ☐ Asendin®
- ☐ Asendis®
- ☐ Defanyl®
- ☐ Demolox®
- ☐ Moxadil®
- ☐ Anafranil®
- ☐ Norpramin®
- ☐ Pertofrane®
- ☐ Thaden™
- ☐ Prothiaden®
- ☐ Adapin®
- ☐ Sinequan®
- ☐ Tofranil®
- ☐ Janamine®
- ☐ Gamanil®
- ☐ Aventyl®
- ☐ Pamelor®
- ☐ Opipramol®
- ☐ Vivactil®
- ☐ Rhotrimine®
- ☐ Surmontil®

Selective Serotonin Reuptake Inhibitors (SSRIs)

- ☐ Paxil®
- ☐ Zoloft®
- ☐ Prozac®
- ☐ Celexa®
- ☐ Lexapro®
- ☐ Esertia®
- ☐ Luvox®
- ☐ Cipramil®
- ☐ Emocal®
- ☐ Seropram®
- ☐ Cipralex®
- ☐ Fontex®
- ☐ Priligy®
- ☐ Seromex®
- ☐ Seronil®
- ☐ Sarafem®
- ☐ Fluctin®
- ☐ Faverin®
- ☐ Seroxat®
- ☐ Aropax®
- ☐ Deroxat®
- ☐ Rexetin®
- ☐ Paroxat®
- ☐ Lustral®
- ☐ Serlain®

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

- ☐ Effexor®
- ☐ Pristiq®
- ☐ Meridia®
- ☐ Serzone®
- ☐ Dalcipran®
- ☐ Norpramin®
- ☐ Cymbalta®

Selective Serotonin Reuptake Enhancers (SSREs)

- ☐ Stablon®
- ☐ Coaxil®
- ☐ Tatinol®

Monoamine Oxidase Inhibitors (MAOIs)

- ☐ Marplan®
- ☐ Aurorix®
- ☐ Manerix®
- ☐ Moclodura®
- ☐ Nardil®
- ☐ Adeline®
- ☐ Eldepryl®
- ☐ Azilect®
- ☐ Marsilid®
- ☐ Iprozid®
- ☐ Ipronid®
- ☐ Rivivol®
- ☐ Propilniazide®
- ☐ Zyvox®
- ☐ Zyvoxid®

Dopamine Receptor Agonists

- ☐ Mirapex®
- ☐ Sifrol®
- ☐ Requip®

Norepinephrine and Dopamine Reuptake Inhibitors (NDRI)

- ☐ Wellbutrin XL®

D2 Dopamine Receptor Blockers (antipsychotics)

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

GABA Antagonist Competitive Binder

- ☐ Romazicon®

Agonist Modulators of GABA Receptors (benzodiazepines)

- ☐ Xanax®
- ☐ Lexotanil®
- ☐ Lexotan®
- ☐ Librium®
- ☐ Klonopin®
- ☐ Valium®
- ☐ ProSom®
- ☐ Rohypnol®
- ☐ Magadon®
- ☐ Dalmane®
- ☐ Ativan®
- ☐ Loramet®
- ☐ Sedoxil®
- ☐ Dormicum®
- ☐ Serax®
- ☐ Restoril®
- ☐ Halcion®

Agonist Modulators of GABA Receptors (non-benzodiazepines)

- ☐ Ambien CR®
- ☐ Sonata®
- ☐ Lunesta®
- ☐ Imovane®

Acetylcholine Receptor Agonists

- ☐ Urecholine®
- ☐ Evoxac®
- ☐ Anectine®
- ☐ Salagen®
- ☐ Isopto®
- ☐ Nicotine

Acetylcholine Receptor Antagonists Antimuscarinic Agents

- ☐ AtroPen®
- ☐ Scopace®
- ☐ Atrovent®
- ☐ Spiriva®

Acetylcholine Receptor Antagonists Ganglionic Blockers

- ☐ Inversine®
- ☐ Nicotine (high doses)
- ☐ Hexamethonium
- ☐ Arfonad®

Acetylcholine Receptor Antagonists Neuromuscular Blockers

- ☐ Atracurium
- ☐ Cisatracurium
- ☐ Doxacurium
- ☐ Metocurine
- ☐ Mivacurium
- ☐ Pancuronium
- ☐ Rocuronium
- ☐ Anectine®
- ☐ Tubocurarine
- ☐ Vecuronium
- ☐ Hemicholinium

Acetylcholinesterase Reactivators

- ☐ Protopam®

Cholinesterase Inhibitors (reversible)

- ☐ Aricept®
- ☐ Razadyne®
- ☐ Exelon®
- ☐ Cognex®
- ☐ THC
- ☐ Carbamate insecticides
- ☐ Enlon®
- ☐ Prostigmin®
- ☐ Antilirium®
- ☐ Mestinon®

Cholinesterase Inhibitors (irreversible)

- ☐ Echothiophate
- ☐ Flexyx®
- ☐ Organophosphate insecticides
- ☐ Organophosphate-containing nerve agents

SMGENTAF04(013013)

Please refer to prescribing physician for nutritional interactions with any medications you are taking.

Assignment and Instruction for Direct Payment to the Doctor
Private and Group, Accident and Health Insurance

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Elkton Chiropractic Neurology
139 East Main Street
Elkton MD 21921

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a Current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or Attorney involved in this case.

Dated at the Elkton Chiropractic Neurology _____

Signature of Policy Holder_____
Signature of Claimant, if other than Policy Holder

Elkton Chiropractic Neurology S G Charles DC DACNB 139 East Main Street Elkton MD 21921

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or her preceptor and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided or forward a copy in via e-mail at my request. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already take action in reliance thereon.
I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____
Name (Printed) Date Signed

_____
Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

_____
Witness to Patients' Signature

Elkton Chiropractic Neurology

139 East Main Street · Elkton MD 21921 · 410 398 2108

Privacy Authorization for the Elkton Chiropractic Neurology

Dr. Charles and members of the practice staff may need to use your name, address, phone number and clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine or with a family member.

You can restrict the individuals to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or that other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments in an open room style, with other patients in the same room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed at your office visits. Private rooms are available for any other needed consultations.

You may inspect or request a copy, for a fee, the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time (#164.524)

This Notice is effective as of April 14, 2003. This authorization will expire seven years after the date in which you last received services from us. You may receive a copy of this form when needed.

I authorize you to use or disclose my health information in the manner described. I also acknowledge that I have read and received a copy of the Elkton Chiropractic Neurology Privacy Policy.

Patient Signature_____ Date_____