BOULDER, CO 80301 3063 STERLING CIRCLE STE 1 WWW.HEALATHEAL.COM F: 303.440.4346 P: 303.440.HEAL(4325)

Comprehensive Patient Intake Form

Today's Date: ___________

Name: ____ Sex: (M / F)
Street: ____ City: ________________ Zip:_______
Phone #: (H) (____) ____________ (W) (____) ____________ (C) (____) ____________
Email: __________________________ DOB: _____/_____/_____ Age: _______ Ht: ____ Wt: _____

Married / Divorced / Single / Widowed / Separated / Partnered (circle one) Place of Birth: __________________
Emergency Contact's Name and Phone #: ____
Occupation: __________________________
Occupational Stresses (Chemical, physical, psychological, etc.): ______________________________________

____

____

Hobbies/Past-times: ____________________________ Denomination/Spiritual Path: ____________________
Referred by: ______________________ Physician: ____________________________ Phone: _____________
Main Concern/health issue: (1) ____
(2) ____
(3) ____
(4) ____
(5) ____
(6) ____
Recent Exams: (give dates)
Physical: _______________ Eye: _______________ Dental: _______________
Ob/Gyn: _______________ Specialist:_______________
What is your philosophy of health care?: ____
Do you have health questions that do not get answered at the doctor's office?: (Y / N)

____

____

Your Physical health status now feels: (poor) 1· · · · · · · · · · 5 · · · · · · · · · · 10 (ideal)
Your Mental health status now feels: (poor) 1· · · · · · · · · · 5 · · · · · · · · · · 10 (ideal)
Your Daily Work stress levels now feel: (poor) 1· · · · · · · · · · 5 · · · · · · · · · · 10 (ideal)
Your Daily or Social stress levels feel: (poor) 1· · · · · · · · · · 5 · · · · · · · · · · 10 (ideal)
Your Home Life stress levels now feel: (poor) 1· · · · · · · · · · 5 · · · · · · · · · · 10 (ideal)
Your ability to handle recent stresses: (poor) 1· · · · · · · · · · 5 · · · · · · · · · · 10 (ideal)

What special topic(s) would you like to ask about at your consultation? _______________________________

____

____

continued on next page

Healthcare: Other Independent or Concurrent Therapies:
Past (P) and/or Current (C)

____ Chiropractic
____ Chiro for family, pets
____ Acupuncture
____ Therapeutic Massage
___ Naturopathic
____ Oriental Medicine
____ Nutritional Consult
____ Medical Treatment
____ Specialist
____ Natural Healer
____ Spiritual Healer
____ Energy Work

Diagnostic or Routine Exams: Please list area, Dr. and reason ordered, date and location of exam if known.

____ X-rays
____ MRI
____ CAT Scan
____ Blood draw
____ Ultrasound
____ Upper/lower GI
____ DEXA Scan
____ Breast Exam
____ Prostate Exam
____ Eye Exam
____ Dental Exam
____ Colonoscopy
____ Other______________
____ Other______________
____ Other______________

Medical History: include dates if possible for both
Past (P) and/or Current (C)

____ Allergies
____ Arthritis
____ Asthma
____ Cancer
____ Depression
____ Diabetes
____ Hepatitis A / B / C
____ Heart disease
____ High blood pressure
____ Low blood pressure
____ Lung disease
____ Neurological
____ Psychological
____ Rheumatic Fever
____ Seizures
____ Thyroid disease
____ Vascular disease
____ Other

Illness/Injuries/Surgeries/Hospitalizations:

____ Broken bones
____ Burns
____ Car accidents
____ Concussion
____ Fallen down/upstairs
____ Fallen from any height
____ Fallen on ice
____ Feeling un-coordinated
____ Fevers
____ Flu/colds
____ Frequent accidents Sports injuries
____ Frequent Illness
____ Frequent Infections
____ Head trauma
____ Hospitalizations
____ Infected wounds
____ Loss of consciousness
____ Psychological Hospitalization
____ Recreational Injuries
____ Serious cuts
____ Serious Depression
____ Significant trauma
____ Surgeries
____ Transfusions
____ Transplants
____ Tripping/Stumbling
____ Wounds slow to heal

Childhood

____ Illnesses
____ Traumatic events
____ Immunizations
____ Injuries
____ Other
____ Other

Skin and Hair

____ Rashes
____ Eczema
____ Hair/skin texture change
____ Ulcerations
____ Pimples
____ Purpura
____ Hives
____ Dandruff
____ Itching
____ Loss of hair
____ New moles/growth
____ Other

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General: List times of day or any correlating factors

____ Poor appetite
____ Heavy appetite
____ Change in appetite
____ Weight gain
____ Weight loss
____ Cravings salt/sweet/fats
____ Poor sleep
____ Can't fall asleep easily
____ Wake feeling rested
____ Decreased sleep
____ Heavy sleep
____ Insomnia
____ Apnea/Narcolepsy
____ Sudden awakening at night, time: ___________(am / pm)
____ Hours of sleep/night
____ Day napping ____ amt
____ Night sweats
____ Cold hands/feet
____ Sudden energy drop
____ Strong thirst hot/cold
____ Fatigue
____ Chills
____ Sudden temp changes
____ Localized weakness
____ Tremors
____ Poor circulation
____ Peculiar tastes/smells
____ Night pain
____ Radiating pain
____ Numbness/tingling
____ Pins and needles
____ Sweats easily
____ Excessive sweating
____ Body odor change
____ Stress
____ Bowel/bladder changes
____ Bleed/bruise easily (where?)

Musculoskeletal: List location and type of pain, i.e. sharp, dull, radiating, traveling, etc…

____ Neck Pain
____ Muscle Pain
____ Back Pain
____ Joint Pain
____ Other muscle or joint problems?
____ Irretractable night pain
____ Scar tissue adhesions

Head, Eyes, Ears Nose and Throat: List any noticeable correlation and frequency these conditions occur

____ Dizziness
____ Migraines
____ Auras, Sounds, Smells
____ Headaches
____ Vision problems
____ Near/Far sighted
____ Blurry vision
____ Night Blindness
____ Eye strain/pain
____ Color blindness
____ Cataracts
____ Glaucoma
____ Spots in eyes
____ Ringing in ears
____ Poor hearing
____ Earaches
____ Ear Pain
____ Ear discharge
____ Heavy ear wax
____ Nose bleeds
____ Sinus problems
____ Mucus
____ Dry throat/mouth
____ Copious saliva (lots)
____ Mouth/tongue sores
____ Sore throats
____ Other

Dental:

____ Teeth problems
____ Cavities
____ Braces
____ Bridges
____ Fillings/amalgams
____ Crowns gold/porcelain
____ Tooth pain
____ Head pain
____ Jaw pain
____ Molars
____ Extractions
____ Surgeries
____ Jaw clicks
____ Grinding teeth
____ Facial pain
____ Implants
____ Dentures
____ Swollen/bleeding gums
____ Periodontal Tx
____ Sealants
____ Fluoride Tx
____ Dry mouth
____ Other______________
____ Other______________

Neurologic:

____ Balance problems
____ Vertigo
____ Nausea
____ Vomiting
____ Sudden blurry vision
____ Loss of consciousness
____ Loss of strength
____ Weakness limb/body
____ Feel un-coordinated
____ Stumbling/tripping
____ "Running into walls or things"
____ Frequently dropping things
____ Loss of hand grip
____ Loss of fine motor skills
____ Other______________
____ Other______________

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Cardio Vascular:

____ High blood pressure
____ Dizziness
____ Blood Clots
____ Low blood pressure
____ Fainting

____ Phlebitis
____ Chest Pain
____ Cold hands/feet
____ Difficulty breathing
____ Irregular heartbeat

____ Hand/feet swelling
____ Rapid pulse
____ Heaviness in chest
____ Other ____________
____ Other____________

Respiratory and Lungs:

____Persistent Cough
____ Coughing Blood
____ Difficulty breathing while lying down
____ Asthma

____ Production of phlegm
Y /N _______Color
____ Tight chest
____ COPD
____ Bronchitis

____ Pneumonia
____ Asthma
____ Other

Genito-Urinary:

____ Pain w/urination
____Loss of bladder function
____Wake to urinate
____ x's/ night; time_____
____ Kidney stones

____ Frequent Urination
_________ color
_________odor
____ Kidney Stones
____ Blood in urine

____ Venereal disease/STD
____ Urgency to urinate
____ Impotency
____ Prostate problems
____ Other ____________

Gastrointestinal:

____ Nausea
____ Gas/bloating
____ Bad breath
____ Constipation
____ Diarrhea
____ Pain or cramps
____ Vomiting
____ Belching

____ Rectal pain
____ Bloody stools
bright/dark red
____ Hemorrhoids
____ Sensitive abdomen
____ Laxative use:
___wk; type_____
____ Bowel Changes

Bowel movements
_______Frequency/day/wk
_______Color
_______Odor (foul)
_______Form (loose, compact)
Texture (smooth, segmented)
Other____________________

Gynecology and pregnancy:

____ Age of 1st menses
____ Flow (describe)
____ Period ___ days
____ Clots
____ Vaginal Sores
____ Vaginal discharge
________odor
________color
________appearance
____ Irregular Periods
____ Last Menses

____ Birth Control
type and duration _________________
____ Number of pregnancies
____ Number of births
____ Live births
____ Premature births;
duration of pregnancy?______
____ Miscarriages;
What month? _____________
____ Breast Lumps (tender?)
____ PMS

____ Mood Changes
____ Body Changes
____ Cramps
____ Bloating
____ Nausea
____ Vomiting
____ Menopause _____
____ Last PAP_______
____ Last Breast Exam
____ Last Ob/GYN Appt

Appliances or Aids

____ Glasses/Prisms
____ Contacts
____ Orthotics
____ Joint replacement

____ Prosthetics
____ Implants of any kind
____ Braces
____ Splints

____ Pace Maker
____ Hearing Aids
____ Other
____ Other

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Neuropsychological:

____ Seizures
____ Depression
____ Anxiety
____ Poor memory
____ Foggy thinking
____ Bad Temper
____ Concussions
____ Easily stressed
____ Considered/attempted suicide
____ Treated for emotional concerns
____ Antidepressant medications
____ Other neurological or psychological concerns

Lifestyle and Social History

Stress Screening:

____ Can you relax when you want?
____ Fall asleep easily?
____ Stay asleep all night?
____ Have trouble dealing with stress?
____ Are you in therapy or counseling? Does it help? (Y / N)
____ Is your family safe to express true emotions?
____ Are romantic relationships fulfilling?
____ Does stress leads to digestive problems?
____ Do you abuse food/alcohol/tobacco to deal w/unpleasant feelings?
____ Do you vent unpleasant emotions in a satisfying way?
____ Do you avoid conflicts at your expense?
____ Do you feel your health is out of your hands?
____ Have you tried to deal with stress, but couldn't succeed?
____ Do you feel capable of resolving your problems, but simply need to know how?
____ How much do you love yourself?
0-------------------------------------100%

Do you find any dysfunction or concern in the following areas?

____ Relationship with Family
____ Relationships with friends
____ Social Skills
____ Career
____ Work
____ Leisure Time
____ Hobbies
____ Past time activities
____ Intimate relationships
____ Sex
____ Religious Life____________
____ Spiritual Path____________
____ Childhood Religious teachings
____ Past relationships
____ Childhood
____ School

Habits: List type and quantities where valid

____ Exercise x's/week________
____ Proper diet
(Please list typical daily meals)
____ Participate in community events
____ Sports___________________
____ Walks___________________
____ Regular Religious activity
____ Regular Spiritual activity
____ Seatbelts
____ Helmets/Protective gear
____ Caffeine/pills/coffee/tea/drinks
____ Consume Alcohol
____ Crave sugar/salt/fats
____ Smoke/chew tobacco
____ Recreational drugs use
____ Un-protected sex
____ Un-necessary risk taking
____ Road Rage
____ Seek conflict

Nutritional: List typical ounces/servings per week and type

____ Drink soda oz/wk__________________________
____ Fruit juices oz/wk_________________________
____ Gatorade oz/wk___________________________
____ Coffee/black tea __________________________
____ Caffeine ________________________________
____ Chocolate_______________________________
____ Alcohol _________________________________
____ health drinks, i.e. Red Bull_________________
____ Nutritional Shakes________________________
____ Health bars______________________________
____ Protein powders__________________________
____ Cravings salt/sweet/fats___________________
____ Meat___________________________________
____ Protein _______________________________
____ Milk, oz/wk ____________________________
____ Dairy, kind _____________________________
____
____ Veg, serving/day________________________
____ Fruits, serving/day______________________
____ Vitamins_______________________________
____
____ Supplements____________________________
____
____ Food Allergies__________________________
____ Other_________________________________
____ Other_________________________________

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Family History: Medical, psychological, social

_____ History of Chief Complaint
_____ Anemia
_____ Alcoholism
_____ Allergies
_____ ALS (Lou Gerhig's)
_____ Arthritis
_____ Asthma
_____ Back/spine problems
_____ Cancer
_____ Dementia/Alzheimer's
_____ Depression
_____ Diabetes
_____ Family violence
_____ Headaches

_____ Heart Disease
_____ High blood pressure
_____ High cholesterol
_____ Low cholesterol
_____ Lung disease
_____ Mental abuse
_____ Mental illness
_____ Migraines
_____ Multiple Sclerosis
_____ Muscular Dystrophy
_____ Neglect
_____ Neuropathy
(numbness, tingling, pain, burning)
_____ Neuromuscular disease

_____ Parkinson's
_____ Physical abuse
_____ Sexual abuse
_____ Seizures
_____ Rigid upbringing
_____ Rigid Religious beliefs
_____ Stroke
_____ Suicide (or attempted)
_____ Thyroid disease
_____ Tremors
_____ Vascular disease
_____ Other_______________
_____ Other_______________

Notes:

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Chief Complaint Worksheet

Symptom/Complaint: ____

____

Onset (What caused it & When did it begin?): ________________________________

____

Provoke (What worsens the complaint: position, activity, stress, food/drinks, motion, etc.?): ____________

____

Palliative (What makes it better: ice, heat, massage, position?): ____________________

____

Quality (Describe what you feel. Is it sharp/dull, burning/aching, throbbing/constant, stabbing/shooting, pinpoint/general):

____

Radiation (Does the pain travel from one area to another?): ______________________

____

Reference: What is the worse pain you've ever experienced?: ______________________

____

Severity:

At Its Worse:	At Its Best:
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Percent of time: ________	Percent of time: ________

Timing: (Is the pain constant or intermittent? Has the pain occurred before? Does it change with time of day or day of week?):

____

Possible Hospitalization Correlation: ______________________________

Possible Infection Correlation: ______________________________

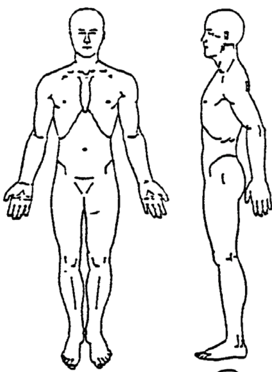
Possible Traumatic Correlation: ______________________________

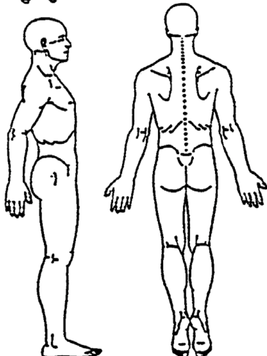
Possible Surgical Correlation: ______________________________

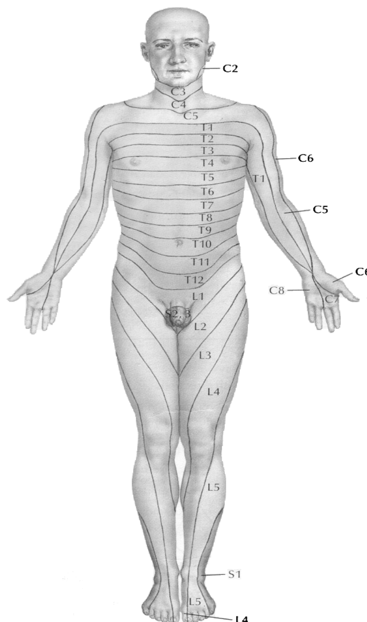
Possible Medication Correlation: ______________________________

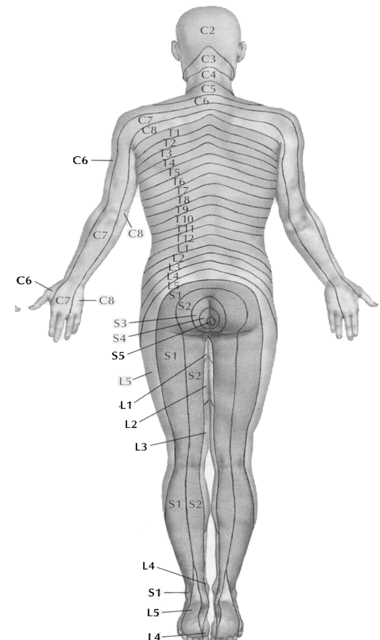
Possible Genetics Correlation: ______________________________

Please mark where you have pain or symptoms. Write down how it feels, such as deep or surface, stabbing or dull, throbbing or constant:









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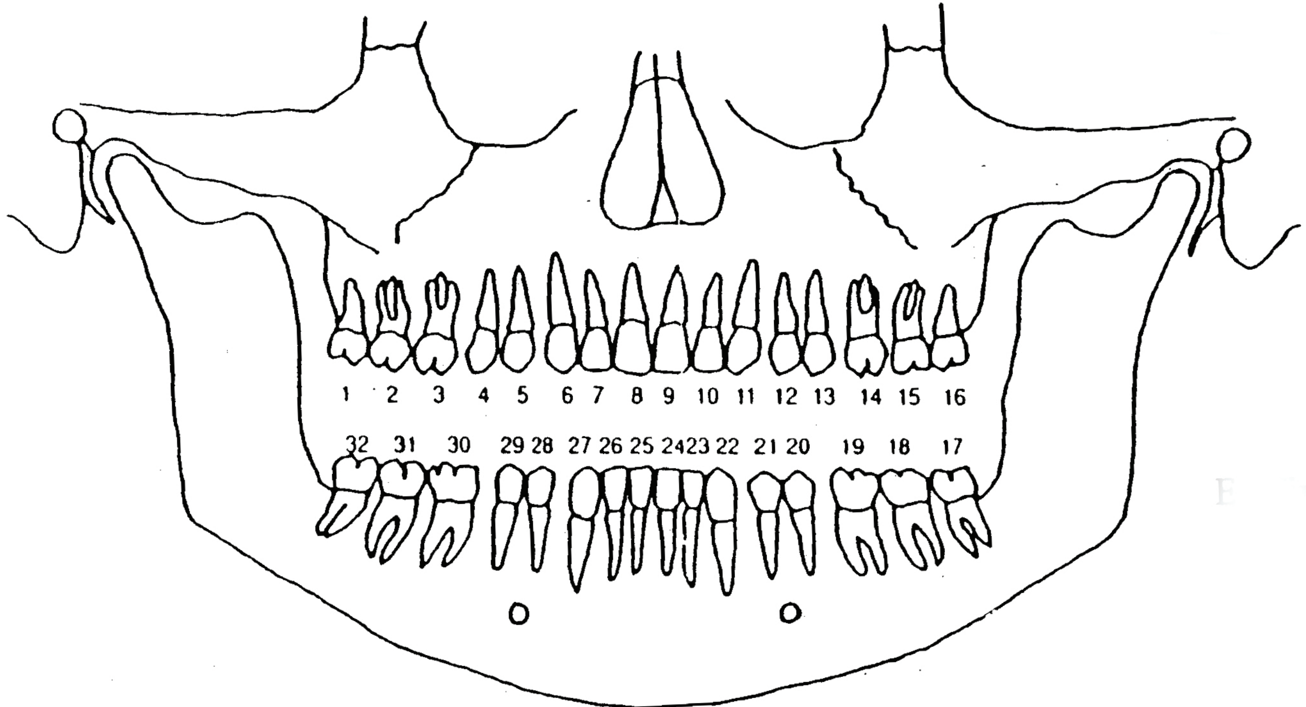
Please use the numbered teeth below to indicate which teeth have had dental intervention. ALSO, please use the KEY to mark approproately on the dental chart, and answer upper/lower if appropriate.

____
____
____
____
____
____
____
____
____

Key

Pulled Teeth	X
Cavities Filled	●
Crowns	■
Bridge	⏞
Root Canals	O

Dentures?	____ upper	____ lower
Braces?	____ upper	____ lower
Retainer or Night Gaurd?	____ upper	____ lower



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Metabolic Assessment Form

Name: ______________________________ Age: ________ Sex: (M / F) Date: ______________

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

(1) ______________________________

(2) ______________________________

(3) ______________________________

(4) ______________________________

(5) ______________________________

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
Diffi cult 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
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 0 1 2 3
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 0 1 2 3

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
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

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 0 1 2 3
little or no activity 0 1 2 3

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Category X

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 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 diffi culty 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
Diffi culty 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 perimenopausal .... (Y / N)
Alternating menstrual cycle lengths .... (Y / N)
Extended menstrual cycle, greater than 32 days ...... (Y / N)
Shortened menses, less than every 24 days .... (Y / N)
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? (Y / N)
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

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 a week do you eat raw nuts or seeds? ________
How many times a week do you eat fish? ________
How many times a week do you workout? ________

List the 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:
(1 2 3 4 5 6 7 8 9 10)

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Health Questionnaire (NTAF)

Name: ______________________________ Age: ________ Sex: (M / F) 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 0 1 2 3
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 fi nd 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 fi nd it diffi cult to get regular exercise?..........0 1 2 3
Do you feel uncared for by the people in your life?
....0 1 2 3
Do you feel you are not accomplishing your life's purpose?
....0 1 2 3
Is sharing your problems with someone difficult for you?
....0 1 2 3

SECTION C

SECTION C1

How often do you get irritable, shaky, or have lightheadedness
between meals?..0 1 2 3
How often do you feel energized after eating? 0 1 2 3
How often do you have difficulty eating large
meals in the morning?.......................................0 1 2 3
How often does your energy level drop in the afternoon?
....0 1 2 3
How often do you crave sugar and sweets in the afternoon?
....0 1 2 3
How often do you wake up in the middle of the night?
....0 1 2 3
How often do you have diffi culty 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 diffi culty losing weight? 0 1 2 3
How much larger is your waist girth compared to your hip girth?
....0 1 2 3
How often do you urinate? 0 1 2 3
Have your thirst and appetite been increased? 0 1 2 3
Do you have weight gain when under stress?.............0 1 2 3
Do you have difficulty falling asleep?......................0 1 2 3

SECTION 1 - S

Are you losing your pleasure in hobbies and interests?
....0 1 2 3
How often do you feel overwhelmed with ideas to manage?
....0 1 2 3
How often do you have feelings of inner rage (anger)?
....0 1 2 3
How often do you have feelings of paranoia? 0 1 2 3
How often do you feel sad or down for no reason?.......0 1 2 3
How often do you feel like you are not enjoying life?
....0 1 2 3
How often do you feel you lack artistic appreciation?...0 1 2 3
How often do you feel depressed in overcast weather? .0 1 2 3
How much are you losing your enthusiasm for your favorite
activities? 0 1 2 3
How much are you losing enjoyment for your favorite foods?
....0 1 2 3
How much are you losing your enjoyment of friendships and
relationships?..0 1 2 3
How often do you have diffi culty 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 fi nish 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

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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 diffififi cult 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 diffi culty calculating numbers?.............0 1 2 3
Do you have diffi culty 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

Medication History

Please circle any of the following medication you have been or are currently taking.

Acetylcholine Receptor Antagonist - Antimuscarinic Agents
Atropine, Ipratopium, Scopolamine, Tiotropium
Acetylcholine Receptor Antagonist - Ganlionic Blockers
Mecamylamine, Hexamethonium, Nicotine (high doses), Trimethaphan
Acetylcholinesterase Reactivators
Pralidoxime
Acetylcholine Receptor Antagonist - Neuromuscular Blockers
Atracurium, Cisatracurium, Doxacurium, Metocurine, Mivacurium, Pancuronium, Rocuronium, Uccinylcholine, Tubocurarine, Vecuronium, Hemicholine
Agonist Modulator of GABA Receptor (benzodiazpines)
Xanax, Lexotanil, Lexotan, Librium, Klonopin, Valium, ProSon, Rohypnol, Dalmane, Ativan, Loramet, Sedoxil, Dormicum, Megadon, Serax , Restoril, Halcion
Agonist Modulator of GABA Receptors (nonbenzodiazpines)
Ambien, Sonata, Lunesta, Imovane
Cholinesterase Inhibitors (irreversible)
Echotiophate, Isofl urophate, Organophosphate Insecticides, Organophosphate-containing nerve agents
Cholinesterase Inhibitors (reversible)
Donepezil, Galatamine, Rivastigmine, Tacrine, THC, Erophonium, Neostigmine, Phystigimine, Pyridostigmine, Carbamate Insecticidses
Dopamine Reuptake Inhibitors
Wellbutrin (Bupropion)
Dopamine Receptor Agonists
Mirapex, Sifrol, Requip
D2 Dopamine Receptor Blockers (antipsychotics)
Thorazine, Prolixin, Trilafon, Compazine, Mellaril, Stelazine, Vesprin, Nozinan, Depixol, Navane, luanxol, Clopixol, Acuphase, Haldol, Orap, Clozaril, Zyprexa, Zydis, Seroquel, Geodon, Solian, Invega, Abilify
GABA Antagonist Competitive binder
Flumazenil
Monoamine Oxidase Inhibitor (MAOI)
Marplan, Aurorix, Maneric, Moclodura, Nardil, Adlegiine, Eleptyl, Azilect, Marsilid, Iprozid, Ipronid, Rivivol, Popilniazida, Zyvox, Zyvoxid
Noradrenergic and Specififi c Sertonergic Antidepressants (NaSSaa)
Remeron, Zispin, Avanza, Norset, Remergil, Axit
Selective Serotonin Reuptake Inhibitor
Paxil, Zoloft, Prozac, Celexa, Lexapro, Luvox, Cipramil , Emocal, Serpam, Seropram, Cipralex, Esteria, Fontex, Seromex, Seronil,
Sarafem, Fluctin, Faverin, Seroxat, Aropax, Deroxat, Rexetin, Xentor, Paroxat, Lustral, Serlain, Dapoxetine
Selective Serotonin Reuptake Enhancers
Stablon, Coaxil, Tatinol
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
Effexor, Pristiq, Meridia, Serzone, Dalcipran, Despramine, Duloxetine
Tricylic Antidepresseants (TCAs)
Elavil, Endep, Tryptanol, Trepiline, Asendin, Asendis, Defanyl, Demolox, Moxadil, Anafranil, Norpramin, Pertofrane, Prothiadin, Thanden,Adapin, Sinequan, Trofranil, Janamine, Gamanil, Aventyl, Pamelor, Opipramol, Vivactil, Rhotrimine, Surmontil

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