Welcome to Arizona Chiropractic Neurology Center

Please fill out the following form in as much detail as possible. All your health information is kept confidential.

Patient and Contact Information
History and Review of Systems

Name_____

Today's Date _____ Date of Birth _____ Age _____

Address _____

City _____ State _____ ZIP _____

Gender: □ Male □ Female Height _____ Weight _____

Home Phone (_____) _____ Cell (_____) _____ Work (_____) _____

Email _____

Occupation _____

Emergency Contact name _____ Emergency Number (_____) _____

List of current/previous doctors (If applicable):

Primary Care Physician _____

Primary Care Office Phone (_____) _____

Other (please specify) _____

Other Office Phone (_____) _____

How did you hear about our office? _____

Please Circle any of the following conditions or complaints that you have or are experiencing:

□ Headache □ Migraine □ Dizziness □ Vertigo

□ Neck Pain □ Shoulder Pain □ Low Back Pain □ Arm or Leg Pain

□ TMJ Pain □ Atypical Facial Pain □ Trigeminal Neuralgia

□ Tingling, Burning or Numbness in the Hands or Feet □ Double Vision □ Balance Problems

□ Dizziness when sitting up or standing up □ Tremors □ Autoimmune Condition

□ Regional Pain Syndrome (CRPS) □ Joint Pain

□ Digestive Issues □ Food Sensitivity Issues □ Thyroid Issues □ Blood Sugar Issues

□ Other _____

Dr. Notes

_____

_____

_____

_____

Dr. Trevor Berry, DC, DACNB – Dr. Russell Teames DC, DACNB
3800 W. Ray Rd. #12 Chandler, AZ 85226 – Phone: (480) 756-2600 Fax: (480) 756-0800

NEUROLOGICAL & METABOLIC CASE HISTORY

What is the main problem/symptom that you are having? (Be as specific as possible)

_____

_____

List other symptoms you are currently experiencing even if not related to complaint listed above:

_____

_____

Describe what you are feeling (diffuse, dull, achey, sharp, burning, cramping)?

_____

When did this begin? _____

How did this begin? _____

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

_____

What makes your condition worse? _____

_____

What makes your condition better? _____

Do you experience Numbness or Tingling? □ Yes □ No If yes, where?

_____

Does it radiate down the arm(s), leg(s), back or other? _____

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

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

When you are awake, how often are you feeling these symptoms? (0-100%) _____

Does this affect you at night? □ Yes □ No

When do you experience this throughout the day (AM/PM/All Day)? _____

How many days per week do you experience your main complaint? _____

Is this progressively getting worse? □ Yes □ No

Is your condition: □ Constant □ Comes & goes □ Noted triggers: _____

Have you had any treatment for this problem in the past? □ Yes □ No If yes, when/by whom?

_____

How did the previous method(s) work for you? _____

Are there any conditions that run in your family? □ Yes □ No If yes, what condition(s) and what family member?

_____

_____

When was your last: Physical _____ Blood/lab work _____ X-ray _____ MRI _____

Have you been treated for your current condition before? □ Yes □ No If yes, when/by whom?

_____

Surgical History: Please list the type and reason of surgery, and year performed (e.g. left breast for cancer in 2004)

_____

_____

_____

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Review of Systems

Do you report any of the following? (circle/check any option that applies)

Changes in or loss of smell? Normal, Loss, increased or decreased? _____ □Yes □No
Visual changes or loss of vision? _____ □Yes □No
Difficulty with visual focus or acuity? _____ □Yes □No
Double vision? If yes, in which direction? _____ □Yes □No
Dry eyes, dry mouth or excessive tearing or saliva? (please circle) _____ □Yes □No
Weakness or numbness of the face? _____ □Yes □No
Difficulty hearing or ringing in your ears? _____ □Yes □No
Maintaining balance with or without head movements? _____ □Yes □No
Light headedness/dizziness when rising from a lying or seated position? _____ □Yes □No
Sensations of spinning? If yes, which direction? _____ □Yes □No
Difficulty swallowing foods? _____ □Yes □No
Poor digestion, constipation, diarrhea, or abnormal bowel movements? (circle) _____ □Yes □No
Bladder control issues? _____ □Yes □No
Changes in sexual function or ability? _____ □Yes □No
Increasing food sensitivities? Gluten / Dairy Other: _____ □Yes □No
Excessive Bloating? _____ □Yes □No
Difficulty shrugging or raising your shoulders or arms? _____ □Yes □No
Slurring your words or your tongue feeling thick? _____ □Yes □No
Sweaty hands or feet? _____ □Yes □No
Cold hands or feet? _____ □Yes □No
Noticeable sweating difference on the □right or the □left? _____ □Yes □No
Changes in finger or toenail appearance? _____ □Yes □No

Dr. Notes

_____
_____
_____
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_____

Dr./Staff Use Only
Forms (to be) completed: MAF BFAF BHNAF VESTIBULAR OSWESTRY NECK LOW BACK

Diagnostics to be performed: CDP VNG Saccadometer Dynamometer SVI

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Brain Assessment Questionaire

(SKIP this Section only if BFAF or BHNAF Forms Competed)

Do you report changes in any of the following instances? If so, please circle the symptoms.

Cerebellum: *(the little brain at base of skull, involved with coordination of muscles and eye movements)*

□ difficulty with coordination □ difficulty with balance □ tendency to trip over things

□ decrease in muscle tone □ tendency to knock things over and no change

Frontal Lobe: *(controls our behavior, emotions, executive decisions, and rapid eye movements)*

□trouble with focus or attention □ changes in personality or behavior □ difficulty readying long

□ periods of time, depression □ anxiety □ irritability □ changes in urination frequency or urges

□ trouble finding spoken words □ changes in smell or taste □difficulty learning new things

Parietal Lobe: *(responsible for feeling everything that touches your skin and slow eye movements)*

□ sensory changes or strange numbness or tingling □ changes in sensation of pain or temperature

□ changes in language comprehension and changes in spatial awareness, i.e. finding your keys or car

Temporal Lobe: *(hearing, slow eye movements, memory)*

□ changes in hearing □ ringing in the ears □ hearing things that aren't there

□changes in memory and experiencing strange tastes or smells

Basal Ganglia: *(movement system of the body, controls muscles and emotions)*

□ tremors or twitching □ cramping □ rigidity □ extreme emotional breakdowns or emotions

Cardiovascular

□ pressure on the chest □ pain in the left arm □excessive sweating □shortness of breath

□ dizziness □ falling □ spinning □ weakness □ drooping of face □ palpitations

□ coughing or wheezing

Doctor Notes

_____

_____

_____

_____

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Medication List: Please list the name of each current prescribed and over the counter medications, it prescribed use and any side effects/reactions/positive responses (example of use: BCP – birth control pills used to prevent pregnancy, manage menopause or acne, etc.; example of side-effect: Tylenol caused liver enzymes to increase)

	Medication	Name of Condition or purpose for taking med	Any side-effects
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

□ AD/HD
□ Adrenal disorder
□ Anxiety
□ Arthritis
□ Asthma
□ Autoimmunity: _____
□ Bleeding disorder
□ Blurred vision
□ Bowel/Bladder issue
□ Buzzing in ear
□ Cancer – type? _____
□ Carpal Tunnel Synd.
□ Celiac disease (gluten sensitive)
□ Chest pains
□ Chronic fatigue
□ Cold hands or feet
□ Colitis/Diverticulitis
□ Compression fractures

□ Concussion
□ Connective tissue disease
□ COPD
□ Depression
□ Dyslexia
□ Diabetes (Type 1 /2)
□ Digestive/bowel problems
□ Dizziness or vertigo
□ Ear infections
□ Fibromyalgia
□ Food sensitivity

□ Fusions (spinal, joint, etc.)
□ Gout
□ Gall Bladder issue
□ Immune deficiency
□ Insomnia
□ Heart disease
□ Hepatitis A, B, C, etc. _____

□ Herpes
□ High blood pressure
□ Hip replacement
□ HIV/AIDS
□ Kidney disease
□ Knee surgery
□ Liver disease
□ Marfan's syndrome
□ Multiple Sclerosis
□ Osteoporosis/penia
□ Parkinson's disease
□ Rotator cuff problem
□ STI/STD
□ Shoulder surgery
□ Spinal surgery
□ Stroke/TIA
□ Thyroid problems
□ Tuberculosis

Arizona Chiropractic Neurology Center

Informed Consent Document

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment we use as a Doctor of Chiropractic is spinal manipulative therapy (SMT, CMT). We will use this procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as you move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

--Spinal manipulative therapy --Palpation --Vital Signs
--Range of motion testing --Orthopedic testing --Neurological testing
--Postural analysis --EMS/TENS/Galvanic --Imaging and Lab studies as indicated
--hot/cold therapy --Stretching --massage therapy --exercise rehabilitation
--Microcurrent --low level laser therapy --SSEP --Functional medicine/supplements --Other_____

The material risks inherent in chiropractic care

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and physiotherapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strains, ligament sprains, cervical myelopathy, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke (CVA). Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. Cauda Equina Syndrome has been reported in rare cases which requires immediate medical care.

The probability of those risks occurring

Statistically, Chiropractic Care has been demonstrated to be one of the safest of all healthcare practices. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the raking of your history and examination. CVA has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur one in five million cervical adjustments. Two major studies (2008, 2015) showed there was not causation between CMT and CVA but rather the patient was already presenting with arterial dissection. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

-Self-administered, over-the-counter (OTC) analgesics, ice, head or rest.
-Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and pain killers.
-Hospitalization/Surgery

If you choose to use on of the above noted "other treatment" options, you should be aware that there are severe risks associated with these treatments. Many patients taking OTC NSAID's such as Ibuprofen and Acetaminophen are not aware that every year there are thousands of deaths associated with their use. No medicine should ever be taken without discussing their side effects and inherent statistical danger with their primary care physician or pharmacist. The PDR is also a good reference regarding pharmaceutical use.

The risks and dangers attendant to remaining untreated

Remaining untreated may create adhesions or scar tissue that can weaken the area and reduce mobility. Further joint degeneration may occur as well as the development of chronic pain syndromes. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

DATED:_____PATIENTS NAME:_____SIGNATURE_____

SIGNATURE OF PARENT OR GUARDIAN (if minor)_____

DATED:_____DOCTOR'S NAME:_____SIGNATURE_____

PATIENT FINANCIAL RESPONSIBILITY

Thank you for choose Arizona Chiropractic Neurology Center. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our Patient Financial Responsibility Policies.

INSURANCE: The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you; however, it is the patient's responsibility to know the details of their insurance in addition to any lapses in insurance coverage. If you do not inform us of special requirements required by your plan, and we provide medically necessary services that are not covered by your plan, we may bill you directly for those charges.

COPAYS, DEDUCTIBLES & CO-INSURANCE: All patients are responsible for their copayments, deductibles, and past due balances at the time of service.

CANCELLATION/NO SHOW OF APPOINTMENTS: When an appointment is not kept, it creates an unused appointment slot that could have been used for another patient. It is very important that you call to cancel your appointment. If for any reason you need to cancel or reschedule an appointment, please notify our office within 24 hours to avoid a fee of $30.00.

RETURNED CHECKS: There will be a $25 service fee for any check returned for insufficient funds.

PLEASE NOTE THAT ANY BENEFIT INFORMATION FURNISHED IS NOT A GUARANTEE OF PAYMENT NOR A DETERMINATION OF MEDICAL NECESSITY AND FINAL CLAIM DETERMINATION WILL BE MADE UPON RECEIPT AND REVIEW OF THE CLAIM. THE PATIENT IS RESPONSIBLE FOR ALL BALANCES OUTSTANDING.

Signature of Patient/Guardian: _____ Date: _____

PATIENT RECORD OF DISCLOSURES/HIPAA ACKNOWLEDGEMENT

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Phone: _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Cell Phone:_____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other: _____

I authorize Dr. Berry and/or Dr. Teames to discuss my protected health information with the following family members or others involved in my care:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone: _____ Phone: _____

☐ Please check mark if you decline to add anyone at this time.

I understand that I may revoke this authorization at any time, which will then apply to any future disclosures of my protected health information. I have been given the opportunity to review the Notice of Privacy Practices available in the office.

Signature of Patient/Guardian: _____ Date: _____

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, mucus 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:

Brain Function Assessment Form™ (BFAF)

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 1

- A decrease in attention span **0 1 2 3**
- Mental fatigue **0 1 2 3**
- Difficulty learning new things **0 1 2 3**
- Difficulty staying focused and concentrating for extended periods of time **0 1 2 3**
- Experiencing fatigue when reading sooner than in the past **0 1 2 3**
- Experiencing fatigue when driving sooner than in the past **0 1 2 3**
- Need for caffeine to stay mentally alert **0 1 2 3**
- Overall brain function impairs your daily life **0 1 2 3**

SECTION 2

- Twitching or tremor in your hands and legs when resting **0 1 2 3**
- Handwriting has gotten smaller and more crowded together **0 1 2 3**
- A loss of smell to foods **0 1 2 3**
- Difficulty sleeping or fitful sleep **0 1 2 3**
- Stiffness in shoulders and hips that goes away when you start to move **0 1 2 3**
- Constipation **0 1 2 3**
- Voice has become softer **0 1 2 3**
- Facial expression that is serious or angry **0 1 2 3**
- Episodes of dizziness or light-headedness upon standing **0 1 2 3**
- A hunched over posture when getting up and walking **0 1 2 3**

SECTION 3

- Memory loss that impacts daily activities **0 1 2 3**
- Difficulty planning, problem solving, or working with numbers **0 1 2 3**
- Difficulty completing daily tasks **0 1 2 3**
- Confusion about dates, the passage of time, or place **0 1 2 3**
- Difficulty understanding visual images and spatial relationships (addresses and locations) **0 1 2 3**
- Difficulty finding words when speaking **0 1 2 3**
- Misplacement of things and inability to retrace steps **0 1 2 3**
- Poor judgment and bad decisions **0 1 2 3**
- Disinterest in hobbies, social activities, or work **0 1 2 3**
- Personality or mood changes **0 1 2 3**

SECTION 4

- Reduced function in overall hearing **0 1 2 3**
- Difficulty understanding language with background or scatter noise **0 1 2 3**
- Ringing or buzzing in the ear **0 1 2 3**
- Difficulty comprehending language without perfect pronunciation **0 1 2 3**
- Difficulty recognizing familiar faces **0 1 2 3**
- Changes in comprehending the meaning of sentences, written or spoken **0 1 2 3**
- Difficulty with verbal memory and finding words **0 1 2 3**
- Difficulty remembering events **0 1 2 3**
- Difficulty recalling previously learned facts and names **0 1 2 3**
- Inability to comprehend familiar words when read **0 1 2 3**
- Difficulty spelling familiar words **0 1 2 3**
- Monotone, unemotional speech **0 1 2 3**
- Difficulty understanding the emotions of others when they speak (nonverbal cues) **0 1 2 3**
- Disinterest in music and a lack of appreciation for melodies **0 1 2 3**
- Difficulty with long-term memory **0 1 2 3**
- Memory impairment when doing the basic activities of daily living **0 1 2 3**
- Difficulty with directions and visual memory **0 1 2 3**
- Noticeable differences in energy levels throughout the day **0 1 2 3**

SECTION 5

- Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach for objects **0 1 2 3**
- Difficulty comprehending written text **0 1 2 3**
- Floaters or halos in your visual field **0 1 2 3**
- Dullness of colors in your visual field during different times of the day **0 1 2 3**
- Difficulty discriminating similar shades of color **0 1 2 3**

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

Brain Function Assessment Form™ (BFAF)

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

SECTION 6

- Difficulty with detailed hand coordination **0 1 2 3**
- Difficulty with making decisions **0 1 2 3**
- Difficulty with suppressing socially inappropriate thoughts **0 1 2 3**
- Socially inappropriate behavior **0 1 2 3**
- Decisions made based on desires, regardless of the consequences **0 1 2 3**
- Difficulty planning and organizing daily events **0 1 2 3**
- Difficulty motivating yourself to start and finish tasks **0 1 2 3**
- A loss of attention and concentration **0 1 2 3**

SECTION 7

- Hypersensitivities to touch or pain **0 1 2 3**
- Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall **0 1 2 3**
- Frequently bumping into the wall or objects **0 1 2 3**
- Difficulty with right-left discrimination **0 1 2 3**
- Handwriting has become sloppier **0 1 2 3**
- Difficulty with basic math calculations **0 1 2 3**
- Difficulty finding words for written or verbal communication **0 1 2 3**
- Difficulty recognizing symbols, words, or letters **0 1 2 3**

SECTION 8

- Difficulty swallowing supplements or large bites of food **0 1 2 3**
- Bowel motility and movements slow **0 1 2 3**
- Bloating after meals **0 1 2 3**
- Dry eyes or dry mouth **0 1 2 3**
- A racing heart **0 1 2 3**
- A flutter in the chest or an abnormal heart rhythm **0 1 2 3**
- Bowel or bladder incontinence, resulting in staining your underwear **0 1 2 3**

SECTION 9

- A decrease in movement speed **0 1 2 3**
- Difficulty initiating movement **0 1 2 3**
- Stiffness in your muscles (not joints) **0 1 2 3**
- A stooped posture when walking **0 1 2 3**
- Cramping of your hand when writing **0 1 2 3**

SECTION 10

- Abnormal body movements (such as twitching legs) **0 1 2 3**
- Desires to flinch, clear your throat, or perform some type of movement **0 1 2 3**
- Constant nervousness and a restless mind **0 1 2 3**
- Compulsive behaviors **0 1 2 3**
- Increased tightness and tone in specific muscles **0 1 2 3**

SECTION 11

- Difficulty with balance, or balance that is noticeably worse on one side **0 1 2 3**
- A need to hold the handrail or watch each step carefully when going down stairs **0 1 2 3**
- Episodes of dizziness **0 1 2 3**
- Nausea, car sickness, or seasickness **0 1 2 3**
- A quick impact after consuming alcohol **0 1 2 3**
- A slight hand shake when reaching for something **0 1 2 3**
- Back muscles that tire quickly when standing or walking **0 1 2 3**
- Chronic neck or back muscle tightness **0 1 2 3**

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Brain Health and Nutrition Assessment Form™ (BHNAF)

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 1

- Low brain endurance for focus and concentration **0 1 2 3**
- Cold hands and feet **0 1 2 3**
- Must exercise or drink coffee to improve brain function **0 1 2 3**
- Poor nail health **0 1 2 3**
- Fungal growth on toenails **0 1 2 3**
- Must wear socks at night **0 1 2 3**
- Nail beds are white instead of pink **0 1 2 3**
- The tip of the nose is cold **0 1 2 3**

SECTION 2

- Irritable, nervous, shaky, or light-headed between meals **0 1 2 3**
- Feel energized after meals **0 1 2 3**
- Difficulty eating large meals in the morning **0 1 2 3**
- Energy level drops in the afternoon **0 1 2 3**
- Crave sugar and sweets in the afternoon **0 1 2 3**
- Wake up in the middle of the night **0 1 2 3**
- Difficulty concentrating before eating **0 1 2 3**
- Depend on coffee to keep going **0 1 2 3**

SECTION 3

- Fatigue after meals **0 1 2 3**
- Sugar and sweet cravings after meals **0 1 2 3**
- Need for a stimulant, such as coffee, after meals **0 1 2 3**
- Difficulty losing weight **0 1 2 3**
- Increased frequency of urination **0 1 2 3**
- Difficulty falling asleep **0 1 2 3**
- Increased appetite **0 1 2 3**

SECTION 4

- Always have projects and things that need to be done **0 1 2 3**
- Never have time for yourself **0 1 2 3**
- Not getting enough sleep or rest **0 1 2 3**
- Difficulty getting regular exercise **0 1 2 3**
- Feel that you are not accomplishing your life's purpose **0 1 2 3**

SECTION 5

- Dry and unhealthy skin **0 1 2 3**
- Dandruff or a flaky scalp **0 1 2 3**
- Consumption of processed foods that are bagged or boxed **0 1 2 3**
- Consumption of fried foods **0 1 2 3**
- Difficulty consuming raw nuts or seeds **0 1 2 3**
- Difficulty consuming fish (not fried) **0 1 2 3**
- Difficulty consuming olive oil, avocados, flax seed oil, or natural fats **0 1 2 3**

SECTION 6

- Difficulty digesting foods **0 1 2 3**
- Constipation or inconsistent bowel movements **0 1 2 3**
- Increased bloating or gas **0 1 2 3**
- Abdominal distention after meals **0 1 2 3**
- Difficulty digesting protein-rich foods **0 1 2 3**
- Difficulty digesting starch-rich foods **0 1 2 3**
- Difficulty digesting fatty or greasy foods **0 1 2 3**
- Difficulty swallowing supplements or large bites of food **0 1 2 3**
- Abnormal gag reflex **Yes or No**

SECTION 7

- Brain fog (unclear thoughts or concentration) **Yes or No**
- Pain and inflammation **Yes or No**
- Noticeable variations in mental speed **Yes or No**
- Brain fatigue after meals **0 1 2 3**
- Brain fatigue after exposure to chemicals, scents, or pollutants **0 1 2 3**
- Brain fatigue when the body is inflamed **0 1 2 3**

SECTION 8

- Grain consumption leads to tiredness **0 1 2 3**
- Grain consumption makes it difficult to focus and concentrate **0 1 2 3**
- Feel better when bread and grains are avoided **0 1 2 3**
- Grain consumption causes the development of any symptoms **0 1 2 3**
- A 100% gluten-free diet **Yes or No**

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Brain Health and Nutrition Assessment Form™ (BHNAF)

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

SECTION 9

- A diagnosis of celiac disease, gluten sensitivity, hypothyroidism, or an autoimmune disease — **Yes or No**
- Family members who have been diagnosed with an autoimmune disease — **Yes or No**
- Family members who have been diagnosed with celiac disease or gluten sensitivity — **Yes or No**
- Changes in brain function with stress, poor sleep, or immune activation — **0 1 2 3**

SECTION 10

- A loss of pleasure in hobbies and interests — **0 1 2 3**
- Feel overwhelmed with ideas to manage — **0 1 2 3**
- Feelings of inner rage or unprovoked anger — **0 1 2 3**
- Feelings of paranoia — **0 1 2 3**
- Feelings of sadness for no reason — **0 1 2 3**
- A loss of enjoyment in life — **0 1 2 3**
- A lack of artistic appreciation — **Yes or No**
- Feelings of sadness in overcast weather — **0 1 2 3**
- A loss of enthusiasm for favorite activities — **0 1 2 3**
- A loss of enjoyment in favorite foods — **0 1 2 3**
- A loss of enjoyment in friendships and relationships — **0 1 2 3**
- Inability to fall into deep, restful sleep — **0 1 2 3**
- Feelings of dependency on others — **0 1 2 3**
- Feelings of susceptibility to pain — **0 1 2 3**

SECTION 11

- Feelings of worthlessness — **0 1 2 3**
- Feelings of hopelessness — **0 1 2 3**
- Self-destructive thoughts — **0 1 2 3**
- Inability to handle stress — **0 1 2 3**
- Anger and aggression while under stress — **0 1 2 3**
- Feelings of tiredness, even after many hours of sleep — **0 1 2 3**
- A desire to isolate yourself from others — **0 1 2 3**
- An unexplained lack of concern for family and friends — **0 1 2 3**
- An inability to finish tasks — **0 1 2 3**
- Feelings of anger for minor reasons — **0 1 2 3**

SECTION 12

- A decrease in visual memory (shapes and images) — **Yes or No**
- A decrease in verbal memory — **0 1 2 3**
- Occurrence of memory lapses — **0 1 2 3**
- A decrease in creativity — **0 1 2 3**
- A decrease in comprehension — **0 1 2 3**
- Difficulty calculating numbers — **0 1 2 3**
- Difficulty recognizing objects and faces — **0 1 2 3**
- A change in opinion about yourself — **0 1 2 3**
- Slow mental recall — **0 1 2 3**

SECTION 13

- A decrease in mental alertness — **0 1 2 3**
- A decrease in mental speed — **0 1 2 3**
- A decrease in concentration quality — **0 1 2 3**
- Slow cognitive processing — **0 1 2 3**
- Impaired mental performance — **0 1 2 3**
- An increase in the ability to be distracted — **0 1 2 3**
- Need coffee or caffeine sources to improve mental function — **0 1 2 3**

SECTION 14

- Feelings of nervousness or panic for no reason — **0 1 2 3**
- Feelings of dread — **0 1 2 3**
- Feelings of a “knot” in your stomach — **0 1 2 3**
- Feelings of being overwhelmed for no reason — **0 1 2 3**
- Feelings of guilt about everyday decisions — **0 1 2 3**
- A restless mind — **0 1 2 3**
- An inability to turn off the mind when relaxing — **0 1 2 3**
- Disorganized attention — **0 1 2 3**
- Worry over things never thought about before — **0 1 2 3**
- Feelings of inner tension and inner excitability — **0 1 2 3**

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