HEALTH HISTORY

Name _____ Date of Birth _____ Today's Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: Date began:

_____ _____

_____ _____

Date of last physical exam _____ Practitioner name and phone number _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

Outcome _____

What types of therapy have you tried for this problem(s):

☐ diet modification ☐ fasting ☐ vitamins/minerals ☐ herbs ☐ homeopathy ☐ chiropractic ☐ acupuncture ☐ conventional drugs

☐ other _____

List current health problems for which you are being treated: _____

_____

Current medications (prescription or over-the-counter): _____

_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ☐ underweight ☐ overweight ☐ just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)?

_____

☐ Corrective lenses ☐ Dentures ☐ Hearing aid ☐ Medical devices/prosthetics/implants, describe: _____

Recent changes in your ability to: ☐ see ☐ hear ☐ taste ☐ smell ☐ feel hot/cold sensations

☐ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Strong dislike for any one of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Do you: ☐ Prefer warmth (i.e., food, drinks, weather, etc.) ☐ Prefer cold (i.e., food, drinks, weather, etc.) ☐ No preference

Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

Time of day you feel the most energy or the least symptoms:

☐ 7 a.m. - 9 a.m. ☐ 9 a.m. - 11 a.m. ☐ 11 a.m. - 1 p.m.
☐ 1 p.m. - 3 p.m. ☐ 3 p.m. - 5 p.m. ☐ 5 p.m. - 7 p.m.
☐ 7 p.m. - 9 p.m. ☐ 9 p.m. - 11 p.m. ☐ 11 p.m. - 1 a.m.
☐ 1 a.m. - 3 a.m. ☐ 3 a.m. - 5 a.m. ☐ 5 a.m. - 7 a.m.

Time of day you feel the worst or your symptoms are aggravated:

☐ 7 a.m. - 9 a.m. ☐ 9 a.m. - 11 a.m. ☐ 11 a.m. - 1 p.m.
☐ 1 p.m. - 3 p.m. ☐ 3 p.m. - 5 p.m. ☐ 5 p.m. - 7 p.m.
☐ 7 p.m. - 9 p.m. ☐ 9 p.m. - 11 p.m. ☐ 11 p.m. - 1 a.m.
☐ 1 a.m. - 3 a.m. ☐ 3 a.m. - 5 a.m. ☐ 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

☐ Debilitating fatigue	☐ Shortness of breath	☐ Insomnia	☐ Constipation	☐ Chronic pain/inflammation
☐ Depression	☐ Panic attacks	☐ Nausea	☐ Fecal incontinence	☐ Bleeding
☐ Disinterest in sex	☐ Headaches	☐ Vomiting	☐ Urinary incontinence	☐ Discharge
☐ Disinterest in eating	☐ Dizziness	☐ Diarrhea	☐ Low grade fever	☐ Itching/rash

Medical History

- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins

Other _____

_____

Medical (Men)

- ☐ Benign prostatic hyperplasia (BPH)
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Sexually transmitted disease

Other _____

_____

Medical (Women)

- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ Premenstrual syndrome (PMS)
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased sex drive
- ☐ Sexually transmitted disease

Other _____

Age of first period _____

Date of last gynecological exam _____

Mammogram ☐ + ☐ –

PAP ☐ + ☐ –

Form of birth control _____

# of children _____

# of pregnancies _____

☐ C-section _____

- ☐ Surgical menopause
- ☐ Menopause

Date of last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Health History (Parents and Siblings)

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

Other _____

Health Habits

☐ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

☐ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

☐ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine: #cans/d _____

Other sources _____

☐ Water: #glasses/d _____

Exercise

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes
- ☐ Walk
- ☐ Run, jog, jump rope
- ☐ Weight lift
- ☐ Swim
- ☐ Box
- ☐ Yoga

Nutrition & Diet

- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction

Specific food restrictions:

☐ dairy ☐ wheat ☐ eggs

☐ soy ☐ corn ☐ all gluten

Other _____

Food Frequency

Servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

- ☐ Skip breakfast
- ☐ Two meals/day
- ☐ One meal/day
- ☐ Graze (small frequent meals)
- ☐ Food rotation
- ☐ Eat constantly whether hungry or not
- ☐ Generally eat on the run
- ☐ Add salt to food

Current Supplements

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening Primrose/GLA
- ☐ Calcium, source _____
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals, describe _____
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g., lutein, resveratrol, etc.)
- ☐ Herbs - teas
- ☐ Herbs - extracts
- ☐ Chinese herbs
- ☐ Ayurvedic herbs
- ☐ Homeopathy
- ☐ Bach flowers
- ☐ Protein shakes
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid meals

Other _____

Would you like to:

- ☐ Have more energy
- ☐ Be stronger
- ☐ Have more endurance
- ☐ Increase your sex drive
- ☐ Be thinner
- ☐ Be more muscular
- ☐ Improve your complexion
- ☐ Have stronger nails
- ☐ Have healthier hair
- ☐ Be less moody
- ☐ Be less depressed
- ☐ Be less indecisive
- ☐ Feel more motivated
- ☐ Be more organized
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Do better on tests in school
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ☐ Stop using laxatives or stool softeners
- ☐ Be free of pain
- ☐ Sleep better
- ☐ Have agreeable breath
- ☐ Have agreeable body odor
- ☐ Have stronger teeth
- ☐ Get less colds and flus
- ☐ Get rid of your allergies
- ☐ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

Metabolic Assessment Form™

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

PART I

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

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

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

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 proteins and meats; 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

Difficulty digesting roughage and fiber	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
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	Yes		No	

Category VIII

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
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 IX

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 X

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 between meals	0	1	2	3
Blurred vision	0	1	2	3

Category XI

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 XII				
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 XIII				
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 XIV				
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 XV				
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-caloric 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 XVI				
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 XVI *(Cont.)*				
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(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 XVIII *(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 XIX *(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 XX *(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

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

DETOXIFICATION QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Rate each of the following symptoms based on your typical health profile for the specified duration:

❒ Past month ❒ Past week ❒ Past 48 hours

Point Scale: **0**—*Never or almost never* have the symptom **1**—*Occasionally* have it, effect is *not severe* **2**—*Occasionally* have it, effect is *severe* **3**—*Frequently* have it, effect is *not severe* **4**—*Frequently* have it, effect is *severe*

I. Medical Symptoms Questionnaire (MSQ)

HEAD	_____	Headaches	
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	**TOTAL** _____
EYES	_____	Watery or itchy eyes	
	_____	Swollen, reddened or sticky eyelids	
	_____	Bags or dark circles under eyes	
	_____	Blurred or tunnel vision	**TOTAL** _____
EARS	_____	Itchy ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	**TOTAL** _____
NOSE	_____	Stuffy nose	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	**TOTAL** _____
MOUTH/ THROAT	_____	Chronic coughing	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or discolored tongue, gums, lips	
	_____	Canker sores	**TOTAL** _____
SKIN	_____	Acne	
	_____	Hives, rashes, dry skin	
	_____	Hair loss	
	_____	Flushing, hot flashes	
	_____	Excessive sweating	**TOTAL** _____
HEART	_____	Chest pain	
	_____	Irregular or skipped heartbeat	
	_____	Rapid or pounding heartbeat	**TOTAL** _____
LUNGS	_____	Chest congestion	
	_____	Asthma, bronchitis	
	_____	Shortness of breath	
	_____	Difficulty breathing	**TOTAL** _____
DIGESTIVE TRACT	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching, passing gas	
	_____	Heartburn	
	_____	Intestinal/stomach pain	**TOTAL** _____
JOINTS/ MUSCLE	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Feeling of weakness or tiredness	
	_____	Pain or aches in muscles	**TOTAL** _____
WEIGHT	_____	Binge eating/drinking	
	_____	Craving certain foods	
	_____	Excessive weight	
	_____	Water retention	
	_____	Underweight	
	_____	Compulsive eating	**TOTAL** _____
ENERGY/ ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	**TOTAL** _____
MIND	_____	Poor memory	
	_____	Confusion, poor comprehension	
	_____	Difficulty in making decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	
	_____	Poor concentration	
	_____	Poor physical coordination	**TOTAL** _____
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear, nervousness	
	_____	Anger, irritability, aggressiveness	
	_____	Depression	**TOTAL** _____
OTHER	_____	Frequent illness	
	_____	Frequent or urgent urination	
	_____	Genital itch or discharge	**TOTAL** _____
GRAND TOTAL			**TOTAL** _____

II. Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
❒ Yes (1 pt.)
If yes, how many are you currently taking? ____ (1 pt. each)
❒ No (0 pt.)

2. Are you presently taking one or more of the following over-the counter drugs?
❒ Cimetidine (2 pts.)
❒ Acetaminophen (2 pts.)
❒ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
❒ Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
❒ Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)
❒ Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)
❒ Experience *no* side effects, drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?
❒ Yes (2 pts.) ❒ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine containing products?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
❒ Yes (1 pt.) ❒ No (0 pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

10. Do you have a personal history of
❒ Environmental and/or chemical sensitivities (5 pts.)
❒ Chronic fatigue syndrome (5 pts.)
❒ Multiple chemical sensitivity (5 pts.)
❒ Fibromyalgia (3 pts.)
❒ Parkinson's type symptoms (3 pts.)
❒ Alcohol or chemical dependence (2 pts.)
❒ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
❒ Yes (1 pt.) ❒ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

GRAND TOTAL: _____

III. Alkalizing Assessment

1. Do you have a history or currently have kidney dysfunction?
❒ Yes ❒ No

2. Have you ever been diagnosed with a condition known as hyperkalemia?
❒ Yes ❒ No

3. Are you currently on diuretics or blood pressure medication?
❒ Yes ❒ No

Note: Prescribe non-alkalizing nutrients if patient answered yes to any part of this section.

For Practitioner Use Only:

OVERALL SCORE TABULATION

See doctor brochure for protocol suggestions.

MSQ SCORE _____ (High >50; moderate 15-49: Low <14)
XTT SCORE _____ (High >10; moderate 5-9: Low <4)
URINARY pH _____

Note: Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfuntion, oxidative stress, hormonal/neuro-transmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.

DATE:

Goals for today:

Breakfast / Time:

Snack / Time:

Lunch / Time:

Snack / Time:

Dinner / Time:

Water (8oz): 1 2 3 4 5 6 7 8 9 10

Other Drinks:

Exercise:

Relaxation:

Sleep time: Supplements: Y N

Energy Levels and notes: _____

_____

DATE:

Goals for today:

Breakfast / Time:

Snack / Time:

Lunch / Time:

Snack / Time:

Dinner / Time:

Water (8oz): 1 2 3 4 5 6 7 8 9 10

Other Drinks:

Exercise:

Relaxation:

Sleep time: Supplements: Y N

Energy Levels and notes: _____

_____

DATE:

Goals for today:

Breakfast / Time:

Snack / Time:

Lunch / Time:

Snack / Time:

Dinner / Time:

Water (8oz): 1 2 3 4 5 6 7 8 9 10

Other Drinks:

Exercise:

Relaxation:

Sleep time: Supplements: Y N

Energy Levels and notes: _____

_____

DATE:

Goals for today:

Breakfast / Time:

Snack / Time:

Lunch / Time:

Snack / Time:

Dinner / Time:

Water (8oz): 1 2 3 4 5 6 7 8 9 10

Other Drinks:

Exercise:

Relaxation:

Sleep time: Supplements: Y N

Energy Levels and notes: _____

_____

NUTRITION INFORMED CONSENT

1. NUTRITIONAL THERAPY: According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: *"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."* A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy. Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment. I understand that if I am on any medications, the healthcare provider will NOT recommend I decrease my dosages or stop taking my medications. As the patient, it is my responsibility to contact and work with the prescribing doctor to reduce dosage or stop medication usage as my health improves and it becomes clear a medication is no longer needed.

Nutritional support is recommended based on your history, examination, and lab results to support your body's unique biochemistry. We utilize nutritional supplements from reputable companies known in the health care field that use ingredients that are tested so as not to contain heavy metals or contamination. Products recommended have a high level of purity, safety, and quality for reliably effective use. They have been tested for biological activity of the ingredient used. Products recommended are the most hypoallergenic products possible.

2. SERVICES: My health care provider has recommended functional, nutritional, and lifestyle evaluation, testing, consulting, and care, including dietary supplements. I understand and am informed that products and services are not provided by medical physicians and do not include prescription drugs, surgery, or other conventional allopathic medical treatments. I further understand that consultations, evaluations, supplementation, lifestyle consultation, testing, recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients pertain to the functional health/whole body concept.

3. **NO GUARANTEE**: I have been informed that the methods of nutritional evaluation or testing made available to me are not intended to diagnose disease from an allopathic model of medicine. Rather, they are intended as a guide to developing an appropriate overall health-supportive program for me, and to monitor progress in achieving goals. I further understand that any recommendations are supportive in nature allowing the body to return to improved health. Like all other health care, results are not guaranteed and there is no promise to cure. Accordingly, I understand that payment(s) for services are not conditional on my response to care. No refunds will be available for any opened products purchased.

4. **RISKS**: I understand the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients that may be recommended are generally considered safe, however, some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be toxic in large doses. I also understand that nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may interact with some legend drugs. Accordingly, I agree to consult with my prescribing physician about any prescription drugs I am taking and the impact of supplements, vitamins, minerals, food grade herbs, and other nutrients on such drugs. I will inform my health practitioner if I experience gastrointestinal upset (nausea, gas, stomachache, vomiting), allergic reactions (hives, rashes, itching, tingling of the tongue, headache), or any unanticipated or unpleasant effects associated with the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients. I understand that I need to check all labels before opening the bottle to verify I am not sensitive or allergic to any ingredients listed.

5. **PREGNANCY**: I understand that some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be inappropriate during pregnancy, and I will notify the health practitioner if I am or become pregnant.

6. **ALTERNATIVES**: I understand that the alternatives to the recommendations include doing nothing and/or seeking additional allopathic medical care.

DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND THIS FORM!

I have read and fully understand this consent. All items have been explained, I have had sufficient time to evaluate the information, and my questions have been answered. Knowing the alternatives and risks, I consent to the services.

Signature _____ Date _____

Name (printed)_____

MISSED APPOINTMENT POLICY

Out of respect and consideration for our practice members, we kindly ask you to honor your scheduled appointment time. Please note that appointment space is limited daily and both of our doctors have waiting lists.

We understand unanticipated events occasionally occur. In our desire to be effective and fair to all of our clients' time, we ask you give a minimum 24 hour advance notice when cancelling an appointment. This allows the opportunity for someone else to schedule and utilize your valuable appointment space

We are happy to excuse one missed chiropractic appointment with no penalty. If there is a second missed appointment, you will be charged a $40 cancellation fee, which is applied to your account. Insurance will not be billed for these charges. Cancellation fees are the responsibility of the patient and must be paid in full before the next visit.

Missed Clinical Nutrition appointments will be billed at $45 for every 15 minutes scheduled. For missed massage appointments, patients will be billed at $35 for an hour.

I have read and understand the River Falls Chiropractic Appointment Cancellation Policy. I am aware that I will be charged for the missed appointment, and I agree to these terms.

I, _____, have received a copy of The Cancellation Policy.

_____ _____

Signature of Patient Date

Clinical Nutrition Payment Policy

The initial clinical nutrition appointment is scheduled for one hour at a fee of $200. Out of respect for other patients, if more time is needed for questions or examination, more time will be scheduled at a later date and charged according to the following fee schedule. Follow up appointments are charged at $20 for 5 minutes and typically are set up at 15 minute increments. (15 minutes for $60, 30 minutes at $120, etc.).

Previous lab work from other health care providers can be reviewed but is subject to the above pricing based on time involved in number of tests reviewed and the time involved with interpreting the results.

Payment is expected the same day of service. MasterCard, Visa and American Express are accepted for your convenience. Clinical nutrition is not insurance reimbursable.

I understand the above payment policy. Prices are subject to change.

Signature:_____ Date:_____

Name (printed): _____

Why survive when you can thrive?

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