MID-ATLANTIC
BRAIN & NEUROLOGICAL
REHABILITATION

Comprehensive Health History

Congratulations on Getting Started!!!

For Your First Appointment, Please Bring the Following Items

1.
Any previous blood work, imaging, lab analyses or medical records you.

2.
Your completed paperwork.

3.
Shorts and a tank top (or loose-fitting and non-restricting clothing) to be worn during exam.

4.
A spouse, relative or friend to make sure of any of their questions are answered

5.
We ask that you please do not wear eye make-up to your exam as it interferes with our testing equipment.

6.
Your completed paperwork.

Please Note: To secure your examination appointment, please completely fill out this form and provide it to the front desk staff upon arrival for your appointment. If we do not receive your form completely filled out, we may have to reschedule your appointment.

Brain Function Assessment

0 = Never 1 = Rare: 25% 2 = Often: 50% 3 = Always: 100%

Section 1: Brain Endurance

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: Posture and Movement

Twitching or tremor in your hands and legs when resting 0 1 2 3
Handwriting has gotten smaller and more crowded together
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 and Cognition

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: Temporal Lobe

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 reading 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: Occipital Lobe

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

Section 6: Frontal Cortex

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: Parietal Lobe

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 finding words for written or verbal communication 0 1 2 3
Difficulty recognizing symbols, words or letters 0 1 2 3

Section 8: Pontomedullary Brainstem

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: Basal Ganglia Direct Pathway

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: Basal Ganglia Indirect Pathway

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: Cerebellum

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

Metabolic Assessment

Section 1: Colon Support

Feeling the bowels do not empty completely	0 1 2 3
Lower abdominal pain relief by passing gas or stool	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
Laxative use	0 1 2 3

Section 2: Intestinal Integrity Support

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

Section 3: Chemical Tolerance Support

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 breakouts	0 1 2 3

Section 4: Stomach Support (Hypochlorhydria)

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
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

Section 5: Stomach Support (Hyperacidity- Ulcer)

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

Section 6: Small Intestinal / Pancreatic Support

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 the left side under ribcage	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

Section 7: Billary Support

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
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

Section 8: Hepatic Detoxification Support

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

Section 9: Blood Sugar Balance Support (Hypoglycemia)

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

Section 10: Blood Sugar Balance Support (Insulin Resistance)

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

Section 11: Adrenal Support (Hypofunction)

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

Section 12: Adrenal Support (Hyperfunction)

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

Section 13: Electrolyte and pH Balance Support

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

Section 14: Thyroid Support (Hypothyroid)

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

Section 15 : Thyroid Support (Hyperfunction)

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

Section 16: Pituitary Support (Hypofunction)

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

Brain Health and Nutrition Assessment

Section 6: Brain-Gut Axis

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 starchy 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	0 1 2 3

Section 7: Brain-Immune Axis

Brain fog (unclear thoughts or concentration)	0 1 2 3
Pain and inflammation	0 1 2 3
Noticeable variations in mental speed	0 1 2 3
Brian 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: Gluten Digestion

Grain consumption leads to tiredness	0 1 2 3
Grain consumption makes it difficult to focus and concentrate	
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 ☐ No

Section 9: Intestinal Barrier

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

Section 10: Serotonin

A loss of pleasure in hobbies and interest	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	
A lack of artistic appreciation	0 1 2 3
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: Dopamine

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: Acetylcholine

A decrease in visual memory (shapes and images)	0 1 2 3
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: Catecholamines

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: GABA

Feelings of nervousness or panic for no reason	0 1 2 3
Feeling of dread	0 1 2 3
Feeling of a “knot” in your stomach	0 1 2 3
Feeling 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

Dietary Assessment

3 Healthiest foods you eat during the average week: _____

Exercise type: _____
Frequency: _____
Daily # of vegetables: _____
Daily # of Fruits: _____
Daily # of Caffeinated Beverages or Soda: _____
Craving or salt/ sweet/ fats: _____
Fruit juices oz/week: _____
Gatorade or Energy drink oz/week: _____
Chocolate ___ Dark ___ Milk
Alcohol drinks/ wk: _____
Nutritional shakes or bars: _____
Meat protein: _____
Times per week you eat raw nuts or seeds: _____
Times per week you eat fish: _____

Times per week you eat out: _____
Protein powders: _____
Veggie Protein: _____
Dairy, kind: _____
Milk, oz/wk _____
What are your least favorite foods: _____
What are your favorite foods: _____
Do you like to cook: ☐ Yes No
Do you eat leftovers? ☐ Yes No
What are your favorite restaurants? _____

Please answer all questions as completely and thoroughly as you can. Through some questions may not seem to pertain, they are all important to help diagnosis and formulate a plan of action specifically for you and make proper referrals. If needed, list number, then use spaces or back of page to explain more details.

For medical history: Current = C, Past = P.

(Greater than 6 months) include dates if possible for both

Independent or Concurrent Therapies

1. __ Chiropractic
2. __ Chiro for family, pets
3. __ Acupuncture
4. __ Therapeutic Massage
5. __ Naturopathic
6. __ Oriental Medicine
7. __ Nutritional Consult
8. __ Medical Treatment
9. __ Specialist
10. __ Natural Healer
11. __ Spiritual Healer
12. __ Energy Work

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

13. __ X-rays
14. __ MRI
15. __ CAT scan
16. __ Blood draw
17. __ Ultrasound
18. __ Upper/lower GI
19. __ DEXA Scan
20. __ Breast Exam
21. __ Prostate Exam
22. __ Eye Exam
23. __ Dental Exam
24. __ Colonoscopy
25. __ Other _____
26. __ Other _____
27. __ Other _____

Significant Illnesses

28. __ Allergies
29. __ Arthritis
30. __ Asthma
31. __ Cancer
32. __ Depression
33. __ Diabetes
34. __ Hepatitis A/B/C
35. __ Heart disease
36. __ High blood pressure
37. __ Low blood pressure
38. __ Lung disease
39. __ Neurological
40. __ Psychological
41. __ Rheumatic Fever
42. __ Seizures
43. __ Thyroid disease
44. __ Vascular disease
45. __ Other _____

Illness/ Injuries/ Surgeries/ Hospitalizations

46. __ Broken bones
47. __ Burns
48. __ Car accidents
49. __ Concussion
50. __ Fallen down/up stairs
51. __ Fallen from any height
52. __ Fallen on ice
53. __ Feeling un-coordinated
54. __ Fevers
55. __ Flu/colds
56. __ Frequent accidents/sport injuries
57. __ Frequent illness
58. __ Frequent infections
59. __ Head trauma
60. __ Hospitalizations
61. __ Infected wounds
62. __ Loss of consciousness
63. __ Psychological Hospitalization
64. __ Recreational injuries
64b. __ Serious cuts
65. __ Serious depression / significant trauma
66. __ Surgeries
67. __ Transfusions
68. __ Transplants
69. __ Tripping / stumbling
70. __ Wounds slow to heal

Childhood

71. __ Illnesses
72. __ Traumatic events
73. __ Immunizations
74. __ Injuries
75. __ Other _____
76. __ Other _____

General Health: List times of day or any correlating factors

77. __ Poor appetite
78. __ Heavy appetite
79. __ Change in appetite
80. __ Unexplained weight gain/loss
81. __ Poor sleep
82. __ Wake feeling tired
83. __ Decreased sleep
84. __ Heavy sleep
85. __ Insomnia
86. __ Apnea/ narcolepsy
87. __ Sudden awakening during night
88. __ Hours of sleep/night
89. __ Day napping ___ Amt_____
90. __ Night sweats
91. __ Sudden energy drop
92. __ Strong thirst
93. __ Hot/ cold
94. __ Fatigue
95. __ Chills
96. __ Sudden temp changes
97. __ Localized weakness
98. __ Tremors
99. __ Poor circulation
100. __ Peculiar tastes/ smells
101. __ Night Pain
102. __ Radiating pain
103. __ Numbness/tingling
104. __ Pins and needles
105. __ Sweats easily
106. __ Excessive sweating
107. __ Body odor change
108. __ Stress
109. __ Bowel/ Bladder changes
110. __ Bleed/bruise easily (where?)

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

111. __ Neck pain
112. __ Muscular Pain
113. __ Back Pain
114. __ Joint Pain
115. __ Intractable night pain
116. __ Other muscle or joint
117. __ Scar tissue adhesions problems

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

118. __ Dizziness
119. __ Migraines, auras, sounds, smells
120. __ Headaches
121. __ Vision problems
122. __ Near/Far sighted
123. __ Blurry vision
124. __ Night blindness
125. __ Eye strain/pain
126. __ Color blindness
127. __ Cataract
128. __ Glaucoma
129. __ Spots in eyes
130. __ Ringing in ears high/low
131. __ Poor hearing
132. __ Earaches
133. __ Ear Pain
134. __ Ear discharge
135. __ Heavy ear wax
136. __ Nose bleeds
137. __ Sinus problems
138. __ Mucus
139. __ Dry throat/mouth
140. __ Copious saliva (lots)
141. __ Mouth/tongue sores
142. __ Sore throat
143. __ Other _____

Skin, Hair, and Nails

144. __ Rashes
145. __ Eczema
146. __ Hair/ skin texture
147. __ Ulcerations
148. __ Pimples
149. __ Purpura (red or purple discoloration of the skin)
150. __ Hives
151. __ Dandruff
152. __ Itching
153. __ Loss of hair
154. __ New moles/growth
155. __ White spots on nails
156. __ Absent half moons or ridged nails
157. __ Other _____

Dental

158. __ Teeth problems
159. __ Cavities
160. __ Braces
161. __ Bridges
166. __ Jaw pain
167. __ Molars
168. __ Extractions
169. __ Surgeries
170. __ Jaw clicks
171. __ Grinding teeth
172. __ Facial pain
173. __ Implants
174. __ Dentures
175. __ Swollen/ Bleeding gums
176. __ Periodontal treatment
177. __ Sealants
178. __ Fluoride treatment
179. __ Dry mouth
180. __ Other _____
181. __ Other _____

Neurologic

182. __ Balance Problems
183. __ Vertigo
184. __ Nausea
185. __ Vomiting
186. __ Sudden blurry vision
187. __ Loss of consciousness
188. __ Loss of strength
189. __ Weakness of limb/body
190. __ Feel un-coordinated
191. __ Stumbling/tripping
192. __ "Running into walls or things"
193. __ Frequently dropping things
194. __ Loss of hand grip
195. __ Loss of fine motor skills
196. Other _____
197. Other _____

Cardio Vascular

198. __ High blood pressure
199. __ Dizziness
200. __ Blood clots
201. __ Low blood pressure
202. __ Fainting
203. __ Phlebitis
204. __ Chest Pain
205. __ Cold hands/feet
206. __ Difficulty breathing
207. __ Irregular heartbeat
208. __ Hands/feet swelling
209. __ Rapid pulse
210. __ Heaviness in chest
211. Other _____
212. Other _____

Respiratory and Lungs

213. __ Persistent Cough
214. __ Coughing blood
215. __ Difficulty breathing while lying down
216. __ Asthma
217. __ Production of phlegm (_____color)
218. __ Tight chest
219. __ COPD
220. __ Bronchitis
221. __ Pneumonia
222. __ Other

Genito-Urinary

223. __ Pain w/urination
224. __ Loss of bladder function
225. __ Wake to urinate (__ x's/night; ___ time)
226. __ Kidney stones
227. __ Frequent urination _____ color _____ odor
228. __ Blood in urine
229. __ Venereal disease/ STD
230. __ Urgency to urinate
231. __ Impotency
232. __ Prostate problems
233. __ Other _____

Gastrointestinal

234. __ Pain or cramps
235. __ Vomiting
236. __ Rectal pain
237. __ Bloody stools bright/dark red
238. __ Sensitive abdomen
239. __ Hemorrhoids
240. __ Laxative use: __wk; type ____
241. __ Bowel Changes
242. __ Bowel movements
__ frequency/ day/ wk
__ Color
__ Form (loose, compact)

Gynecology and Pregnancy

243. __ Age of 1st menses
244. __ Flow (describe)
245. __ Period __days
246. __ Clots
247. __ Vaginal Sores
248. __ Vaginal discharge
_____ odor _____ color _____ appearance
249. __ Irregular Periods
250. __ Last menses
251. __ Birth control type and duration
252. __ Number of pregnancies
253. __ Number of births
254. __ Live births
255. __ Premature births; duration of pregnancy _____
256. __ Miscarriages
257. __ Breast lumps (tender) □Yes □No
258. __ PMS
259. __ Mood changes
260. __ Body changes
261. __ Cramps
262. __ Bloating
263. __ Nausea
264. __ Vomiting
265. __ Menopause
____ What year?

Appliances or Aids

266. __ Glasses/ Prisms
267. __ Contacts
268. __ Orthotics
269. __ Joint Replacement
270. __ Prosthetics
271. __ Implants of any kind
272. __ Braces
273. __ Splints
274. __ Pace Maker
275. __ Hearing Aids
276. __ Other
277. __ Other

Neuropsychological

278. __ Seizures
279. __ Depression
280. __ Anxiety
281. __ Poor memory
282. __ Foggy thinking
283. __ Bad temper
284. __ Concussions
285. __ Easily stressed
286. __ Considered/attempted suicide
287. __ Treated for emotional concerns
288. __ Antidepressant medications
289. __ Other neurological or psychological concerns

Lifestyle and Social History

Stress Screening

290. Can you relax when you want?	☐Yes ☐ No
291. Do you have trouble dealing with stress?	☐Yes ☐ No
292. Are you in therapy or counseling? Does it help?	☐Yes ☐ No
293. Is your family safe to express true emotions?	☐Yes ☐ No
294. Are romantic relationships fulfilling?	☐Yes ☐ No
295. Does stress leads to digestive problems?	☐Yes ☐ No
296. Do you abuse food/alcohol/ Tobacco to deal w/unpleasant feeling?	☐Yes ☐ No
297. Do you vent unpleasant emotions in a satisfying way?	☐Yes ☐ No
298. Do you avoid conflicts at your expense?	☐Yes ☐ No
299. Do you feel your health is out of your hands?	☐Yes ☐ No
300. Have you tried to deal with stress, but couldn't succeed?	☐Yes ☐ No
301. Do you feel capable of resolving your problems, but simply need to know how?	☐Yes ☐ No
302. How much do you love yourself? 0.....100%	_____ %

Do you find any dysfunction or concern in the following areas? (Yes/No)

303. __ Relationships with Family
304. __ Relationships with Friends
305. __ Social Skills
306. __ Career
307. __ Work
308. __ Leisure
309. __ Hobbies
310. __ Past Time Activities
311. __ Intimate Relationships
312. __ Sex
313. __ Religious Life
314. __ Spiritual Path
315. __ Childhood Religious teachings
316. __ Past relationships
317. __ Childhood
318. __ School