PATIENT APPLICATION SURVEY

If you require more space for any of these answers, please use the back side of this form or attach additional information.

Please complete this application in black pen.

Today's Date _____

First Name _____ Middle Initial _____ Last Name _____

Suffix _____ Preferred Name _____ Date of Birth _____

Address_____ Apt # _____ City_____

State_____ Zip_____ Email _____

Cell Phone _____ Home Phone _____

Best place to reach you □ Home □ Cell □ Email Would you like to receive text appointment reminders? □ Yes □ No

If necessary, may we leave a message for you at any of the above numbers? □ Yes □ No

Employment Status □ Employed □ FT Student □ PT Student □ Other □ Retired □ Self Employed

Place of Employment: _____ Job Title: _____

Marital Status □ Single □ Married □ Widowed □ Have a 'significant other'

Name (First/Last) of Spouse I Partner I Significant Other _____

Phone Number: _____ Email _____

Emergency Contact Name: _____Rel. to Patient _____

Phone Number: _____ Email _____

Who referred you to our office/How did you hear about our services? _____

PLEASE LIST AND PRIORITIZE YOUR CURRENT AREAS OF MAIN COMPLAINT: (#1 is your chief complaint, #2 is of secondary importance, etc.)

1. 2. 3. 4.

What % of the day does your chief complaint (#1) bother you? (circle one)

□ 10% □ 20% □ 30% □ 40% □ 50% □ 60% □ 70% □ 80% □ 90% □ 100%

PLEASE ANSWER THE FOLLOWING QUESTIONS AS RELATED TO YOUR CHIEF COMPLAINT (#1 listed above)

How long have you had this problem? _____

Did your symptoms begin suddenly? □ Yes □ No

Considering the amount of discomfort you've had THIS week, how long has your problem been this severe? _____

Is this problem related to an auto accident/work injury? □ Yes □ No

Please Describe: _____

Do you have any accident claims currently open for any reason? □ Yes □ No.

Please Describe: _____

Have you had an auto accident or work injury in the last 7 years? □ Yes □ No

Please Describe: _____

If you can, describe any activity change, event, or accident that occurred around the time of the onset of your symptoms which may have contributed to your symptoms? (Include any significant emotionally stressful situations) :

_____

_____

_____

_____

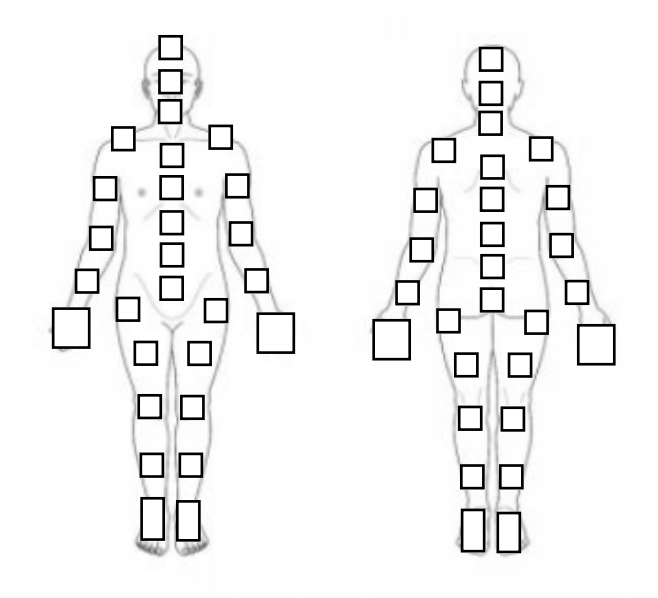
_____

_____

Pain Scale Survey

If you require more space for any of these answers, please use the back side of this form or attach additional information.

Use the diagram below to mark all areas of pain or discomfort you have experienced in the past 90 days. Describe your pain/discomfort in the margins and connect with arrow to each area the description applies to.



Please circle the appropriate number(s) for the intensity of your pain when aggravated and the letter(s) for the frequency of pain.

O: Occasional (0-25% of time) I: Intermittent (26-50% of time) F: Frequent (51-75% of time). C: Constant (76-100% of time)

	Normal	Minimal	Slight			Moderate			Severe				25%	50%	75%	100%
Neck	0	1	2	3	4	5	6	7	8	9	10		O	I	F	C
Upper Back	0	1	2	3	4	5	6	7	8	9	10		O	I	F	C
Middle Back	0	1	2	3	4	5	6	7	8	9	10		O	I	F	C
Lower Back	0	1	2	3	4	5	6	7	8	9	10		O	I	F	C
Hips L R	0	1	2	3	4	5	6	7	8	9	10		O	I	F	C
Shoulders L R	0	1	2	3	4	5	6	7	8	9	10		O	I	F	C
Arms L R	0	1	2	3	4	5	6	7	8	9	10		O	I	F	C
Legs L R	0	1	2	3	4	5	6	7	8	9	10		O	I	F	C
Headaches	0	1	2	3	4	5	6	7	8	9	10		O	I	F	C
Dizziness/Vertigo	0	1	2	3	4	5	6	7	8	9	10		O	I	F	C
Other:	0	1	2	3	4	5	6	7	8	9	10		O	I	F	C

Regarding your chief complaint, on a scale of 0-10 (10 = unbearable, 0= no discomfort) Please rate the following:

The HIGHEST your pain/discomfort gets WITHOUT medication _____ WITH medication _____

The LOWEST your pain/discomfort gets WITHOUT medication _____ WITH medication _____

PAST TREATMENT HISTORY

Nutritional Supplements

Supplement Name	Company	Amount	Reason	How Long?

Prescription Medications

Medication Name	Amount	Frequency	Reason	How Long?

Have you previously had...

Epidural: ☐ Yes ☐ No How Many?_____When?_____

Physical Therapy: ☐ Yes ☐ No How Long?_____When?_____

Chiropractic Care: ☐ Yes ☐ No How Long?_____When?_____

If so, please briefly explain your likes and dislikes: _____

_____

_____

Did any of these treatments work? If so, which treatments? How long did they work?: _____

_____

_____

Other than routine checkups, for what conditions have you sought medical attention (include what specialist and when)? How did you respond?:_____

_____

_____

Have you received any other diagnostic tests? ☐ Yes ☐ No

If so, please describe which tests and what the results were: _____

_____

_____

In the last 18 months, have you received any X-Rays, MRIs, Blood Testing/Analysis? ☐ Yes ☐ No

If yes, please bring a copy of the results to your consultation or email them to us at info@puckette.health prior to your appointment

Please list any injuries or surgeries you have had:

Falls: _____

Head Injuries: _____

Broken Bones: _____

Dislocations: _____

Auto Accidents: _____

Other: _____

Allergies:

Please list all allergies you have to food, drugs, or other substances, along with the symptoms they produce and indicate how long you have suffered from each:

_____

_____

_____

Surgeries:

Please list all surgeries you've had, including: the date, why it was done, and if there were complications:

_____

_____

_____

Family History

Relationship	Age (Now or Death)	Alive/Deceased	Diseases	Serious illness or cause of death
Father		☐Alive ☐Deceased	☐No Significant Disease ☐Has/Had _____	
Paternal Grandfather		☐Alive ☐Deceased	☐No Significant Disease ☐Has/Had _____	
Paternal Grandmother		☐Alive ☐Deceased	☐No Significant Disease ☐Has/Had _____	
Mother		☐Alive ☐Deceased	☐No Significant Disease ☐Has/Had _____	
Maternal Grandfather		☐Alive ☐Deceased	☐No Significant Disease ☐Has/Had _____	
Maternal Grandmother		☐Alive ☐Deceased	☐No Significant Disease ☐Has/Had _____	
Brother(s)		☐Alive ☐Deceased	☐No Significant Disease ☐Has/Had _____	
Sister (s)		☐Alive ☐Deceased	☐No Significant Disease ☐Has/Had _____	
Son (s)		☐Alive ☐Deceased	☐No Significant Disease ☐Has/Had _____	
Daughter (s)		☐Alive ☐Deceased	☐No Significant Disease ☐Has/Had _____	
Uncle (s)		☐Alive ☐Deceased	☐No Significant Disease ☐Has/Had _____	
Aunt (s)		☐Alive ☐Deceased	☐No Significant Disease ☐Has/Had _____	

Please check the corresponding box if you have had any of the following:

Childhood Illnesses (Before the Age of 18):

- ☐ ADHD/ADD
- ☐ Allergies/Hay Fever
- ☐ Anemia
- ☐ Asthma
- ☐ Bedwetting
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Headaches
- ☐ HIV
- ☐ Lyme Disease
- ☐ Measles
- ☐ Rash/Psoriasis
- ☐ Scoliosis
- ☐ Other:_____

Adult Illnesses (After the Age of 18):

- ☐ ADHD/ADD
- ☐ Alzheimer's
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Colitis
- ☐ CRPS (RSD)
- ☐ CVA (Stroke)
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Eye Problems
- ☐ Fibromyalgia
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ HIV
- ☐ Hypertension
- ☐ Influenza
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus Erythema
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Pleural Effusion
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Seizures
- ☐ Shingles
- ☐ STD's (Unspecified)
- ☐ Suicide Attempt(s)
- ☐ Thyroid Problems
- ☐ Vertigo
- ☐ Other:_____

Other Symptoms/Illnesses:

- ☐ Difficulty starting/stopping/ controlling/ urine flow
- ☐ Numbness around the seated area / anus
- ☐ Spinal Disc Space Infections
- ☐ Fractures due to osteoporosis
- ☐ Bowel Movement Difficulty
- ☐ Recent compression fracture? Where? _____
- ☐ Diagnosed with Abdominal Aortic Aneurysm
- ☐ Osteoporosis
- ☐ Diagnosis of Spinal Stenosis
- ☐ Chronic use of steroids or narcotics
- ☐ Coughing/Sneezing/laughing increases back/leg pain (Circle applicable)

LIFE IMPACT ASSESSMENT

As you answer the following questions, please do not minimize any impact on your life no matter how small it appears. We consider any loss of ability or function which affects your daily life as significant. Please check as many that apply; add additional comments in the margin or on the back as needed.

How have others been affected by your health condition?
☐No one is affected ☐I haven't noticed any problems ☐If they tell me to do something
☐People avoid me ☐Other: _____

What are you afraid this might be (or is beginning) to affect (or will affect) in any way?
☐ Energy ☐ Your mood /attitude ☐Stress ☐ Job ☐ Any relationships (frequency visiting, quality, etc.)
☐ Kids ☐ Future ability ☐ Self-esteem ☐ Sleep ☐Marriage ☐Time ☐Finances ☐Freedom
☐Other:_____

Are there health conditions you are afraid this might tum into?
☐ Family health problems ☐ Heart disease ☐ Diabetes ☐Arthritis ☐ Fibromyalgia ☐Depression
☐Chronic Fatigue ☐Need surgery ☐Other:_____

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:
_____
_____
_____
_____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Try to give 3 examples:
_____
_____
_____
_____

What are you most concerned with regarding your problem?
_____
_____
_____
_____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of?
_____
_____
_____
_____

What would be different/better without this problem? Please be specific.
_____
_____
_____
_____
_____

What do you desire most to get from working with us?
_____
_____
_____
_____
_____

SELF ASSESSMENT & TREATMENT GOALS

Although you are not a specialist, what, in your opinion, do you think the real problem is?

_____
_____

Do you blame anyone or hold anyone partially responsible for your current condition or for making your condition worse? (Be specific)

_____
_____

Would you consider this problem (check one):

- ☐ SLIGHT (Tolerable but causing a little limitation)
- ☐ SEVERE (Causing significant limitations and/or concern)
- ☐ MINIMAL (Annoying but causing NO limitations)
- ☐ MODERATE (Sometimes tolerable but causing limitations)
- ☐ EXTREME (Causing near constant limitations, >80% of the time)

Which best describes your health goals:

- ☐ Pain Relief Only (not interested in correction of the problem).
- ☐ Would like to find the cause of this problem and have it improved or corrected.
- ☐ Wellness/Preventative Care – I want to stay well and be at optimal health

How strong is your desire to correct this problem? ☐Mild ☐Moderate ☐High ☐Extremely High

How supportive is your Spouse/Family/Significant Other to you seeking care? (Be specific)

_____
_____
_____
_____

What is YOUR idea of an ideal doctor?

_____
_____
_____
_____

Based on your complementary consultation, history, and exam findings, you may require additional tests that require payment at time of service. If this is required, you will be informed in advance.

* I (name) _____ consent to allow Dr. Puckette to speak with me and perform an examination (if necessary) to determine if I am a good candidate for care at Puckette Integrative Healthcare and to determine if he is willing to accept my case. I have thoroughly completed this application and all supportive documents, answering every question to the best of my ability. I understand that failure to complete this application fully and review the enclosed material may mean that the doctor will not be able to conduct the consultation and evaluation. I will also bring any labs, images or reports which have been requested in this application. I give this office permission to communicate with me via mail, telephone, and email. I understand that Puckette Integrative Healthcare offers an alternative holistic treatment approach to support my general health, not a cure for a specific diagnosis. By identifying and addressing areas of neurological and physiological imbalances, and supporting those areas, areas of dysfunction can be improved upon as well as overall health. I further understand that if I choose to be treated at Puckette Integrative Healthcare, I am to continue to follow the treatment plan of my medical doctor and stay on all my prescribed medications. Any changes to my medical treatment plan or to my prescription medications will ONLY be made by my medical doctor, NOT by Dr. Puckette.

Signature: _____ Date: _____

Fragrance Free Policy:
I understand that, as a courtesy to our patients, and Doctor, with acute sensitivities to allergens, I am to refrain from using any scented products prior to my visit. A single exposure to lingering scents can trigger strong physical reactions or migraines that last for days in people who are chemically sensitive. This office policy refers to perfumes, colognes scented deodorant, scented skin or hair care products, AND essential oils. As powerfully as essential oils can help when it is the right one for you, they can be equally detrimental to those who have a sensitivity to any of them. ____ (initial)

Appointment Policies:
I understand that if I "No Show" an appointment without cancelling it, I will be charged $25.00 to my account. I understand that if I am late to my appointment, I will be seen as soon as possible. If more than 15 minutes late, the appointment will be cancelled and will have to be rescheduled. I understand that being more than 15 minutes late will acquire a $25.00 fee being applied to my account. ____ (initial)

I understand that Integrative healthcare is a stance that looks at your whole body's system and how to improve all different aspects that affect your health and because of this I am expected to keep my appointment dedicated to the assigned appointment type. This means when you are in for an adjustment, you save your neurological or nutritional questions for before or after your appointment by leaving a message with the front desk, emailing, or calling the doctor directly. The doctor will get your message and respond at the earliest convenience. ____ (initial)

I understand that Puckette Integrative Healthcare has the right to refuse treatment and or terminate care due to any inappropriate behavior toward other patients or staff. ____ (initial)

Media Consent
I (please choose one) ☐ **AUTHORIZE or** ☐ **DO NOT AUTHORIZE** the use of photographs, video, or other media to be distributed for educational purposes, social media and marketing, advertisements, or any other distribution suitable to the business owner for any reason. By consenting to the release of images, you agree that you will not receive any form of compensation in cash, credit, check, or any other payment method. You likewise understand that your name will not be included in the images. Nonetheless, it is still possible that someone may still recognize you.
____ (initial)

Patient Health Information& HIPAA Policies:
The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow his chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment. ____ (initial)

The patient understands that they have the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions. ____ (initial)

The patient understands that written consent need only be obtained one time for all subsequent care given the patient in this office. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented. ____ (initial)

For your security and right to privacy, all staff has been trained on patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

By signing below I agree that I have had the opportunity to read the office's HIPAA privacy regulations and patient's rights and have been offered a copy of them for my records. All my questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
Patient or Legal Guardian Printed Name | Rel. to patient or Self

_____ _____
Patient or Legal Guardian Signature | Date

_____ _____
Witness / Office Staff Signature | Date

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

SMGEMAF(122215)Version 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-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 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**

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