Welcome to Chiropractic Neurology Center of Indianapolis.

Enclosed in this packet you will find all the necessary paperwork and forms that need to be filled out and returned to our office. It is mandatory that you complete them fully and bring them with you to your scheduled consultation and examination. Incomplete paperwork and forms will result in our office rescheduling your visit or reserving the right to cancel your consultation and examination.

Completing these forms before your appointment will allow our office to be efficient with your appointment time and ultimately give the doctor a greater understanding of your health status. Please reserve about 20-30 minutes of your time to complete the paperwork.

We do request that previous health records such as blood work, MRI, CT scan, EMG, etc. be supplied so that the doctor can review this part of your health history. These studies can be faxed to our office at (317) 848-6011 from your other physicians. You can simply give that doctor's office a call for this request and supply them our fax number.

We are located at 9302 N. Meridian Street, Suite 299 Indianapolis, IN 46260 when time comes for you to return the required forms and paperwork and meet with the doctor. If you are unfamiliar with our location, we are just south of the I-465 and Meridian Street exit. Our office building is located on the west side of Meridian at the stop light for 93rd Street, which is across the road from Regions Bank.

We ask that you arrive 15 minutes prior to your scheduled appointment time so that our office staff can complete preparation of your file and welcome you to our office.

Be sure to complete:

- All enclosed paperwork
- Have these required forms returned to us in their entirety on your scheduled visit
- Have all prior health records (i.e. blood work or any other valuable information concerning your condition) faxed to our office before your appointment time

I look forward to being your partner in regaining your health.

Sincerely,

Brad R. Ralston DC, DACNB
Chiropractic Neurologist

Lucas D. Gafken DC, DACNB
Chiropractic Neurologist

Welcome to Chiropractic Neurology Center

Dr. Brad Ralston, Dr. Lucas Gafken
9302 N. Meridian Street, Suite 299 Indianapolis, IN 46260 (317) 848-6000

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

Patient and Contact Information

Patient Name_____ **Today's Date** _____

Address _____ **City** _____

State _____ **ZIP** _____ **Social Security #** _____

Gender: ❑ Male ❑ Female **Height** _____ **Weight** _____ **Date of Birth** _____

Marital Status: ❑ Single ❑ Married ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed

Home Phone (_____) _____ **Cell** (_____) _____

Work Phone (_____) _____ **Email** _____

Contact you via: ❑ Home ❑ Cell ❑ Work ❑ Email ❑ Text

(appointment confirmations only) **Cell phone provider** _____

Occupation _____ **Employer/School** _____

Spouse/Partners Name _____ **Employer** _____

Spouse/Partners Work Phone (_____) _____ **Cell** (_____) _____

Emergency Contact name _____ **Relationship** _____

Emergency Contact cell phone (_____) _____ **Work phone** (_____) _____

List of current/previous doctors (If applicable):

Primary Care Physician _____

Primary Care Physician Office Phone (_____) _____

Medical Neurologist _____

Medical Neurologist Office Phone (_____) _____

Endocrinologist _____

Endocrinologist Office Phone (_____) _____

Rheumatologist _____

Rheumatologist Office Phone (_____) _____

Surgeon _____

Surgeon Office Phone (_____) _____

How did you choose our office? (e.g. Referral, internet, advertisement, etc.)

_____

CHRONIC NEUROLOGICAL & METABOLIC CASE HISTORY

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

_____

_____

When did this begin? _____ **How did this begin?** _____

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

What aggravates your condition? _____

What makes it better? _____

Describe what you are feeling? _____

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

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

None —> 0 1 2 3 4 5 6 7 8 9 10 <— Unbearable

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

Is this progressively getting worse? ❑ Yes ❑ No

Is your condition: ❑ Constant ❑ Comes & goes

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily routine
❑ Other _____

Has there been any medical diagnosis of your complaint: ❑ Yes ❑ No
If yes, please list doctor's name and diagnosis: _____

How have you tried to take care of this problem in the past? <u>Circle all that apply</u>
Medications Emergency room Surgery Routine Medical Exercise Supplements
Regular Chiropractic Other (specify) _____

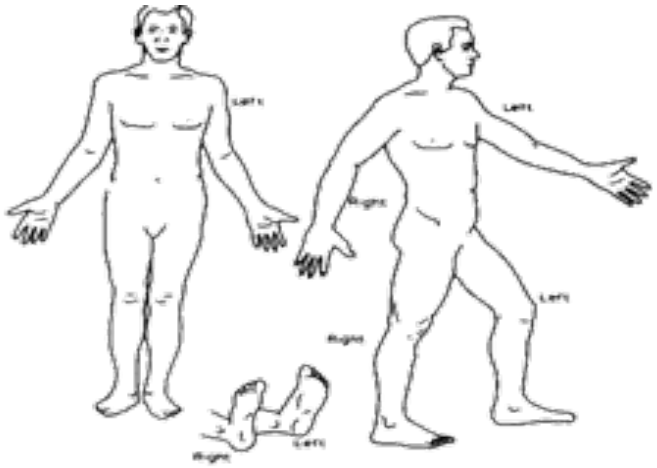
How did the previous method(s) work out for you? <u>Circle all that apply</u>
Bad results Some results Great results Nothing changed
Didn't get worse Didn't work very long

What are you afraid this might be?

_____

Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the diagram to accurately describe your problem.

PPP	PAIN
WWW	WEAKNESS
NNN	NUMBNESS
HHH	HEAT
TTT	TINGLING
BBB	BURNING
CCC	CRAMPING
FFF	STIFFNESS



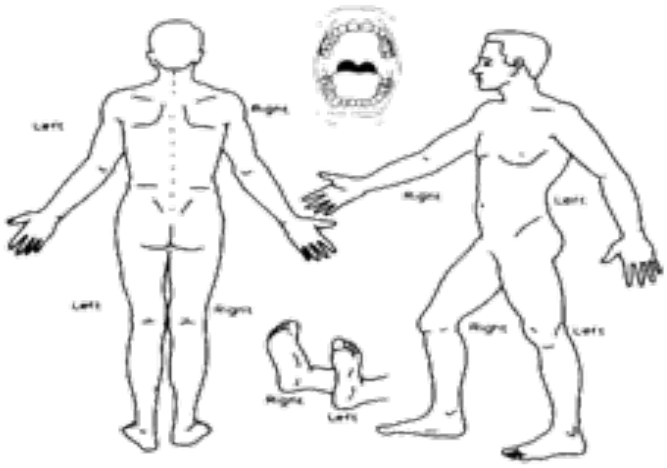
Does the symptom radiate? ❑ Yes ❑ No

If yes, where and how frequently

_____

_____

_____



How long/often does the radiation last/occur?

_____

_____

_____

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

_____

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

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

Please list any natural supplements you're currently take and for what conditions:

_____

_____

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

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

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

Other Medical or Physical conditions: Please check all that apply

❑ ADD/ADHD
❑ Adrenal gland disorder
❑ Anxiety
❑ Arthritis
❑ Asthma
❑ Autoimmune disease:
_____
❑ Bladder issue
❑ Bleeding disorder
❑ Blurred vision
❑ Buzzing/Ringing in ear
❑ Cancer – type?
_____
❑ Carpal Tunnel Synd.
❑ Celiac disease (gluten sensitive)
❑ Chest pains
❑ Chronic fatigue
❑ Cold hands or feet
❑ Colitis/Diverticulitis
❑ Compression fractures
❑ Concussion
❑ COPD
❑ Dementia/Memory Loss
❑ Depression
❑ Diabetes (Type 1 /2)
❑ Digestive/bowel issues
❑ Dizziness or vertigo
❑ Dyslexia
❑ Ear infections
❑ Fibromyalgia
❑ Food sensitivity
❑ Fusions (spinal, joint)
❑ Gall Bladder issue
❑ Gout
❑ Hashimoto's thyroiditis
❑ Heart disease
❑ Hepatitis A, B, C, etc.
❑ Herpes
❑ High blood pressure
❑ Hip replacement
❑ HIV/AIDS
❑ Immune deficiency
❑ Insomnia
❑ Kidney disease
❑ Knee surgery
❑ Leaky Gut Syndrome
❑ Light/Sound sensitivity
❑ Liver disease
❑ Marfan's syndrome
❑ Motion sickness
❑ Multiple Sclerosis
❑ Osteoporosis/penia
❑ Parkinson's disease
❑ Rotator cuff problem
❑ Shoulder surgery
❑ Spinal surgery
❑ STI/STD
❑ Stroke/TIA
❑ Thyroid problems
❑ Traumatic Brain Injury
❑ Tuberculosis
❑ Other
_____
❑ Other
_____

Where do you picture yourself being in the next 1-3 years if this problem isn't 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?

What is it worth to you?

What is your idea of the ideal doctor?

Please complete the following pages.

We thank you for your patience and cooperation in completely filling out this form.

*****Write down <u>EVERYTHING</u> you eat & drink for 3 days. What you're eating and when you're eating can have a HUGE NEGATIVE IMPACT on your health. Don't worry about trying to impress us by telling the doctor what you think he wants to hear. *****

<u>DAY 1</u>

Breakfast	Lunch	Dinner
Time:	**Time:**	**Time:**
Mid-morning snack	**Mid-afternoon snack**	**Post-dinner snack**
Time:	**Time:**	**Time:**

<u>DAY 2</u>

Breakfast	Lunch	Dinner
Time:	**Time:**	**Time:**
Mid-morning snack	**Mid-afternoon snack**	**Post-dinner snack**
Time:	**Time:**	**Time:**

<u>DAY 3</u>

Breakfast	Lunch	Dinner
Time:	**Time:**	**Time:**
Mid-morning snack	**Mid-afternoon snack**	**Post-dinner snack**
Time:	**Time:**	**Time:**

Metabolic Assessment Form™

Name: ______________________ **Age:** ______ **Sex:** _____ **Date:** ______________________

PART I

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

1. ______________________

2. ______________________

3. ______________________

4. ______________________

5. ______________________

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

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category VII

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
Lowered gastrointestinal motility, constipation	0	1	2	3
Raised 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
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes	No		

Category 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	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

[illegible]

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 Health and Nutrition Assessment Form™ (BHNAF)

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

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

SECTION 1

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

SECTION 2

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

SECTION 3

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

SECTION 4

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

SECTION 5

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

SECTION 6

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

SECTION 7

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

SECTION 8

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

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

Brain Health and Nutrition Assessment Form™ (BHNAF)

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

SECTION 9

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

SECTION 10

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

SECTION 11

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

SECTION 12

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

SECTION 13

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

SECTION 14

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

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)

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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Chronic Condition Narrative History

Please use this space to give us more details about the history of your problem(s).
Please tell us about:

1) **Your complete health history (be sure to include rough dates, tests performed, treatments that worked and how well, how long did they help, what treatments didn't help)**
2) **Was there a pivotal injury/illness/stressor when your conditions first developed (e.g. Lyme's disease, Mononucleosis, etc.)?**
3) **What diagnoses have other doctors given you for your current condition(s)?**
4) **Why do you think other doctors failed you?**
5) **Why do you think I can help you?**
6) **What do you hope to gain by coming to see us? How long do you think it will take to accomplish this?**
7) **Does your family support you coming to this office?**
8) **What do you think is wrong?**