Welcome to Chiropractic Neurology Center

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

Patient and Contact Information

Patient Name ______________________ Today's Date __________ DOB __________

Address ______________________ City ______________ State ____ ZIP ______

Social Security #: ____________ Gender: ❑ Male ❑ Female Height ____ Weight ____

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

Home Telephone (____) ________ Cell (____) ________ Work (____) ________

Email ____________________ Contact you via: ❑Home phone ❑Cell ❑Work phone ❑Email

Occupation ______________________ Employer/School ______________________

Spouse/Partners Name ____________________ Employer ______________________

Spouse/Partners Work Phone (____) ________ Cell Phone (____) ________

Contact name in case of emergency ____________________ Relationship ______________

Emergency Contact cell phone (___) ________ Emergency Contact work 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 and 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 ______________________________

Chiropractic Neurology Center
Dr. Brad Ralston Dr. Lucas Gafken
9302 N. Meridian Street, Suite 170 Indianapolis, IN 46260
(317) 848-6000

Welcome to Chiropractic Neurology Center

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

Has there been any medical diagnosis of your complaint: ❑ Yes ❑ No
If yes, please list the Dr.'s name and Diagnosis: ______________________________

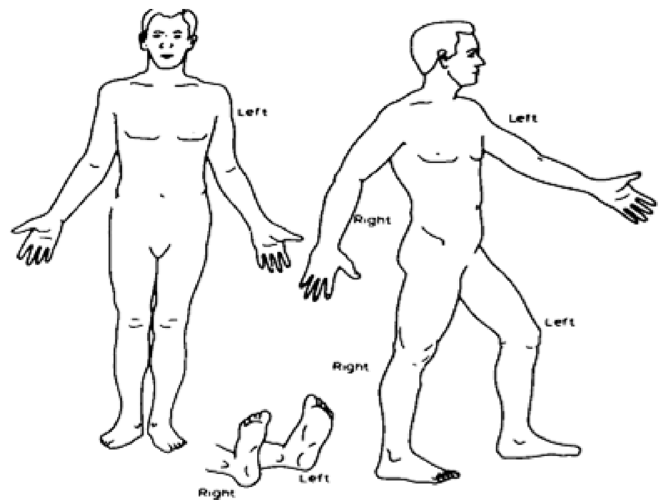
How have you tried to take care of this problem in the past? Circle all that apply
Medications   Emergency room   Surgery   Routine Medical   Exercise
Supplements   Regular Chiropractic   Other (specify) ____________________

How did the previous method(s) work out for you? Circle all that apply
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



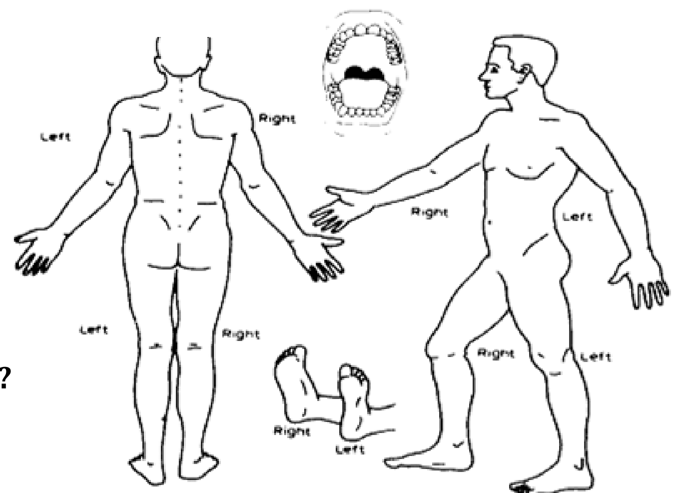
Does the symptom radiate? ❑ Yes ❑ No

If yes, where and how frequently

____

____

____



How long/often does the radiation last/occur?

____

____

____

Chiropractic Neurology Center
Dr. Brad Ralston Dr. Lucas Gafken
9302 N. Meridian Street, Suite 170 Indianapolis, IN 46260
(317) 848-6000

Welcome to Chiropractic Neurology Center

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

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 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)			

Chiropractic Neurology Center
Dr. Brad Ralston Dr. Lucas Gafken
9302 N. Meridian Street, Suite 170 Indianapolis, IN 46260
(317) 848-6000

Welcome to Chiropractic Neurology Center

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

Other Medical or Physical conditions: Please check all that apply

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

- ❒ Connective tissue disease
- ❒ COPD
- ❒ Depression
- ❒ Dyslexia
- ❒ Diabetes (Type 1 /2)
- ❒ Digestive/bowel problems
- ❒ Dizziness or vertigo
- ❒ Ear infections
- ❒ Fibromyalgia
- ❒ Food sensitivity
- ❒ Fusions (spinal, joint, etc.)
- ❒ Gout
- ❒ Gall Bladder issue
- ❒ Immune deficiency
- ❒ Insomnia
- ❒ Heart disease
- ❒ Hepatitis A, B, C, etc. ______________________

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

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

____

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?

____

____

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

Chiropractic Neurology Center
Dr. Brad Ralston Dr. Lucas Gafken
9302 N. Meridian Street, Suite 170 Indianapolis, IN 46260
(317) 848-6000

Welcome to Chiropractic Neurology Center

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

*****Write down EVERYTHING 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. *****

DAY 1

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

DAY 2

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

DAY 3

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

Chiropractic Neurology Center
Dr. Brad Ralston Dr. Lucas Gafken
9302 N. Meridian Street, Suite 170 Indianapolis, IN 46260
(317) 848-6000

Welcome to Chiropractic Neurology Center

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

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?**

Chiropractic Neurology Center
Dr. Brad Ralston Dr. Lucas Gafken
9302 N. Meridian Street, Suite 170 Indianapolis, IN 46260
(317) 848-6000

Welcome to Chiropractic Neurology Center

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

Metabolic Assessment Form™

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

PART I

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

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

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

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3
Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3
Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category VI				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3

Category VI *(Cont.)*				
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Category VII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes	No		
Category VIII				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3
Category IX				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category X				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

© 2015 Datis Kharrazian. All Rights Reserved.
[illegible]

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

Chiropractic Neurology Center
Dr. Brad Ralston Dr. Lucas Gafken
9302 N. Meridian Street, Suite 170 Indianapolis, IN 46260
(317) 848-6000

Welcome to Chiropractic Neurology Center

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

Category XI

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIII

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XV *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVIII *(Menstruating Females Only)*

Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XIX *(Menopausal Females Only)*

How many years have you been menopausal?	_______ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _________

How many caffeinated beverages do you consume per day? _________

How many times do you eat out per week? _________

How many times do you eat raw nuts or seeds per week? _________

Rate your stress level on a scale of 1-10 during the average week: _________

How many times do you eat fish per week? _________

How many times do you work out per week? _________

List the three worst foods you eat during the average week: ____________ ____________ ____________

List the three healthiest foods you eat during the average week: ____________ ____________ ____________

PART IV

Please list any medications you currently take and for what conditions:

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

Chiropractic Neurology Center
Dr. Brad Ralston Dr. Lucas Gafken
9302 N. Meridian Street, Suite 170 Indianapolis, IN 46260
(317) 848-6000

Welcome to Chiropractic Neurology Center

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

Neurotransmitter Assessment Form™ (NTAF)

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 A

- Is your memory noticeably declining? 0 1 2 3
- Are you having a hard time remembering names and phone numbers? 0 1 2 3
- Is your ability to focus noticeably declining? 0 1 2 3
- Has it become harder for you to learn new things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament generally getting worse? 0 1 2 3
- Is your attention span decreasing? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you become fatigued when driving compared to in the past? 0 1 2 3
- How often do you become fatigued when reading compared to in the past? 0 1 2 3
- How often do you walk into rooms and forget why? 0 1 2 3
- How often do you pick up your cell phone and forget why? 0 1 2 3

SECTION B

- How high is your stress level? 0 1 2 3
- How often do you feel you have something that must be done? 0 1 2 3
- Do you feel you never have time for yourself? 0 1 2 3
- How often do you feel you are not getting enough sleep or rest? 0 1 2 3
- Do you find it difficult to get regular exercise? 0 1 2 3
- Do you feel uncared for by the people in your life? 0 1 2 3
- Do you feel you are not accomplishing your life's purpose? 0 1 2 3
- Is sharing your problems with someone difficult for you? 0 1 2 3

SECTION C

SECTION C1

- How often do you get irritable, shaky, or have light-headedness between meals? 0 1 2 3
- How often do you feel energized after eating? 0 1 2 3
- How often do you have difficulty eating large meals in the morning? 0 1 2 3
- How often does your energy level drop in the afternoon? 0 1 2 3
- How often do you crave sugar and sweets in the afternoon? 0 1 2 3
- How often do you wake up in the middle of the night? 0 1 2 3
- How often do you have difficulty concentrating before eating? 0 1 2 3
- How often do you depend on coffee to keep yourself going? 0 1 2 3
- How often do you feel agitated, easily upset, and nervous between meals? 0 1 2 3

SECTION C2

- How often do you get fatigued after meals? 0 1 2 3
- How often do you crave sugar and sweets after meals? 0 1 2 3
- How often do you feel you need stimulants, such as coffee, after meals? 0 1 2 3
- How often do you have difficulty losing weight? 0 1 2 3
- How much larger is your waist girth compared to your hip girth? 0 1 2 3
- How often do you urinate? 0 1 2 3
- Have your thirst and appetite increased? 0 1 2 3
- How often do you gain weight when under stress? 0 1 2 3
- How often do you have difficulty falling asleep? 0 1 2 3

SECTION 1

- Are you losing interest in hobbies? 0 1 2 3
- How often do you feel overwhelmed? 0 1 2 3
- How often do you have feelings of inner rage? 0 1 2 3
- How often do you have feelings of paranoia? 0 1 2 3
- How often do you feel sad or down for no reason? 0 1 2 3
- How often do you feel like you are not enjoying life? 0 1 2 3
- How often do you feel you lack artistic appreciation? 0 1 2 3
- How often do you feel depressed in overcast weather? 0 1 2 3
- How much are you losing your enthusiasm for your favorite activities? 0 1 2 3
- How much are you losing your enjoyment for your favorite foods? 0 1 2 3
- How much are you losing your enjoyment of friendships and relationships? 0 1 2 3
- How often do you have difficulty falling into deep, restful sleep? 0 1 2 3
- How often do you have feelings of dependency on others? 0 1 2 3
- How often do you feel more susceptible to pain? 0 1 2 3
- How often do you have feelings of unprovoked anger? 0 1 2 3
- How much are you losing interest in life? 0 1 2 3

SECTION 2

- How often do you have feelings of hopelessness? 0 1 2 3
- How often do you have self-destructive thoughts? 0 1 2 3
- How often do you have an inability to handle stress? 0 1 2 3
- How often do you have anger and aggression while under stress? 0 1 2 3
- How often do you feel you are not rested, even after long hours of sleep? 0 1 2 3
- How often do you prefer to isolate yourself from others? 0 1 2 3
- How often do you have unexplained lack of concern for family and friends? 0 1 2 3
- How easily are you distracted from your tasks? 0 1 2 3
- How often do you have an inability to finish tasks? 0 1 2 3
- How often do you feel the need to consume caffeine to stay alert? 0 1 2 3
- How often do you feel your libido has been decreased? 0 1 2 3
- How often do you lose your temper for minor reasons? 0 1 2 3
- How often do you have feelings of worthlessness? 0 1 2 3

SECTION 3

- How often do you feel anxious or panicked for no reason? 0 1 2 3
- How often do you have feelings of dread or impending doom? 0 1 2 3
- How often do you feel knots in your stomach? 0 1 2 3
- How often do you have feelings of being overwhelmed for no reason? 0 1 2 3
- How often do you have feelings of guilt about everyday decisions? 0 1 2 3
- How often does your mind feel restless? 0 1 2 3
- How difficult is it to turn your mind off when you want to relax? 0 1 2 3
- How often do you have disorganized attention? 0 1 2 3
- How often do you worry about things you were not worried about before? 0 1 2 3
- How often do you have feelings of inner tension and inner excitability? 0 1 2 3

SECTION 4

- Do you feel your visual memory (shapes & images) has decreased? 0 1 2 3
- Do you feel your verbal memory has decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity decreased? 0 1 2 3
- Has your comprehension diminished? 0 1 2 3
- Do you have difficulty calculating numbers? 0 1 2 3
- Do you have difficulty recognizing objects & faces? 0 1 2 3
- Do you feel like your opinion about yourself has changed? 0 1 2 3
- Are you experiencing excessive urination? 0 1 2 3
- Are you experiencing a slower mental response? 0 1 2 3

© 2013, Datis Kharrazian. All Rights Reserved.
SMGENTAF04(031513)

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

Chiropractic Neurology Center
Dr. Brad Ralston Dr. Lucas Gafken
9302 N. Meridian Street, Suite 170 Indianapolis, IN 46260
(317) 848-6000

Welcome to Chiropractic Neurology Center

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

Medication History*

Please check any of the following medications you have taken in the past or are currently taking.

Noradrenergic and Specific Serotonergic Antidepressants (NaSSAs)

- ☐ Remeron®
- ☐ Norset®
- ☐ Zispin®
- ☐ Remergil®
- ☐ Avanza®
- ☐ Axit®

Tricyclic Antidepressants (TCAs)

- ☐ Elavil®
- ☐ Prothiaden®
- ☐ Endep®
- ☐ Adapin®
- ☐ Tryptanol®
- ☐ Sinequan®
- ☐ Trepiline®
- ☐ Tofranil®
- ☐ Asendin®
- ☐ Janamine®
- ☐ Asendis®
- ☐ Gamanil®
- ☐ Defanyl®
- ☐ Aventyl®
- ☐ Demolox®
- ☐ Pamelor®
- ☐ Moxadil®
- ☐ Opipramol®
- ☐ Anafranil®
- ☐ Vivactil®
- ☐ Norpramin®
- ☐ Rhotrimine®
- ☐ Pertofrane®
- ☐ Surmontil®
- ☐ Thaden™
- ☐ Norpramin®

Selective Serotonin Reuptake Inhibitors (SSRIs)

- ☐ Paxil®
- ☐ Seromex®
- ☐ Zoloft®
- ☐ Seronil®
- ☐ Prozac®
- ☐ Sarafem®
- ☐ Celexa®
- ☐ Fluctin®
- ☐ Lexapro®
- ☐ Faverin®
- ☐ Esertia®
- ☐ Seroxat®
- ☐ Luvox®
- ☐ Aropax®
- ☐ Cipramil®
- ☐ Deroxat®
- ☐ Emocal®
- ☐ Rexetin®
- ☐ Seropram®
- ☐ Paroxat®
- ☐ Cipralex®
- ☐ Lustral®
- ☐ Fontex®
- ☐ Serlain®
- ☐ Priligy®

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

- ☐ Effexor®
- ☐ Pristiq®
- ☐ Meridia®
- ☐ Serzone®
- ☐ Dalcipran®
- ☐ Cymbalta®

Selective Serotonin Reuptake Enhancers (SSREs)

- ☐ Stablon®
- ☐ Coaxil®
- ☐ Tatinol®

Monoamine Oxidase Inhibitors (MAOIs)

- ☐ Marplan®
- ☐ Marsilid®
- ☐ Aurorix®
- ☐ Iprozid®
- ☐ Manerix®
- ☐ Ipronid®
- ☐ Moclodura®
- ☐ Rivivol®
- ☐ Nardil®
- ☐ Propilniazida®
- ☐ Adeline®
- ☐ Zyvox®
- ☐ Eldepryl®
- ☐ Zyvoxid®
- ☐ Azilect®

Dopamine Receptor Agonists

- ☐ Mirapex®
- ☐ Sifrol®
- ☐ Requip®

Norepinephrine–Dopamine Reuptake Inhibitors (NDRIs)

- ☐ Wellbutrin XL®

D2 Dopamine Receptor Blockers (antipsychotics)

- ☐ Thorazine®
- ☐ Acuphase®
- ☐ Prolixin®
- ☐ Haldol®
- ☐ Trilafon®
- ☐ Orap®
- ☐ Compazine®
- ☐ Clozaril®
- ☐ Mellaril®
- ☐ Zyprexa®
- ☐ Stelazine®
- ☐ Zydis®
- ☐ Vesprin®
- ☐ Seroquel XR®
- ☐ Nozinan®
- ☐ Geodon®
- ☐ Depixol®
- ☐ Solian®
- ☐ Navane®
- ☐ Invega®
- ☐ Fluanxol®
- ☐ Abilify®
- ☐ Clopixol®

GABA Antagonist Competitive Binder

- ☐ Romazicon®

Agonist Modulators of GABA Receptors (benzodiazepines)

- ☐ Xanax®
- ☐ Dalmane®
- ☐ Lexotanil®
- ☐ Ativan®
- ☐ Lexotan®
- ☐ Loramet®
- ☐ Librium®
- ☐ Sedoxil®
- ☐ Klonopin®
- ☐ Dormicum®
- ☐ Valium®
- ☐ Serax®
- ☐ Prosom®
- ☐ Restoril®
- ☐ Rohypnol®
- ☐ Halcion®
- ☐ Magadon®

Agonist Modulators of GABA Receptors (non-benzodiazepines)

- ☐ Ambien CR®
- ☐ Sonata®
- ☐ Lunesta®
- ☐ Imovane®

Acetylcholine Receptor Agonists

- ☐ Urecholine®
- ☐ Isopto®
- ☐ Evoxac®
- ☐ Nicotone
- ☐ Salagen®

Acetylcholine Receptor Antagonists (antimuscarinic agents)

- ☐ AtroPen®
- ☐ Atrovent®
- ☐ Scopace®
- ☐ Spiriva®

Acetylcholine Receptor Antagonists (ganglionic blockers)

- ☐ Inversine®
- ☐ Hexamethonium
- ☐ Nicotine (high doses)
- ☐ Arfonad®

Acetylcholine Receptor Antagonists (neuromuscular blockers)

- ☐ Tracrium®
- ☐ Zemuron®
- ☐ Nimbex®
- ☐ Anectine®
- ☐ Nuromax®
- ☐ Tubocurarine®
- ☐ Metubine®
- ☐ Norcuron®
- ☐ Mivacron®
- ☐ Hemicholinium-3®
- ☐ Pavulon®

Acetylcholinesterase Reactivators

- ☐ Protopam®

Cholinesterase Inhibitors (reversible)

- ☐ Aricept®
- ☐ Enlon®
- ☐ Razadyne®
- ☐ Prostigmin®
- ☐ Exelon®
- ☐ Antilirium®
- ☐ Cognex®
- ☐ Mestinon®
- ☐ THC
- ☐ Carbamate insecticides

Cholinesterase Inhibitors (irreversible)

- ☐ Echothiophate
- ☐ Isoflurophate
- ☐ Organophosphate insecticides
- ☐ Organophosphate-containing nerve agents

© 2013, Datis Kharrazian. All Rights Reserved.
SMGENTAF04(031513)

**Please refer to prescribing physician for nutritional interactions with any medications you are taking.*

Chiropractic Neurology Center
Dr. Brad Ralston Dr. Lucas Gafken
9302 N. Meridian Street, Suite 170 Indianapolis, IN 46260
(317) 848-6000