GENESIS
PERFORMANCE
CHIROPRACTIC

# Patient Registration

Please fill out form completely. Be aware of the Notice of Privacy Practices.

Patient's full name: _____

Date of Birth: _____ Age:_____ Sex: M ☐ F ☐

Street Address / Apt. #: _____

City, State, Zip: _____

Home Phone: _____ Leave a message? ☐ Yes ☐ No

Local or Cell Phone: _____ Leave a message? ☐ Yes ☐ No

Best form of contact? ☐ Home ☐ Cell ☐ Other _____

Email Address: _____

Would you like to be subscribed to our e-newsletter? ☐ Yes, please! ☐ No, thanks.

Primary Care Physician: _____

Primary Care Phone or City & State: _____

How did you hear about us? _____

Patient's Employer: _____

Work Phone: _____

Emergency Contact: _____

Emergency Contact Phone: _____ Relationship to Patient: _____

## Reason For Visit

Priority #1 _____

_____

Priority #2 _____

_____

Priority #3 _____

_____

Name of other doctor(s) who has/have treated you for today's condition:

_____

_____

If you have seen another doctor, please describe the treatment plan for your condition:

_____

_____

_____

_____

_____

_____

## Social History

Marital Status: _____

Children (number, gender, and ages):

_____

_____

_____

Who currently lives with you?:

Occupation (if retired, please list prior jobs):

Smoking Status :

Non-smoker, Ex-smoker, Current smoker/chew tobacco

If current or ex-smoker: _____ # packs/day for _____ # of years; Quit date: _____

Illegal drug or marijuana use:

Which drugs?

# Lifestyle

**Circle all that apply**

Bowel Movements:

Normal, Diarrhea, Loose, Constipation, Alternating, Blood in Stool

#BM _____ per DAY or WEEK

How is your Energy?:

Poor, Average, Good

Sleep :

Problems falling asleep: Y / N, Problems staying asleep: Y / N

# Hours of sleep per night _____

Age of mattress: _____ # of pillows used: _____ Typical sleep position: _____

What time do you go to bed? _____

How long do you sleep? _____

Do you wake often? Y / N

If yes, why and what time(s)? _____

Do you feel rested when you wake up for the day? Y / N

Exercise:

What type: _____

How often?:_____

how much time/session: _____

How do you feel afterwards?

Current stress level:

Rank from 1 (not at all stressed) to 10 (extremely stressed): 1 2 3 4 5 6 7 8 9 10

Chronic or recent reason?

Personal health assessment:

Rank from 1 (not healthy at all) to 10 (optimally healthy):

Physical health: 1 2 3 4 5 6 7 8 9 10

Emotional health: 1 2 3 4 5 6 7 8 9 10

Spiritual health: 1 2 3 4 5 6 7 8 9 10

## Family History of diseases

| | | | | |
|---|---|---|---|---|
| Mother | ☐ Cancer | ☐ Autoimmune | ☐ Cardiovascular | ☐ Diabetes |
| Father | ☐ Cancer | ☐ Autoimmune | ☐ Cardiovascular | ☐ Diabetes |
| Siblings | ☐ Cancer | ☐ Autoimmune | ☐ Cardiovascular | ☐ Diabetes |
| Grandparents | ☐ Cancer | ☐ Autoimmune | ☐ Cardiovascular | ☐ Diabetes |
| Children | ☐ Cancer | ☐ Autoimmune | ☐ Cardiovascular | ☐ Diabetes |

# Nutrition (complete / circle)

What would you eat in a typical day?

Breakfast

Lunch

Dinner

Snack

Beverage

Caffeine # 8 oz cup/day _____
Alcohol # Drinks/day _____
Alcohol # Drinks/week _____

Are you currently trying a diet? Y / N

If yes, which diet?

Gluten-free

Dairy-free

Soy-free

Egg-free

Vegetarian (eat egg, dairy, fish?)

Vegan

How many ounces of water do you drink a day?

What kind of water do you drink?

What other beverages do you drink and how much?

Do you use artificial sweeteners? Y / N
If yes, which ones?

How often do you use these sweeteners, and in what?

In the box below, list any supplements you are taking:

| Supplement | Brand | Dosage | Who prescribed it? |
|---|---|---|---|
| | | | |

List any medications you are taking: _____
_____
_____

Allergies and Reactions: ☐ No Known Food Allergies ☐ No Known Drug allergies
_____
_____
_____

## Symptoms

For the following sections, circle or check all that apply.
Fill in blanks as necessary.

### *Musculoskeletal*

Neck pain
Back pain
Joint pain -
where? _____
Migratory joint pain
Myalgia
Tick bite / Bulls eye rash
Frequent falls

Opportunity for tick - dog,
woods, hiking, etc.
Fibromyalgia
Rheumatoid arthritis
Psoriatic arthritis
Joint replacement -
where? _____
Osteopenia

Osteoporosis
Swelling of joints
Herniations
TMJ
Osteoarthritis
Orthotic use ☐ Yes ☐ No
Age _____
Provider _____

| | Description | Date(s) |
|---|---|---|
| Have you had any auto accidents? | _____ | _____ |
| Broken bones? | _____ | _____ |
| Falls or head injuries? | _____ | _____ |

## *Past Surgical History (list dates)*

| | | | |
|---|---|---|---|
| Tubes in Ears | _____ | Appendix Removed | _____ |
| Sinus Surgery | _____ | Bariatric Surgery | _____ |
| Tonsils and Adenoids Removed | _____ | Colon Surgery | _____ |
| Extensive Dental Work | _____ | Joint Replacement | _____ |
| Coronary Artery Surgery (CABG) | _____ | Knee Surgery (L or R) | _____ |
| Coronary Stent | _____ | Hip Surgery (L or R) | _____ |
| Inguinal Hernia Repair (L or R) | _____ | Shoulder Surgery (L or R) | _____ |
| Umbilical Hernia Repair | _____ | Uterus Removed | _____ |
| Breast Implants | _____ | Tubes or Ovary Removed (L or R) | _____ |
| Thyroidectomy - complete or partial | _____ | Uterus and both tubes | |
| Gall Bladder Removed | _____ | and ovaries removed | _____ |

Other surgeries and dates:

_____

_____

_____

_____

## *Skin / Hair*

| | |
|---|---|
| Rash | Rosacea |
| Itching | Acne |
| Hair Loss | Psoriasis |
| Facial hair growth on females | Eczema |
| Recurrent hives | Skin cancer |

## *Head / Ear / Nose / Throat*

| | |
|---|---|
| Vertigo | Recurrent pharyngitis |
| Dizziness | Increased phlegm in throat |
| Photophobia (sensitive to light) | Hx of tubes in ears |
| Sensitive to sound | Tonsils and adenoids removed |
| Eye discharge | Sinus surgery |
| Dry eyes / dry mouth | Extensive dental work |
| Coating on tongue | Frequent antibiotic use |
| Thrush | Tinnitus - ringing in the ear |
| Recurrent sinus infections | Burning mouth |
| Recurrent ear infections | Sore throat |
| Stuffy runny nose | Hoarse |
| Vasovagal episodes | Headaches / migraines |

## *Constitutional*

| | |
|---|---|
| Fatigue | Caffeine consumption >2 cups/week |
| Weight loss - how much/time? _____ | Low Vitamin D |
| Weight gain - how much/time? _____ | Low Vitamin B12 |
| Trouble falling asleep | Nap during the day |
| Trouble staying asleep | Fever |

## *Cardiovascular*

| | |
|---|---|
| Chest pain or tightness | +MTHFR - Which form? Homozygous, |
| Palpitations | heterozygous, C677T, A1298C, |
| Leg edema | Compound Heterozygous |
| High homocysteine | Blood thinners |
| High cholesterol | Hypertension |
| Hi triglycerides | Atrial Fibrillation |
| Low HDL (good cholesterol) | Heart Attack History |
| Coronary Artery Disease | |

## *Pulmonary*

| | |
|---|---|
| Cough | Obstructive Sleep Apnea |
| Wheeze | COPD-Chronic Obstructive Pulm. Disease |
| Short of breath | Asthma |
| Recurrent bronchitis or pneumonia | Snoring |

## *Hematology*

| | |
|---|---|
| Increased bruising / bleeding | Anemia |
| High ferritin / iron | Hereditary Hemochromatosis |
| Low ferritin / iron | Low WBC |

## *GI*

| | |
|---|---|
| Nausea | Food Allergies |
| Vomiting | Leaky gut |
| Heartburn | SIBO-Small Bowel Overgrowth |
| Abdominal pain | Irritable Bowel Syndrome |
| Diarrhea | Candida |
| Constipation | Parasites |
| Bloating | H Pylori |
| Abnormal Liver Function Tests | C-Diff |
| History Alcohol Abuse | Colon Polyp |
| Gall bladder problem | Colon Cancer |
| Blood in Stool | Diverticulitis |

## *GYN / Urology*

Dysuria
Frequency
Urgency
Recurrent UTI
Recurrent vaginal infections
Heavy menses
Are you pregnant? ☐ Yes ☐ No
Breast Cancer
Hormone Replacement Therapy (HRT)
Premature Menopause
Menopausal
Kidney stones
Urinary Incontinence
Chronic Kidney Disease
Blood in Urine
Fertility cancers
Hormone-based contraception? Y / N
Last cycle? Date _____

Are you now or in the future planning to become pregnant? _____
How many days is your average menstrual cycle? _____
Is your flow longer or shorter than 5 days? _____

## *Endocrine*

Low blood sugar
Sugar cravings
Salt cravings
Excessive thirst
Trouble losing weight
Trouble coping with stress / cry easily
Adrenal fatigue
Pre-diabetes
Diabetes
Hypothyroid
Hashimoto's
Hyperthyroid/Graves
Thyroid Cancer
Hyperparathyroidism / High Calcium
Amenorrhea - no period
Interstitial cystitis
Hot flashes: Night sweats
Trouble sleeping
Vaginal dryness
Palpitations
Increased tissue on upper back
Fatigue, reduced stamina
Bloating
Weight gain - thigh, hips, buttocks
Decreased libido
Anxiety / Depression / Irritableness
Fuzzy thinking: trouble concentrating
Food cravings
Painful breasts
Brain fog
Sparse body hair
Cry easily / easily startled / lack motivation
Dry skin / hair loss / dry brittle hair
Cold intolerance / low body temperature
Fibrocystic Breast Disease
PMS
Uterine fibroids / Ovarian Cysts
Blood clots
Belly fat
Men - breasts enlarge, BPH, impotence
Endometriosis
High cholesterol and triglycerides
Low HDL
Acne; oily skin
Increased facial hair - in women
Decreased scalp hair - in women
Decreased sweating
Infertility
Thinning / bruising skin
Slow wound healing
Tremor
Heat intolerance

## *Neurology*

| | |
|---|---|
| Headaches | Migraine HA |
| Dizziness | Parkinson's |
| Tingling in extremities | Alzheimer's |
| Burning/numbness | Epilepsy |

## *Psychiatry*

| | |
|---|---|
| Anxiety | GAD - Generalized anxiety disorder |
| Depression | OCD - Obsessive Compulsive Disorder |
| Suicidal thoughts | Parkinson's |
| Brain fog | Alzheimer's |
| Memory loss | ADHD |
| Worrier | Dyslexia |
| Bipolar | Dyspraxia |

## *Emotional*

Loss of loved one:
family / friend / acquaintance
Abuse: physical / sexual / verbal
End of relationship:
divorce / break up / family / friend
Physical trauma:
car accident / injury / surgery / chronic pain / other trauma
Occupational hardship:
fired / work stress / discontent
Sensitivities: sound / food / light

Primary sources of stress: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Other emotional traumas: _____
_____
_____
_____
_____
_____
_____
_____

How would you rate your relationship with parents?
(1-10: 1 is very poor, 10 is excellent): _____

How would you rate your relationship with siblings?
(1-10: 1 is very poor, 10 is excellent): _____

How would you rate your relationship with spouse / significant other?
(1-10: 1 is very poor, 10 is excellent): _____

How would you rate your relationship with children?
(1-10: 1 is very poor, 10 is excellent): _____

# *Environmental*

| | |
|---|---|
| Allergies - environment | New Home/Construction/Remodeling |
| Toxin exposure | Allergies shots |
| Mercury fillings in mouth | Swimming regularly |
| Mercury fillings removed | Mold exposure |

## Mercury

Have you ever had any dental crowns? If yes, how many? ☐ Yes ☐ No

Have you had any bridges? ☐ Yes ☐ No

Have you had any root canals? ☐ Yes ☐ No

Have you had any tooth extractions? ☐ Yes ☐ No

Do you have any dental implants, retainers, or other metal in your mouth? ☐ Yes ☐ No

Explain: _____

Did you receive yearly flu shots or have you recently received a flu shot? ☐ Yes ☐ No

Any allergy shots or vaccinations? ☐ Yes ☐ No

Do you have any tattoos with red ink? ☐ Yes ☐ No

## Lead

Does your occupation involve soldering or metal salvage? ☐ Yes ☐ No

Was your home built before 1978? ☐ Yes ☐ No

Are you around a lot of fake leather or vinyl? ☐ Yes ☐ No

Do you wear conventional cosmetics? ☐ Yes ☐ No

## General Toxicity

Do you have your house sprayed with pesticides for pest control? ☐ Yes ☐ No

Do you spray herbicide (weed killers) in or around your home? ☐ Yes ☐ No

Do you use conventional insect repellants on yourself or your family? ☐ Yes ☐ No

Do you use conventional perfume or cologne? ☐ Yes ☐ No

Do you get your hair colored? ☐ Yes ☐ No

## Mold

Does your home, workplace, or school have a damp or mildew smell? ☐ Yes ☐ No

Does your basement ever get wet? ☐ Yes ☐ No

Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms? ☐ Yes ☐ No

Is there anything else you want to share with us that is pertinent to your case?

_____

_____

_____

Please provide us with any labs or tests done within the last 6 months and your "health story" on a seperate document that is no more that two pages long.

Thank you for taking the time to thoroughly complete this form, and we look forward to working with you.

Welcome to Genesis Performance Chiropractic!

GENESIS
PERFORMANCE
CHIROPRACTIC

# Guarantor Information

☐ Check if same as patient information and sign at X below.
If not, please complete entire section and sign.

Name: _____ Sex: ☐ M ☐ F
Date of Birth: _____ SSN#: _____
Street Address / Apt #: _____
City, State, Zip: _____
Home Phone: _____
Local or Cell Phone: _____ Email: _____
Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other
Guarantor Employer: _____
Employer Phone & Ext #: _____

*I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event that my account is turned over to a collection agency, I agree to pay all late fees, costs of collection fees, and/or attorney's fees and all court costs, if any.*

X: _____ DATE: _____
*Patient/Guarantor Signature*

*I specifically authorize Dr. Abigail Vermeesch, BCND to perform a Nutrition Response Testing health analysis. I understand that I am here to learn about nutrition and better health practices, that I will be offered information about food supplements and herbs as a guide to general good health. I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnostic purpose or treatment procedures. I am not on this visit, or any subsequent visit, an agent for federal, state, or local agencies or on a mission of entrapment or investigation. The services performed here are at all times restricted to consultation on nutritional matters intended for the maintenance of the best possible state of natural health, and do not involve the diagnosing, treatment, or prescribing of remedies for disease.*

X: _____ DATE: _____
*Patient/Guarantor Signature*

# Consent for Treatment

*I, the undersigned, consent to the care and treatment by the attending physician, his/her associates or assistants. I acknowledge that no guarantees have been made as to the effect of such treatment.*

X: _____ DATE: _____
*Patient/Guardian Signature if patient is a minor*

# Notice of Privacy Practices

This notice describes how medical information about you may be used or disclosed, and how you can access this information. Please review it carefully and sign when completed.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, legal obligations, an your rights concerning your health information ("Protected Health Information" or "PHI"). We must follow the privacy practices that are described in this Notice (which may be amended from time to time). For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:**

**A. Your PHI may be used and disclosed by the physician, our office staff and others outside of our offices that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the business, and any other use required by the law. We may use and disclose PHI without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.**

1. **Treatment**: We may use and disclose PHI in order to provide treatment to you. For example we may use PHI including your medication history to diagnose, treat, and provide medical services to you. In addition, we may disclose PHI to other health care providers involved in your treatment.
2. **Payment**: Under federal law we may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. By way of example, we may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services. We may contact the Guarantor for your visit in order to obtain payment.
3. **Health Care Operations**: We may use or disclose your PHI in order to support our business activities. These activities include, but are not limited to business associates, quality assessment activities, internal investigations, performance reviews, and training employees. In addition, we will use a sign-in sheet at the registration desk where you will be asked to provide your name and date of birth. We may also call you by name in the waiting room when the physician is ready to see you. We may use or disclose your PHI to contact you to remind you of an appointment, to notify you of test results, to inform you of health-related services that may be of interest to you, and to check on your treatment, progress, and satisfaction with our services.
4. **Required or Permitted by Law**: As required by Law, Public Health Issues are required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, National Security, Worker's Compensation, Inmates, and other Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services.

**B. Permissible Uses and Disclosures That May Be Made Without Your Authorization, But For Which You Have An Opportunity To Object.**

1. **Family and Other Persons Involved In Your Care.** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representatives or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclosure health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
2. **Disaster Relief Efforts.** We may use or disclosure protected health information to a public or private entity authorized by law or its charter to assist in disaster relief efforts for the purpose of coordinating notification of family members of your location, general condition, or death.

**C. Other permitted and required uses and disclosures:** Use or Disclose of your PHI for marketing or sale of your PHI to third parties, will be made only with your authorization. Once given, you may withdraw authorization at any time in writing.

**II. YOUR INDIVIDUAL RIGHTS**

A. **Right to Inspect And Copy.** You may request access to your medical records and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny access to your records. Under federal law, you may not inspect or copy psychotherapy notes, information compiled in anticipation of, or use in, a legal proceeding, and PHI that is otherwise prohibited. We may charge a fee for the costs of copying and sending you and records requested.

B. **Right to Alternative Communications.** You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. **Right to Request Restrictions.** You may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or health care operations. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. If you have paid for your services in full and ask us not to disclose your visit to your insurance company, we will honor that request. We are not required to agree to any other restriction that you may request.

D. **Right to Accounting Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI made by us in the last six years. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations. We are required by law to notify you if your unsecured PHI is breached.

E. **Right to Request Amendment**: You have the right to request that we amend your health information. You request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we deny your written request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

F. **Right to Obtain Notice.** You have the right to obtain a paper copy of this Notice by submitting a request to the center's Compliance Officer at any time.

G. **Questions and Complaints.** If you desire further information about your privacy rights, or are concerned that we have violated your privacy rights, you may contact the center's Compliance Officer. You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or with our office.

**III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE**

A. **Effective Date.** This Notice is effective on April 1, 2017.

B. **Changes to this Notice.** We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in the waiting area of our office and on our web site. You may also obtain any revised notice by contacting the center's Compliance Officer.

X: _____ _____

*Printed name* *Date*

X: _____ _____

*Signature* *Date*

X: _____ _____

*Parent / Guardian if patient is a minor* *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 |


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*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:**

# 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


SMGENTAF04(031513)

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

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

## Tricyclic Antidepressants (TCAs)

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

## Selective Serotonin Reuptake Inhibitors (SSRIs)

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

## Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

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

## Selective Serotonin Reuptake Enhancers (SSREs)

- ☐ Stablon®
- ☐ Coaxil®
- ☐ Tatinol®

## Monoamine Oxidase Inhibitors (MAOIs)

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

## Dopamine Receptor Agonists

- ☐ Mirapex®
- ☐ Sifrol®
- ☐ Requip®

## Norepinephrine–Dopamine Reuptake Inhibitors (NDRIs)

- ☐ Wellbutrin XL®

## D2 Dopamine Receptor Blockers (antipsychotics)

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

## GABA Antagonist Competitive Binder

- ☐ Romazicon®

## Agonist Modulators of GABA Receptors (benzodiazepines)

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

## Agonist Modulators of GABA Receptors (non-benzodiazepines)

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

## Acetylcholine Receptor Agonists

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

## Acetylcholine Receptor Antagonists (antimuscarinic agents)

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

## Acetylcholine Receptor Antagonists (ganglionic blockers)

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

## Acetylcholine Receptor Antagonists (neuromuscular blockers)

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

## Acetylcholinesterase Reactivators

- ☐ Protopam®

## Cholinesterase Inhibitors (reversible)

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

## Cholinesterase Inhibitors (irreversible)

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




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