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*

Child Neurotransmitter and Nutrition Questionnaire™ (CNNQ)

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: GENERAL DIET

- Does your child have any food sensitivities or allergies? (If yes, please list)

- List your child's 4 healthiest foods eaten during the average week.

  _____ _____

  _____ _____

- List your child's 4 unhealthiest foods eaten during the average week.

  _____ _____

  _____ _____

- How many times does your child eat candy per week? _____
- How many times does your child drink soda per week? _____
- List the top 4 foods your child craves regularly.

  _____ _____

  _____ _____

- List the medication(s) your child is currently prescribed and any over-the-counter products used.

- Do you find it difficult to have your child on a special diet?

  _____

SECTION A

- Does your child eat pasta, breads, and breaded foods? **0 1 2 3**
- Does your child have symptoms (fatigue, hyperactivity, etc) after eating foods containing wheat/gluten? **0 1 2 3**
- Does your child consume dairy products? **0 1 2 3**
- Does your child have symptoms (fatigue, hyperactivity, etc) after consuming dairy products? **0 1 2 3**

SECTION B

- Does your child eat fried fish? **0 1 2 3**
- Does your child eat roasted nuts or seeds? **0 1 2 3**
- Is your child missing essential fatty acid-rich foods in his/her diet? (for example: avocados, flax seeds, olives) **0 1 2 3**
  (circle "0" if present, "3" if missing)
- Does your child eat fried foods? **0 1 2 3**

SECTION C

- Is your child's mental speed slow? **0 1 2 3**
- Does your child have difficulty with learning or memory? **0 1 2 3**
- Does your child have difficulty with balance and coordination? **0 1 2 3**

SECTION D

- Does your child have stress? **0 1 2 3**
- Does your child not have enough sleep and rest? **0 1 2 3**
  (circle "0" if enough, "3" if not enough)
- Does your child not have regular exercise? **0 1 2 3**
  (circle "0" if regular exercise, "3" if no exercise)
- Does your child feel overly worried and scared? **0 1 2 3**

SECTION E

- Does your child have temper tantrums? **0 1 2 3**
- Does your child exhibit wild behavior? **0 1 2 3**
- Does your child frequently yell or scream for unnecessary reasons? **0 1 2 3**
- Does your child have an inability to nap or sleep when physically exhausted? (circle "0" if able, "3" if unable) **0 1 2 3**
- Is your child overly talkative? **0 1 2 3**
- Does your child fidget and squirm when seated? **0 1 2 3**
- Does your child run and climb excessively? **0 1 2 3**
- Does your child have difficulty playing quietly or engaging in leisure activities? **0 1 2 3**

SECTION F

- Does your child get excited easily? **0 1 2 3**
- Does your child have anxiety and panic for minor reasons? **0 1 2 3**
- Does your child feel overwhelmed for minor reasons? **0 1 2 3**
- Does your child find it difficult to relax when he/she is awake? **0 1 2 3**
- Does your child have disorganized attention? **0 1 2 3**

SECTION G

- Does your child seem depressed? **0 1 2 3**
- Does your child have mood changes with overcast weather? **0 1 2 3**
- Does your child have symptoms of inner rage? **0 1 2 3**
- Does your child seem uninterested in games or hobbies? **0 1 2 3**
- Does your child have difficulty falling into deep, restful sleep? **0 1 2 3**
- Does your child seem uninterested in friendships? **0 1 2 3**
- Does your child have unprovoked anger? **0 1 2 3**
- Does your child seem uninterested in eating? **0 1 2 3**

SECTION H

- Does your child have difficulty handling stress? **0 1 2 3**
- Does your child have anger and aggression while being challenged? **0 1 2 3**
- Does your child feel tired even after many hours of sleep? **0 1 2 3**
- Does your child tend to isolate himself/herself from others? **0 1 2 3**
- Does your child get distracted easily? **0 1 2 3**
- Does your child have a constant need and desire for candy and sugar? **0 1 2 3**
- Does your child have disorganized attention? **0 1 2 3**

SECTION I

- Does your child have difficulty with visual memory (shapes and images)? **0 1 2 3**
- Does your child have difficulty remembering locations? **0 1 2 3**
- Does your child have fatigue or low endurance for learning activities? **0 1 2 3**
- Does your child have difficulty with attention or a short attention span? **0 1 2 3**
- Does your child have slow or difficult speech? **0 1 2 3**
- Does your child have uncoordinated or slow movements? **0 1 2 3**

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

SMGECNNQ01(081015)