Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU

NAME _____ DATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ WORK PHONE _____

DATE OF BIRTH ____/____/____ AGE _____ M ☐ F ☐ MARITAL STATUS _____ NO. CHILDREN _____ FAX # _____

OCCUPATION _____ SS# _____ SPOUSE _____ E-MAIL _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ REFERRED BY _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT

O - OCCASIONAL
F - FREQUENT
C - CONSTANT

GENERAL

O	F	C	
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors

MUSCLE & JOINT

☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders

Pain or numbness in:

☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tail bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal curvature
☐	☐	☐	Swollen joints

GASTRO-INTESTINAL

O	F	C	
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood

EYES, EARS, NOSE & THROAT

☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

CARDIO-VASCULAR

O	F	C	
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles

RESPIRATORY

☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing

SKIN

☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins

GENITO-URINARY

☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine

FOR WOMEN ONLY

☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:

☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Measles	☐ Rheumatic fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Miscarriage	☐ Scarlet fever
☐ Appendicitis	☐ Diphtheria	☐ Heart disease	☐ Multiple sclerosis	☐ Stroke
☐ Arteriosclerosis	☐ Eczema	☐ HIV/AIDS	☐ Mumps	☐ Tuberculosis
☐ Arthritis	☐ Emphysema	☐ Influenza	☐ Pleurisy	☐ Typhoid fever
☐ Cancer	☐ Epilepsy	☐ Lumbago	☐ Pneumonia	☐ Ulcers
☐ Chorea	☐ Fever blisters	☐ Malaria	☐ Polio	☐ Venereal Disease
				☐ Whooping cough

Have you ever had previous chiropractic care? _____ If yes, date of last care _____

Do you have Health and Accident Insurance? _____ If yes, with what company? _____

Is this an Industrial Accident Case? ☐ Yes ☐ No

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#4327

What is your major complaint? _____

_____

Other complaints: _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

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

How long has it been since you really felt good? _____

List previous diagnoses and treatments you have received for present condition: _____

What do you believe is wrong with you? _____

List surgical operations and years: _____

_____

Drugs you now take: ❑ Nerve pills ❑ Pain killers ❑ Muscle relaxers ❑ "Pep" pills ❑ Tranquilizers ❑ Birth control pills
Others _____

Dental visits: ❑ Every six months ❑ Yearly ❑ Toothache or emergency only ❑ Complete dentures

Age of mattress: _____ ❑ Comfortable ❑ Uncomfortable Do you use a bed board? _____

Are you wearing: ❑ Heel lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

Have you been in an auto accident: ❑ Past year ❑ Past five years ❑ More than five years ❑ Never
Describe _____

Have you ever had any mental or emotional disorders? ❑ Yes ❑ No When? _____
Have others in your family had such disorders? ❑ Yes ❑ No When? _____

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	Yes	No	DESCRIBE BRIEFLY
Been knocked unconscious?	❑	❑	
Used a cane, crutch, or other support?	❑	❑	
Been treated for a spine or nerve disorder?	❑	❑	
Had a fractured bone?	❑	❑	
Been hospitalized for other than surgery?	❑	❑	

DO YOU:	Yes	No	DESCRIBE BRIEFLY
Now take vitamins or minerals?	❑	❑	
Think you may need vitamins or minerals?	❑	❑	
Have an allergy to any drug?	❑	❑	

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	❑	❑	❑	❑
Physical examination	❑	❑	❑	❑
Blood test	❑	❑	❑	❑
Chest x-ray	❑	❑	❑	❑
Spinal x-ray	❑	❑	❑	❑

HABITS	Heavy	Moderate	Light	None
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Appetite	❑	❑	❑	❑

LIST BELOW ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED IN THE PAST 10 YEARS.

_____

_____

_____

_____

_____

IN CASE OF EMERGENCY (Name of relative or close friend not living in your home):

Name _____

Address _____ Phone _____

SYSTEMS SURVEY FORM

Maestro

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Vegetarian ☐ Gluten-free ☐

INSTRUCTIONS: Fill in only the circles which apply to you. Leave blank if you don't have the problem.

●○○ Fill in the circle marked 1 for MILD symptoms (occurs rarely).
○●○ Fill in the circle marked 2 for MODERATE symptoms (occurs several times a month).
○○● Fill in the circle marked 3 for SEVERE symptoms (occurs almost constantly).
○○○ **Leave circles BLANK if they don't apply to you!**

GROUP 1

	1 2 3		1 2 3		1 2 3
1	○○○	Acid foods upset	8 ○○○	Gag easily	15 ○○○ Appetite reduced
2	○○○	Get chilled often	9 ○○○	Unable to relax; startles easily	16 ○○○ Cold sweats often
3	○○○	"Lump" in throat	10 ○○○	Extremities cold, clammy	17 ○○○ Fever easily raised
4	○○○	Dry mouth-eyes-nose	11 ○○○	Strong light irritates	18 ○○○ Neuralgia-like pains
5	○○○	Pulse speeds after meal	12 ○○○	Urine amount reduced	19 ○○○ Staring, blinks little
6	○○○	Keyed up - fail to calm	13 ○○○	Heart pounds after retiring	20 ○○○ Sour stomach often
7	○○○	Cut heals slowly	14 ○○○	"Nervous" stomach	

GROUP 2

	1 2 3		1 2 3		1 2 3
21	○○○	Joint stiffness on arising	29 ○○○	Digestion rapid	37 ○○○ "Slow starter"
22	○○○	Muscle-leg-toe cramps at night	30 ○○○	Vomiting frequent	38 ○○○ Get "chilled" infrequently
23	○○○	"Butterfly" stomach, cramps	31 ○○○	Hoarseness frequent	39 ○○○ Perspire easily
24	○○○	Eyes or nose watery	32 ○○○	Breathing irregular	40 ○○○ Circulation poor, sensitive to cold
25	○○○	Eyes blink often	33 ○○○	Pulse slow; feels "irregular"	
26	○○○	Eyelids swollen, puffy	34 ○○○	Gagging reflex slow	41 ○○○ Subject to colds, asthma, bronchitis
27	○○○	Indigestion soon after meals	35 ○○○	Difficulty swallowing	
28	○○○	Always seems hungry; feels "lightheaded" often	36 ○○○	Constipation, diarrhea alternating	

GROUP 3

	1 2 3		1 2 3		1 2 3
42	○○○	Eat when nervous	49 ○○○	Heart palpitates if meals missed or delayed	53 ○○○ Crave candy or coffee in afternoons
43	○○○	Excessive appetite	50 ○○○	Afternoon headaches	54 ○○○ Moods of depression - "blues" or melancholy
44	○○○	Hungry between meals	51 ○○○	Overeating sweets upsets	
45	○○○	Irritable before meals	52 ○○○	Awaken after few hours sleep - hard to get back to sleep	55 ○○○ Abnormal craving for sweets or snacks
46	○○○	Get "shaky" if hungry			
47	○○○	Fatigue, eating relieves			
48	○○○	"Lightheaded" if meals delayed			

GROUP 4

	1 2 3		1 2 3		1 2 3
56	○○○	Hands and feet go to sleep easily, numbness	63 ○○○	Get "drowsy" often	68 ○○○ Bruise easily, "black and blue" spots
57	○○○	Sigh frequently, "air hunger"	64 ○○○	Swollen ankles, worse at night	69 ○○○ Tendency to anemia
58	○○○	Aware of "breathing heavily"	65 ○○○	Muscle cramps, worse during exercise; get "charley horses"	70 ○○○ "Nose bleeds" frequent
59	○○○	High altitude discomfort	66 ○○○	Shortness of breath on exertion	71 ○○○ Noises in head, or "ringing in ears"
60	○○○	Opens windows in closed rooms	67 ○○○	Dull pain in chest or radiating into left arm, worse on exertion	72 ○○○ Tension under the breastbone, or feeling of "tightness", worse on exertion
61	○○○	Susceptible to colds and fevers			
62	○○○	Afternoon "yawner"			

SYSTEMS SURVEY FORM - PAGE 2

GROUP 5

1 2 3

73 ○○○ Dizziness
74 ○○○ Dry skin
75 ○○○ Burning feet
76 ○○○ Blurred vision
77 ○○○ Itching skin and feet
78 ○○○ Excessive falling hair
79 ○○○ Frequent skin rashes
80 ○○○ Bitter, metallic taste in mouth in mornings
81 ○○○ Bowel movements painful or difficult
82 ○○○ Worrier, feels insecure
83 ○○○ Feeling queasy; headache over eyes
84 ○○○ Greasy foods upset
85 ○○○ Stools light colored
86 ○○○ Skin peels on foot soles
87 ○○○ Pain between shoulder blades
88 ○○○ Use laxatives
89 ○○○ Stools alternate from soft to watery
90 ○○○ History of gallbladder attacks or gallstones
91 ○○○ Sneezing attacks
92 ○○○ Dreaming, nightmare type bad dreams
93 ○○○ Bad breath (halitosis)
94 ○○○ Milk products cause distress
95 ○○○ Sensitive to hot weather
96 ○○○ Burning or itching anus
97 ○○○ Crave sweets

GROUP 6

1 2 3

98 ○○○ Loss of taste for meat
99 ○○○ Lower bowel gas several hours after eating
100 ○○○ Burning stomach sensations, eating relieves
101 ○○○ Coated tongue
102 ○○○ Pass large amounts of foul-smelling gas
103 ○○○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104 ○○○ Mucous colitis or "irritable bowel"
105 ○○○ Gas shortly after eating
106 ○○○ Stomach "bloating" after

GROUP 7

(A)

1 2 3

107 ○○○ Insomnia
108 ○○○ Nervousness
109 ○○○ Can't gain weight
110 ○○○ Intolerance to heat
111 ○○○ Highly emotional
112 ○○○ Flush easily
113 ○○○ Night sweats
114 ○○○ Thin, moist skin
115 ○○○ Inward trembling
116 ○○○ Heart palpitates
117 ○○○ Increased appetite without weight gain
118 ○○○ Pulse fast at rest
119 ○○○ Eyelids and face twitch
120 ○○○ Irritable and restless
121 ○○○ Can't work under pressure

(B)

1 2 3

122 ○○○ Increase in weight
123 ○○○ Decrease in appetite
124 ○○○ Fatigue easily
125 ○○○ Ringing in ears
126 ○○○ Sleepy during day
127 ○○○ Sensitive to cold
128 ○○○ Dry or scaly skin
129 ○○○ Constipation
130 ○○○ Mental sluggishness
131 ○○○ Hair coarse, falls out
132 ○○○ Headaches upon arising, wear off during day
133 ○○○ Slow pulse, below 65
134 ○○○ Frequency of urination
135 ○○○ Impaired hearing
136 ○○○ Reduced initiative

(C)

1 2 3

137 ○○○ Failing memory
138 ○○○ Low blood pressure
139 ○○○ Increased sex drive
140 ○○○ Headaches, "splitting or rending" type
141 ○○○ Decreased sugar tolerance

(D)

1 2 3

142 ○○○ Abnormal thirst
143 ○○○ Bloating of abdomen
144 ○○○ Weight gain around hips or waist
145 ○○○ Sex drive reduced or lacking
146 ○○○ Tendency to ulcers, colitis
147 ○○○ Increased sugar tolerance
148 ○○○ Women: menstrual disorders
149 ○○○ Young girls: lack of menstrual function

(E)

1 2 3

150 ○○○ Dizziness
151 ○○○ Headaches
152 ○○○ Hot flashes
153 ○○○ Increased blood pressure
154 ○○○ Hair growth on face or body (female)
155 ○○○ Sugar in urine (not diabetes)
156 ○○○ Masculine tendencies (female)

(F)

1 2 3

157 ○○○ Weakness, dizziness
158 ○○○ Chronic fatigue
159 ○○○ Low blood pressure
160 ○○○ Nails weak, ridged
161 ○○○ Tendency to hives
162 ○○○ Arthritic tendencies
163 ○○○ Perspiration increase
164 ○○○ Bowel disorders
165 ○○○ Poor circulation
166 ○○○ Swollen ankles
167 ○○○ Crave salt
168 ○○○ Brown spots or bronzing of skin
169 ○○○ Allergies - tendency to asthma
170 ○○○ Weakness after colds, influenza
171 ○○○ Exhaustion - muscular and nervous
172 ○○○ Respiratory disorders

SYSTEMS SURVEY FORM - PAGE 3

GROUP 8

1 2 3

173 ○○○ Muscle weakness
174 ○○○ Lack of Stamina
175 ○○○ Drowsiness after eating
176 ○○○ Muscular soreness
177 ○○○ Rapid heart beat
178 ○○○ Hyper-irritable
179 ○○○ Feeling of a band around your head
180 ○○○ Melancholia (feeling of sadness)
181 ○○○ Swelling of ankles
182 ○○○ Diminished urination
183 ○○○ Tendency to consume sweets or carbohydrates
184 ○○○ Muscle spasms
185 ○○○ Blurred vision
186 ○○○ Loss of muscular control
187 ○○○ Numbness
188 ○○○ Night sweats
189 ○○○ Rapid digestion
190 ○○○ Sensitivity to noise
191 ○○○ Redness of palms of hands and bottom of feet
192 ○○○ Visible veins on chest and abdomen
193 ○○○ Hemorrhoids
194 ○○○ Apprehension (feeling that something bad will happen)
195 ○○○ Nervousness causing loss of appetite
196 ○○○ Nervousness with indigestion
197 ○○○ Gastritis
198 ○○○ Forgetfulness
199 ○○○ Thinning hair

FEMALE ONLY

1 2 3

200 ○○○ Very easily fatigued
201 ○○○ Premenstrual tension
202 ○○○ Painful menses
203 ○○○ Depressed feelings before menstruation
204 ○○○ Menstruation excessive and prolonged
205 ○○○ Painful breasts
206 ○○○ Menstruate too frequently
207 ○○○ Vaginal discharge
208 ○ Hysterectomy / ovaries removed
209 ○○○ Menopausal hot flashes
210 ○○○ Menses scanty or missed
211 ○○○ Acne, worse at menses
212 ○○○ Depression of long standing

MALE ONLY

1 2 3

213 ○○○ Prostate trouble
214 ○○○ Urination difficult or dribbling
215 ○○○ Night urination frequent
216 ○○○ Depression
217 ○○○ Pain on inside of legs or heels
218 ○○○ Feeling of incomplete bowel evacuation
219 ○○○ Lack of energy
220 ○○○ Migrating aches and pains
221 ○○○ Tire too easily
222 ○○○ Avoids activity
223 ○○○ Leg nervousness at night
224 ○○○ Diminished sex drive

IMPORTANT

Please list the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES
Any two days during the month
FEMALES HAVING MENSTRUAL CYCLES
The 2nd and 3rd day of flow OR any 5 days in a row
MALES
Any 2 days during the month

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date	_____	Temperature	_____
Date	_____	Temperature	_____
Date	_____	Temperature	_____
Date	_____	Temperature	_____
Date	_____	Temperature	_____
Date	_____	Temperature	_____
Date	_____	Temperature	_____

SYSTEMS SURVEY FORM - PAGE 4

Please list any medications you are taking: ☐ No Medications

Please list any vitamins, herbs, or supplements you are taking: ☐ No Vitamins

Please list any allergies you have: ☐ No Allergies

Please list any surgeries you have had in the past 12 months: ☐ No Recent Surgeries

Please list any other surgeries or medical procedures you have had: ☐ No Other Surgeries

TO BE COMPLETED BY DOCTOR

Blood Pressure: Recumbent _____ Standing _____

Pulse: Recumbent _____ Standing _____

Hema-Combistix Urine Readings: pH _____ Albumin % _____ Glucose % _____

Occult Blood _____ pH of Saliva _____ pH of Stool Specimen _____

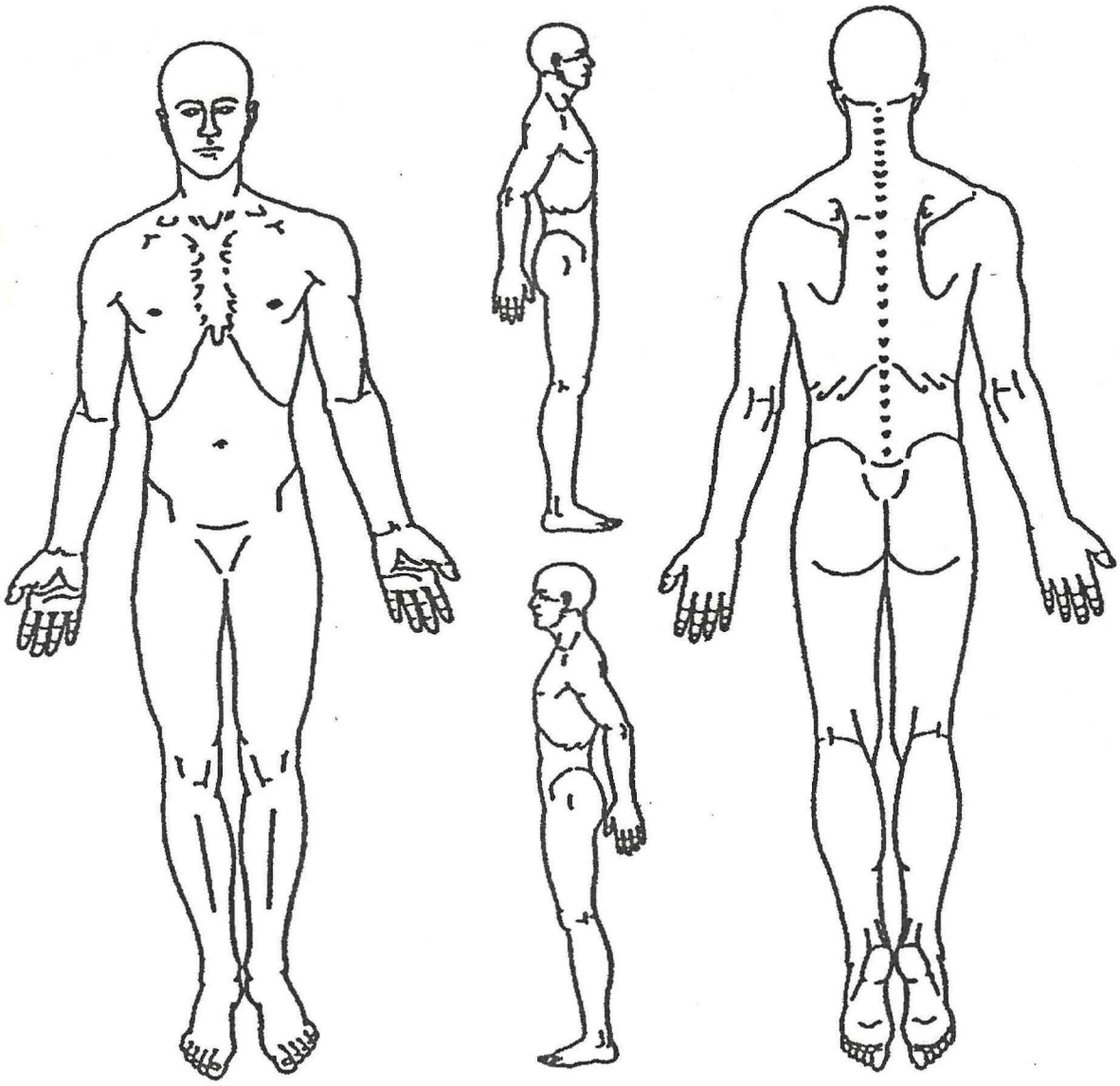
Blood Clotting Time _____ Hemoglobin _____ Blood Type _____ Weight _____

SYSTEMS SURVEY FORM - PAGE 5

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES
O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____ Date _____

[illegible]lth Questionnaire (NT[illegible]F)

8

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

* Please circle the appropriate number "0 - 3" 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 things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament getting worse in general? 0 1 2 3
- Are you losing your attention span endurance? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you fatigue when driving compared to the past? 0 1 2 3
- How often do you fatigue when reading compared to 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 that 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 lightheadedness 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

- Do you get fatigued after meals? 0 1 2 3
- Do you crave sugar and sweets after meals? 0 1 2 3
- Do you feel you need stimulants such as coffee after meals? 0 1 2 3
- 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 been increased? 0 1 2 3
- Do you have weight gain when under stress? 0 1 2 3
- Do you have difficulty falling asleep? 0 1 2 3

SECTION 1 - S

- Are you losing your pleasure in hobbies and interests? 0 1 2 3
- How often do you feel overwhelmed with ideas to manage? 0 1 2 3
- How often do you have feelings of inner rage (anger)? 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
- How often do you feel depressed in overcast weather? 0 1 2
- How much are you losing your enthusiasm for your favorite activities? 0 1 2 3
- How much are you losing 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 - D

- 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 - G

- How often do you feel anxious or panic 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 - ACH

- Do you feel your visual memory (shapes & images) is decreased? 0 1 2 3
- Do you feel your verbal memory is decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity been decreased? 0 1 2 3
- Has your comprehension been 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 slower mental response? 0 1 2 3

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For nutritional purposes only.

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Child Neurotransmitter & Nutrition Questionnaire (CNNQ)

5 1/2 9

IF CHILD

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

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

SECTION: GENERAL

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

  _____

  _____
- List your child's 4 healthiest foods eaten regularly.

  _____, _____,

  _____, _____
- List your child's 4 unhealthiest foods eaten regularly.

  _____, _____,

  _____, _____
- How many times a week does your child eat candy? _____
- How many times a week does your child drink soda pop? _____
- Please list the top 4 foods your child craves regularly?

  _____, _____,

  _____, _____
- List the medication(s) your child is currently prescribed and over the counter.

  _____

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

  _____

SECTION: A (K52)

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

SECTION: B (K53)

- 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: avocadoes, flax seeds, olives) *(mark "0" if present, "3" if missing)* 0 1 2 3
- Does your child eat *fried* foods? 0 1 2 3

SECTION: C (K34)

- 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 (K16)

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

SECTION: E (K16, K51)

- 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? *(mark "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 when it is inappropriate? 0 1 2 3
- Does your child have difficulty playing quietly or engaging in leisure activities? 0 1 2 3

SECTION: F (K51)

- Does your child get excited easily? 0 1 2 3
- Does your child have anxiousness 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 she/he is awake? 0 1 2 3
- Does your child have disorganized attention? 0 1 2 3

SECTION: G (K50)

- 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 symptoms of unprovoked anger? 0 1 2 3
- Does your child seem uninterested in eating? 0 1 2 3

SECTION: H (K49)

- 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 long sleeps? 0 1 2 3
- Does your child tend to isolate from others? 0 1 2 3
- Does your child get distracted easily? 0 1 2 3
- Does your child have constant need and desire for candy and sugar? 0 1 2 3
- Does your child have disorganized attention? 0 1 2 3

SECTION: I (K48)

- Does your child have difficulty with visual memory? 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 low attention span or endurance? 0 1 2 3
- Does your child have slow or difficult speech? 0 1 2 3
- Does your child have uncoordinated or slow movement? 0 1 2 3

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Personal Injury Claims:

Please present your insurance forms and sign the appropriate forms. If an attorney is involved, please notify us right away. We are happy to handle these cases, but ultimately, you are responsible for the payments.

"On the Job" Injury:

In case of a work related accident or illness, your care will be paid 100% Vitamins supplements are not included if needed.

If you do not have insurance coverage for Chiropractic, you may want to request it in your current policy or have it included in a future policy. This inclusion can be valuable in obtaining total health care for your family.

Our Financial Policy

Dr Bonnie Becker

Dr Donna Lautermilch

Chiropractic Office

3 Ridge Road
Telford, PA 18969

215-258-5633

Drbonniebecker.com

Our Policy for Patients without Insurance Coverage:

Payment is expected at the time of the visit. While you are under intensive care we ask that you clear your balance once a week.

Our Policy for Patients with Insurance Coverage:

We do not know if your insurance covers Chiropractic care. However, most insurance policies do cover Chiropractic services, but the amount they pay varies from one policy to another. Payment is expected at the time of the visit. During the intensive portion of your care we ask that you clear your balance once a week.

It is important that you understand your Health and Accident Insurance. Your insurance is an agreement between you and your insurance company. You must clearly understand and agree that for all services rendered to you in our office you are charged directly and are personally responsible.

Medicare Patients:

We will be happy to submit your Medicare claim for you. There are limits on Medicare Coverage. We will review this with you in detail and have you sign a form indicating that you understand Medicare Coverage. We do not accept assignment for Medicare. (This means that you will be receiving the payment from Medicare directly.) Therefore, you will be on a cash basis. If you have additional insurance, it will be your responsibility to bring your "Explanation of Benefits from Medicare" into our office in order for us to bill the additional insurance.

Automobile Insurance:

Please present your insurance forms and sign the appropriate forms in order to defer payment. If an attorney is involves please notify us right away. In Pennsylvania, everything will be covered except vitamin supplements.