

# HEALTH HISTORY

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Occupation \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Sex \_\_\_\_\_ Number of Children \_\_\_\_\_

Marital Status:  Single  Partner  Married  Separated  Divorced  Widow(er)

Are you recovering from a cold or flu? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

Reason for office visit: \_\_\_\_\_ Date began: \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Practitioner name and phone number \_\_\_\_\_

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis): \_\_\_\_\_

Outcome \_\_\_\_\_

What types of therapy have you tried for this problem(s):  
 diet modification  fasting  vitamins/minerals  herbs  homeopathy  chiropractic  acupuncture  conventional drugs  
 other \_\_\_\_\_

List current health problems for which you are being treated: \_\_\_\_\_

Current medications (prescription or over-the-counter): \_\_\_\_\_

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): \_\_\_\_\_

Do you consider yourself:  underweight  overweight  just right Your weight today \_\_\_\_\_

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? \_\_\_\_\_

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)? \_\_\_\_\_

Corrective lenses  Dentures  Hearing aid  Medical devices/prosthetics/implants, describe: \_\_\_\_\_

Recent changes in your ability to:  see  hear  taste  smell  feel hot/cold sensations  
 move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors:  sour  bitter  sweet  rich/fatty  spicy/pungent  salty

Strong dislike for any one of the following flavors:  sour  bitter  sweet  rich/fatty  spicy/pungent  salty

Do you:  Prefer warmth (i.e., food, drinks, weather, etc.)  Prefer cold (i.e., food, drinks, weather, etc.)  No preference

Is your sleep disturbed at the same time each night? \_\_\_\_\_ If yes, what time? \_\_\_\_\_

Time of day you feel the most energy or the least symptoms: \_\_\_\_\_ Time of day you feel the worst or your symptoms are aggravated: \_\_\_\_\_

<input type="checkbox"/> 7 a.m. - 9 a.m.	<input type="checkbox"/> 9 a.m. - 11 a.m.	<input type="checkbox"/> 11 a.m. - 1 p.m.	<input type="checkbox"/> 7 a.m. - 9 a.m.	<input type="checkbox"/> 9 a.m. - 11 a.m.	<input type="checkbox"/> 11 a.m. - 1 p.m.
<input type="checkbox"/> 1 p.m. - 3 p.m.	<input type="checkbox"/> 3 p.m. - 5 p.m.	<input type="checkbox"/> 5 p.m. - 7 p.m.	<input type="checkbox"/> 1 p.m. - 3 p.m.	<input type="checkbox"/> 3 p.m. - 5 p.m.	<input type="checkbox"/> 5 p.m. - 7 p.m.
<input type="checkbox"/> 7 p.m. - 9 p.m.	<input type="checkbox"/> 9 p.m. - 11 p.m.	<input type="checkbox"/> 11 p.m. - 1 a.m.	<input type="checkbox"/> 7 p.m. - 9 p.m.	<input type="checkbox"/> 9 p.m. - 11 p.m.	<input type="checkbox"/> 11 p.m. - 1 a.m.
<input type="checkbox"/> 1 a.m. - 3 a.m.	<input type="checkbox"/> 3 a.m. - 5 a.m.	<input type="checkbox"/> 5 a.m. - 7 a.m.	<input type="checkbox"/> 1 a.m. - 3 a.m.	<input type="checkbox"/> 3 a.m. - 5 a.m.	<input type="checkbox"/> 5 a.m. - 7 a.m.

**Do you experience any of these general symptoms EVERY DAY?**

<input type="checkbox"/> Debilitating fatigue	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Constipation	<input type="checkbox"/> Chronic pain/inflammation
<input type="checkbox"/> Depression	<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Nausea	<input type="checkbox"/> Fecal incontinence	<input type="checkbox"/> Bleeding
<input type="checkbox"/> Disinterest in sex	<input type="checkbox"/> Headaches	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Discharge
<input type="checkbox"/> Disinterest in eating	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Low grade fever	<input type="checkbox"/> Itching/rash

## Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other \_\_\_\_\_

## Medical (Men)

- Benign prostatic hyperplasia (BPH)
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other \_\_\_\_\_

## Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other \_\_\_\_\_
- Age of first period \_\_\_\_\_
- Date of last gynecological exam \_\_\_\_\_
- Mammogram  +  -
- PAP  +  -
- Form of birth control \_\_\_\_\_
- # of children \_\_\_\_\_
- # of pregnancies \_\_\_\_\_
- Csection \_\_\_\_\_
- Surgical menopause
- Menopause
- Date of last menstrual cycle \_\_\_\_\_
- Length of cycle \_\_\_\_\_ days
- Interval of time between cycles \_\_\_\_\_ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) \_\_\_\_\_

## Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other \_\_\_\_\_

## Health Habits

- Tobacco:  
Cigarettes: #/day \_\_\_\_\_
- Cigars: #/day \_\_\_\_\_
- Alcohol:  
Wine: #glasses/d or wk \_\_\_\_\_
- Liquor: #ounces/d or wk \_\_\_\_\_
- Beer: #glasses/d or wk \_\_\_\_\_
- Caffeine:  
Coffee: #6 oz cups/d \_\_\_\_\_
- Tea: #6 oz cups/d \_\_\_\_\_
- Soda w/caffeine: #cans/d \_\_\_\_\_
- Other sources \_\_\_\_\_
- Water: #glasses/d \_\_\_\_\_

## Exercise

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk
- Run, jog, jump rope
- Weight lift
- Swim
- Box
- Yoga

## Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:  
 dairy  wheat  eggs  
 soy  corn  all gluten
- Other \_\_\_\_\_

## Food Frequency

- Servings per day:  
Fruits (citrus, melons, etc.) \_\_\_\_\_
- Dark green or deep yellow/orange vegetables \_\_\_\_\_
- Grains (unprocessed) \_\_\_\_\_
- Beans, peas, legumes \_\_\_\_\_
- Dairy, eggs \_\_\_\_\_
- Meat, poultry, fish \_\_\_\_\_

## Eating Habits

- Skip breakfast
- Two meals/day
- One meal/day
- Graze (small frequent meals)
- Food rotation
- Eat constantly whether hungry or not
- Generally eat on the run
- Add salt to food

## Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium, source \_\_\_\_\_
- Magnesium
- Zinc
- Minerals, describe \_\_\_\_\_
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs - teas
- Herbs - extracts
- Chinese herbs
- Ayurvedic herbs
- Homeopathy
- Bach flowers
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Other \_\_\_\_\_

## Would you like to:

- Have more energy
- Be stronger
- Have more endurance
- Increase your sex drive
- Be thinner
- Be more muscular
- Improve your complexion
- Have stronger nails
- Have healthier hair
- Be less moody
- Be less depressed
- Be less indecisive
- Feel more motivated
- Be more organized
- Think more clearly and be more focused
- Improve memory
- Do better on tests in school
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives or stool softeners
- Be free of pain
- Sleep better
- Have agreeable breath
- Have agreeable body odor
- Have stronger teeth
- Get less colds and flus
- Get rid of your allergies
- Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

# 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.

<b>Category I</b>				<b>Category VII</b>					
Feeling that bowels do not empty completely	0	1	2	3	Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3	Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3	Decreased gastrointestinal motility, constipation	0	1	2	3
Diarrhea	0	1	2	3	Increased gastrointestinal motility, diarrhea	0	1	2	3
Constipation	0	1	2	3	Alternating constipation and diarrhea	0	1	2	3
Hard, dry, or small stool	0	1	2	3	Suspicion of nutritional malabsorption	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3	Frequent use of antacid medication	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3	Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/Diverticulitis, or Leaky Gut Syndrome?	Yes	No		
More than 3 bowel movements daily	0	1	2	3					
Use laxatives frequently	0	1	2	3					
<b>Category II</b>				<b>Category VIII</b>					
Increasing frequency of food reactions	0	1	2	3	Greasy or high-fat foods cause distress	0	1	2	3
Unpredictable food reactions	0	1	2	3	Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3	Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3	Burpy, fishy taste after consuming fish oils	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3	Unexplained itchy skin	0	1	2	3
<b>Category III</b>				<b>Category IX</b>					
Intolerance to smells	0	1	2	3	Yellowish cast to eyes	0	1	2	3
Intolerance to jewelry	0	1	2	3	Stool color alternates from clay colored to normal brown	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3	Reddened skin, especially palms	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3	Dry or flaky skin and/or hair	0	1	2	3
Constant skin outbreaks	0	1	2	3	History of gallbladder attacks or stones	0	1	2	3
<b>Category IV</b>				<b>Category X</b>					
Excessive belching, burping, or bloating	0	1	2	3	Have you had your gallbladder removed?	Yes	No		
Gas immediately following a meal	0	1	2	3					
Offensive breath	0	1	2	3	Acne and unhealthy skin	0	1	2	3
Difficult bowel movements	0	1	2	3	Excessive hair loss	0	1	2	3
Sense of fullness during and after meals	0	1	2	3	Overall sense of bloating	0	1	2	3
Difficulty digesting proteins and meats; undigested food found in stools	0	1	2	3	Bodily swelling for no reason	0	1	2	3
<b>Category V</b>				<b>Category XI</b>					
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3	Fatigue after meals	0	1	2	3
Use of antacids	0	1	2	3	Crave sweets during the day	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3	Eating sweets does not relieve cravings for sugar	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3	Must have sweets after meals	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3	Waist girth is equal or larger than hip girth	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3	Frequent urination	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3	Increased thirst and appetite	0	1	2	3
<b>Category VI</b>				<b>Category XI</b>					
Difficulty digesting roughage and fiber	0	1	2	3	Difficulty losing weight	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					

<b>Category XII</b>				
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
<b>Category XIII</b>				
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
<b>Category XIV</b>				
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
<b>Category XV</b>				
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
<b>Category XVI</b>				
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

<b>Category XVI (Cont.)</b>				
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3
<b>Category XVII (Males Only)</b>				
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
<b>Category XVIII (Males Only)</b>				
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
<b>Category XIX (Menstruating Females Only)</b>				
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
<b>Category XX (Menopausal Females Only)</b>				
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? \_\_\_\_\_

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

How many caffeinated beverages do you consume per day? \_\_\_\_\_

How many times do you eat fish per week? \_\_\_\_\_

How many times do you eat out per week? \_\_\_\_\_

How many times do you work out per week? \_\_\_\_\_

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

List the three worst foods you eat during the average week: \_\_\_\_\_

List the three healthiest foods you eat during the average week: \_\_\_\_\_

### PART IV

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

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

# Brain Function Assessment Form™ (BFAF)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

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

## SECTION 1

- A decrease in attention span 0 1 2 3
- Mental fatigue 0 1 2 3
- Difficulty learning new things 0 1 2 3
- Difficulty staying focused and concentrating for extended periods of time 0 1 2 3
- Experiencing fatigue when reading sooner than in the past 0 1 2 3
- Experiencing fatigue when driving sooner than in the past 0 1 2 3
- Need for caffeine to stay mentally alert 0 1 2 3
- Overall brain function impairs your daily life 0 1 2 3

## SECTION 2

- Twitching or tremor in your hands and legs when resting 0 1 2 3
- Handwriting has gotten smaller and more crowded together 0 1 2 3
- A loss of smell to foods 0 1 2 3
- Difficulty sleeping or fitful sleep 0 1 2 3
- Stiffness in shoulders and hips that goes away when you start to move 0 1 2 3
- Constipation 0 1 2 3
- Voice has become softer 0 1 2 3
- Facial expression that is serious or angry 0 1 2 3
- Episodes of dizziness or light-headedness upon standing 0 1 2 3
- A hunched over posture when getting up and walking 0 1 2 3

## SECTION 3

- Memory loss that impacts daily activities 0 1 2 3
- Difficulty planning, problem solving, or working with numbers 0 1 2 3
- Difficulty completing daily tasks 0 1 2 3
- Confusion about dates, the passage of time, or place 0 1 2 3
- Difficulty understanding visual images and spatial relationships (addresses and locations) 0 1 2 3
- Difficulty finding words when speaking 0 1 2 3
- Misplacement of things and inability to retrace steps 0 1 2 3
- Poor judgment and bad decisions 0 1 2 3
- Disinterest in hobbies, social activities, or work 0 1 2 3
- Personality or mood changes 0 1 2 3

## SECTION 4

- Reduced function in overall hearing 0 1 2 3
- Difficulty understanding language with background or scatter noise 0 1 2 3
- Ringing or buzzing in the ear 0 1 2 3
- Difficulty comprehending language without perfect pronunciation 0 1 2 3
- Difficulty recognizing familiar faces 0 1 2 3
- Changes in comprehending the meaning of sentences, written or spoken 0 1 2 3
- Difficulty with verbal memory and finding words 0 1 2 3
- Difficulty remembering events 0 1 2 3
- Difficulty recalling previously learned facts and names 0 1 2 3
- Inability to comprehend familiar words when read 0 1 2 3
- Difficulty spelling familiar words 0 1 2 3
- Monotone, unemotional speech 0 1 2 3
- Difficulty understanding the emotions of others when they speak (nonverbal cues) 0 1 2 3
- Disinterest in music and a lack of appreciation for melodies 0 1 2 3
- Difficulty with long-term memory 0 1 2 3
- Memory impairment when doing the basic activities of daily living 0 1 2 3
- Difficulty with directions and visual memory 0 1 2 3
- Noticeable differences in energy levels throughout the day 0 1 2 3

## SECTION 5

- Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach for objects 0 1 2 3
- Difficulty comprehending written text 0 1 2 3
- Floaters or halos in your visual field 0 1 2 3
- Dullness of colors in your visual field during different times of the day 0 1 2 3
- Difficulty discriminating similar shades of color 0 1 2 3

# Brain Function Assessment Form™ (BFAF)

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

## SECTION 6

- Difficulty with detailed hand coordination 0 1 2 3
- Difficulty with making decisions 0 1 2 3
- Difficulty with suppressing socially inappropriate thoughts 0 1 2 3
- Socially inappropriate behavior 0 1 2 3
- Decisions made based on desires, regardless of the consequences 0 1 2 3
- Difficulty planning and organizing daily events 0 1 2 3
- Difficulty motivating yourself to start and finish tasks 0 1 2 3
- A loss of attention and concentration 0 1 2 3

## SECTION 7

- Hypersensitivities to touch or pain 0 1 2 3
- Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall 0 1 2 3
- Frequently bumping into the wall or objects 0 1 2 3
- Difficulty with right-left discrimination 0 1 2 3
- Handwriting has become sloppier 0 1 2 3
- Difficulty with basic math calculations 0 1 2 3
- Difficulty finding words for written or verbal communication 0 1 2 3
- Difficulty recognizing symbols, words, or letters 0 1 2 3

## SECTION 8

- Difficulty swallowing supplements or large bites of food 0 1 2 3
- Bowel motility and movements slow 0 1 2 3
- Bloating after meals 0 1 2 3
- Dry eyes or dry mouth 0 1 2 3
- A racing heart 0 1 2 3
- A flutter in the chest or an abnormal heart rhythm 0 1 2 3
- Bowel or bladder incontinence, resulting in staining your underwear 0 1 2 3

## SECTION 9

- A decrease in movement speed 0 1 2 3
- Difficulty initiating movement 0 1 2 3
- Stiffness in your muscles (not joints) 0 1 2 3
- A stooped posture when walking 0 1 2 3
- Cramping of your hand when writing 0 1 2 3

## SECTION 10

- Abnormal body movements (such as twitching legs) 0 1 2 3
- Desires to flinch, clear your throat, or perform some type of movement 0 1 2 3
- Constant nervousness and a restless mind 0 1 2 3
- Compulsive behaviors 0 1 2 3
- Increased tightness and tone in specific muscles 0 1 2 3

## SECTION 11

- Difficulty with balance, or balance that is noticeably worse on one side 0 1 2 3
- A need to hold the handrail or watch each step carefully when going down stairs 0 1 2 3
- Episodes of dizziness 0 1 2 3
- Nausea, car sickness, or seasickness 0 1 2 3
- A quick impact after consuming alcohol 0 1 2 3
- A slight hand shake when reaching for something 0 1 2 3
- Back muscles that tire quickly when standing or walking 0 1 2 3
- Chronic neck or back muscle tightness 0 1 2 3



## II. Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?

Yes (1 pt.)

If yes, how many are you currently taking? \_\_\_\_\_ (1 pt. each)

No (0 pt.)

2. Are you presently taking one or more of the following over-the-counter drugs?

Cimetidine (2 pts.)

Acetaminophen (2 pts.)

Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:

Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.)

Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)

Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)

Experience *no* side effects, drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?

Yes (2 pts.)  No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine containing products?

Yes (1 pt.)  No (0 pt.)  Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?

Yes (1 pt.)  No (0 pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?

Yes (1 pt.)  No (0 pt.)  Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?

Yes (1 pt.)  No (0 pt.)  Don't know (0 pt.)

10. Do you have a personal history of

Environmental and/or chemical sensitivities (5 pts.)

Chronic fatigue syndrome (5 pts.)

Multiple chemical sensitivity (5 pts.)

Fibromyalgia (3 pts.)

Parkinson's type symptoms (3 pts.)

Alcohol or chemical dependence (2 pts.)

Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?

Yes (1 pt.)  No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?

Yes (1 pt.)  No (0 pt.)  Don't know (0 pt.)

**GRAND TOTAL:** \_\_\_\_\_

## III. Alkalinizing Assessment

1. Do you have a history or currently have kidney dysfunction?

Yes  No

2. Have you ever been diagnosed with a condition known as hyperkalemia?

Yes  No

3. Are you currently on diuretics or blood pressure medication?

Yes  No

**Note:** Prescribe non-alkalinizing nutrients if patient answered yes to any part of this section.

*For Practitioner Use Only:*

## OVERALL SCORE TABULATION

See doctor brochure for protocol suggestions.

MSQ SCORE \_\_\_\_\_ (High >50; moderate 15-49; Low <14)

XTT SCORE \_\_\_\_\_ (High >10; moderate 5-9; Low <4)

URINARY pH \_\_\_\_\_

**Note:** Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfunction, oxidative stress, hormonal/neuro-transmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.

DATE:	
Goals for today:	
Breakfast / Time:	
Snack / Time:	
Lunch / Time:	
Snack / Time:	
Dinner / Time:	
Water (8oz):	1 2 3 4 5 6 7 8 9 10
Other Drinks:	
Exercise:	
Relaxation:	
Sleep time:	Supplements: Y N
Energy Levels and notes:	

DATE:	
Goals for today:	
Breakfast / Time:	
Snack / Time:	
Lunch / Time:	
Snack / Time:	
Dinner / Time:	
Water (8oz):	1 2 3 4 5 6 7 8 9 10
Other Drinks:	
Exercise:	
Relaxation:	
Sleep time:	Supplements: Y N
Energy Levels and notes:	

DATE:	
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Other Drinks:	
Exercise:	
Relaxation:	
Sleep time:	Supplements: Y N
Energy Levels and notes:	

## NUTRITION INFORMED CONSENT

**1. NUTRITIONAL THERAPY:** According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "*Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.*" A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy. Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment. I understand that if I am on any medications, the healthcare provider will NOT recommend I decrease my dosages or stop taking my medications. As the patient, it is my responsibility to contact and work with the prescribing doctor to reduce dosage or stop medication usage as my health improves and it becomes clear a medication is no longer needed.

Nutritional support is recommended based on your history, examination, and lab results to support your body's unique biochemistry. We utilize nutritional supplements from reputable companies known in the health care field that use ingredients that are tested so as not to contain heavy metals or contamination. Products recommended have a high level of purity, safety, and quality for reliably effective use. They have been tested for biological activity of the ingredient used. Products recommended are the most hypoallergenic products possible.

**2. SERVICES:** My health care provider has recommended functional, nutritional, and lifestyle evaluation, testing, consulting, and care, including dietary supplements. I understand and am informed that products and services are not provided by medical physicians and do not include prescription drugs, surgery, or other conventional allopathic medical treatments. I further understand that consultations, evaluations, supplementation, lifestyle consultation, testing, recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients pertain to the functional health/whole body concept.

**3. NO GUARANTEE:** I have been informed that the methods of nutritional evaluation or testing made available to me are not intended to diagnose disease from an allopathic model of medicine. Rather, they are intended as a guide to developing an appropriate overall health-supportive program for me, and to monitor progress in achieving goals. I further understand that any recommendations are supportive in nature allowing the body to return to improved health. Like all other health care, results are not guaranteed and there is no promise to cure. Accordingly, I understand that payment(s) for services are not conditional on my response to care. No refunds will be available for any opened products purchased.

**4. RISKS:** I understand the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients that may be recommended are generally considered safe, however, some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be toxic in large doses. I also understand that nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may interact with some legend drugs. Accordingly, I agree to consult with my prescribing physician about any prescription drugs I am taking and the impact of supplements, vitamins, minerals, food grade herbs, and other nutrients on such drugs. I will inform my health practitioner if I experience gastrointestinal upset (nausea, gas, stomachache, vomiting), allergic reactions (hives, rashes, itching, tingling of the tongue, headache), or any unanticipated or unpleasant effects associated with the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients. I understand that I need to check all labels before opening the bottle to verify I am not sensitive or allergic to any ingredients listed.

**5. PREGNANCY:** I understand that some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be inappropriate during pregnancy, and I will notify the health practitioner if I am or become pregnant.

**6. ALTERNATIVES:** I understand that the alternatives to the recommendations include doing nothing and/or seeking additional allopathic medical care.

### **DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND THIS FORM!**

I have read and fully understand this consent. All items have been explained, I have had sufficient time to evaluate the information, and my questions have been answered. Knowing the alternatives and risks, I consent to the services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name (printed) \_\_\_\_\_

## Clinical Nutrition Payment Policy

The initial clinical nutrition appointment is scheduled for one hour at a fee of \$250. Out of respect for other patients, if more time is needed for questions or examination, more time will be scheduled at a later date and charged according to the following fee schedule. Follow up appointments are charged at \$75 (15 minutes), \$150 (30 minutes), \$225 (45 minutes).

Previous lab work from other health care providers can be reviewed but is subject to the above pricing based on time involved in number of tests reviewed and the time involved with interpreting the results.

Payment is expected the same day of service. Clinical nutrition is not insurance reimbursable.

I understand the above payment policy. Prices are subject to change.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (printed): \_\_\_\_\_



**RIVER FALLS CHIROPRACTIC**

**River Falls Chiropractic & Decompression**

**Todd Frisch, D.C.**

**Amy Hietala, D.C.**

**Heidi Webb, D.C.**

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**Website: [www.rfchiro.com](http://www.rfchiro.com)**

# MISSED APPOINTMENT POLICY

Out of respect and consideration for our practice members, we kindly ask you to honor your scheduled appointment time. Please note that appointment space is limited daily and both of our doctors have waiting lists.

We understand unanticipated events occasionally occur. In our desire to be effective and fair to all of our clients' time, we ask you give a minimum 24 hour advance notice when cancelling an appointment. This allows the opportunity for someone else to schedule and utilize your valuable appointment space.

We are happy to excuse one missed chiropractic appointment with no penalty. If there is a second missed appointment, you will be charged a \$50 cancellation fee which is applied to your account. Insurance will not be billed for these charges. Cancellation fees are the responsibility of the patient and must be paid in full before the next visit.

Missed Clinical Nutrition appointments will be billed at \$75 for every 15 minutes scheduled.

**I have read and understand the River Falls Chiropractic Appointment Cancellation Policy. I am aware that I will be charged for the missed appointment, and I agree to these terms.**

I, \_\_\_\_\_, have received a copy of The Cancellation Policy.

\_\_\_\_\_

Signature of Patient

\_\_\_\_\_

Date