CARRICK
BRAIN CENTERS

Welcome to Carrick Brain Centers. Carefully complete all of the following health history questionnaires. The accuracy of your answers will help us better diagnose your condition. Thank you for your patience with what may appear to be some duplication in questions in different areas. Each questionnaire has been carefully designed to identify your specific condition.

Patient Name: _____ **DOB:** _____

❑ Male ❑ Female

Street Address: _____ **Unit/Apt.** _____

City: _____ **State:** _____ **ZIP:** _____

Phone: (____)_____ ❑ Home ❑ Mobile **Alternate phone:** (____)_____

E-mail address: _____

Emergency Contact Information:

Contact Name: _____

Phone: (____)_____ ❑ Home ❑ Mobile **Alternate phone:** (____)_____

Relationship to Patient: _____

Check as many that apply to you about your reason for visiting us today:

❑ Headaches
❑ Balance issues
❑ Medication management
❑ Sports improvement
❑ Head injury
❑ Neurological assessment
❑ Sleeplessness
❑ Nutritional counseling
❑ Other: _____

❑ If injury occurred, when? _____/_____/_____

❑ Another type of accident, trauma, or injury

❑ Date symptoms started _____/_____/_____
❑ Sudden ❑ Rapid ❑ Gradual in onset
Please explain what the incident was. Was it at work, home, or somewhere else?

❑ Neurological problem or disease

Please explain & include any prior diagnoses:

❑ Diagnostics

Please list previous diagnostic tests given for current complaints:

Were you referred to us by another health care provider?

❑ No ❑ Yes. If yes, who? _____

Medications?

If you currently taking any, please list them. (If more than 12, please continue on the back of this form.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Herbs or Nutritional Supplements?

If you currently taking any, please list them. (If more than 9, please continue on the back of this form.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

CARRICK BRAIN CENTERS

Patient Name: _____

Date of Birth: _____/_____/_____

Do you have any known food, drug or environmental allergies? *If so, please list them. (If more than 6, please continue on the back of this form.)*

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

What is the most important thing we can do for you? _____

_____

Quality of Life Rank. *Please circle where you rate your current quality of life.*

Poor **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **11** Excellent

Brain Health Rank. *How well do you think your brain is functioning?*

Terribly **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **11** Great

Have you seen anyone else for this condition? ❑ No. ❑ Yes. If yes, who? _____

Have you lost work days because of this condition? ❑ No. ❑ Yes. If yes, How Many? _____

How long has this problem been present? ❑ Weeks _____ ❑ Months _____ ❑ Years _____

What do you think is causing your present condition? _____

Indicate any other symptoms you think may be important. _____

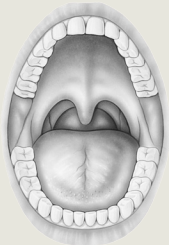
What are your 3 greatest concerns about your present state of health?

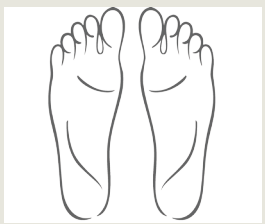
1. _____ 2. _____ 3. _____

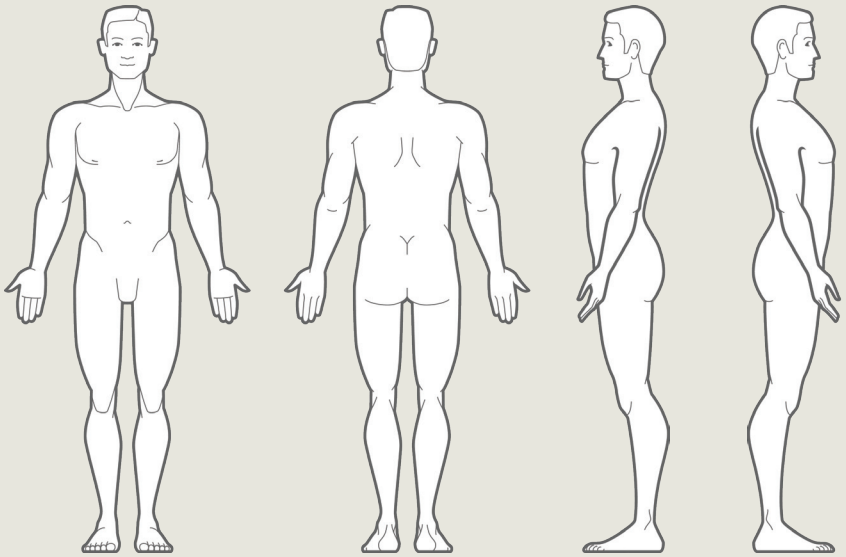
THIS AREA TO BE FILLED OUT BY THE DOCTOR

On the diagram, please mark the following symptoms, if you are experiencing them:

"//"	stabbing pain
"B"	for burning pain
"D"	for dull pain
"A"	for aching pain
"N"	on or in areas where you have numbness
"T"	in areas where you have tingling
"St"	in areas where you feel stiffness
"Sw"	in areas where you've had swelling
"C"	In areas where you have cramps
"W"	for weakness
"Tr"	for tremor







Doctor's Notes. _____

_____

_____ Doctor's initials: ____

CARRICK BRAIN CENTERS

Patient Name: _____

Date of Birth: _____/_____/_____

Personal Health History

Please answer the following questions as completely as possible. *Continue answers on the back side of this form, if necessary.*

List all operations and surgeries you may have had, with dates *(month/year)* _____

_____

List any major illness you have had, with dates *(month/year)* _____

_____

Have you had any recent infections, colds, or flu? ❑ No ❑ Yes. When? _____/_____/_____

Please list any and all traumas or injuries you've ever had, with dates, from the simple to the serious. _____

_____

Have you ever been diagnosed with a tumor, cancer, or neoplasia? ❑ No ❑ Yes. When? _____/_____/_____

Have you ever been diagnosed with diabetes? ❑ No ❑ Yes. When? _____/_____/_____

Have you ever been diagnosed with a cardiac (heart) condition, a blood vessel condition (like arteriosclerosis, atherosclerosis, or vasculitis), or hypertension (high blood pressure)? ❑ No ❑ Yes. When? _____/_____/_____

Have you ever had a stroke or heart attack? ❑ No ❑ Yes. When? _____/_____/_____

Does anyone in your biological family (parent, grandparent, sibling, or child) have a history of:

Heart disease, stroke, cancer or diabetes? ❑ No ❑ Yes. Explain _____

Psychiatric diseases like depression, anxiety, schizophrenia, etc? ❑ No ❑ Yes. Explain _____

Neuropathies (nerve disease) or myopathies (muscle disease)? ❑ No ❑ Yes. Explain _____

Cancer? ❑ No ❑ Yes. Explain _____

Back or neck pain? ❑ No ❑ Yes. Explain _____

Any other known conditions? ❑ No ❑ Yes. Explain _____

The following questions help us determine levels of stress. Please answer as completely as possible.

Please indicate your familial status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Partnered

How many children do you have? ❑ None ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ Other: ____

What do you do for a living? _____ How many hours a week? _____

Do you have a second job? _____ How many hours a week? _____

Describe your work environment: _____

Describe your home life: _____

What is your highest level of education? _____

What are your hobbies? _____

CARRICK BRAIN CENTERS

Patient Name: _____

Date of Birth: _____/_____/_____

Personal Health History, continued

Please answer the following questions as completely as possible. *Social history*

Do you exercise? ❑ No ❑ Yes. What type and how often? _____

Do you currently use any tobacco products? ❑ No ❑ Yes. What kind, how often and how long? _____

Have you used tobacco products in the past? ❑ No ❑ Yes. What kind, how long, and when did you quit?_____

Do you drink alcoholic beverages? ❑ No ❑ Yes. What kind and how many a week? _____

Have you had issues with alcohol in the past? ❑ No ❑ Yes. How long ago and for how long? _____

Do you drink caffeinated beverages? ❑ No ❑ Yes. What kind and how many a day? _____

Do you drink sodas? ❑ No ❑ Yes. How many a day? _____

Do you currently use recreational drugs? ❑ No ❑ Yes. What type, how often, and how long?_____

Have you used recreational drugs in the past? ❑ No ❑ Yes. What kind, how long, and for how long? _____

Do you have any special dietary restrictions? ❑ No ❑ Yes. What type? _____

Are you sexually active? ❑ No ❑ Yes. Have you ever been diagnosed win an STD or VD? ❑ No ❑ Yes.

Do you currently see a chiropractor? ❑ No ❑ Yes.

When did you last see a chiropractor? _____

What were those visits for and how were the outcomes? _____

Review of Systems & Medical History

1. Doe anything trigger your symptoms such as ❑ exercise ❑ sleep ❑ posture ❑ environment?

2. Do your symptoms get worse with physical or mental activity? ❑ No ❑ Yes _____

3. Are you currently experiencing any of the following symptoms, now or recently?

- ❑ Chest pain
- ❑ Jaw pain
- ❑ Left arm pain
- ❑ Shortness of breath
- ❑ Excessive sweating without exertion
- ❑ Pale skin or pallor
- ❑ Blackouts
- ❑ Swelling in your left arm
- ❑ Light-headedness

4. Please check off any of the below symptoms that you are experiencing now or recently.

- ❑ Nausea
- ❑ Vomiting
- ❑ Disequilibrium or feeling unsteady
- ❑ Dizziness or vertigo
- ❑ Difficulty with swallowing
- ❑ Abnormal eye movements
- ❑ Double vision
- ❑ Feeling like you're going to fall
- ❑ Balance problems
- ❑ Numbness
- ❑ Abnormal sweating
- ❑ Headache
- ❑ Blurred vision
- ❑ Difficulty with speaking

5. Have you noticed any of the following?

- ❑ Change in appetite
- ❑ Unexplained weight gain
- ❑ Recent fatigue
- ❑ Unexplained weight loss
- ❑ Recent fever

CARRICK BRAIN CENTERS

Patient Name: _____

Date of Birth: _____/_____/_____

Personal Health History, continued

Please mark below any of the conditions that apply to you, past or present. ❑ Past Condition ❑ Present Condition

Osteoporosis ❑ ❑	Pain in your face ❑ ❑	Anemia ❑ ❑
Dislocated bones ❑ ❑	Temporal arteritis ❑ ❑	Allergies ❑ ❑
Fractured bones ❑ ❑	Fainting spells ❑ ❑	Anxiety ❑ ❑
Bone infection (osteomyelitis) ❑ ❑	Blurred vision ❑ ❑	Phobias ❑ ❑
Herniated disc ❑ ❑	Double vision ❑ ❑	HPV/Genital warts ❑ ❑
Scoliosis or other spinal curvature ❑ ❑	Muscle cramping ❑ ❑	Breast discharge ❑ ❑
Osteoarthritis or DJD ❑ ❑	Tremors (shaking) ❑ ❑	Vaginal discharge ❑ ❑
Rheumatoid arthritis ❑ ❑	Dyslexia ❑ ❑	Breast lumps/soreness ❑ ❑
Other arthritis ❑ ❑	Asperger's syndrome ❑ ❑	Vascular disease ❑ ❑
Gout ❑ ❑	Sleep apnea ❑ ❑	Varicose veins ❑ ❑
Ankylosing spondylitis ❑ ❑	Cataracts ❑ ❑	Auto immune disease ❑ ❑
Accidental fall ❑ ❑	Arrhythmia ❑ ❑	Panic attacks ❑ ❑
Mental or emotional disorder ❑ ❑	Heart murmur ❑ ❑	PTSD ❑ ❑
Learning disability ❑ ❑	Atherosclerosis/arteriosclerosis ❑ ❑	OCD ❑ ❑
Glaucoma ❑ ❑	Wheezing ❑ ❑	Syphilis ❑ ❑
Heart palpitations (heart racing) ❑ ❑	Asthma ❑ ❑	Kidney problems or disease ❑ ❑
Swelling in legs or feet ❑ ❑	Gastric ulcers ❑ ❑	Kidney stone ❑ ❑
Congestive heart failure ❑ ❑	Celiac Disease (Sprue) ❑ ❑	Difficulty urinating ❑ ❑
Chronic/frequent cough ❑ ❑	Irritable bowel syndrome ❑ ❑	Feelings of urgency to urinate ❑ ❑
COPD ❑ ❑	Night sweats ❑ ❑	Leg pain with walking ❑ ❑
Coughing up blood ❑ ❑	Bruise easy ❑ ❑	Blood clots/phlebitis ❑ ❑
Colon problems ❑ ❑	Psoriasis ❑ ❑	Frequent colds or flus ❑ ❑
Gall bladder trouble ❑ ❑	Skin cancer ❑ ❑	Alcoholism ❑ ❑
Liver disease ❑ ❑	Loss of consciousness ❑ ❑	Cancer ❑ ❑
Stomach/duodenal ulcer ❑ ❑	Concussions ❑ ❑	Feelings of suicide ❑ ❑
Cirrhosis ❑ ❑	Head injury ❑ ❑	Eating disorders ❑ ❑
Change in hat size ❑ ❑	Weak muscles of face ❑ ❑	Infrequent urination ❑ ❑
Change in skin mole ❑ ❑	Autism (PDD or ASD) ❑ ❑	Blood in urine ❑ ❑
Acne ❑ ❑	Bed wetting ❑ ❑	Painful urination ❑ ❑
Hypertension ❑ ❑	Retinopathy ❑ ❑	Awaken to urinate ❑ ❑
Seizures ❑ ❑	High cholesterol ❑ ❑	Bladder infections ❑ ❑
Trouble concentrating ❑ ❑	Scarlet fever ❑ ❑	Other STD/VD ❑ ❑
Paralysis ❑ ❑	Rheumatic fever ❑ ❑	Venous insufficiency ❑ ❑
Twitching muscles ❑ ❑	Emphysema ❑ ❑	Bruise easily ❑ ❑
ADD or ADHD ❑ ❑	Bronchitis ❑ ❑	HIV/AIDS ❑ ❑
Macular degeneration ❑ ❑	Hepatitis ❑ ❑	Other *(please describe)* ❑ ❑
Ringing in ears ❑ ❑	Chrohn's disease ❑ ❑	
Sinus problems ❑ ❑	Diabetes ❑ ❑	_____
Mouth sores ❑ ❑	Hyperthyroidism ❑ ❑	_____
Irregular heart beats ❑ ❑	Hypothyroidism ❑ ❑	_____
Experience passing out ❑ ❑	Shingles ❑ ❑	
Skipped heart beats ❑ ❑	Herpes ❑ ❑	
Congenital heart disease ❑ ❑	Warts ❑ ❑	
Shortness of breath with activity ❑ ❑	Psychological issues ❑ ❑	
Short of breath at rest ❑ ❑	Depression ❑ ❑	
Polyps ❑ ❑	Prostate problems ❑ ❑	
Diverticulitis ❑ ❑	Erectile dysfunction ❑ ❑	
Change in nails ❑ ❑	Discharge from urethra ❑ ❑	
Eczema ❑ ❑	Gonorrhea ❑ ❑	
Dermatitis ❑ ❑	Bleeding disorder ❑ ❑	

Females only:

Is there any possibility that you are currently pregnant? ❑ No ❑ Yes

What was the date of your last menstrual period?

Date _____/_____/_____

CARRICK BRAIN CENTERS

Patient Name: _____

Date of Birth: _____/_____/_____

Metabolic/Neurologic Assessment Form

The following questions and sections will guide staff clinicians in understanding your physiology. These forms are not meant for self diagnosis.

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

Category I *CH*

Feeling that bowels do not empty completely	0 1 2 3
Lower abdominal pain relieved by passing stool or gas	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Diarrhea	0 1 2 3
Constipation	0 1 2 3
Hard, dry, or small stool	0 1 2 3
Coated tongue or "fuzzy" debris on tongue	0 1 2 3
Pass large amount of foul-smelling gas	0 1 2 3
More than 3 bowel movements daily	0 1 2 3
Use laxatives frequently	0 1 2 3

Category II *HC*

Excessive belching, burping or bloating	0 1 2 3
Gas immediately following a meal	0 1 2 3
Offensive breath	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during and after meals	0 1 2 3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0 1 2 3

Category III *HA*

Stomach pain, burning or aching 1-4 hours after eating	0 1 2 3
Use antacids	0 1 2 3
Feel hungry and hour or two after eating	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3
Temporary relief by using antacids, food, milk or carbonated beverages	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0 1 2 3

Category IV *SI*

Roughage and fiber cause constipation	0 1 2 3
Indigestion and fullness last 2-4 hours after eating	0 1 2 3
Pain, tenderness, soreness on left side under rib cage	0 1 2 3
Excessive passage of gas	0 1 2 3
Nausea and/or vomiting	0 1 2 3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

Category V *BT*

Greasy or high fat foods cause distress	0 1 2 3
Lower bowel gas and/or bloating several hours after eating	0 1 2 3
Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool color alternates from clay colored to normal brown	0 1 2 3
Reddened skin, especially palms	0 1 2 3
Dry or flaky skin and/or hair	0 1 2 3
History of gallbladder attacks or stones	0 1 2 3
Have you had your gall blader removed?	0 1 2 3

Category VI *HO*

Crave sweets during the day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on coffee to keep going/get started	0 1 2 3
Get light-headed if meals are missed	0 1 2 3
Eating relieves fatigue	0 1 2 3
Feel shaky, jittery or have tremors	0 1 2 3
Agitated, easily upset, nervous	0 1 2 3
Poor memory/forgetful	0 1 2 3
Blurred vision	0 1 2 3

Category VII *IR*

Fatigue after meals	0 1 2 3
Crave sweets during the day	0 1 2 3
Eating sweets does not relieve cravings for sugar	0 1 2 3
Must have sweets after meals	0 1 2 3
Waist girth is equal to or larger than hip girth	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

Category VIII *AF*

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

CARRICK BRAIN CENTERS

Patient Name: _____

Date of Birth: _____/_____/_____

Metabolic/Neurologic Assessment, continued

Please circle the appropriate number "0-3" on all questions below. 0 = least/never 3 = most/never

Category IX *AH*

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

Category X *HoT*

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; excessive hair loss	0 1 2 3
Dryness of skin and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3

Category XI *Thr*

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

Category XII *Pho*

Diminished sex drive	0 1 2 3
Menstrual disorders or lack of menstruation	0 1 2 3
Increased ability to eat sugars without symptoms	0 1 2 3

Category XIII *Phr*

Increased sex drive	0 1 2 3
Tolerance to sugars reduced	0 1 2 3
"Splitting"-type headaches	0 1 2 3

Category XIV (Males only) *PH*

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

Category XV (Males only) *AP*

Decreased libido	0 1 2 3
Decreased number of spontaneous morning erections	0 1 2 3
Decreased fullness of 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 past	0 1 2 3

Category XVI (Menstruating Females only)

Premenopausal	0 1 2 3
Alternating menstrual cycle lengths	0 1 2 3
Extended menstrual cycle (greater than every 32 days)	0 1 2 3
Shortened menstrual cycle (less than every 24 days)	0 1 2 3
Pain and cramping during periods	0 1 2 3
Scanty blood flow	0 1 2 3
Heavy blood flow	0 1 2 3
Breast pain and swelling during menses	0 1 2 3
Pelvic pain during menses	0 1 2 3
Irritable and depressed during menses	0 1 2 3
Acne	0 1 2 3
Facial hair growth	0 1 2 3
Hair loss/thinning	0 1 2 3

Category XVII (Menopausal Females only)

How many years have you been menopausal	0 1 2 3
Since menopause, do you ever have uterine bleeding?	0 1 2 3
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

CARRICK BRAIN CENTERS

Patient Name: _____

Date of Birth: _____/_____/_____

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

Section 1 *BE*

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 *BMC*

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 falling asleep	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 *MCF*

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 spacial 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 band 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 *TLF*

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 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 difference in energy levels throughout the day	0 1 2 3

Section 5 *OLF*

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 field during different times of day	0 1 2 3
Difficulty discriminating similar shades of color	0 1 2 3

Section 6 *FCF*

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

CARRICK BRAIN CENTERS

Patient Name: _____

Date of Birth: _____/_____/_____

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

Section 7 *PLF*

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 *PMF*

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 *IDP*

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 *DP*

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 *CB*

Difficulty with balance, or balance that is noticeably worse on one side	0 1 2 3
A need to old 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

Section 12 *BCC*

Low brain endurance for focus and concentration	0 1 2 3
Cold hands and feet	0 1 2 3
Must exercise or drink coffee to improve brain function	0 1 2 3
Poor nail health	0 1 2 3
Fungal growth on toenails	0 1 2 3
Must wear socks at night	0 1 2 3
Nail beds are white instead of pink	0 1 2 3
The tip of the nose is cold	0 1 2 3

Section 13 *SM*

Irritable, nervous, shaky, or light-headed between meals	0 1 2 3
Feel energized after meals	0 1 2 3
Difficulty eating large meals in the morning	0 1 2 3
Energy level drops in the afternoon	0 1 2 3
Crave sugar and sweets in the afternoon	0 1 2 3
Wake up in the middle of the night	0 1 2 3
Difficulty concentrating before eating	0 1 2 3
Depend on coffee to keep going	0 1 2 3

Section 14 *PUS*

Fatigue after meals	0 1 2 3
Sugar and sweet cravings after meals	0 1 2 3
Difficulty losing weight	0 1 2 3
Increased frequency of urination	0 1 2 3
Difficulty falling asleep	0 1 2 3
Increased appetite	0 1 2 3

Section 15 *SBF*

Always have projects and things that need to be done	0 1 2 3
Never have time for yourself	0 1 2 3
Not getting enough sleep or rest	0 1 2 3
Difficulty getting regular exercise	0 1 2 3
Feel that you are not accomplishing your life's purpose	0 1 2 3

Section 16 *EFA*

Dry and unhealthy skin	0 1 2 3
Dandruff or a flaky scalp	0 1 2 3
Consumption of processed foods that are bagged or boxed	0 1 2 3
Consumption of fried foods	0 1 2 3
Difficulty consuming raw nuts or seeds	0 1 2 3
Difficulty consuming fish (not fried)	0 1 2 3
Difficulty consuming olive oil, avocados, flax seed oil, or natural fats	0 1 2 3

CARRICK BRAIN CENTERS

Patient Name: _____

Date of Birth: _____/_____/_____

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

Section 17 *BGA*

Difficulty digesting foods	0 1 2 3
Constipation or inconsistent bowel movements	0 1 2 3
Increased bloating or gas	0 1 2 3
Abdominal distention after meals	0 1 2 3
Difficulty digesting protein rich foods	0 1 2 3
Difficulty digesting starch rich foods	0 1 2 3
Difficulty swallowing supplements or large bites of food	0 1 2 3
Abnormal gag reflex	Yes or No

Section 18 *BIA*

Brain fog (unclear thoughts or concentration)	Yes or No
Pain and inflammation	Yes or No
Noticeable variation in mental speed	Yes or No
Brain fatigue after meals	0 1 2 3
Brain fatigue after exposure to chemicals, scents, or pollutants	0 1 2 3
Brain fatigue when the body is inflamed	0 1 2 3

Section 19 *GI*

Grain consumption leads to tiredness	0 1 2 3
Grain consumption makes it difficult to focus and concentrate	0 1 2 3
Feel better when bread and grains are avoided	0 1 2 3
Grain consumption causes the development of any symptoms	0 1 2 3
A 100% gluten-free diet	Yes or No

Section 20 *IB*

A diagnosis of celiac disease, gluten sensitivity, hypothyroidism, or an autoimmune disease	Yes or No
Family members who have been diagnosed with an autoimmune disease	Yes or No
Family members who have been diagnosed with celiac disease or gluten sensitivity	Yes or No
Changes in brain function with stress, poor sleep, or immune activation	0 1 2 3

Section 21 *SC*

A loss of pleasure in hobbies and interests	0 1 2 3
Feel overwhelmed with ideas to manage	0 1 2 3
Feelings of inner rage or unprovoked anger	0 1 2 3
Feelings of paranoia	0 1 2 3
Feelings of sadness for no reason	0 1 2 3
A loss of enjoyment in life	0 1 2 3
A lack of artistic appreciation	Yes or No
Feelings of sadness in overcast weather	0 1 2 3
A loss of enjoyment in favorite foods	0 1 2 3
A loss of enjoyment in friendships and relationships	0 1 2 3
Inability to fall into deep, restful sleep	0 1 2 3
Feelings of dependency on others	0 1 2 3
Feelings of susceptibility to pain	0 1 2 3

Section 22 *DC*

Feelings of worthlessness	0 1 2 3
Feelings of hopelessness	0 1 2 3
Self-destructive thoughts	0 1 2 3
Inability to handle stress	0 1 2 3
Anger and aggression while under stress	0 1 2 3
Feelings of tiredness, even after many hours of sleep	0 1 2 3
A desire to isolate yourself from others	0 1 2 3
An unexplained lack of concern for family and friends	0 1 2 3
An inability to finish tasks	0 1 2 3
Feelings of anger for minor reasons	0 1 2 3

Section 23 *ACH*

A decrease in visual memory (shapes and images)	Yes or No
A decrease in verbal memory	0 1 2 3
Occurrence of memory lapses	0 1 2 3
A decrease in creativity	0 1 2 3
A decrease in comprehension	0 1 2 3
Difficulty calculating numbers	0 1 2 3
Difficulty recognizing objects and faces	0 1 2 3
A change in opinion about yourself	0 1 2 3
Slow mental recall	0 1 2 3

Section 24 *CAT*

A decrease in mental alertness	0 1 2 3
A decrease in mental speed	0 1 2 3
A decrease in concentration quality	0 1 2 3
Slow cognitive processing	0 1 2 3
Impaired mental performance	0 1 2 3
An increase in the ability to be distracted	0 1 2 3
Need coffee or caffeine sources to improve mental function	0 1 2 3

Section 25 *GC*

Feelings of nervousness or panic for no reason	0 1 2 3
Feelings of dread	0 1 2 3
Feelings of a "knot" in your stomach	0 1 2 3
Feelings of being overwhelmed for no reason	0 1 2 3
Feelings of guilt about everyday decisions	0 1 2 3
A restless mind	0 1 2 3
An inability to turn off the mind when relaxing	0 1 2 3
Disorganized attention	0 1 2 3
Worry over things never thought about before	0 1 2 3
Feelings of inner tension and inner excitability	0 1 2 3

CARRICK
BRAIN CENTERS

Patient Name: _____

Date of Birth: _____/_____/_____

Are there any other concerns or interests you have about your health that you would like us to address?

You may describe any other concerns or questions in this space:

_____

_____

_____

_____

_____

_____

Patient Authorization

Thank you for taking the time to fill out this health history questionnaire. This information is important to the doctor obtaining an accurate clinical picture so as to make an appropriate diagnosis and treatment plan. Please sign below authorizing that the information in this form has been read and filled out completely and accurately to the best of your understanding. Also, understand that the information in this form is considered confidential and for use by your doctor at Carrick Brain Centers. Any disclosure is outlined in our privacy policies.

_____ _____

Patient's (or guardian's) signature Date

_____ _____

Signature of translator or person assisting you (if any) Date

_____

Printed name

Doctor's Notes. _____

_____

_____

_____

_____

_____

_____ Doctor's initials: _____