Metabolic Quick Check

Patient Name: _____ Date: _____

Check all the following that apply:

_____ Fatigue

_____ Muscle aches and pains

_____ Joint Pains

_____Thyroid Issues

_____ Fibromyalgia

_____ Hair Loss

_____ Memory Loss

_____ Concentration difficulties

_____ Mental sluggishness

_____ Dry, coarse hair

_____ Depression

_____ Cold hands and/or feet

_____ Weight Gain

_____ Skin problems (itching, eczema, psoriasis, acne, or coarse, dry, scaly, skin)

_____ Feeling of fullness in neck

_____ Loss of outer 1/3 of eyebrows

_____ Tendency towards constipation

_____ Low blood sugar/hypoglycemia

Space Coast Advanced Health 321-425-2519

Dr. Steve Alukonis, DC

Today's Date: _____/_____/_____

Name: _____ Age_____ Date of Birth_____

Local Address_____ City_____ State____ Zip_____

Out of Town Address_____ City_____

State____ Zip_____

Marital Status_____ Sex_____ S.S.# _____ Home Phone_____

Cell. Phone_____

Email Address: _____Employer_____

Occupation _____ Address/Phone _____

Spouse _____

Emergency Contact_____ Phone_____

Relationship_____

How did you hear about our office?

Yellow Pages ☐ Drive By ☐ Walk-In ☐ Internet ☐ Referral

(Please tell us who) _____ ☐ Other: _____

Health Insurance Information

Primary Insurance _____

Policy Holder's Name _____ DOB _____

Policy Holder's Relationship to Patient _____

Policy Holder's Employer _____

Current complaint I.

Please list your **worst** complaint: _____

How long have you had it? _____

How did it start: _____

A) **Is it**: Improving ☐ Worsening ☐ Staying the Same ☐

B) **Is it**: Mild ☐ Moderate ☐ Severe ☐

C) What worsens it: General activity ☐ Moving Wrong ☐ Bending ☐ Lifting ☐ Walking ☐

Sports ☐ Getting up from a chair ☐ Using a computer/desk work ☐

Other: _____

D) What makes it better: Rest ☐ General Activity ☐ Ice Packs ☐ Heating Pad ☐ OTC Meds ☐

Rx Meds ☐ Massage ☐ Chiropractic ☐ Other: _____

E) Is it worse in the: AM ☐ PM ☐ After day wears on ☐ Steady ☐ Off and on ☐

F) Is the symptom: Dull and Achy ☐ Tight and Stiff ☐ Sharp and Stabbing ☐

Numb and Tingly ☐ Shooting ☐ Burning ☐ Cramping ☐

II. Please list your **2nd worst** complaint: _____

How long have you had it? _____

How did it start: _____

A) **Is it**: Improving ☐ Worsening ☐ Staying the Same ☐

B) **Is it**: Mild ☐ Moderate ☐ Severe ☐

C) What worsens it: General activity ☐ Moving Wrong ☐ Bending ☐ Lifting ☐ Walking ☐

Sports ☐ Getting up from a chair ☐ Using a computer/desk work ☐

Other: _____

D) What makes it better: Rest ☐ General Activity ☐ Ice Packs ☐ Heating Pad ☐ OTC Meds ☐

Rx Meds ☐ Massage ☐ Chiropractic ☐ Other:_____

E) Is it worse in the: AM ☐ PM ☐ After day wears on ☐ Steady ☐ Off and on ☐

F) Is the symptom: Dull and Achy ☐ Tight and Stiff ☐ Sharp and Stabbing ☐

Numb and Tingly ☐ Shooting ☐ Burning ☐ Cramping ☐

Any current loss of bowel or bladder control: Yes ☐ No ☐

Any current seizures, paralysis, speech, vision problems: Yes ☐ No ☐

Any unexplained recent weight loss: Yes ☐ No ☐ Current fever: Yes ☐ No ☐
Current nutritional problems: Yes ☐ No ☐

• Have you had spinal X-Rays within the past 5 years? If yes, when and where

_____

• Do you have a pacemaker? Yes ☐ No ☐

If yes, please ALERT our doctor and/or assistant

• Do you have any blood/lymph disorders? Yes ☐ No ☐ If yes, please list

_____

• Do you have osteoporosis or rheumatoid arthritis? Yes ☐ No ☐

• Please list any other electrical device that you currently

wear_____

• Have you ever had chiropractic care? Yes ☐ No ☐

If yes, last date of treatment_____ By whom: _____

Similar or difference condition: _____

Results: _____

What are your overall expectations from your treatment with our doctor?

_____

• **WOMEN ONLY** I hereby declare that to the best of my knowledge **I am ☐ I am not pregnant ☐**. If there is a chance that I may be pregnant, I will inform the doctor prior to my examination.

I, the undersigned, voluntarily give my consent for to receive medical and health care services by the doctor to examine and treat my condition as he deems appropriate using chiropractic care and/or medical care. I also give my consent for the doctor to take x-rays (if needed) or to perform other diagnostic aids as he deems appropriate.

Patient Signature_____

(Parent/Guardian signature if under 18 years of age)

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events. Research: We may use or disclose information for approved medical research.

CURRENT HEALTH

Name and phone number of family doctor:

_____

CHIEF COMPLANT (Why are you here to see the doctor): _____

_____

MEDICAL HISTORY

Please indicate whether you have had or currently have any of the following illnesses.

Heart Disease ☐ Chronic Lung Disease ☐ Diabetes ☐ Cancer ☐ High Blood Pressure ☐

Eye Disease ☐ Hepatitis ☐ Asthma ☐ Stomach Problems ☐ Kidney Problems ☐

Bleeding Problems ☐ Anemia ☐

Excessive Scarring Other Please Explain:

_____

_____

_____

Current or previous serious illnesses or injuries:

_____

Previous surgeries:

_____

_____

NOTICE OF PRIVACY PRACTICE

Patient Health Information: Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We use your Patient Health Information: We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, the physician, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, and to family members who are helping with your care. *Payment*: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan. Health *Care Operations*: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses: We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures: We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes: *Public Health Activities*: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities. *Health oversight*: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities. *Judicial and administrative proceedings*: We may disclose information in response to an appropriate subpoena or court order. Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials. *Deaths*: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies. *Serious threat to health or safety*: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. *Military and Special Government Functions*: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes. *Workers Compensation*: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illnesses.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights: You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights. *Request Restrictions*: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions. *Confidential Communications*: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments. *Inspect and Obtain Copies*: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies. *Amend Information*: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information. *Accounting of Disclosures*: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty: We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices: We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints: If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person If you have any questions, requests, or complaints, please contact:

Hailey: 321-425-2519
Space Coast Advanced Health
401 N Wickham Road
Melbourne, FL. 32935
Effective Date: January 1, 2020

I hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____ Date: _____

If not signed, reason why acknowledgement was not obtained:

GENERAL/FINANCIAL POLICY

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.

- Your account is to be kept current. All self-pay or insurance copayments, co-insurances and deductibles will be collected at the time of service payable by cash, check, Visa, MasterCard, Discover, American Express or Care Credit.

- If you do not have your payment (s), your appointment may be rescheduled.

- If you are unable to keep a scheduled appointment, please notify us 24 hours before your appointment so that we may offer that time to another patient.

- A returned check will result in a $25.00 service charge and all future payments being required in the form of cash or credit card.

- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.

IF YOU HAVE HEALTH INSURANCE COVERAGE: As a courtesy to you, our office will attempt to pre-verify your primary insurance coverage for your Chiropractic care. Coverage information is obtained from your insurance company using information provided by you prior to your initial visit. We must emphasize that as medical providers, our relationship is with you, not your insurance company. Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of inquiry.

By signing below, you confirm you understand that:

• It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified.

• Not all services are a covered benefit with all insurance plans.

• It is your responsibility to be aware of what service (s) is being provided to you and if it is a covered benefit under your insurance.

• You are responsible for any non-covered charges not payable by your insurance policy.

• We will send all required claim forms and documentation to ensure your claims are processed in a timely manner.

• Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits from them.

• After all co-pays, contracted plan reductions and insurance payment credits are applied to your account, any remaining portion will be your responsibility.

• If you are a MEDICARE PATIENT, please be advised that Medicare only covers Spinal Adjustments in a Chiropractor's office. All services outside of the Spinal Adjustment in our office will be your financial responsibility.

- I am responsible for all attorney fees or collection fees related to the collection of my account.

- I agree to pay interest at the rate of 1.5% per month on any unpaid balance.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. WE ARE HERE TO HELP YOU.

I understand that services rendered by Dr. Steve Alukonis, DC, are NOT reimbursed by insurance and that the office does not provide or fill out forms for insurance purposes. I will be solely responsible for payment for these services.

By signing below, you have read and understand the above Financial Policy and agree to meet all financial obligations.

_____

Printed Name

_____ _____

Signature of Patient/Legal Guardian Date

CONSENT TO RELEASE INFORMATION: In the event that you ever wish to have a family member or friend come to our office and get a copy of your medical records for whatever reason, we ask that you sign below allowing them to do so. By signing below, I hereby give my consent for Space Coast Advanced Health, Dr. Steve Alukonis, DC to release my medical records to:

_____

Name of Family Member/Friend

_____ _____

Signature of Patient/Parent/Legal guardian Date

CONSENT TO TREAT A MINOR: I hereby authorize and give consent for Dr. Steve Alukonis, DC to examine, and if needed, treat my minor child _____.

Print Child's Name Here

_____

Print Name

_____ _____

Signature of Patient/Legal Guardian Date

Dr. Steve Alukonis DC, DABCO

General Medical History

Please Check All That Apply

- ○ ADHD
- ○ ALLERGIES
- ○ ANXIETY
- ○ ARTHRITIS
- ○ ASTHMA
- ○ ATRIAL FIBRILLATION
- ○ CANCER
- ○ COPD
- ○ CONSTIPATION
- ○ CORONARY HEART DISEASE
- ○ DEPRESSION
- ○ DIABETES
- ○ DISC PROBLEMS
- ○ GERD
- ○ FIBROMYALGIA
- ○ SCOLIOSIS
- ○ SINUS TROUBLE
- ○ HEADACHES/MIGRAINES
- ○ HEPATITAS
- ○ HIGH BLOOD PRESSURE
- ○ HYPERTENTION
- ○ HYPERTHYROIDISM
- ○ KIDNEY TROUBLE
- ○ LOW BACK TROUBLE
- ○ LOW BLOOD PRESSURE
- ○ LUPUS
- ○ NECK PAIN
- ○ NERVOUSNESS
- ○ PACEMAKER/DIFIBULATOR (CIRCLE)
- ○ PINCHED NERVE
- ○ POOR CIRCULATION
- ○ PSORIASIS
- ○ SEIZURES
- ○ STOMACH TROUBLE
- ○ STROKE

SURGICAL HISTORY:

TYPE_____ DATE_____

TYPE_____ DATE_____

TYPE_____ DATE_____

TYPE_____ DATE_____

CURRENT MEDICATIONS:

_____

_____

_____

_____

Dr. Steve Alukonis DC, DABCO

ALLERGIES:

_____

_____

_____

_____

MAJOR COMPLAINTS/SYMPTOMS:

Please check all that apply:

- o BLURRED VISION
- o BUZZING EARS
- o COLD FEET
- o COLD SWEATS
- o CONCENTRATION LOSS
- o CONFUSION
- o CONSTIPATION
- o DEPRESSION
- o DIARRHEA
- o DIZZINESS
- o FACE FLUSHED
- o FAINTED
- o FATIGUE
- o FEVER
- o HEAD SEEMS HEAVY
- o HEACHACHES
- o INSOMNIA
- o LIGHT SENSITIVE
- o BALANCE LOSS
- o LOSS OF SMELL
- o LOSS OF TASTE
- o LOW RESISTANCE TO COLDS
- o MUSCLE JERKING
- o FINGERS NUMB
- o TOES NUMB
- o PINS/NEEDLES IN ARMS
- o PINS/NEEDLES IN LEGS
- o RINGING IN EAR
- o SHORTNESS OF BREATH
- o STIFF NECK
- o STOMACH UPSET

ON A SCALE FROM 1-10, 10 BEING THE MOST SERIOUS: WHAT IS YOUR LEVEL OF COMMITMENT? _____

Dr. Steve Alukonis DC, DABCO

REPORT OF FINDINGS APPOINTMENT

Dr. Alukonis requires all metabolic patients to bring their spouse or significant other unless otherwise stated to the report of findings appointment. Reasons being:

- Functional medicine is different than conventional medicine. There is a lot of information that is discussed at this appointment, having two sets of ears makes understanding and processing the information easier.

- Sometimes having someone who knows you well in attendance can help bring additional information to the table.

- It has been proven that having the support of others will speed up your dietary and lifestyle improvements.

- Finances will be discussed at the appointment and if opted, treatment will begin at this visit.

- This appointment gives all parties the opportunity to ask questions about your condition as well as how our office will help to treat.

I,_____will bring my spouse/significant other to my ROF appointment and understand if they are unable to attend, I may need to reschedule my appointment.

_____ _____

Signature Date

Dr. Steve Alukonis, D.C., DABCO

Space Coast Advanced Health

(321) 425-2519

Office Policies

Dr. Steve Alukonis' s office is a busy practice and we do our best to have everyone seen in a timely manner. Due to this we will only allow a 10-minute late window for all appointment, please call the office to reschedule.

If you are unable to keep your appointment and do not call, there will be a $25.00 no show fee.

Also note, many of our patients have a sensitivity to food, so we respectfully ask that you not bring food into the office.

Thank you for your cooperation,

Dr. Steve Alukonis and Staff

_____ _____

Print Name Signature

_____

Date

Metabolic Assessment Form

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

Please list the 5 major health concerns in your order of importance:

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

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

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief 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 of "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

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

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, 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

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 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

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 gallbladder removed	Yes		No	

Category VI

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded 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

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

Category VIII

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

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Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.

Category IX

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts 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

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 gain 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 falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI

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

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

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)

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 evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males only)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in 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
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVI (Menstruating Females Only)

Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 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 breakouts	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? _____

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

How many alcoholic beverages do you consume per week? _____ How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____ How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____ How many times a week do you workout? _____

List the three worst foods you eat during the average week: _____, _____, _____

List the three healthiest foods you eat during the average week: _____, _____, _____

Do you smoke?_____ If yes, how many times a day: _____

Rate your stress levels on a scale of 1-10 during the average week: _____

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

_____

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

_____

Neurotransmitter Assessment Form™ (NTAF)

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

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

SECTION A

- Is your memory noticeably declining? 0 1 2 3
- Are you having a hard time remembering names and phone numbers? 0 1 2 3
- Is your ability to focus noticeably declining? 0 1 2 3
- Has it become harder for you to learn new things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament generally getting worse? 0 1 2 3
- Is your attention span decreasing? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you become fatigued when driving compared to in the past? 0 1 2 3
- How often do you become fatigued when reading compared to in the past? 0 1 2 3
- How often do you walk into rooms and forget why? 0 1 2 3
- How often do you pick up your cell phone and forget why? 0 1 2 3

SECTION B

- How high is your stress level? 0 1 2 3
- How often do you feel you have something that must be done? 0 1 2 3
- Do you feel you never have time for yourself? 0 1 2 3
- How often do you feel you are not getting enough sleep or rest? 0 1 2 3
- Do you find it difficult to get regular exercise? 0 1 2 3
- Do you feel uncared for by the people in your life? 0 1 2 3
- Do you feel you are not accomplishing your life's purpose? 0 1 2 3
- Is sharing your problems with someone difficult for you? 0 1 2 3

SECTION C

SECTION C1

- How often do you get irritable, shaky, or have light-headedness between meals? 0 1 2 3
- How often do you feel energized after eating? 0 1 2 3
- How often do you have difficulty eating large meals in the morning? 0 1 2 3
- How often does your energy level drop in the afternoon? 0 1 2 3
- How often do you crave sugar and sweets in the afternoon? 0 1 2 3
- How often do you wake up in the middle of the night? 0 1 2 3
- How often do you have difficulty concentrating before eating? 0 1 2 3
- How often do you depend on coffee to keep yourself going? 0 1 2 3
- How often do you feel agitated, easily upset, and nervous between meals? 0 1 2 3

SECTION C2

- How often do you get fatigued after meals? 0 1 2 3
- How often do you crave sugar and sweets after meals? 0 1 2 3
- How often do you feel you need stimulants, such as coffee, after meals? 0 1 2 3
- How often do you have difficulty losing weight? 0 1 2 3
- How much larger is your waist girth compared to your hip girth? 0 1 2 3
- How often do you urinate? 0 1 2 3
- Have your thirst and appetite increased? 0 1 2 3
- How often do you gain weight when under stress? 0 1 2 3
- How often do you have difficulty falling asleep? 0 1 2 3

SECTION 1

- Are you losing interest in hobbies? 0 1 2 3
- How often do you feel overwhelmed? 0 1 2 3
- How often do you have feelings of inner rage? 0 1 2 3
- How often do you have feelings of paranoia? 0 1 2 3
- How often do you feel sad or down for no reason? 0 1 2 3
- How often do you feel like you are not enjoying life? 0 1 2 3
- How often do you feel you lack artistic appreciation? 0 1 2 3
- How often do you feel depressed in overcast weather? 0 1 2 3
- How much are you losing your enthusiasm for your favorite activities? 0 1 2 3
- How much are you losing your enjoyment for your favorite foods? 0 1 2 3
- How much are you losing your enjoyment of friendships and relationships? 0 1 2 3
- How often do you have difficulty falling into deep, restful sleep? 0 1 2 3
- How often do you have feelings of dependency on others? 0 1 2 3
- How often do you feel more susceptible to pain? 0 1 2 3
- How often do you have feelings of unprovoked anger? 0 1 2 3
- How much are you losing interest in life? 0 1 2 3

SECTION 2

- How often do you have feelings of hopelessness? 0 1 2 3
- How often do you have self-destructive thoughts? 0 1 2 3
- How often do you have an inability to handle stress? 0 1 2 3
- How often do you have anger and aggression while under stress? 0 1 2 3
- How often do you feel you are not rested, even after long hours of sleep? 0 1 2 3
- How often do you prefer to isolate yourself from others? 0 1 2 3
- How often do you have unexplained lack of concern for family and friends? 0 1 2 3
- How easily are you distracted from your tasks? 0 1 2 3
- How often do you have an inability to finish tasks? 0 1 2 3
- How often do you feel the need to consume caffeine to stay alert? 0 1 2 3
- How often do you feel your libido has been decreased? 0 1 2 3
- How often do you lose your temper for minor reasons? 0 1 2 3
- How often do you have feelings of worthlessness? 0 1 2 3

SECTION 3

- How often do you feel anxious or panicked for no reason? 0 1 2 3
- How often do you have feelings of dread or impending doom? 0 1 2 3
- How often do you feel knots in your stomach? 0 1 2 3
- How often do you have feelings of being overwhelmed for no reason? 0 1 2 3
- How often do you have feelings of guilt about everyday decisions? 0 1 2 3
- How often does your mind feel restless? 0 1 2 3
- How difficult is it to turn your mind off when you want to relax? 0 1 2 3
- How often do you have disorganized attention? 0 1 2 3
- How often do you worry about things you were not worried about before? 0 1 2 3
- How often do you have feelings of inner tension and inner excitability? 0 1 2 3

SECTION 4

- Do you feel your visual memory (shapes & images) has decreased? 0 1 2 3
- Do you feel your verbal memory has decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity decreased? 0 1 2 3
- Has your comprehension diminished? 0 1 2 3
- Do you have difficulty calculating numbers? 0 1 2 3
- Do you have difficulty recognizing objects & faces? 0 1 2 3
- Do you feel like your opinion about yourself has changed? 0 1 2 3
- Are you experiencing excessive urination? 0 1 2 3
- Are you experiencing a slower mental response? 0 1 2 3

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

Medication History*

Please check any of the following medications you have taken in the past or are currently taking.

Noradrenergic and Specific Sertonergic Antidepressants (NaSSAas)

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

Tricylic Antidepressants (TCAs)

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

Selective Serotonin Reuptake Inhibitors (SSRIs)

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

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

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

Selective Serotonin Reuptake Enhancers (SSREs)

- ☐ Stablon®
- ☐ Coaxil®
- ☐ Tatinol®

Monoamine Oxidase Inhibitors (MAOIs)

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

Dopamine Receptor Agonists

- ☐ Mirapex®
- ☐ Sifrol®
- ☐ Requip®

Norepinephrine and Dopamine Reuptake Inhibitors (NDRI)

- ☐ Wellbutrin XL®

D2 Dopamine Receptor Blockers (antipsychotics)

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

GABA Antagonist Competitive Binder

- ☐ Romazicon®

Agonist Modulators of GABA Receptors (benzodiazepines)

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

Agonist Modulators of GABA Receptors (non-benzodiazepines)

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

Acetylcholine Receptor Agonists

- ☐ Urecholine®
- ☐ Evoxac®
- ☐ Anectine®
- ☐ Salagen®
- ☐ Isopto®
- ☐ Nicotine

Acetylcholine Receptor Antagonists Antimuscarinic Agents

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

Acetylcholine Receptor Antagonists Ganglionic Blockers

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

Acetylcholine Receptor Antagonists Neuromuscular Blockers

- ☐ Atracurium
- ☐ Cisatracurium
- ☐ Doxacurium
- ☐ Metocurine
- ☐ Mivacurium
- ☐ Pancuronium
- ☐ Rocuronium
- ☐ Anectine®
- ☐ Tubocurarine
- ☐ Vecuronium
- ☐ Hemicholinium

Acetylcholinesterase Reactivators

- ☐ Protopam®

Cholinesterase Inhibitors (reversible)

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

Cholinesterase Inhibitors (irreversible)

- ☐ Echothiophate
- ☐ Flexyx®
- ☐ Organophosphate insecticides
- ☐ Organophosphate-containing nerve agents

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