JOHNSON HEALTH & WELLNESS CENTER

Dr. Karl R.O.S. Johnson, DC, DNMSc, BCIM

Author of: *"Reclaim Your Life: Your Guide To Revealing Your Body's Life Changing Secrets For Renewed Health" available on Amazon at* ***http://amzn.to/TmPgZW***. Dr. Johnson is also the author of the eBooks:*"The Ultimate Strategy for Ending Your Thyroid Symptoms so YOU Can Increase the Zest in Your Life", "The Ultimate Strategy for Ending Your Vertigo, Dizziness AND Brain Fog", "The Ultimate Strategy for Ending Your Fibromyalgia and Chronic Pain",* and *"The Ultimate Strategy for Ending Migraines AND Other Debilitating Headaches".*

www.JohnsonHealthandWellness.com - www.DrKarlJohnson.com - www.ReadReclaimYourLife.com

ADD/ADHD/ASPERGER'S/PDD-NOS ADULT CLIENT APPLICATION

Welcome to Johnson Health & Wellness Center!

We specialize in helping clients achieve their highest level of health through our natural health care support programs.

This application is extensive because we are committed to being thorough with your care. The questions we ask provide important information that will help us determine whether or not we can help you. You deserve the best, so please give us yours when you answer these questions.

Please remember to sign the last page indicating you have thoroughly completed this application and **return this application and any lab and diagnostic test results you've had (in the last 6-12 months) at least two business days prior** to your scheduled appointment. This must be accomplished before your consultation. Please feel free to call us if you need assistance.

Thank you, we look forward to serving you.

If you require more space for any of these answers, please note with " → " and use the back side of this form or attach additional information. Please complete this application in pen or electronic format.

Today's Date: _____

Name: Mr./Mrs./Ms. _____ Sex: ❒M ❒F

Address _____ Apt #_____

City _____ State _____ Zip _____

Age: _____ Date of Birth _____/_____/_____ Best place to reach you: ❒Home ❒Work ❒Cell

Home Phone ( ) _____ Work ( ) _____ Cell ( ) _____

If necessary, may we leave a message for you at any of the above numbers? ❒Yes ❒No

Marital Status: ❒Single ❒Married ❒Divorced ❒Widowed ❒I have a significant other/Partner

Name (First/Last) of Spouse / Partner / Significant Other: _____

Email: _____ (**Additional appointment information may need to be emailed**.)

Employer: _____ Occupation (Before retirement): _____

Duration of Employment: _____ Duties: _____

* I (signature) _____ consent to allow Dr. Johnson to speak with me and perform an examination (if necessary) in order to determine if I am a good candidate for care at Johnson Health & Wellness Center and also to determine if he is willing to accept my case.

❒If this consult/examination is for a minor over whom I have legal guardianship, I give my permission (signature): _____.

Who referred you to our office? / How did you find out about our services? _____

What is your **main concern / symptom (a.k.a., chief complaint)** prompting your request for a consultation with the doctor? _____

How long have you had this problem? _____ Did your symptoms begin suddenly? ❒Yes ❒No

Considering the amount of discomfort, you've had THIS week, how long has your problem been this severe? _____

Is this problem related to an auto **accident / work injury?** ❒Yes ❒No If so, when & describe: _____

_____

Have you had an **auto accident / or work injury** in the last 7 years? ❒Yes ❒No. Do you have any accident claims currently open for any reason? ❒Yes ❒No : Describe: _____

_____

If you can, describe any **activity change, event, or accident** that occurred around the time of the onset of your symptoms which may have contributed to your symptoms? (Include any significant emotionally stressful situations)

_____

_____

_____

Have you had MRI's / CT scans taken? ❒Yes ❒No

Of **what part(s)** of your body? _____

Where (what facility took them) & **When** _____

MRI & Report brought to our office ❒Yes ❒No (Please bring these to our office or we can help you request them.)

Previous Spine X-rays taken **within last year** ❒Laying down ❒Standing ❒Seated ❒Neck ❒Low Back ❒Other: _____ ❒Where were they taken?_____

Women Only: Is there a possibility that you may be pregnant? ❒Yes ❒No

PLEASE LIST AND PRIORITIZE YOUR CURRENT AREAS OF MAIN COMPLAINT:
(#1 is your chief complaint, #2 is of secondary importance, etc.)

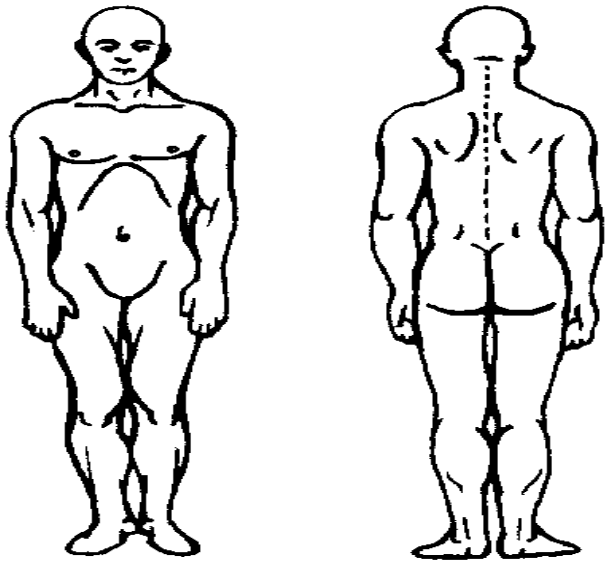
1) _____ 2) _____ 3) _____ 4) _____

What % of the day does **your chief complaint (#1)** bother you?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

Dull	= D
Aching	= A
Stiffness	= S
Burning	= B
Tingling	= T
Numbness	= N
Sharp	= ^^^^^
Shooting	= →
Weakness	= W
Other_____	= ***



Please check the appropriate number(s) for the intensity of your pain when aggravated and the letter(s) for the frequency of the pain.

O = Occasional (0-25% of the time)	**F = Frequent** (51-75%)
I = Intermittent (26-50%)	**C = Constant** (76-100%)

Area of pain/issue			**Normal**	**Minimal**	**Slight**			**Moderate**			**Severe**			**Frequency**			
														25%	50%	75%	100%
Neck				1	2	3	4	5	6	7	8	9	10	O	I	F	C
Middle Back				1	2	3	4	5	6	7	8	9	10	O	I	F	C
Lower Back				1	2	3	4	5	6	7	8	9	10	O	I	F	C
Hands	L	R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Feet	L	R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Shoulders	L	R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Arms	L	R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Hips	L	R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Legs	L	R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Knees	L	R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Headaches				1	2	3	4	5	6	7	8	9	10	O	I	F	C
Dizziness/Vertigo																	
Other:																	

Regarding your chief complaint (#1 issue):

On a Scale of 0-10 (0 = no discomfort 10 = unbearable) please rate the following:

The HIGHEST your pain/discomfort gets WITHOUT medication _____ WITH Medication _____

The LOWEST your pain/discomfort gets WITHOUT medication _____ WITH Medication _____

Questions regarding your Chief Complaint (#1):

When is it worse? ❒ in the morning ❒ as the day progresses ❒ in the evening

❒ when I sleep ❒ at work ❒ no specific time

❒ Other: _____

❒ I have an increase & decrease in pain/discomfort/sensation with no apparent trigger.

Details: _____

Does anything relieve your pain/problem? _____

What activities/movements are guaranteed to make it worse? _____

What positions are difficult? ❒ Sitting ❒ Standing ❒ Walking ❒ Bending ❒ Lying Down

❒ Other _____

If you have **Low Back Pain**: Which direction hurts more when bending? ❒ Backwards ❒ Forwards ❒ Both

STRUCTURAL CONDITIONS

Please **list and date all** memorable previous accidents and falls, even if unrelated to complaints: _____

_____

_____

Have you been diagnosed with herniated / bulging disc(s)/or another spine condition? ❒ Yes ❒ No

Who diagnosed you and when? _____

The diagnosis was made by ❒ MRI ❒ CT Scan ❒ X-ray ❒ Other: _____

Have you been advised to have **surgery** or **injections** for the above condition? ❒ Yes ❒ No

Details about recommendations: _____

_____

How interested are you in following the above recommendations for surgery / injections / etc.:_____

Spine & Hip Surgeries:

Specific Area	Date	**Type** (please be specific)	**Results** (to another region)
		❒ Fusion → ❒ metal ❒ no metal ❒ Laminectomy ❒ Discectomy ❒ _____	❒ Improved ❒ No Change ❒ Worse
		❒ Fusion → ❒ metal ❒ no metal ❒ Laminectomy ❒ Discectomy ❒ _____	❒ Improved ❒ No Change ❒ Worse
		❒ Fusion → ❒ metal ❒ no metal ❒ Laminectomy ❒ Discectomy ❒ _____	❒ Improved ❒ No Change ❒ Worse

Additional Surgeries:

(anything which may have included internal scar tissue, e.g., hysterectomy, gallbladder removal, thyroid, shoulder surgery, etc.)

Area	Date	**What was done** (please be specific)	**Results** (to another region)
			❒ Improved ❒ No Change ❒ Worse
			❒ Improved ❒ No Change ❒ Worse
			❒ Improved ❒ No Change ❒ Worse

History of Cancer: ❒Yes ❒No

Location of Origin	Status	Spread (to another region)	Additional Remarks
	❒Active ❒Remission ❒Monitored	❒No ❒Yes to:	
	❒Active ❒Remission ❒Monitored	❒No ❒Yes to:	

Please check any of the following as applicable to you

❒Difficulty starting/stopping/ controlling/ urine flow
❒Bowel Movement Difficulty
❒Numbness around the seated area / anus
❒Diagnosed with Abdominal Aortic Aneurysm
❒Spinal Disc Space Infections
❒Osteoporosis ❒ Fractures due to osteoporosis
❒Recent Compression Fracture? Where?
❒Diagnosis of Spinal Stenosis
❒Chronic use of steroids or narcotics
❒Coughing __/ Sneezing __/ Laughing increases back __/ leg pain __(check applicable)

PAST TREATMENT HISTORY

What kinds of treatments have you received for your chief complaint?
❒Surgeries (Listed previously) ❒Medications (list later in application)

Epidural: How Many _____ When _____
Physical Therapy: How Long _____ When _____

❒Chiropractic Care: _____

If so, please briefly explain your likes and dislikes: _____

_____

Other: _____ When _____
_____ When _____

Did any of these treatments work? If so, which one(s)? For how long? _____
_____

Other than routine checkups, for what conditions have you sought medical attention and from what specialist and when? How did you respond? _____
_____
_____

Have you received other diagnostic tests? ❒Yes ❒No Type and results: _____
_____
_____

Have you received any Blood Analysis/Blood testing within the past 18 months? ❒Yes ❒No

~ PLEASE BRING A COPY OF YOUR RESULTS TO YOUR CONSULTATION ~

Do you blame anyone or hold anyone partially responsible for your current condition or for making your condition worse? (Be very specific) _____
_____

CONTINUED NARRATIVE OF CHIEF COMPLAINT

Please provide a detailed description of events in chronological order (please include dates) immediately preceding the development of your condition and through today. If this complaint is due to a recent auto or work accident with an open claim, please also include a description of the accident details. Additionally, you may use this space to provide additional information you feel will help us assess your case.

Continue on next page if additional room is needed

(Additional Info ❒ Attached ❒ On Back)

HEALTH HISTORY

Do you currently have or have you previously had any of the following symptoms or conditions**: (Use back if needed**)

Past	Present	Current Treatment	Past	Present	Current Treatment
❒	❒	Mid back Pain / Stiffness	❒	❒	Chest Pain or Pressure
❒	❒	Pins & Needle Sensation anywhere?	❒	❒	Shortness of Breath
❒	❒	Cold hands __ / Feet __ (check)	❒	❒	High Blood Pressure
❒	❒	Anxiety	❒	❒	Digestive Difficulties
❒	❒	Depression	❒	❒	Heartburn
❒	❒	Mood Swings	❒	❒	Ulcers
❒	❒	Sleeping Problems	❒	❒	Constipation
❒	❒	Fatigue	❒	❒	Urinary Problems
❒	❒	Dizziness – Describe:	❒	❒	Allergies
❒	❒	Loss of Balance	❒	❒	Menstrual Pain
❒	❒	Fainting	❒	❒	Menstrual Irregularity
❒	❒	Increased sensitivity to light	❒	❒	Hot flashes
❒	❒	Ringing/ Buzzing in Ears	❒	❒	Fever
❒	❒	Loss of memory	❒	❒	(other)
❒	❒	Loss of smell	❒	❒	
❒	❒	Loss of taste	❒	❒	

Additional Details: _____

_____

Medications Currently Taking **(If not easily listed, please provide a list.)**

Name	Dosage	For What Condition

HEALTH & LIFESTYLE

Check box if you: ❒Drink coffee/another source of caffeine _____? Amount & Frequency: _____
❒Drink diet soda? Amount & Frequency: _____ ❒Do you **smoke**? Amount & Frequency: _____
❒Consume alcohol? Amount & Frequency: _____ ❒Use recreational drugs? Type & How often: _____
❒Exercise? ❒Yes ❒No How often? _____ X per week/month.
What activities? _____

❒Take any supplements (i.e. vitamins, minerals, herbs)? What type? **(If not easily listed, please provide a list.)**

_____

Do you have to **sleep** in a particular position to be comfortable? _____

When you wake, are you ❒ refreshed ❒ in more pain then when you went to bed. Describe:

_____

_____

Mattress/Bed comfort → ❒ poor ❒ fair ❒ excellent Age of mattress:_____

Pillow comfort → ❒ poor ❒ fair ❒ excellent Age of pillow: _____

Please write down ***in detail*** everything you eat and drink for 3 consecutive days. **We want this to be your 'normal' diet!**

Day 1 (Include approximate **times**)	**Day 2**	**Day 3**
Breakfast:		
Snacks		
Lunch		
Mid-Day		
Dinner		
Other		

Have you had recent changes to your diet or eating habits? ❒ Yes ❒ No Describe:_____

_____

Do you suspect you have any food allergy or intolerance? ❒ Yes ❒ No Describe: _____

_____

What tests have you received to determine food sensitivities? _____

FAMILY HISTORY

Has anyone **in your family** had the following?

❒ Any **immune disease** such as Arthritis, Rheumatoid Arthritis, Juvenile RA, Lupus, Diabetes I or II, Hashimoto's or other Thyroid condition, Psoriasis or other? Who and What? (List even if unsure if it is an immune system disorder). _____

_____

_____

❒ Gastrointestinal condition or food intolerance (allergies to wheat, dairy, soy, egg, etc.)?

_____

_____

List any additional significant health history issues in your family:

_____

_____

LIFE IMPACT ASSESSMENT

As you answer the following questions, please do not minimize any impact on your life no matter how small it appears. We consider any loss of ability or function which affects your daily life as significant. **Please check as many that apply; add additional comments in the margin or on the back as needed.**

How have others been affected by your health condition? ❒No one is affected ❒Haven't noticed any problem
❒They tell me to do something ❒People avoid me ❒Other: _____

What are you afraid this might be (or is beginning) to affect (or will affect) in any way?
❒Energy ❒Your mood / attitude ❒Stress ❒Job ❒Kids ❒Future ability ❒Marriage
❒Any relationships (frequency visiting, quality, etc.) ❒Self-esteem ❒Sleep ❒Time
❒Finances ❒Freedom ❒Other: _____

Are there health conditions you are afraid this might turn into? ❒Family health problems
❒Heart disease ❒Diabetes ❒Arthritis ❒Fibromyalgia ❒Depression
❒Chronic Fatigue ❒Need surgery ❒Other: _____

How has your health condition affected your job, relationships, finances, family, or other activities?
Please give examples: _____
_____
_____
_____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) **Try to give 3 examples**:
_____
_____
_____

What are you most concerned with regarding your problem? _____
_____
_____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of?
_____

What would be different/better without this problem? Please be specific _____
_____
_____

What do you desire most to get from working with us? _____
_____
_____
_____

If you could achieve your desire, what is that worth to you? _____
_____
_____

SELF ASSESSMENT & TREATMENT GOALS

In spite of the fact that you are not a specialist, what, in your opinion, do you think the real problem is?

_____

_____

Would you consider this problem **(check one)**?

❒ MINIMAL (Annoying but causing NO limitations)
❒ SLIGHT (Tolerable but causing a little limitation)
❒ MODERATE (Sometimes tolerable but causing limitations)
❒ SEVERE (Causing significant limitations and/or concern)
❒ EXTREME (Causing near constant (Limits you > 80% of the time)

Which best describes your health goals:

❑ Pain Relief Only (not interested in correction of the problem).

❑ Would like to find the cause of this problem and have it improved or corrected.

How strong is your desire to correct this problem ❒ Mild ❒ Moderate ❒ High ❒ Extremely High

❑ Wellness / Preventative care – I just want to stay well and be at optimal health

How supportive is your Spouse/Family/Significant Other to you seeking care? (Be very specific)

_____

_____

Are you able to handle a complete investigation and management of your case? _____

_____

What is YOUR idea of an ideal doctor? _____

_____

There may be services that your insurance company does not cover. If this is the case, we have many reasonable and affordable payment options. If you have a problem that we can help, would you be willing to pay out of pocket to get better? ❒ Yes ❒ No

Based on your consultation, history and exam findings, you may require additional tests that require payment at time of service. If this is required, you will be informed in advance.

Method of payment for any additional uncovered services today: ❒ Cash ❒ Check ❒ Credit Card

I, _____ (**Please Print Full Name**), have thoroughly completed this application and all supportive documents, answering every question to the best of my ability. Additionally, I have read and reviewed all supportive information that has been included with my application – this may include written or recorded material. If I do not have the means to review the material, I have contacted Johnson Chiropractic Neurology & Nutrition to arrange for additional support. I understand that failure to complete this application fully and review the enclosed material may mean the doctor will not be able to conduct the consultation and evaluation. I will also bring any labs, images or reports which have been requested in this application. I give this office permission to communicate with me via mail, telephone and email.

Signature: _____ Date: _____

Please Note:

In the following paperwork you may notice there are repeat questions.

Please answer all of the questions as there are different forms and paperwork that will be assessed differently.

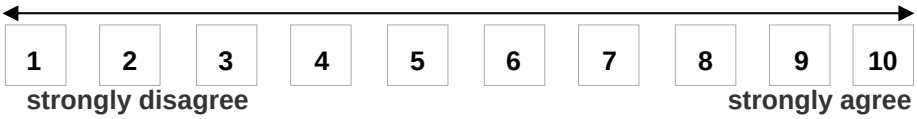
Thank you!

Pre IM Survey

Please complete the following survey, which will help identify and quantify areas of your daily performance, which **may be improved by IM**. Answers will be kept confidential.

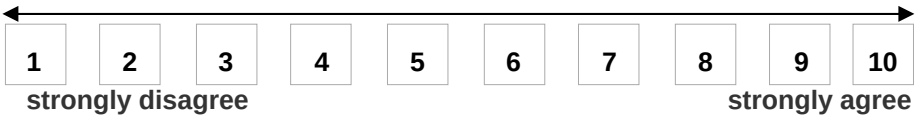
A. Memory recall

I have a good memory. (e.g. I remember lists of items to buy and information I hear.)



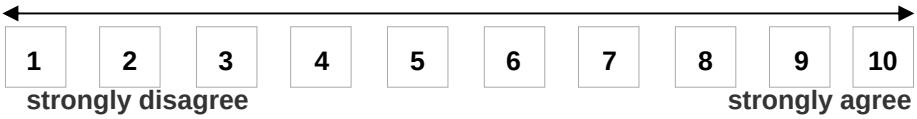
B. Organizational skills

I am generally well organized. (e.g. I keep items in order and consistently in their place.)



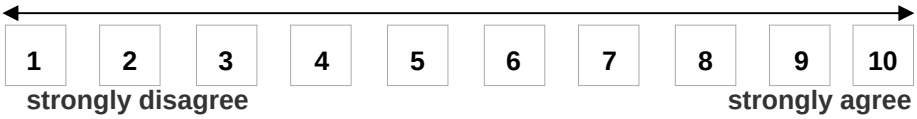
C. Concentration/Focus

I have good concentration skills. (e.g. I can read or work without being easily distracted.)



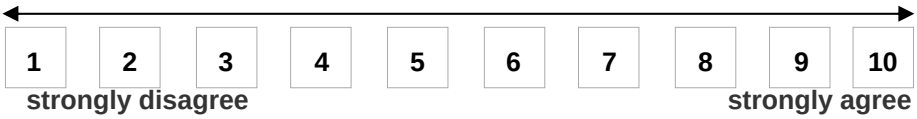
D. Multi-tasking

I can manage multiple tasks at one time. (e.g. I can converse while also writing.)



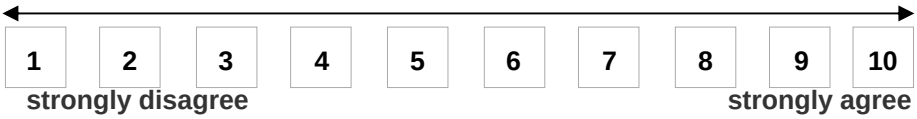
E. Coping skills

I have good coping skills. (e.g. I do not become frustrated easily or overreact to issues.)



F. Rhythm/Timing

I have good rhythm. (e.g. I can “keep the beat” to music.)



Hemispheric Imbalance Questionnaire – *Please check all that apply. You will total at the end.*

A

___Clumsiness and an odd posture

___Poor coordination

___Not athletically inclined and has no interest in popular childhood participation sports

___Low muscle tone – muscles seem kind of floppy

___Poor gross motor skills, such as difficulty learning to ride a bike and/or runs and/or walks oddly

___Repetitive/stereotyped motor mannerisms (spins in circles, flaps arms)

___Fidgets excessively

___Poor eye contact

___Walks or walked on toes when younger

___Poor spatial orientation – bumps into things often

___Sensitivity to sound

___Confusion when asked to point to different body parts

___Poor sense of balance

___High threshold for pain – doesn't cry when gets a cut

___Likes to spin, go on rides, swing, etc. – anything with motion

___Touches things compulsively

___A girl uninterested in makeup or jewelry

___Does not like the feel of clothing on arms or legs; pulls off clothes

B

___Fine motor problems (poor or slow handwriting)

___Difficulty with fine motor skills, such as buttoning a shirt

___Tends to write very large for age or grade level

___Stumbles over words when fatigued

___Exhibited delay in crawling, standing, and/or walking

___Loves sports and is good at them

___Good muscle tone

___Poor drawing skills

___Difficulty learning to play music

___Likes to fix things with the hands and is interested in anything mechanical

___Difficulty planning and coordinating body movements

___Doesn't seem to have many sensory issues or problems, such as a sensitivity to sound

___Has good spatial awareness

___Has good sense of balance

___Eats just about anything

___Has a normal to above-average sense of taste and smell

___Likes to be hugged and held

___Does not have any oddities concerning clothing

___Has auditory processing problems

Hemispheric Imbalance Questionnaire – *Please check all that apply. You will total at the end.*

A

___Doesn't like being touched and doesn't like to touch things

___Incessantly smells everything

___Prefers bland foods

___Does not notice strong smells, such as burning wood, popcorn, or cookies baking in the oven

___Avoids food because of the way it looks

___Hates having to eat and is not even interested in sweets

___Extremely picky eater

___Spontaneously cries and/or laughs and has sudden outbursts of anger or fear

___Worries a lot and has several phobias

___Holds on to past "hurts"

___Has sudden emotional outbursts that appear over-reactive and inappropriate to the situation

___Experiences panic and/or anxiety attacks

___Sometimes displays dark or violent thoughts

___Face lacks expression; doesn't exhibit much body language

___Too uptight; cannot seem to loosen up

___Lacks empathy and feelings for others

___Lacks emotional reciprocity

___Often seems fearless and is a risk taker

___Logical thinker

___Often misses the gist of a story

___Didn't look at self in mirror as a toddler

B

___Seems not to hear well, although hearing tests normal

___Delay in speaking was attributed to ear infections

___Gets motions sickness and has other motion sickness issues

___Is not undersensitive or over sensitive to pain

___Overly happy and affectionate; loves to hug and kiss

___Frequently moody and irritable

___Loves doing new or different things but gets bored easily

___Lacks motivation

___Withdrawn and shy

___Excessively cautious, pessimistic, or negative

___Doesn't seem to get any pleasure out of life

___Socially withdrawn

___Cries easily; feelings get hurt easily

___Seems to be in touch with own feelings

___Empathetic to other people's feelings; reads people's emotions well

___Gets embarrassed easily

___Very sensitive to what others think about him or her

___Procrastinates

___Is extremely shy, especially around strangers

Hemispheric Imbalance Questionnaire – *Please check all that apply. You will total at the end.*

A

___Gets stuck in set behavior; can't let it go

___Lacks social tact and/or is antisocial and/or socially isolated

___Poor time management; is always late

___Disorganized

___Has a problem paying attention

___Is hyperactive and/or impulsive

___Has obsessive thoughts or behaviors

___Argues all the time and is generally uncooperative

___Exhibits signs of an eating disorder

___Failed to thrive as an infant

___Mimics sounds or words repeatedly without really understanding the meaning

___Appears bored, aloof, and abrupt

___Considered strange by other children

___Inability to form friendships

___Has difficulty sharing enjoyment, interests, or achievements with other people

___Inappropriately giddy or silly

___Acts inappropriately in social situations

___Talks incessantly and asks the same question repetitively

___Has no or little joint attention, such as the need to point to an object to get your attention

___Poor math reasoning (word problems, geometry, algebra)

B

___Is very good at nonverbal communication

___Is well liked by other children and teachers

___Does not have any behavioral problems in school

___Understands social rules

___Has poor self esteem

___Hates doing homework

___Is very good at social interaction

___Makes good eye contact

___Likes to be around people and enjoys social activities, such as going to parties

___Doesn't like to go to sleepovers

___Is not good at following routines

___Can't follow multiple-step directions

___Is in touch with own feelings

___Jumps to conclusions

___Very good at big picture skills

___Is an intuitive thinker and is led by feelings

___Good at abstract "free" association

___Has a bedwetting problem

___Has or had an irregular heartbeat, such as an arrhythmia or a heart murmur

___Poor analytical skills

___Very visual; loves images and patterns

Hemispheric Imbalance Questionnaire – *Please check all that apply. You will total at the end.*

A

___Poor reading comprehension and pragmatic skills

___Misses the big picture

___Very analytical

___Likes "slapstick" or obvious physical humor

___Is very good at finding mistakes (spelling)

___Takes everything literally

___Doesn't always reach a conclusion when speaking

___Started speaking early

___Has tested for a high IQ, but scores run the whole spectrum; or IQ is above normal in verbal ability and below average in performance abilities

___Was an early word reader

___Is interested in unusual topics

___Learns in a rote (memorizing) manner

___Learns extraordinary amounts of specific facts about a subject

___Is impatient

___Speaks in a monotone; has little inflection

___Is a poor nonverbal communicator

___Doesn't like loud noises (like fireworks)

___Speaks out loud regarding what he or she is thinking

___Talks "in your face" – is a space invader

B

___Constantly questions why you're doing something or why rules exist

___Has poor sense of time

___Enjoys touching and feeling actual objects

___Has trouble prioritizing

___Is unlikely to read instructions before trying something new

___Is naturally creative, but needs to work hard to develop full potential

___Would rather do things instead of observe

___Uses good voice inflection when speaking

___Misreads or omits common small words

___Has difficulty saying long words

___Reads very slowly and laboriously

___Had difficulty naming colors, objects, and letters as a toddler

___Needs to hear or see concepts many times to learn them

___Has shown a downward trend in achievement test scores or school performance

___Schoolwork is inconsistent

___Was a late talker

___No allergies

___Has difficulty pronouncing words (poor with phonics)

___Had difficulty learning the alphabet, nursery rhymes, or songs when young

Hemispheric Imbalance Questionnaire – *Please check all that apply. You will total at the end.*

A

___Good reader but does not enjoy reading

___Analytical; led by logic

___Follows rules without questioning them

___Good at keeping track of time

___Easily memorizes spelling and mathematical formulas

___Enjoys observing rather than participating

___Would rather read an instructions manual before trying something new

___Math was often the first academic subject that became a problem

___Has lots of allergies

___Rarely gets colds and infections Has had or has eczema or asthma

___Skin has little white bumps, especially on the backs of the arms

___Displays erratic behavior – good one day, bad the next

___Craves certain foods, especially dairy and wheat products

___Problems with bowels, such as constipation and diarrhea

___Has a rapid heart rate and/or high blood pressure for age

___Appears bloated, especially after meals, and often complains of stomach pains

___Has body odor /Sweats a lot

___Hands are always moist and clammy

___Always the last to get a joke

B

___Acts before thinking and makes careless mistakes

___Daydreams a lot

___Has difficulty sequencing events in the proper order

___Often writes letters backward

___Is poor at basic math skills

___Has poor memorization skills

___Has poor academic ability

___Has an IQ lower than expected and verbal scores are lower than nonverbal scores

___Performs poorly on verbal tests

___Needs to be told to do something several times before acting on it

___Stutters or stuttered when younger

___Is a poor speller

___Doesn't read directions well

___Gets chronic ear infections

___Prone to benign tumors or cysts

___Has taken antibiotics more than 10 to 15 times before the age of ten

___Has had tubes put in the ears

___Catches colds frequently

___Has difficulty finishing homework or finishing a conversation

The highest number of check marks show which side of the brain is weaker.

Total Number (A) ___1___ Right side

Total Number (B) ___0___ Left side

Metabolic Assessment Form

PART I **Please list your 5 major health concerns in order of importance: Please check on the scale of 1-10, how committed are you to correcting each concern with "10" being the most committed.**

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

PART II **Please check the appropriate number 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 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

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

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 movement	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3

Category V

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 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 VI

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

Category VI (continued)

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 VII

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 VIII

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category IX

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 X

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

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

Category XI

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

Category XII

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 XIII

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

Category XIV

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

Category XV

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 XVI

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 XVII

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

Category XVIII *(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 emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XIX *(Males Only)*

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

Category XX *(Menstruating Females Only)*

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

Category XXI *(Menopausal Females Only)*

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? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

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

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

How many times do you eat fish per week? _____

How many times do you work out per week? _____

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

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

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®
- ☐ Prothiaden®
- ☐ Adapin®
- ☐ Sinequan®
- ☐ Tofranil®
- ☐ Janamine®
- ☐ Gamanil®
- ☐ Aventyl®
- ☐ Pamelor®
- ☐ Opipramol®
- ☐ Vivactil®
- ☐ Rhotrimine®
- ☐ Surmontil®

Selective Serotonin Reuptake Inhibitors (SSRIs)

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

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

- ☐ Effexor®
- ☐ Pristiq®
- ☐ Meridia®
- ☐ Serzone®
- ☐ Dalcipran®
- ☐ Desipramine
- ☐ Duloxetine

Selective Serotonin Reuptake Enhancers (SSREs)

- ☐ Stablon®
- ☐ Coaxil®
- ☐ Tatinol®

Monoamine Oxidase Inhibitors (MAOIs)

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

- ☐ Flumazenil

Agonist Modulators of GABA Receptors (benzodiazepines)

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

Agonist Modulators of GABA Receptors (nonbenzodiazepines)

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

Acetylcholine Receptor Antagonists Antimuscarinic Agents

- ☐ Atropine
- ☐ Ipratropium
- ☐ Scopolamine
- ☐ Tiotropium

Acetylcholine Receptor Antagonists Ganglionic Blockers

- ☐ Mecamylamine
- ☐ Hexamethonium
- ☐ Nicotine (high doses)
- ☐ Trimethaphan

Acetylcholine Receptor Antagonists Neuromuscular Blockers

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

Acetylcholinesterase Reactivators

- ☐ Pralidoxime

Cholinesterase Inhibitors (reversible)

- ☐ Donepezil
- ☐ Galantamine
- ☐ Rivastigmine
- ☐ Tacrine
- ☐ THC
- ☐ Carbamate Insecticides
- ☐ Edrophonium
- ☐ Neostigmine
- ☐ Physostigmine
- ☐ Pyridostigmine

Cholinesterase Inhibitors (irreversible)

- ☐ Echothiophate
- ☐ Isoflurophate
- ☐ Organophosphate Insecticides
- ☐ Organophosphate-containing nerve agents

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

Brain Region Localization Form

INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please answer every question, do not skip any questions. Follow the 0 to 4 key, and select which best fits for all of your answers.

KEY:

0 = I never have symptoms (0% of the time)
1 = I rarely have symptoms (Less than 25% of the time)
2 = I often have symptoms (Half of the time)
3 = I frequently have symptoms (75% of the time)
4 = I always have symptoms (100% of the time)

Frontal lobe Prefrontal, Dorsolateral and Orbitofrontal (Areas 9, 10, 11, and 12)		Level
1.	Difficulty with restraint and controlling impulses or desires	0 1 2 3 4
2.	Emotional instability (lability)	0 1 2 3 4
3.	Difficulty planning and organizing	0 1 2 3 4
4.	Difficulty making decisions	0 1 2 3 4
5.	Lack of motivation, enthusiasm, interest and drive (apathetic)	0 1 2 3 4
6.	Difficulty getting a sound or melody out of your thoughts (Perseveration)	0 1 2 3 4
7.	Constantly repeat events or thoughts with difficulty letting go	0 1 2 3 4
8.	Difficulty initiating and finishing tasks	0 1 2 3 4
9.	Episodes of depression	0 1 2 3 4
10.	Mental fatigue	0 1 2 3 4
11.	Decrease in attention span	0 1 2 3 4
12.	Difficulty staying focused and concentrating for extended periods of time	0 1 2 3 4
13.	Difficulty with creativity, imagination, and intuition R	0 1 2 3 4
14.	Difficulty in appreciating art and music R	0 1 2 3 4
15.	Difficulty with analytical thought L	0 1 2 3 4
16.	Difficulty with math, number skills and time consciousness L	0 1 2 3 4
17.	Difficulty taking ideas, actions, and words and putting them in a linear sequence L	0 1 2 3 4

Frontal Lobe Precentral and Supplementary Motor Areas (Area 4 and 6)		Level
18.	Initiating movements with your arm or leg has become more difficult	0 1 2 3 4
19.	Feeling of arm or leg heaviness, especially when tired	0 1 2 3 4
20.	Increased muscle tightness in your arm or leg	0 1 2 3 4
21.	Reduced muscle endurance in your arm or leg	0 1 2 3 4
22.	Noticeable difference in your muscle function or strength from one side to the other	0 1 2 3 4
23.	Noticeable difference in your muscle tightness from one side to the other	0 1 2 3 4
Frontal Lobe Broca's Motor Speech Area (Area 44 and 45)		**Level**
24.	Difficulty producing words verbally, especially when fatigued	0 1 2 3 4
25.	Find the actual act of speaking difficult at times	0 1 2 3 4
26.	Notice word pronunciation and speaking fluency change at times	0 1 2 3 4
Parietal Somatosensory Area and Parietal Superior Lobule (Areas 3,1,2 and 7)		**Level**
27.	Difficulty in perception of position of limbs	0 1 2 3 4
28.	Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall	0 1 2 3 4
29.	Frequently bumping body or limbs into the wall or objects accidently	0 1 2 3 4
30.	Reoccurring injury in the same body part or side of the body	0 1 2 3 4
31.	Hypersensitivities to touch or pain perception	0 1 2 3 4

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Parietal Inferior Lobule (Area 39 and 40)		Level
32.	Right/left confusion [L]	0 1 2 3 4
33.	Difficulty with math calculations [L]	0 1 2 3 4
34.	Difficulty finding words [L]	0 1 2 3 4
35.	Difficulty with writing [L]	0 1 2 3 4
36.	Difficulty recognizing symbols or shapes [R]	0 1 2 3 4
37.	Difficulty with simple drawings [R]	0 1 2 3 4
38.	Difficulty interpreting maps [R]	0 1 2 3 4
Temporal Lobe Auditory Cortex (Areas 41, 42)		**Level**
39.	Reduced function in overall hearing	0 1 2 3 4
40.	Difficulty interpreting speech with background or scatter noise	0 1 2 3 4
41.	Difficulty comprehending language without perfect pronunciation	0 1 2 3 4
42.	Need to look at someone's mouth when they are speaking to understand what they are saying	0 1 2 3 4
43.	Difficulty in localizing sound	0 1 2 3 4
44.	Dislike of predictable rhythmic, repeated tempo and beat music [L]	0 1 2 3 4
45.	Dislike of non-predictable rhythmic with multiple instruments [R]	0 1 2 3 4
46.	Noticeable ear preference when using your phone	__right, __left, __no preference
Temporal Lobe Auditory Association Cortex (Area 22)		**Level**
47.	Difficulty comprehending meaning of spoken words [L]	0 1 2 3 4
48.	Tend toward monotone speech without fluctuations or emotions [R]	0 1 2 3 4

Medial Temporal lobe and Hippocampus		Level
49.	Memory less efficient	0 1 2 3 4
50.	Memory loss that impacts daily activities	0 1 2 3 4
51.	Confusion about dates, the passage of time, or place	0 1 2 3 4
52.	Difficulty remembering events	0 1 2 3 4
53.	Misplacement of things and difficulty retracing steps	0 1 2 3 4
54.	Difficulty with memory of locations (addresses) [R]	0 1 2 3 4
55.	Difficulty with visual memory [R]	0 1 2 3 4
56.	Always forgetting where you put items such as keys, wallet, phone, etc. [R]	0 1 2 3 4
57.	Difficulty remembering faces [R]	0 1 2 3 4
58.	Difficulty remembering names with faces [L]	0 1 2 3 4
59.	Difficulty with remembering words [L]	0 1 2 3 4
60.	Difficulty remembering numbers [L]	0 1 2 3 4
61.	Difficulty remembering to stay or be on time (reduced left) [L]	0 1 2 3 4
Occipital Lobe (Area, 17, 18, and 19)		**Level**
62.	Difficulty in discriminating similar shades of color	0 1 2 3 4
63.	Dullness of colors in visual field	0 1 2 3 4
64.	Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach out for objects	0 1 2 3 4
66.	Floater or halos in visual field	0 1 2 3 4

Brain Region Localization Form

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2 = I often have symptoms (Half of the time)
3 = I frequently have symptoms (75% of the time)
4 = I always have symptoms (100% of the time)

Cerebellum - Spinocerebellum		Level
67.	Difficulty with balance, or balance that is worse on one side	0 1 2 3 4
68.	A need to hold the handrail or watch each step carefully when going down stairs	0 1 2 3 4
69.	Feeling unsteady and prone to falling in the dark	0 1 2 3 4
70.	Proness to sway to one side when walking or standing	0 1 2 3 4
Cerebellum - Cerebrocerebellum		**Level**
71.	Recent clumsiness in hands	0 1 2 3 4
72.	Recent clumsiness in feet or frequent tripping	0 1 2 3 4
73.	A slight hand shake when reaching for something at the end of movement	0 1 2 3 4
Cerebellum - Vestibulocerebellum		**Level**
74.	Episodes of dizziness or disorientation	0 1 2 3 4
75.	Back muscles that tire quickly when standing or walking	0 1 2 3 4
76.	Chronic neck or back muscle tightness	0 1 2 3 4
77.	Nausea, car sickness, or sea sickness	0 1 2 3 4
78.	Feeling of disorientation or shifting of the environment	0 1 2 3 4
79.	Crowded places cause anxiety	0 1 2 3 4
Basal Ganglia Direct Pathway		**Level**
80.	Slowness in movements	0 1 2 3 4
81.	Stiffness in your muscles (not joints) that goes away when you move	0 1 2 3 4
82.	Cramping of hands when writing	0 1 2 3 4
83.	A stooped posture when walking	0 1 2 3 4
84.	Voice has become softer	0 1 2 3 4
85.	Facial expression changed leading people to frequently ask if you are upset or angry	0 1 2 3 4
Basal Ganglia Indirect Pathway		**Level**
86.	Uncontrollable muscle movements	0 1 2 3 4
87.	Intense need to clear your throat regularly or contract a group of muscles	0 1 2 3 4
88.	Obsessive compulsive tendencies	0 1 2 3 4
89.	Constant nervousness and restless mind	0 1 2 3 4
Autonomic Reduced Parasympathetic Activity		**Level**
90.	Dry mouth or eyes	0 1 2 3 4
91.	Difficulty swallowing supplements or large bites of food	0 1 2 3 4
92.	Slow bowel movements and tendency for constipation	0 1 2 3 4
93.	Chronic digestive complaints	0 1 2 3 4
94.	Bowel or bladder incontinence resulting in staining your underwear	0 1 2 3 4
Autonomic Increased Sympathetic Activity		**Level**
95.	Tendency for anxiety	0 1 2 3 4
96.	Easily startled	0 1 2 3 4
97.	Difficulty relaxing	0 1 2 3 4
98.	Sensitive to bright or flashing lights	0 1 2 3 4
99.	Episodes of racing heart	0 1 2 3 4
100.	Difficulty sleeping	0 1 2 3 4

Brain Region Localization Form

INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please select yes or no.

Epileptiform Activity	Yes / No
Have you ever been diagnosed with a seizure disorder?	Yes / No
Have you ever been diagnosed with epilepsy?	Yes / No
Have you ever been told that you seemed frozen, absent, or tuned out at times without any recollection of the event?	Yes / No
Have you ever experienced sudden muscle stiffness and rigidity throughout your body?	Yes / No
Have you ever experienced sudden muscle jerks throughout your body?	Yes / No
Have you ever experienced a total loss of your muscle tone that lead to loss of control of your muscles or a fall?	Yes / No
Have you ever been told that you stare into space while you're lip smacking, chewing, or fidgeting that you are not aware of?	Yes / No
Do you ever experience sudden emotional responses such as anxiety, sadness, cry, or laugh for no real reason?	Yes / No
Do you ever experience sudden racing heart rate, sudden loss of bladder function, intestinal spasm, respiration, sweating, or any other sudden changes of function?	Yes / No
Do you ever experience sudden involuntary muscle contractures or jerks in any individual parts of your limbs or face?	Yes / No
Do you ever experience sudden involuntary head rotation and your eyes move forcefully to one side?	Yes / No
Do you ever experience sudden involuntary shift in your eyes to the side or upwards?	Yes / No
Do you ever experience sudden vocalization of random words or notice a sudden inability to speak?	Yes / No
Do you ever experience any spontaneous sensations of tingling, pins and needles" numbness, coldness, burning or other random sensations in any region of your body?	Yes / No
Do you ever experience a ringing sensation in your ears (tinnitus), sounds, or voices spontaneously?	Yes / No
Do you ever experience spontaneous perception of smells such as burning rubber, foul smells, or other odors without finding the source of the odor?	Yes / No
Do you ever experience flashing lights, stars, or jagged lines in your visual field?	Yes / No

Determine Your Stress Level

Check all events that apply to you, that have occurred over the past twelve months.

- ☐ ____ Death of a Spouse
- ☐ ____ Divorce
- ☐ ____ Marital Separation
- ☐ ____ Jail Term
- ☐ ____ Death of close family member
- ☐ ____ Personal Injury or illness
- ☐ ____ Marriage
- ☐ ____ Fired at work
- ☐ ____ Marital reconciliation
- ☐ ____ Retirement
- ☐ ____ Change in health of family member
- ☐ ____ Pregnancy
- ☐ ____ Sex difficulties
- ☐ ____ Gain of new family member
- ☐ ____ Business Readjustment
- ☐ ____ Change in financial state
- ☐ ____ Death of a close friend
- ☐ ____ Change to different kind of work
- ☐ ____ Change in number of arguments with spouse
- ☐ ____ Mortgage over $10,000
- ☐ ____ Foreclosure of mortgage or loan
- ☐ ____ Change in responsibilities at work
- ☐ ____ Son or daughter leaving home
- ☐ ____ Trouble with in-laws
- ☐ ____ Outstanding personal achievement
- ☐ ____ Spouse begins or stops work
- ☐ ____ Begin or end school
- ☐ ____ Change in living conditions
- ☐ ____ Revision of personal habits
- ☐ ____ Trouble with boss
- ☐ ____ Change in work hours or conditions
- ☐ ____ Change in residence
- ☐ ____ Change in schools
- ☐ ____ Change in recreation
- ☐ ____ Change in church activities
- ☐ ____ Change in social activities
- ☐ ____ Mortgage or loan less than $10,000
- ☐ ____ Change in sleeping habits
- ☐ ____ Change in number of family gatherings
- ☐ ____ Change in eating habits
- ☐ ____ Vacation
- ☐ ____ Christmas
- ☐ ____ Minor violations of law

Scoring Your Test

0 Your Total Score

If you are stressed out taking this test, add 10 points to your score.

Note: If there are events which took place in your life during the past year which are not listed, select a value from an event listed which approximates your experience closely.

Notice that 'positive' events (outstanding personal achievement, vacation, Christmas) can be as stressful as 'negative' ones.

Add up your Stress Scale points for the past twelve months. If it is above 250, you should be keenly alert for the early signs of OVERSTRESS. Even a level of 150 will OVERSTRESS ten percent of persons. For this reason, it is best to aim for a continuing stress load of below 150 on the Stress Scale. Adapted from the "Social Readjustment Rating Scale" by Thomas Holmes and Richard Rahe. This scale was first published in the "Journal of Psychosomatic Research", vol.II p. 214.

****IMPORTANT****

PLEASE READ THIS PAGE CAREFULLY

In order for you to get better as fast as possible, we need the help of ALL persons significantly involved in your support system. Spouses, friends, and family members all play a crucial role in your treatment and the results that you achieve. In short, it is extremely important that all of your support systems are "on the same page".

Therefore, we require that all persons directly involved with your support system watch the online condition specific video or the DVD sent to you and then sign this affidavit. This form must be returned with your Patient Application and Case Review forms before Dr. Karl R.O.S. Johnson can examine you.

AFFIDAVIT

I (each) the undersigned individual certifies that:

- I understand that Dr. Johnson's methods and treatment are unique.
- I understand that Dr. Johnson does not accept every person into his treatment program.

Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature
Print Name	Signature

Thank you for taking the time to make sure you get the best results possible in the fastest amount of time.

Please return this paper with your Patient Application forms.

RESET SAVE PRINT SEND