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

DIABETES
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.)

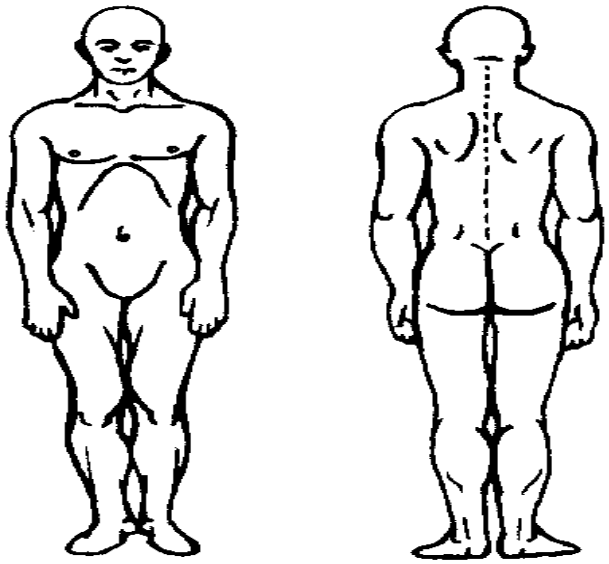
1) _____ 2) _____ 3) _____ 4) _____

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 Health & Wellness Center 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!

In the PAST WEEK, did you ever have any of the following symptoms…

1. Increased thirst?	❑ No	❑ Yes	❑ Don't know
2. Dry mouth?	❑ No	❑ Yes	❑ Don't know
3. Decreased appetite?	❑ No	❑ Yes	❑ Don't know
4. Nausea or vomiting?	❑ No	❑ Yes	❑ Don't know
5. Abdominal pain?	❑ No	❑ Yes	❑ Don't know
6. Frequent urination at night? Do you have to get up to urinate 3 or more times a night?	❑ No	❑ Yes	❑ Don't know
7. Severely high blood sugar (blood glucose readings of 300 mg or higher?)	❑ No	❑ Yes	❑ Don't know
8. Morning headaches?	❑ No	❑ Yes	❑ Don't know
9. Nightmares?	❑ No	❑ Yes	❑ Don't know
10. Night sweats?	❑ No	❑ Yes	❑ Don't know
11. Lightheadedness?	❑ No	❑ Yes	❑ Don't know
12. Shakiness or weakness?	❑ No	❑ Yes	❑ Don't know
13. Intense hunger?	❑ No	❑ Yes	❑ Don't know
14. Times when you passed out fainted or lost consciousness, even for a short time?	❑ No	❑ Yes	❑ Don't know

Daily Activities

During the **past 4 weeks**, how much... *(Circle **one**)*

	Not at all	**Slightly**	**Moderately**	**Quite a bit**	**Almost totally**
1. Has your health interfered with your normal social activities with family, friends, neighbors or groups?	0 ___	1___	2___	3___	4___
2. Has your health interfered with your hobbies or recreational activities?	0 ___	1___	2___	3___	4___
3. Has your health interfered with your household chores?	0 ___	1___	2___	3___	4___
4. Has your health interfered with your errands and shopping?	0 ___	1___	2___	3___	4___

Your Glucose Testing

1. Do you have a machine to measure your blood sugar (glucose) level? ❑ Yes ❑ No

2. On how many days in the **last week** did you test your blood sugar level? *(If you were sick in the last week, think of the most recent 7 days when you were NOT sick)* _____ days

3. On **days** that you test your blood sugar, how many **times** do you test on **average**? _____ times

Physical Activities

During the past week, even if it was not a typical week for you, how much **total** time *(for the **entire week**)* did you spend on each of the following? *(Please circle **one** number for each question.)*

	none	less than 30 min/wk	30-60 min/wk	1-3 hrs per week	more than 3 hrs/wk
1. Stretching or strengthening exercises (range of motion, using weights, etc.)	0 ___	1 ___	2 ___	3 ___	4 ___
2. Walk for exercise	0 ___	1 ___	2 ___	3 ___	4 ___
3. Swimming or aquatic exercise	0 ___	1 ___	2 ___	3 ___	4 ___
4. Bicycling (including stationary exercise bikes)	0 ___	1 ___	2 ___	3 ___	4 ___
5. Other aerobic exercise equipment (Stairmaster, rowing, skiing machine, etc.)	0 ___	1 ___	2 ___	3 ___	4
6. Other aerobic exercise *Specify*_____	0 ___	1 ___	2 ___	3 ___	4 ___

Your Diet

1. How many **times last week** did you eat breakfast when you got up? _____ times last week

2. **This morning**, did you eat any of the following foods for breakfast? *(Please check all that apply)*

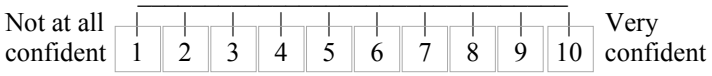
❑ milk (½ cup) ❑ cheese ❑ yogurt
❑ eggs ❑ meat, poultry, or fish ❑ beans

If you ate anything else, please write here: _____

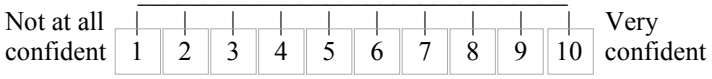
Confidence About Doing Things

For each of the following questions, please ***circle*** the number that corresponds with your **confidence** that you can do the tasks regularly at the present time.

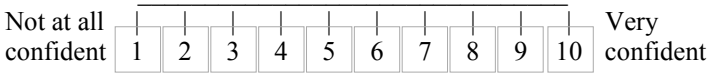
1. **How confident** do you feel that you can eat your meals every 4 to 5 hours every day, including breakfast every day?



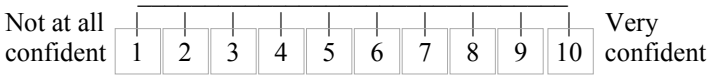
2. **How confident** do you feel that you can follow your diet when you have to prepare or share food with other people who do not have diabetes?



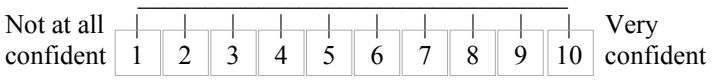
3. **How confident** do you feel that you can chose the appropriate foods to eat when you are hungry (for example, snacks)?



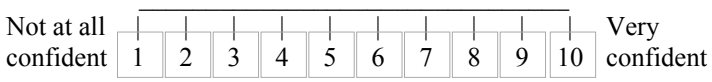
4. **How confident** do you feel that you can exercise 15 to 30 minutes, 4 to 5 times a week?



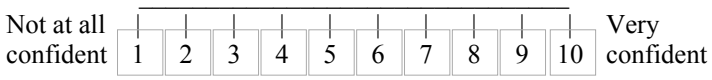
5. **How confident** do you feel that you can do something to prevent your blood sugar level from dropping when you exercise?



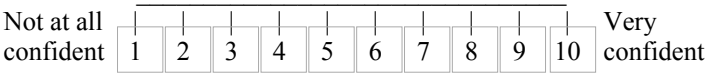
6. **How confident** do you feel that you know what to do when your blood sugar level goes higher or lower than it should be?



7. **How confident** do you feel that you can judge when the changes in your illness mean you should visit the doctor?



8. **How confident** do you feel that you can control your diabetes so that it does not interfere with the things you want to do?



Form used with permission from:

Stanford MEDICINE | Patient Education *In the Department of Medicine*

Subjective Peripheral Neuropathy Screen Questionnaire

Name:_____ Date _____

Please take a few minutes to answer the following questions about the feeling in your legs and feet. Check **yes** or **no** based on how you usually feel. Thank you

1. Do you ever have legs and/or feet that feel numb?	☐ Yes ☐ No
2. Do you ever have any burning pain in your legs and/or feet?	☐ Yes ☐ No
3. Are your feet too sensitive to touch?	☐ Yes ☐ No
4. Do you get muscle cramps in your legs and/or feet?	☐ Yes ☐ No
5. Do you ever have any prickling or tingling feelings in your legs or feet?	☐ Yes ☐ No
6. Does it hurt at night or when the covers touch your skin?	☐ Yes ☐ No
7. When you get into the tub or shower, are you unable to tell the hot water from the cold water with your feet?	☐ Yes ☐ No
8. Do you ever have any sharp, stabbing, shooting pain in your feet or legs?	☐ Yes ☐ No
9. Have you experienced an asleep feeling or loss of sensation in your legs or feet?	☐ Yes ☐ No
10. Do you feel weak when you walk?	☐ Yes ☐ No
11. Are your symptoms worse at night?	☐ Yes ☐ No
12. Do your legs and/or feet hurt when you walk?	☐ Yes ☐ No
13. Are you unable to sense your feet when you walk?	☐ Yes ☐ No
14. Is the skin on your feet so dry that it cracks open?	☐ Yes ☐ No
15. Have you ever had electric shock-like pain in your feet or legs?	☐ Yes ☐ No

Diagnostic utility of the subjective peripheral neuropathy screen in HIV-infected persons with peripheral sensory polyneuropathy. Venkataramana AB, Skolasky RL, Creighton JA, McArthur JC. AIDS Read. 2005 Jul;15(7):341-4, 348-9, 354.

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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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.

- ☐ 0 Death of a Spouse
- ☐ 0 Divorce
- ☐ 0 Marital Separation
- ☐ 0 Jail Term
- ☐ 0 Death of close family member
- ☐ 0 Personal Injury or illness
- ☐ 0 Marriage
- ☐ 0 Fired at work
- ☐ 0 Marital reconciliation
- ☐ 0 Retirement
- ☐ 0 Change in health of family member
- ☐ 0 Pregnancy
- ☐ 0 Sex difficulties
- ☐ 0 Gain of new family member
- ☐ 0 Business Readjustment
- ☐ 0 Change in financial state
- ☐ 0 Death of a close friend
- ☐ 0 Change to different kind of work
- ☐ 0 Change in number of arguments with spouse
- ☐ 0 Mortgage over $10,000
- ☐ 0 Foreclosure of mortgage or loan
- ☐ 0 Change in responsibilities at work
- ☐ 0 Son or daughter leaving home
- ☐ 0 Trouble with in-laws
- ☐ 0 Outstanding personal achievement
- ☐ 0 Spouse begins or stops work
- ☐ 0 Begin or end school
- ☐ 0 Change in living conditions
- ☐ 0 Revision of personal habits
- ☐ 0 Trouble with boss
- ☐ 0 Change in work hours or conditions
- ☐ 0 Change in residence
- ☐ 0 Change in schools
- ☐ 0 Change in recreation
- ☐ 0 Change in church activities
- ☐ 0 Change in social activities
- ☐ 0 Mortgage or loan less than $10,000
- ☐ 0 Change in sleeping habits
- ☐ 0 Change in number of family gatherings
- ☐ 0 Change in eating habits
- ☐ 0 Vacation
- ☐ 0 Christmas
- ☐ 0 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