



**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](http://www.JohnsonHealthandWellness.com) - [www.DrKarlJohnson.com](http://www.DrKarlJohnson.com) - [www.ReadReclaimYourLife.com](http://www.ReadReclaimYourLife.com)

## **IBS (IRRITABLE BOWEL SYNDROME) 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.

Notice: Dr. Karl R.O.S. Johnson is state licensed by the chiropractic board in Michigan to provide conventional chiropractic health care services and is also certified by the International Association of NeuroMetabolic Professionals to provide natural health services and therapies. The services provided to clients are intended to improve the adaptive physiology of the client through nutritional, exercise, lifestyle and physiological education, information, recommendations, and training. Conventional chiropractic and neurometabolic services are complete separate services and each is provided in strict compliance with the rules and regulations set forth by the separate agencies. If you wish to receive natural health services you must first sign a Client Services Agreement.

**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: \_\_\_\_\_

Overall Health (check one): Excellent / Good / Fair / Poor

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Referred By: \_\_\_\_\_

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What is the main reason (#1 chief complaint) you are consulting with us? (use separate sheet if more room is needed)

\_\_\_\_\_  
\_\_\_\_\_

How long have you had your main (#1) health complaint? \_\_\_\_\_

\_\_\_\_\_

Other complaint(s) and/or problem(s) you have: (use separate sheet if necessary) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

When was the last time you really felt great (good energy levels, good mental attitude, etc.) \_\_\_\_\_

\_\_\_\_\_

How often does your health problem(s) bother you? ☐Constantly ☐Frequently ☐Intermittently ☐Occasionally

In regards to your #1 chief complaint:

Did this problem have a: \_\_\_\_\_ gradual onset? \_\_\_\_\_ sudden onset?

Have you become discouraged about getting your health problem(s) handled? (explain) \_\_\_\_\_

\_\_\_\_\_

Are you currently under the care of a physician or other health professional(s)? (if so, please give name(s) and date of last visit) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

**~ PLEASE BRING A COPY OF YOUR RESULTS WITH YOUR CLIENT APPLICATION ~**

Are you currently taking any medications/supplements/vitamins? (if so, please list and provide dosages)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What have you tried to do to get rid of the problem(s) you have that did not work? (explain) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had to change your diet or eating habits? ☐ Yes ☐ No Describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When your chief (#1) complaint is **at its worst**, how does it feel? \_\_\_\_\_

\_\_\_\_\_

How does your chief (#1) complaint interfere with your:

a. Work? \_\_\_\_\_

b. Family? \_\_\_\_\_

c. Hobbies? \_\_\_\_\_

What are you most concerned with regarding your health problem(s)? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your health problem(s) have any effect on your mental stress (if so, explain) \_\_\_\_\_

\_\_\_\_\_

What activities, positions, situations seem to **worsen** your problem(s) \_\_\_\_\_

\_\_\_\_\_

What activities, positions, situations seem to **improve** your problem(s) \_\_\_\_\_

\_\_\_\_\_

On a commitment scale of 1-10, how committed are you in getting your health to its optimal state? \_\_\_\_\_

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

\_\_\_\_\_

What do you hope to do better or enjoy more when you regain your health? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **HISTORY**

Please list any serious illness you've had in the past (with approximate dates)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any previous accidents or injuries you've had in the past (with approximate dates)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **HABITS**

\_\_\_\_ Coffee      Cups per day \_\_\_\_

\_\_\_\_ Smoking      Packs per day \_\_\_\_

\_\_\_\_ Drugs      Type/How often \_\_\_\_\_

\_\_\_\_ Drinking      Type/How often \_\_\_\_\_

## **EXERCISE**

\_\_\_\_ None      Type(s) you enjoy most:

\_\_\_\_ Slight      \_\_\_\_\_

\_\_\_\_ Moderate      \_\_\_\_\_

\_\_\_\_ Daily      \_\_\_\_\_

Do you sleep on your:      \_\_\_\_ Side      \_\_\_\_ Back      \_\_\_\_ Stomach

### 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.** Additionally, you may use this space to provide additional information you feel will help us assess your case.

This image shows a full page of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page, typical of notebook paper. There are no margins, text, or other markings on the page.

Continue on next page if additional room is needed

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

(Additional Info ☐ Attached ☐ On Back)

**OPERATIONS AND PROCEDURES** (please check the area of operation/procedure or describe)

<input type="checkbox"/> Tonsils	<input type="checkbox"/> Hernia	Other surgeries or procedures: _____ _____ _____ _____
<input type="checkbox"/> Adenoids	<input type="checkbox"/> Uterus/Ovaries	
<input type="checkbox"/> Sinus	<input type="checkbox"/> Prostate	
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Breasts	
<input type="checkbox"/> Heart	<input type="checkbox"/> Rectal	
<input type="checkbox"/> Liver	<input type="checkbox"/> Exploratory	
<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Tubes in ears	
<input type="checkbox"/> Appendix	<input type="checkbox"/> Neck/Back (Spinal)	
<input type="checkbox"/> Stomach	<input type="checkbox"/> Biopsy	
<input type="checkbox"/> Colon		

**FAMILY HISTORY** (please check off if these member have/have had any illness/condition of the following areas)

	Diabetes	Heart	Kidney	Spinal	Cancer
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____

Describe health of spouse/significant other: \_\_\_\_\_

Number of children, if any: \_\_\_\_\_

Name of Child	Age	Sex	Any physical condition or concerns?
_____	_____	M /F	_____
_____	_____	M /F	_____
_____	_____	M /F	_____
_____	_____	M /F	_____
_____	_____	M /F	_____

Any household pets or other animals you or your family members are in close contact with? (list what type)

\_\_\_\_\_  
\_\_\_\_\_

## **Authorization for Care**

Be advised that any suggested nutritional program is not intended as a primary therapy for any disease. Any schedule of nutrients is provided solely to support good nutrition with the intent of supporting the physiological and biochemical processes of the human body, and not to diagnose, treat, cure, or prevent any disease or condition. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. Based on your consultation, history and 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 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 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: \_\_\_\_\_

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### **Office Use Only**

<u><b>Reason For Consultation</b></u>	<u><b>CRA/NRT/NAET</b></u>	<u><b>Recommendations</b></u>

# **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!**

# DAILY RECORD OF FOOD INTAKE

We require that you keep track of every meal for 4 days in a row.  
This will help Dr. Johnson with his evaluation.

Day 1	Day 2
Breakfast:	Breakfast:
Lunch:	Lunch:
Dinner:	Dinner:
Snacks:	Snacks:
Day 3	Day 4
Breakfast:	Breakfast:
Lunch:	Lunch:
Dinner:	Dinner:
Snacks:	Snacks:

## BIRMINGHAM IBS SYMPTOM QUESTIONNAIRE

The following questions ask you about your abdominal and bowel symptoms. When we use the word abdomen we mean belly/tummy. Some of the questions ask about passing a stool. By this we mean going to the toilet for a reason other than to urinate (pass water). All of these questions refer to the last 4 weeks.

Please tick one box for each statement.

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
1. During the last 4 weeks, how often have you had discomfort or pain in your abdomen?						
2. How often have you been troubled with loose, mushy or watery bowel motions during the last 4 weeks?						
3. How often during the last 4 weeks have you been troubled with diarrhoea?						
4. During the last 4 weeks how often have you been troubled by hard bowel motions?						
5. During the last 4 weeks how often have you felt the need to strain to pass a motion (stool)?						
6. During the last 4 weeks how often have you been troubled by constipation?						
7. During the last 4 weeks how often did you experience pain or discomfort in your abdomen after eating?						
8. How often has your abdominal pain prevented you from sleeping, or woken you during the night during the last 4 weeks?						
9. During the last 4 weeks how often have you leaked or soiled yourself?						
10. How often during the last 4 weeks have you suffered from a feeling of urgency (feeling that you must immediately rush to the toilet to pass a stool)?						
11. How often have you passed mucus or slime in your stools over the last 4 weeks?						

Requests for permission to utilise the Birmingham IBS symptom questionnaire should be sent to one of the following:

Andrea Roalfe/Lesley Roberts/Sue Wilson, Department of Primary Care and General Practice, University of Birmingham, Edgbaston, Birmingham, B15 2TT, UK

# 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.

<b>Category I</b>					<b>Category VI (continued)</b>				
Feeling that bowels do not empty completely	0	1	2	3	Excessive passage of gas	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3	Nausea and/or vomiting	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3	Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Diarrhea	0	1	2	3	Frequent urination	0	1	2	3
Constipation	0	1	2	3	Increased thirst and appetite	0	1	2	3
Hard, dry, or small stool	0	1	2	3	Difficulty losing weight	0	1	2	3
Coated tongue or “fuzzy” debris on tongue	0	1	2	3	<b>Category VII</b>				
Pass large amount of foul-smelling gas	0	1	2	3	Greasy or high-fat foods cause distress	0	1	2	3
More than 3 bowel movements daily	0	1	2	3	Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Use laxatives frequently	0	1	2	3	Bitter metallic taste in mouth, especially in the morning	0	1	2	3
<b>Category II</b>					Unexplained itchy skin	0	1	2	3
Increasing frequency of food reactions	0	1	2	3	Yellowish cast to eyes	0	1	2	3
Unpredictable food reactions	0	1	2	3	Stool color alternates from clay colored to normal brown	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3	Reddened skin, especially palms	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3	Dry or flaky skin and/or hair	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3	History of gallbladder attacks or stones	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3	Have you had your gallbladder removed?	Yes	No		
<b>Category III</b>					<b>Category VIII</b>				
Intolerance to smells	0	1	2	3	Acne and unhealthy skin	0	1	2	3
Intolerance to jewelry	0	1	2	3	Excessive hair loss	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3	Overall sense of bloating	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3	Bodily swelling for no reason	0	1	2	3
Constant skin outbreaks	0	1	2	3	Hormone imbalances	0	1	2	3
<b>Category IV</b>					Weight gain	0	1	2	3
Excessive belching, burping, or bloating	0	1	2	3	Poor bowel function	0	1	2	3
Gas immediately following a meal	0	1	2	3	Excessively foul-smelling sweat	0	1	2	3
Offensive breath	0	1	2	3	<b>Category IX</b>				
Difficult bowel movement	0	1	2	3	Crave sweets during the day	0	1	2	3
Sense of fullness during and after meals	0	1	2	3	Irritable if meals are missed	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3	Depend on coffee to keep going/get started	0	1	2	3
<b>Category V</b>					Get light-headed if meals are missed	0	1	2	3
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3	Eating relieves fatigue	0	1	2	3
Use antacids	0	1	2	3	Feel shaky, jittery, or have tremors	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3	Agitated, easily upset, nervous	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3	Poor memory/forgetful	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3	Blurred vision	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3	<b>Category X</b>				
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3	Fatigue after meals	0	1	2	3
<b>Category VI</b>					Crave sweets during the day	0	1	2	3
Roughage and fiber cause constipation	0	1	2	3	Eating sweets does not relieve cravings for sugar	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3	Must have sweets after meals	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	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

<b>Category XI</b>				<b>Category XVII</b>			
Cannot stay asleep	0	1	2 3	Increased sex drive	0	1	2 3
Crave salt	0	1	2 3	Tolerance to sugars reduced	0	1	2 3
Slow starter in the morning	0	1	2 3	“Splitting” - type headaches	0	1	2 3
Afternoon fatigue	0	1	2 3	<b>Category XVIII (Males Only)</b>			
Dizziness when standing up quickly	0	1	2 3	Urination difficulty or dribbling	0	1	2 3
Afternoon headaches	0	1	2 3	Frequent urination	0	1	2 3
Headaches with exertion or stress	0	1	2 3	Pain inside of legs or heels	0	1	2 3
Weak nails	0	1	2 3	Feeling of incomplete bowel emptying	0	1	2 3
<b>Category XII</b>				Leg twitching at night	0	1	2 3
Cannot fall asleep	0	1	2 3	<b>Category XIX (Males Only)</b>			
Perspire easily	0	1	2 3	Decreased libido	0	1	2 3
Under high amount of stress	0	1	2 3	Decreased number of spontaneous morning erections	0	1	2 3
Weight gain when under stress	0	1	2 3	Decreased fullness of erections	0	1	2 3
Wake up tired even after 6 or more hours of sleep	0	1	2 3	Difficulty maintaining morning erections	0	1	2 3
Excessive perspiration or perspiration with little or no activity	0	1	2 3	Spells of mental fatigue	0	1	2 3
<b>Category XIII</b>				Inability to concentrate	0	1	2 3
Edema and swelling in ankles and wrists	0	1	2 3	Episodes of depression	0	1	2 3
Muscle cramping	0	1	2 3	Muscle soreness	0	1	2 3
Poor muscle endurance	0	1	2 3	Decreased physical stamina	0	1	2 3
Frequent urination	0	1	2 3	Unexplained weight gain	0	1	2 3
Frequent thirst	0	1	2 3	Increase in fat distribution around chest and hips	0	1	2 3
Crave salt	0	1	2 3	Sweating attacks	0	1	2 3
Abnormal sweating from minimal activity	0	1	2 3	More emotional than in the past	0	1	2 3
Alteration in bowel regularity	0	1	2 3	<b>Category XX (Menstruating Females Only)</b>			
Inability to hold breath for long periods	0	1	2 3	Perimenopausal	Yes	No	
Shallow, rapid breathing	0	1	2 3	Alternating menstrual cycle lengths	Yes	No	
<b>Category XIV</b>				Extended menstrual cycle (greater than 32 days)	Yes	No	
Tired/sluggish	0	1	2 3	Shortened menstrual cycle (less than 24 days)	Yes	No	
Feel cold—hands, feet, all over	0	1	2 3	Pain and cramping during periods	0	1	2 3
Require excessive amounts of sleep to function properly	0	1	2 3	Scanty blood flow	0	1	2 3
Increase in weight even with low-calorie diet	0	1	2 3	Heavy blood flow	0	1	2 3
Gain weight easily	0	1	2 3	Breast pain and swelling during menses	0	1	2 3
Difficult, infrequent bowel movements	0	1	2 3	Pelvic pain during menses	0	1	2 3
Depression/lack of motivation	0	1	2 3	Irritable and depressed during menses	0	1	2 3
Morning headaches that wear off as the day progresses	0	1	2 3	Acne	0	1	2 3
Outer third of eyebrow thins	0	1	2 3	Facial hair growth	0	1	2 3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2 3	Hair loss/thinning	0	1	2 3
Dryness of skin and/or scalp	0	1	2 3	<b>Category XXI (Menopausal Females Only)</b>			
Mental sluggishness	0	1	2 3	How many years have you been menopausal?	years		
<b>Category XV</b>				Since menopause, do you ever have uterine bleeding?	Yes	No	
Heart palpitations	0	1	2 3	Hot flashes	0	1	2 3
Inward trembling	0	1	2 3	Mental fogginess	0	1	2 3
Increased pulse even at rest	0	1	2 3	Disinterest in sex	0	1	2 3
Nervous and emotional	0	1	2 3	Mood swings	0	1	2 3
Insomnia	0	1	2 3	Depression	0	1	2 3
Night sweats	0	1	2 3	Painful intercourse	0	1	2 3
Difficulty gaining weight	0	1	2 3	Shrinking breasts	0	1	2 3
<b>Category XVI</b>				Facial hair growth	0	1	2 3
Diminished sex drive	0	1	2 3	Acne	0	1	2 3
Menstrual disorders or lack of menstruation	0	1	2 3	Increased vaginal pain, dryness, or itching	0	1	2 3
Increased ability to eat sugars without symptoms	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?

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

List the three healthiest foods you eat during the average 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?

# Medication History\*

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

## Noradrenergic and Specific Serotonergic Antidepressants (NaSSAAs)

- |                                   |                                    |
|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Remeron® | <input type="checkbox"/> Norset®   |
| <input type="checkbox"/> Zispin®  | <input type="checkbox"/> Remergil® |
| <input type="checkbox"/> Avanza®  | <input type="checkbox"/> Axit®     |

## Tricyclic Antidepressants (TCAs)

- |                                      |                                      |
|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Elavil®     | <input type="checkbox"/> Prothiaden® |
| <input type="checkbox"/> Endep®      | <input type="checkbox"/> Adapin®     |
| <input type="checkbox"/> Tryptanol   | <input type="checkbox"/> Sinequan®   |
| <input type="checkbox"/> Trepiline®  | <input type="checkbox"/> Tofranil®   |
| <input type="checkbox"/> Asendin®    | <input type="checkbox"/> Janamine®   |
| <input type="checkbox"/> Asendis®    | <input type="checkbox"/> Gamanil®    |
| <input type="checkbox"/> Defanyl®    | <input type="checkbox"/> Aventyl®    |
| <input type="checkbox"/> Demolox®    | <input type="checkbox"/> Pamelor®    |
| <input type="checkbox"/> Moxadil®    | <input type="checkbox"/> Opipramol®  |
| <input type="checkbox"/> Anafranil®  | <input type="checkbox"/> Vivactil®   |
| <input type="checkbox"/> Norpramin®  | <input type="checkbox"/> Rhotrimine® |
| <input type="checkbox"/> Pertofranc® | <input type="checkbox"/> Surmontil®  |

## Selective Serotonin Reuptake Inhibitors (SSRIs)

- |                                     |                                   |
|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Paxil®     | <input type="checkbox"/> Seromex® |
| <input type="checkbox"/> Zoloft®    | <input type="checkbox"/> Seronil® |
| <input type="checkbox"/> Prozac®    | <input type="checkbox"/> Sarafem® |
| <input type="checkbox"/> Celexa®    | <input type="checkbox"/> Fluctin® |
| <input type="checkbox"/> Lexapro®   | <input type="checkbox"/> Faverin® |
| <input type="checkbox"/> Luvox®     | <input type="checkbox"/> Seroxat  |
| <input type="checkbox"/> Cipramil®  | <input type="checkbox"/> Aropax®  |
| <input type="checkbox"/> Emocal®    | <input type="checkbox"/> Deroxat® |
| <input type="checkbox"/> Seropram®  | <input type="checkbox"/> Rexetin® |
| <input type="checkbox"/> Cipralext® | <input type="checkbox"/> Paroxat® |
| <input type="checkbox"/> Fontex®    | <input type="checkbox"/> Lustral® |
| <input type="checkbox"/> Dapoxetine | <input type="checkbox"/> 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)

- |                                     |                                    |
|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Marplan®   | <input type="checkbox"/> Azilect®  |
| <input type="checkbox"/> Aurorix®   | <input type="checkbox"/> Marsilid® |
| <input type="checkbox"/> Manerix®   | <input type="checkbox"/> Iprozid®  |
| <input type="checkbox"/> Moclodura® | <input type="checkbox"/> Ipronid®  |
| <input type="checkbox"/> Nardil®    | <input type="checkbox"/> Rivivol®  |
| <input type="checkbox"/> Adelinc®   | <input type="checkbox"/> Zyvox®    |
| <input type="checkbox"/> Eldepryl®  | <input type="checkbox"/> Zyvoxid®  |

## Dopamine Receptor Agonists

- ☐ Mirapex®
- ☐ Sifrol®
- ☐ Requip®

## Norepinephrine and Dopamine Reuptake Inhibitors (NDRI)

- ☐ Wellbutrin XL®

## D2 Dopamine Receptor Blockers (antipsychotics)

- |                                     |                                       |
|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Thorazine® | <input type="checkbox"/> Acuphase®    |
| <input type="checkbox"/> Prolixin®  | <input type="checkbox"/> Haldol®      |
| <input type="checkbox"/> Trilafon®  | <input type="checkbox"/> Orap®        |
| <input type="checkbox"/> Compazine® | <input type="checkbox"/> Clozaril®    |
| <input type="checkbox"/> Mellaril®  | <input type="checkbox"/> Zyprexa®     |
| <input type="checkbox"/> Stelazine® | <input type="checkbox"/> Zydis®       |
| <input type="checkbox"/> Vesprin®   | <input type="checkbox"/> Seroquel XR® |
| <input type="checkbox"/> Nozinan®   | <input type="checkbox"/> Geodon®      |
| <input type="checkbox"/> Depixol®   | <input type="checkbox"/> Solian®      |
| <input type="checkbox"/> Navane®    | <input type="checkbox"/> Invega®      |
| <input type="checkbox"/> Fluanxol®  | <input type="checkbox"/> Abilify®     |
| <input type="checkbox"/> Clopixol®  |                                       |

## GABA Antagonist Competitive Binder

- ☐ Flumazenil

## Agonist Modulators of GABA Receptors (benzodiazepines)

- |                                     |                                    |
|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Xanax®     | <input type="checkbox"/> Dalmane®  |
| <input type="checkbox"/> Lexotanil® | <input type="checkbox"/> Ativan®   |
| <input type="checkbox"/> Lexotan®   | <input type="checkbox"/> Loramet®  |
| <input type="checkbox"/> Librium®   | <input type="checkbox"/> Sedoxil®  |
| <input type="checkbox"/> Klonopin®  | <input type="checkbox"/> Dormicum® |
| <input type="checkbox"/> Valium®    | <input type="checkbox"/> Serax®    |
| <input type="checkbox"/> ProSom®    | <input type="checkbox"/> Restoril® |
| <input type="checkbox"/> Rohypnol®  | <input type="checkbox"/> 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

- |  |  |
|--|--|
| <input type="checkbox"/> Atracurium    | <input type="checkbox"/> Rocuronium      |
| <input type="checkbox"/> Cisatracurium | <input type="checkbox"/> Succinylcholine |
| <input type="checkbox"/> Doxacurium    | <input type="checkbox"/> Tubocurarine    |
| <input type="checkbox"/> Metocurine    | <input type="checkbox"/> Vecuronium      |
| <input type="checkbox"/> Mivacurium    | <input type="checkbox"/> Hemicholinium   |
| <input type="checkbox"/> Pancuronium   |  |

## Acetylcholinesterase Reactivators

- ☐ Pralidoxime

## Cholinesterase Inhibitors (reversible)

- |   |   |
|---|---|
| <input type="checkbox"/> Donepezil              | <input type="checkbox"/> Edrophonium    |
| <input type="checkbox"/> Galantamine            | <input type="checkbox"/> Neostigmine    |
| <input type="checkbox"/> Rivastigmine           | <input type="checkbox"/> Physostigmine  |
| <input type="checkbox"/> Tacrine                | <input type="checkbox"/> Pyridostigmine |
| <input type="checkbox"/> THC                    |   |
| <input type="checkbox"/> Carbamate Insecticides |   |

## 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

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## KEY:

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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 <span style="border: 1px solid black; padding: 0 2px;">R</span>	0 1 2 3 4
14.	Difficulty in appreciating art and music <span style="border: 1px solid black; padding: 0 2px;">R</span>	0 1 2 3 4
15.	Difficulty with analytical thought <span style="border: 1px solid black; padding: 0 2px;">L</span>	0 1 2 3 4
16.	Difficulty with math, number skills and time consciousness <span style="border: 1px solid black; padding: 0 2px;">L</span>	0 1 2 3 4
17.	Difficulty taking ideas, actions, and words and putting them in a linear sequence <span style="border: 1px solid black; padding: 0 2px;">L</span>	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 accidentally	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	Medial Temporal lobe and Hippocampus			Level
32.	Right/left confusion <input type="checkbox"/> L	0 1 2 3 4	49.	Memory less efficient	0 1 2 3 4		
33.	Difficulty with math calculations <input type="checkbox"/> L	0 1 2 3 4	50.	Memory loss that impacts daily activities	0 1 2 3 4		
34.	Difficulty finding words <input type="checkbox"/> L	0 1 2 3 4	51.	Confusion about dates, the passage of time, or place	0 1 2 3 4		
35.	Difficulty with writing <input type="checkbox"/> L	0 1 2 3 4	52.	Difficulty remembering events	0 1 2 3 4		
36.	Difficulty recognizing symbols or shapes <input type="checkbox"/> R	0 1 2 3 4	53.	Misplacement of things and difficulty retracing steps	0 1 2 3 4		
37.	Difficulty with simple drawings <input type="checkbox"/> R	0 1 2 3 4	54.	Difficulty with memory of locations (addresses) <input type="checkbox"/> R	0 1 2 3 4		
38.	Difficulty interpreting maps <input type="checkbox"/> R	0 1 2 3 4	55.	Difficulty with visual memory <input type="checkbox"/> R	0 1 2 3 4		
Temporal Lobe Auditory Cortex (Areas 41, 42)			Level	56.	Always forgetting where you put items such as keys, wallet, phone, etc. <input type="checkbox"/> R	0 1 2 3 4	
39.	Reduced function in overall hearing	0 1 2 3 4	57.	Difficulty remembering faces <input type="checkbox"/> R	0 1 2 3 4		
40.	Difficulty interpreting speech with background or scatter noise	0 1 2 3 4	58.	Difficulty remembering names with faces <input type="checkbox"/> L	0 1 2 3 4		
41.	Difficulty comprehending language without perfect pronunciation	0 1 2 3 4	59.	Difficulty with remembering words <input type="checkbox"/> L	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	60.	Difficulty remembering numbers <input type="checkbox"/> L	0 1 2 3 4		
43.	Difficulty in localizing sound	0 1 2 3 4	61.	Difficulty remembering to stay or be on time (reduced left) <input type="checkbox"/> L	0 1 2 3 4		
44.	Dislike of predictable rhythmic, repeated tempo and beat music <input type="checkbox"/> L	0 1 2 3 4	Occipital Lobe (Area, 17, 18, and 19)				
45.	Dislike of non-predictable rhythmic with multiple instruments <input type="checkbox"/> R	0 1 2 3 4	62.	Difficulty in discriminating similar shades of color	0 1 2 3 4		
46.	Noticeable ear preference when using your phone	right, left, no preference	63.	Dullness of colors in visual field	0 1 2 3 4		
Temporal Lobe Auditory Association Cortex (Area 22)			Level	64.	Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach out for objects	0 1 2 3 4	
47.	Difficulty comprehending meaning of spoken words <input type="checkbox"/> L	0 1 2 3 4	66.	Floater or halos in visual field	0 1 2 3 4		
48.	Tend toward monotone speech without fluctuations or emotions <input type="checkbox"/> R	0 1 2 3 4					



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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.	Prone 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:

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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

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Dr. Datis Kharrazian and Dr. Brandon Brock

## 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

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.

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Print Name

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Signature

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Print Name

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Signature

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Print Name

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Signature

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Print Name

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Signature

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Print Name

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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.**