

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

# INSOMNIA/SLEEP DISTURBANCE 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.

[^0]If you require more space for any of these answers, please note with " $\rightarrow$ " and use the back side of this form or attach additional information. Please complete this application in pen or electronic format.

Today's Date:


If necessary, may we leave a message for you at any of the above numbers? $\square$ Yes $\square$ No
Marital Status: $\square$ Single $\square$ Married $\square$ Divorced $\square$ Widowed $\square$ have a significant other/Partner
Name (First/Last) of Spouse / Partner / Significant Other: $\qquad$
Email: $\qquad$ (Additional appointment information may need to be emailed.)
Employer: $\qquad$ Occupation (Before retirement): $\qquad$
Duration of Employment: $\qquad$ Duties: $\qquad$

* I (signature) $\qquad$ 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.

IIf this consult/examination is for a minor over whom I have legal guardianship, I give my permission (signature):
$\qquad$ .

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? $\qquad$ Did your symptoms begin suddenly? $\square$ Yes $\square$ 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? $\square$ Yes $\square$ No If so, when \& describe:

Have you had an auto accident / or work injury in the last 7 years? aYes $\square$ No. Do you have any accident claims currently open for any reason? $\square$ Yes $\square$ No: Describe: $\qquad$

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? aYes ano

Of what part(s) of your body?
Where (what facility took them) \& When
MRI \& Report brought to our office $\square$ Yes ano
(Please bring these to our office or we can help you request them.)
Previous Spine X-rays taken within last year $\square$ Laying down $\square$ Standing $\square$ Seated $\square$ Neck $\square$ Low Back
$\square$ Other: $\quad \square$ Where were they taken?
Women Only: Is there a possibility that you may be pregnant? aYes aNo

## PLEASE LIST AND PRIORITIZE YOUR CURRENT AREAS OF MAIN COMPLAINT:

(\#1 is your chief complaint, \#2 is of secondary importance, etc.)

1) $\qquad$
2) 

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 | $=\mathrm{D}$ |
| :--- | :--- |
| Aching | $=\mathrm{A}$ |
| Stiffness | $=\mathrm{S}$ |
| Burning | $=\mathrm{B}$ |
| Tingling | $=\mathrm{T}$ |
| Numbness | $=\mathrm{N}$ |
| Sharp | $=\wedge \wedge \wedge \wedge$ |
| Shooting | $=\rightarrow$ |
| Weakness | $=\mathrm{W}$ |
| 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\%) |  |  |  | $\mathbf{C}=\mathbf{C o n s t a n t}$ (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 $\qquad$ WITH Medication $\qquad$
The LOWEST your pain/discomfort gets WITHOUT medication
WITH Medication $\qquad$

| Questions regarding your Chief Complaint (\#1): |  |  |  |
| :--- | :--- | :--- | :--- |
| When is it worse? | $\square$ in the morning | $\square$ as the day progresses | $\square$ in the evening |
|  | $\square$ when I sleep | $\square$ at work | $\square$ no specific time |

aOther: $\qquad$
$\square$ I have an increase $\&$ decrease in pain/discomfort/sensation with no apparent trigger.
Details: $\qquad$
Does anything relieve your pain/problem?
What activities/movements are guaranteed to make it worse?
What positions are difficult? $\square$ Sitting $\square$ Standing $\square$ Walking $\square$ Bending $\square$ Lying Down
$\square$ Other $\qquad$
If you have Low Back Pain: Which direction hurts more when bending? Backwards $\square$ Forwards $\square$ Both

## STRUCTURAL CONDITIONS

Please list and date all memorable previous accidents and falls, even if unrelated to complaints: $\qquad$

Have you been diagnosed with herniated / bulging disc(s)/or another spine condition? $\quad \mathrm{Y}$ Yes $\quad \mathrm{No}$ Who diagnosed you and when? $\qquad$
The diagnosis was made by $\square$ MRI $\square C T S c a n ~ \square X-r a y ~ \square O t h e r: ~$ $\qquad$

Have you been advised to have surgery or injections for the above condition? $\square$ Yes $\square$ No
Details about recommendations: $\qquad$
$\qquad$

How interested are you in following the above recommendations for surgery / injections / etc.: $\qquad$
Spine \& Hip Surgeries:

| Specific Area | Date | Type (please be specific) | Results (to another region) |
| :---: | :---: | :---: | :---: |
|  |  | $\square$ Fusion $\rightarrow \square$ metal $\square_{\text {no metal }}$ $\square$ Laminectomy $\square$ Discectomy $\square$ | IImproved $\square_{\text {No Change }}$ WWorse |
|  |  | $\square$ Fusion $\rightarrow$ $\square_{\text {metal }} \quad \square_{\text {no metal }}$ $\square$ Laminectomy $\square$ Discectomy $\square$ $\qquad$ | IImproved ${ }^{\text {a }}$ No Change ${ }^{\text {a Worse }}$ |
|  |  | $\square$ Fusion $\rightarrow$ Imetal $\square_{\text {no metal }}$ $\square$ Laminectomy $\square$ Discectomy $\square$ $\qquad$ | IImproved ${ }^{\text {a }}$ No Change ${ }^{\text {a Worse }}$ |

## 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) |  |
| :---: | :--- | :--- | :--- | :---: |
|  |  |  | $\square$ Improved $\square$ No Change $\square$ Worse |  |
|  |  |  | $\square$ Improved $\square$ No Change $\square$ Worse |  |
|  |  |  | $\square$ Improved $\square$ No Change $\square$ Worse |  |

History of Cancer: $\square$ Yes $\square$ No

| Location of Origin | Status | Spread <br> (to another region) | Additional Remarks |
| :--- | :--- | :--- | :--- |
|  | $\square$ Active $\square$ Remission | $\square$ No |  |
|  | $\square$ Monitored | $\square$ Yes to: |  |
|  | $\square$ Active $\square$ Remission |  |  |
| $\square$ | $\square$ No |  |  |
|  | $\square$ Monitored to: |  |  |

Please check any of the following as applicable to you

IDifficulty starting/stopping/ controlling/ urine flow
$\square$ Bowel Movement Difficulty
$\square$ Numbness around the seated area / anus
$\square$ Diagnosed with Abdominal Aortic Aneurysm
$\square$ Spinal Disc Space Infections
$\square$ Osteoporosis $\square \square$ Fractures due to osteoporosis
$\square$ Recent Compression Fracture? Where?
$\square$ Diagnosis of Spinal Stenosis
$\square$ Chronic use of steroids or narcotics
$\square$ Coughing__/ Sneezing__/ Laughing increases back__/ leg pain__(check applicable)

## PAST TREATMENT HISTORY

## What kinds of treatments have you received for your chief complaint?

$\square$ Surgeries (Listed previously)
$\square$ Medications (list later in application)

Epidural:
Physical Therapy:

How Many How Long
$\qquad$ When $\qquad$
When $\qquad$
$\square$ Chiropractic Care: $\qquad$
If so, please briefly explain your likes and dislikes:

Other:
$\qquad$
$\qquad$
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? $\qquad$

Have you received other diagnostic tests? $\square$ Yes $\square$ No Type and results: $\qquad$

Have you received any Blood Analysis/Blood testing within the past 18 months? $\square$ Yes $\square$

## ~ 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 $\square$ Attached $\square$ 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 | $\underline{\text { Past Present }}$ Current Treatment |
| :---: | :---: |
| $\square \square$ Mid back Pain／Stiffness | $\square \square$ Chest Pain or Pressure |
| $\square \square$ Pins \＆Needle Sensation anywhere？ | $\square \square$ Shortness of Breath |
| $\square \square$ Cold hands＿＿／Feet＿（check） | $\square \square$ High Blood Pressure |
| 〕 〕 Anxiety | $\square \square$ Digestive Difficulties |
| $\square \square$ Depression | ㄱ ㄱ Heartburn |
| \ \ Mood Swings | $\square \square$ Ulcers |
| $\square \square$ Sleeping Problems | $\square \square$ Constipation |
| $\square \square$ Fatigue | $\square \square$ Urinary Problems |
| $\square \square$ Dizziness－Describe： | 〕 〕 Allergies |
| $\square \square$ Loss of Balance | \ \ Menstrual Pain |
| \ \ Fainting | \ \ Menstrual Irregularity |
| $\square \square$ Increased sensitivity to light | $\checkmark \square$ Hot flashes |
| \ \ Ringing／Buzzing in Ears | \ \ Fever |
| $\square \square$ Loss of memory | $\square \square$（other） |
| $\square \square$ Loss of smell | ㄱ－ |
| $\square \square$ Loss of taste | $\square \square$ |

## Additional Details：

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

| Name | Dosage | For What Condition |
| :--- | :--- | :--- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## HEALTH \＆LIFESTYLE

Check box if you：$\square$ Drink coffee／another source of caffeine
口Drink diet soda？Amount \＆Frequency：
$\square$ Consume alcohol？Amount \＆Frequency： $\square$ $\square$ Exercise？$\square$ Yes $\square$ No How often？ What activities？
$\square$ 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? $\qquad$

When you wake, are you $\square$ refreshed $\square$ in more pain then when you went to bed. Describe:
Mattress/Bed comfort $\rightarrow \quad \square$ poor $\square$ fair $\square$ excellent $\quad$ Age of mattress:___

Pillow comfort $\rightarrow \quad \square$ poor $\square$ fair $\square$ excellent $\quad$ Age of pillow: $\qquad$
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? $\square$ Yes $\square$ No Describe: $\qquad$

Do you suspect you have any food allergy or intolerance? $\square$ Yes $\square$ No Describe: $\qquad$
$\qquad$
What tests have you received to determine food sensitivities?

## FAMILY HISTORY

Has anyone in your family had the following?
$\square$ 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).
$\qquad$
$\square$ Gastrointestinal condition or food intolerance (allergies to wheat, dairy, soy, egg, etc.)?
$\qquad$

List any additional significant health history issues in your family:
$\qquad$
$\qquad$
$\qquad$

## 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? $\square$ No one is affected $\square$ Haven't noticed any problem $\square$ They tell me to do something $\square$ People avoid me $\square$ Other: $\qquad$
What are you afraid this might be (or is beginning) to affect (or will affect) in any way?
$\square$ Energy $\square$ Your mood/attitude $\square$ Stress $\square$ Job $\square$ Kids $\square$ Future ability $\square$ Marriage $\square$ Any relationships (frequency visiting, quality, etc.) $\square$ Self-esteem $\square$ Sleep $\square$ Time $\square$ Finances $\square$ Freedom Other: $\qquad$
Are there health conditions you are afraid this might turn into? $\square$ Family health problems

| $\square$ Heart disease | $\square$ Diabetes $\quad \square$ Arthritis |
| :--- | :---: | :---: | :---: | :---: |
| $\square$ Chronic Fatigue | $\square$ Feed surgery $\quad \square$ Other: |

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

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

What are you most concerned with regarding your problem? $\qquad$
$\qquad$

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 $\qquad$
$\qquad$

What do you desire most to get from working with us? $\qquad$
$\qquad$
$\qquad$
$\qquad$

If you could achieve your desire, what is that worth to you?
$\qquad$
$\qquad$

## 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)?
$\square$ MINIMAL (Annoying but causing NO limitations)
$\square$ SLIGHT (Tolerable but causing a little limitation)
$\square$ MODERATE (Sometimes tolerable but causing limitations)
$\square$ SEVERE (Causing significant limitations and/or concern)
$\square$ 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 $\square$ Mild $\square$ Moderate $\square$ High $\square$ 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? $\square$ Yes $\square$ 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: $\square$ Cash $\square$ Check $\square$ Credit Card

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

Signature: $\qquad$ Date: $\qquad$

## 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!

## Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CHECK the number that best describes your answer.
Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

| Insomnia Problem | None | Mild | Moderate | Severe | Very Severe |
| :--- | :---: | :---: | :---: | :---: | :---: |
| 1. Difficulty falling asleep | 0 | 1 | 2 | 3 | 4 |
| 2. Difficulty staying asleep | 0 | 1 | 2 | 3 | 4 |
| 3. Problems waking up too early | 0 | 1 | 2 | 3 | 4 |

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

| Very Satisfied | Satisfied | Moderately Satisfied | Dissatisfied | Very Dissatisfied |
| :---: | :---: | :---: | :---: | :---: |
| 0 | 1 | 2 | 3 | 4 |

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all

| Noticeable | A Little | Somewhat | Much | Very Much Noticeable |
| :---: | :---: | :---: | :---: | :---: |
| 0 | 1 | 2 | 3 | 4 |

6. How WORRIED/DISTRESSED are you about your current sleep problem?

| Not at all |  |  |  |  |
| :---: | :---: | :---: | :---: | :---: |
| Worried | A Little | Somewhat | Much | Very Much Worried |
| 0 | 1 | 2 | 3 | 4 |

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

| Not at all |  |  |  |  |
| :---: | :---: | :---: | :---: | :---: |
| Interfering | A Little | Somewhat | Much | Very Much Interfering |
| 0 | 1 | 2 | 3 | 4 |

## Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions $1+2+3+4+5+6+7)=$ $\qquad$ your total score

Total score categories:
$0-7=$ No clinically significant insomnia
8-14 = Subthreshold insomnia
15-21 = Clinical insomnia (moderate severity)
22-28 = Clinical insomnia (severe)

## HEALTH STATUS QUESTIONNAIRE - RAND 36

1. In general, would you say your health is: (check one number)
Excellent
Very Good
Good
Fair
Poor
1
$2=$
$3=$
$4=$
$5=$
2. Compared to one year ago, how would you rate your health in general now? (check one number)

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?
(check one number on each line)
Yes, limited a lot Yes, limited a little No, not limited at all
3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.
4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.
5. Lifting or carrying groceries.
6. Climbing several flights of stairs.
7. Climbing one flight of stairs.
8. Bending, kneeling or stooping
9. Walking more than a mile.
10. Walking several blocks
11. Walking one block
12. Bathing or dressing yourself


Much better now than one year ago 1 Somewhat better now than one year ago 2 About the same
Somewhat worse now than one year ago 4 Much worse now than one year ago
$\qquad$

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? (check one number on each line)
13. Cut down the amount of time you spent on work or other activities.
14. Accomplished less than you would like.
15. Were limited in the kind of work or other activities.
16. Had difficulty performing the work or other activities. (for example, it took extra effort)

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?
(check one number on each line)
17. Cut down the amount of time you spent on work or other activities.
18. Accomplished less than you would like.
19. Didn't do work or other activities as carefully as usual.

| Yes | No |
| :--- | :--- |
| 1 | $2-$ |
| $1-$ | $2-$ |
| $1-$ | $2-$ |
| $1-$ | $2-$ |

20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends,
neighbors, or groups?
neighbors, or groups? (check one number)
Not at all
Slightly
Moderately
Quite a bit
Extremely

1
$2=$
$3-$
$4=$
$5=$
21. How much bodily pain have you had during the past 4 weeks?
(check one number)

| None | 1 |
| :--- | :--- |
| Very mild | $2-$ |
| Mild | $3-$ |
| Moderate | $4=$ |
| Severe | $5-$ |
| Very Severe | $6=$ |

22. During the past 4 weeks how much did pain interfere with your normal work (including both work outside the home and housework)?
(check one number)
None at all
A little bit
Moderately
Quite a bit
Extremely
1
$2=$
$3=$
$4=$
$5=$

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks . . .
(check one number on each line)

| All of | Most of | A good bit | Some of | Little of <br> the time |
| :--- | :---: | :---: | :---: | :---: |
| the time | None of |  |  |  |
| of the time |  |  |  |  |
| the time |  |  |  |  |

23. Did you feel full of pep?
24. Have you been a very nervous person?
25. Have you felt so down in the dumps that nothing could cheer you up?
26. Have you felt calm and peaceful?
27. Did you have a lot of energy?
28. Have you felt downhearted and blue?
29. Did you feel worn out?
30. Have you been a happy person?
31. Did you feel tired?

$\qquad$
2 $\qquad$
2 $\qquad$
2 $\qquad$
2
2
$\qquad$
$\qquad$
$\qquad$ 4 $\qquad$ 5 $\qquad$ 6 $\qquad$ $4 \ldots \quad 5$ $\qquad$
3
$\qquad$ 4 $\qquad$ 6 $\qquad$
$\qquad$ 4 $\qquad$
32. During the past 4 weeks, how much of the time has your physical health or emotional health problems interfered with your social activities? (like visiting with friends, relatives, etc.)
(check one number)

| All of the time | 1 |
| :--- | :--- |
| Most of the time | 2 |
| Some of the time | $3-$ |
| A little of the time | 4 |
| None of the time | 5 |

How TRUE or FALSE is each of the following statements for you?
Definitely true
33. I seem to get sick a little easier than other people.
34. I am as healthy as anybody I know.
35. I expect my health to get worse.
36. My health is excellent.

## 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. 

| -12345678910 |
| :--- |
|  | | 123345678910 |
| :--- |

## PART II Please check the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.



| 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 |  |  |  |  |
| 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 | , | 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 |  |  |  | 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? |  |  |  | ars |
| 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? $\qquad$ Rate your stress level on a scale of 1-10 during the average week: $\qquad$ How many times do you eat fish per week? How many times do you work out per week? $\qquad$
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:

## Medication History*

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

| Frontal lobe Prefrontal, Dorsolateral and Orbitofrontal (Areas 9, 10, 11, and 12) |  | Level |  |
| :---: | :---: | :---: | :---: |
| 1. | Difficulty with restraint and controlling impulses or desires | 0123 | 4 |
| 2. | Emotional instability (lability) | 0123 | 4 |
| 3. | Difficulty planning and organizing | $\begin{array}{llll}0 & 1 & 2\end{array}$ | 4 |
| 4. | Difficulty making decisions | 012 | 4 |
| 5. | Lack of motivation, enthusiasm, interest and drive (apathetic) | 0123 | 4 |
| 6. | Difficulty getting a sound or melody out of your thoughts (Perseveration) | 0123 | 4 |
| 7. | Constantly repeat events or thoughts with difficulty letting go | 0123 | 4 |
| 8. | Difficulty initiating and finishing tasks | 0123 | 4 |
| 9. | Episodes of depression | 0123 | 4 |
| 10. | Mental fatigue | 012 | 4 |
| 11. | Decrease in attention span | 0123 | 4 |
| 12. | Difficulty staying focused and concentrating for extended periods of time | 0123 | 4 |
| 13. | Difficulty with creativity, imagination, and intuition | 0123 | 4 |
| 14. | Difficulty in appreciating art and music | 0123 | 4 |
| 15. | Difficulty with analytical thought $\square$ | 0123 | 4 |
| 16. | Difficulty with math, number skills and time consciousness | 0123 | 4 |
| 17. | Difficulty taking ideas, actions, and words and putting them in a linear sequence | 0123 | 4 |

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| KEY: |
| :--- |
| $0=1$ never have symptoms ( $0 \%$ of the time) |
| $1=1$ rarely have symptoms (Less than $25 \%$ of the time) |
| $2=1$ often have symptoms (Half of the time) |
| $3=1$ frequently have symptoms (75\% of the time) |
| $4=1$ always have symptoms (100\% of the time) |

## Frontal Lobe Precentral and

Supplementary
Level
Motor Areas (Area 4 and 6)

| 18. | Initiating movements with your arm or leg has become more difficult | 01234 |  |  |
| :---: | :---: | :---: | :---: | :---: |
| 19. | Feeling of arm or leg heaviness, especially when tired | 0 | 12 | 4 |
| 20. | Increased muscle tightness in your arm or leg | 0 | 123 | 4 |
| 21. | Reduced muscle endurance in your arm or leg | 0 | 123 | 4 |
| 22. | Noticeable difference in your muscle function or strength from one side to the other | 0 | 123 | 4 |
| 23. | Noticeable difference in your muscle tightness from one side to the other | 0 | 12 | 4 |
| Frontal Lobe Broca's Motor Speech Area (Area 44 and 45) |  | Level |  |  |
| 24. | Difficulty producing words verbally, especially when fatigued | 01234 |  |  |
| 25. | Find the actual act of speaking difficult at times | 01234 |  |  |
| 26. | Notice word pronunciation and speaking fluency change at times | 01234 |  |  |
| Parietal Somatosensory Area and Parietal Superior Lobule (Areas 3,1,2 and 7) |  | Level |  |  |
| 27. | Difficulty in perception of position of limbs | 01234 |  |  |
| 28. | Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall | 01234 |  |  |
| 29. | Frequently bumping body or limbs into the wall or objects accidently | 0123 |  |  |
| 30. | Reoccurring injury in the same body part or side of the body | 01234 |  |  |
| 31. | Hypersensitivities to touch or pain perception | 01234 |  |  |

## 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.

| Parietal Inferior Lobule (Area 39 and 40) |  | Level |
| :---: | :---: | :---: |
| 32. | Right/left confusion $\square$ | $\begin{array}{lllll}0 & 1 & 2 & 3 & 4\end{array}$ |
| 33. | Difficulty with math calculations $\quad$ L | $\begin{array}{lllll}0 & 1 & 2 & 3 & 4\end{array}$ |
| 34. | Difficulty finding words $\quad$ L | $\begin{array}{lllll}0 & 1 & 2 & 3 & 4\end{array}$ |
| 35. | Difficulty with writing $\quad$ L | $\begin{array}{lllll}0 & 1 & 2 & 3 & 4\end{array}$ |
| 36. | Difficulty recognizing symbols or shapes | $\begin{array}{lllll}0 & 1 & 2 & 3\end{array}$ |
| 37. | Difficulty with simple drawings $\mathbf{R}$ | $\begin{array}{lllll}0 & 1 & 2 & 3 & 4\end{array}$ |
| 38. | Difficulty interpreting maps $\quad$ R | $\begin{array}{lllll}0 & 1 & 2 & 3 & 4\end{array}$ |
| Temporal Lobe Auditory Cortex (Areas 41, 42) |  | Level |
| 39. | Reduced function in overall hearing | $\begin{array}{lllll}0 & 1 & 2 & 3\end{array}$ |
| 40. | Difficulty interpreting speech with background or scatter noise | $\begin{array}{lllll}0 & 1 & 2 & 3\end{array}$ |
| 41. | Difficulty comprehending language without perfect pronunciation | $\begin{array}{lllll}0 & 1 & 2 & 3\end{array}$ |
| 42. | Need to look at someone's mouth when they are speaking to understand what they are saying | 01234 |
| 43. | Difficulty in localizing sound | $\begin{array}{lllll}0 & 1 & 2 & 3 & 4\end{array}$ |
| 44. | Dislike of predictable rhythmic, repeated tempo and beat music |  |
| 45. | Dislike of non-predictable rhythmic with multiple instruments | $\begin{array}{lllll}0 & 1 & 2 & 3\end{array}$ |
| 46. | Noticeable ear preference when using your phone | ___right, ___ left, |
| Temporal Lobe Auditory Association Cortex (Area 22) |  | Level |
| 47. | Difficulty comprehending meaning of spoken words |  |
| 48. | Tend toward monotone speech without fluctuations or emotions | $\begin{array}{lllll}0 & 1 & 2 & 3\end{array}$ |


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


| Medial Temporal lobe and Hippocampus |  | Level |  |  |
| :---: | :---: | :---: | :---: | :---: |
| 49. | Memory less efficient |  | 123 | 4 |
| 50. | Memory loss that impacts daily activities |  | 123 | 4 |
| 51. | Confusion about dates, the passage of time, or place |  | 123 | 4 |
| 52. | Difficulty remembering events |  | 123 | 4 |
| 53. | Misplacement of things and difficulty retracing steps |  | 123 | 4 |
| 54. | Difficulty with memory of locations (addresses) |  | 123 | 4 |
| 55. | Difficulty with visual memory R | 0 | 123 | 4 |
| 56. | Always forgetting where you put items such as keys, wallet, phone, etc. | 0 | 123 | 4 |
| 57. | Difficulty remembering faces $\quad$ R | 0 | 123 | 4 |
| 58. | Difficulty remembering names with faces |  | 123 | 4 |
| 59. | Difficulty with remembering words |  | 123 | 4 |
| 60. | Difficulty remembering numbers $\square$ | 0 | 123 | 4 |
| 61. | Difficulty remembering to stay or be on time (reduced left) |  | 123 | 4 |
| Occipital Lobe (Area, 17, 18, and 19) |  |  | Level |  |
| 62. | Difficulty in discriminating similar shades of color |  | 123 | 4 |
| 63. | Dullness of colors in visual field | 0 | 123 | 4 |
| 64. | Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach out for objects | 0 | 123 | 4 |
| 66. | Floater or halos in visual field | 0 | 123 | 4 |

## 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.

| Cerebellum - Spinocerebellum |  | Level |  |  |
| :---: | :---: | :---: | :---: | :---: |
| 67. | Difficulty with balance, or balance that is worse on one side |  | 12 | 4 |
| 68. | A need to hold the handrail or watch each step carefully when going down stairs |  | 123 | 4 |
| 69. | Feeling unsteady and prone to falling in the dark |  | 123 | 4 |
| 70. | Proness to sway to one side when walking or standing |  | 12 | 4 |
| Cerebellum - Cerebrocerebellum |  | Level |  |  |
| 71. | Recent clumsiness in hands |  | 12 | 4 |
| 72. | Recent clumsiness in feet or frequent tripping |  | 12 | 4 |
| 73. | A slight hand shake when reaching for something at the end of movement | 0 | 123 | 4 |
| Cerebellum - Vestibulocerebellum |  | Level |  |  |
| 74. | Episodes of dizziness or disorientation | 0 | 123 | 4 |
| 75. | Back muscles that tire quickly when standing or walking |  | 123 | 4 |
| 76. | Chronic neck or back muscle tightness | 0 | 123 | 4 |
| 77. | Nausea, car sickness, or sea sickness |  | 123 | 4 |
| 78. | Feeling of disorientation or shifting of the environment | 0 | 123 | 4 |
| 79. | Crowded places cause anxiety | 0 | 12 | 4 |
| Basal Ganglia Direct Pathway |  |  | Level |  |
| 80. | Slowness in movements | 0 | 12 | 4 |
| 81. | Stiffness in your muscles (not joints) that goes away when you move | 0 | 123 | 4 |


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


| 82. | Cramping of hands when writing | 0123 |  |  |  |  |  |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| 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 |

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## 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 <br> 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 <br> muscles or a fall? | Yes / No |
| Have you ever been told that you stare into space while you're lip smacking, chewing, <br> 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 <br> real reason? | Yes / No |
| Do you ever experience sudden racing heart rate, sudden loss of bladder function, intestinal spasm, <br> 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 <br> your limbs or face? | Yes / No |
| Do you ever experience sudden involuntary head rotation and your eyes move forcefully to one side? | Yes / Noo |
| Do you ever experience sudden involuntary shift in your eyes to the side or upwards? | Yes / Noo |
| 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, <br> 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 <br> 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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## 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
Peath of close family member
Marsonal Injury or illness
Fired at work
Marital reconciliation
Retirement
Prange in health of family member
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
Morgage over $\$ 10,000$
Foreclosure of mortgage or loan
Change in responsibilities at work
Son or daughter leaving home
Outstanding in-laws
Spouse begins or stops achievement
Begin or end school
Change in living conditions
Revision of personal habits
Trouble with boss
Change in work hours or conditions
Change in residence

## Scoring Your Test <br> 0 <br> 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.

## 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

Print Name

Print Name

Print Name

Print Name

Signature

Signature

Signature

Signature

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


[^0]:    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.

