MONTGOMERY

CHIROPRACTIC WELLNESS CENTER

Dear Applicant,

Thanks for contacting my office and giving me the opportunity to help with your chronic health problem. First of all, let me explain how I handle cases like yours. You will notice there is a great deal of paperwork included in this packet. The reason for this is because I want to get as much information as I can about your health concerns, how your life has been impacted, and how your case has been managed.

Please fill out the enclosed paperwork THOROUGHLY. Because of the time involved in helping individuals with chronic conditions, I only work with individuals who are serious about getting well. If paperwork is filled out "half-heartedly" with one-word answers or skipped questions, your payment will be returned to you and I will not evaluate the application. Make sure you fill out the Records Request form so that we can fax your physician's office and get a copy of your records for review. Once you've finished your paperwork, please mail it to:

Montgomery Chiropractic Wellness Center, LLC
ATTN: Dr. Rick Montgomery
3818 North First Avenue
Evansville, IN 47710

The fee for your first visit is $125 and includes: evaluating your records, consultation, office visit, and developing initial strategy. Please enclose a check, money order or call and make your payment by phone.

I will look over all of your information and likely come up with questions designed to help me understand your case better. One of my staff will call you to set up an appointment where we will discuss things, perform some examination procedures to rule things in or out, and help me determine the best course of action to take.

On your following visit, I will let you know if I think I can help you and present my recommendations for how to handle your case. Understand that I do not treat diseases – that's the job of your medical doctor. I treat the person by looking for areas of dysfunction in the body and then develop a plan to support the body with various non-drug approaches. My goal is to improve how your body functions and empower you to live a healthier, more joyous life.

If you have any questions, feel free to give me a call. I look forward to working with you.

Sincerely,

Dr. Rick Montgomery

NORTHBROOK SHOPPING CENTER • 3818 N. FIRST AVENUE • EVANSVILLE, IN 47710
PHONE (812) 424-7823 • MONTGOMERYCHIRO@SBCGLOBAL.NET
WWW.MONTGOMERYCHIRO.COM

Dr. Rick Montgomery
Montgomery Chiropractic Wellness Center, LLC
3818 N. 1st Ave.
Evansville, IN 47710
(812) 424-7823

Request for Records

Patient's Name: ______________________

Address: Street: ______________________

City: ______________________ State: ________ Zip: ____________

Date of Birth: ______________________ Social Security #: ______________________

Telephone Number: ______________________

Requesting Records of Doctor:

Doctor's Name: ______________________

Address: Street: ______________________

City: ______________________ State: ________ Zip: ____________

Please release the following records:

Health Records X-Ray Reports X-Rays Lab Results

Other: ______________________

Requested by: Rick Montgomery, DC
Montgomery Chiropractic Wellness Center, LLC
3818 N. 1st Ave
Evansville, IN 47710

Attn. Dr. ______________________

Patient's Signature: ______________________

Date Requested: ______________________

CHRONIC NEUROLOGICAL & METABOLIC CASE HISTORY

Name ____

How do you wish to be addressed in our office? ☐First name ☐ Mr ☐ Mrs ☐Ms ☐Miss ☐ Dr

Address ______________________ City ______________ State_____ Zip__________

SSN#________________ Date of Birth ___________ Marital Status: Single Married Widowed Divorced

Home Telephone ________________ Cell ______________ Work______________

Email address: ____

Occupation ________________ Employer ____________________

Spouse/Partner's Name __________________ Employer ____________________

Spouse/Partner's Work Ph__________________ Cell Ph ________________

Name of person to contact in case of emergency:______________________________

Relationship:________________ Phone ____________________________

How did you choose our office? (e.g. Referral, internet, advertisement etc.)

____

What is the main problem or symptom that made you come here today?:

____

When and How did this begin? ______________________________

Have you had this or similar conditions in the past? ☐Yes ☐No If yes, when? ______________

What aggravates your condition? ______________________________

What makes it better? ______________________________

Describe what you are feeling? ______________________________

Do you experience Numbness or Tingling? ☐No ☐Yes If yes, where? ________________

SYMPTOM INTENSITY: Please circle the number describing the intensity of your symptoms.

None→ 0 1 2 3 4 5 6 7 8 9 10 **←Unbearable**

When you're awake, how often are you feeling these symptoms?(0-100%) _________%

Is this getting progressively worse? ☐Yes ☐ No **Is your condition:** ☐Constant ☐Comes & goes

Is this condition interfering with your: ☐Work ☐Sleep ☐Daily routine ☐Other ____________

Has there been any medical diagnosis of your complaint? ☐ Yes ☐ No If yes, list the Dr.'s name and the Diagnosis ______________________________

How have you tried to take care of this problem in the past? __**Circle all that apply**__

Medications • Emergency Room • Surgery • Routine Medical • Exercise • Supplements • Regular Chiropractic

Other (please specify)______________________________

How did the previous method(s) work out for you? Circle all that apply

Bad results • Some Results • Great Results • Nothing Changed • Didn't get worse • Didn't work very long

What are you afraid this might be? ______________________________

HEALTH HISTORY QUESTIONS

1. Please list your education, profession, sports and hobbies. ______________________
2. List your chief complaints in order of your importance. ______________________
3. Provide a detailed narrative (story) of your health history in a timeline sequence. ______________________
4. List all diagnoses given to you in a timeline sequence and your personal opinions about the diagnosis. ______________________
5. List your opinion on what you think has happened to your health. ______________________
6. List of all healthcare providers you have consulted and their opinions and treatments about your case. ______________________
7. List any treatments, medications, or supplements that have improved your health. ______________________
8. List any treatments, medications, or supplements that have caused reactions or decreased your health. ______________________

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

____

____

____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples: ____________________

____

____

____

What are you most concerned with regarding your problem? ____________________

____

____

____

____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific. ____________________

____

____

____

____

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

____

____

____

____

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

____

____

____

____

What is that worth to you? ____________________

____

____

____

____

Past Evaluations

Here is a list of possible testing and evaluations you may have. If you have any of these please make sure to send copies of these results and reports with this questionnaire. (We do not need daily office notes).

- MRI, CT, EEG
- Psychological / Neuropsychological Evaluations
- Psychiatric
- Neurological Evaluations
- Gastroenterology Evaluations
- Rheumatology Evaluations
- Internal Medicine Evaluations
- Genetic Evaluations
- Celiac/Gluten testing

Hospitalizations

Age	Reason for Hospitalization	Discharge Summary Attached?

Age	Operations	
	Appendix	
	Hernia	
	Tonsils	
	Adenoids	
	Tubes in Ears	
	Other Surgery:	
	Other Surgery:	

Please describe any head injuries, broken bones or other injuries/ traumas	Age

Please mark the following in each category by ranking each one 0-4.
0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently

	0	1	2	3	4	Past ONLY	Comments
Sensitive to odors, perfumes, smoke	☐	☐	☐	☐	☐	☐	
Sensitive to pollens, molds	☐	☐	☐	☐	☐	☐	
Extreme sugar cravings (child seeks out sugary foods)	☐	☐	☐	☐	☐	☐	
Genital rash (vaginal, "jock itch")	☐	☐	☐	☐	☐	☐	
Ringworm	☐	☐	☐	☐	☐	☐	
Fungus on toenails or fingernails	☐	☐	☐	☐	☐	☐	
Repeated use of antibiotics (even in distant past)	☐	☐	☐	☐	☐	☐	
Repeated use of steroids	☐	☐	☐	☐	☐	☐	
Mouth thrush (yeast infection)	☐	☐	☐	☐	☐	☐	
Dark skin under eyes; looks like you might have a mild 'black eye"	☐	☐	☐	☐	☐	☐	
Bloating	☐	☐	☐	☐	☐	☐	
Belching	☐	☐	☐	☐	☐	☐	
Intestinal gas	☐	☐	☐	☐	☐	☐	
Constipation	☐	☐	☐	☐	☐	☐	
Diarrhea	☐	☐	☐	☐	☐	☐	
Indigestion	☐	☐	☐	☐	☐	☐	
Esophageal reflux	☐	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	☐	
Itching, tingling or burning (child may scratch a lot, or tell you)	☐	☐	☐	☐	☐	☐	
Hives, psoriasis or dandruff	☐	☐	☐	☐	☐	☐	
Acne	☐	☐	☐	☐	☐	☐	
Hair loss	☐	☐	☐	☐	☐	☐	
Chronic infections (repeated infections)	☐	☐	☐	☐	☐	☐	
Your symptoms/behaviors worse in the following weather: Damp, hot, misty, moldy, musty	☐	☐	☐	☐	☐	☐	
Bronchitis	☐	☐	☐	☐	☐	☐	
Congestion with changing seasons	☐	☐	☐	☐	☐	☐	
Cough	☐	☐	☐	☐	☐	☐	
Pneumonia	☐	☐	☐	☐	☐	☐	
Post nasal drip	☐	☐	☐	☐	☐	☐	
Sighing	☐	☐	☐	☐	☐	☐	
Sinus fullness	☐	☐	☐	☐	☐	☐	
Wheezing	☐	☐	☐	☐	☐	☐	

List surgical operations and years: ______________________________

Other Medical or Physical conditions you have been diagnosed with (e.g. diabetes, heart conditions, arthritis, osteoporosis, low thyroid, hormone imbalance, food allergies, anxiety or panic attacks etc.) ______________

____

____

Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the diagram to accurately describe your problem.

PPP	PAIN
WWW	WEAKNESS
NNN	NUMBNESS
HHH	HEAT
TTT	TINGLING
BBB	BURNING
CCC	CRAMPING
FFF	STIFFNESS

Write "YES" or "NO" in the box next to each of the questions.

Please mark the following in each category by ranking each one 0-4.
0=Never, 1=Rarely, 2=Occasionally, 3=Frequently, 4=Very Frequently

RB

LB

NT Assessment Form

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

SECTION A				
Is your memory noticeably declining?	0	1	2	3
Are you having a hard time remembering names and phone numbers	0	1	2	3
Is your ability to focus noticeably declining?	0	1	2	3
Has it become harder for you to learn things?	0	1	2	3
How often do you have a hard time remembering your appointments?	0	1	2	3
Is your temperament getting worse in general?	0	1	2	3
Are you losing your attention span endurance?	0	1	2	3
How often do you find yourself down or sad?	0	1	2	3
How often do you fatigue when driving compared to the past?	0	1	2	3
How often do you fatigue when reading compared to the past?	0	1	2	3
How often do you walk into rooms and forget why?	0	1	2	3
How often do you pick up your cell phone and forget why?	0	1	2	3
SECTION B				
How high is your stress level?	0	1	2	3
How often do you feel that you have something that must be done?	0	1	2	3
Do you feel you never have time for yourself?	0	1	2	3
How often do you feel you are not getting enough sleep or rest?	0	1	2	3
Do you have the time to get regular exercise?	0	1	2	3
How often do you not feel cared about by the people in your life?	0	1	2	3
How often do you not feel you are accomplishing your life purpose?	0	1	2	3
How often do you share your problems with someone?	0	1	2	3
SECTION C				
SECTION C1	0	1	2	3
How often do you get irritable, shaky, or have lightheadedness between meals?	0	1	2	3
How often do you feel energized after eating?	0	1	2	3
How often do you have difficulty eating large meals in the morning?	0	1	2	3
How often does your energy level drop in the afternoon?	0	1	2	3
How often do you crave sugar and sweets in the afternoon?	0	1	2	3
How often do you wake up in the middle of the night?	0	1	2	3
How often do you have difficulty concentrating before eating?	0	1	2	3
How often do you depend on coffee to keep yourself going?	0	1	2	3
How often do you feel agitated, easily upset, and nervous between meals?	0	1	2	3
SECTION C2				
Do you get fatigued after meals?	0	1	2	3
Do you crave sugar and sweets after meals?	0	1	2	3
Do you feel you need stimulants such as coffee after meals?	0	1	2	3
Do you have difficulty losing weight?	0	1	2	3
How much larger is your waist girth compared to your hip girth?	0	1	2	3
How often do you urinate?	0	1	2	3
Have your thirst and appetite been increased?	0	1	2	3
Do you have weight gain when under stress?	0	1	2	3
Do you have difficulty falling asleep?	0	1	2	3
SECTION 1 - S				
Are you losing your pleasure in hobbies and interests?	0	1	2	3
How often do you feel overwhelmed with ideas to manage?	0	1	2	3
How often do you have feelings of inner rage (anger)?	0	1	2	3
How often do you have feelings of paranoia?	0	1	2	3
How often do you feel sad or down for no reason?	0	1	2	3
How often do you feel like you are not enjoying life?	0	1	2	3
How often do you feel you lack artistic appreciation?	0	1	2	3
How often do you feel depressed in overcast weather?	0	1	2	3
How much are you losing your enthusiasm for your favorite activities?	0	1	2	3
How much are you losing enjoyment for your favorite foods?	0	1	2	3
How much are you losing your enjoyment of friendships and relationships?	0	1	2	3
How often do you have diffi culty falling into deep restful sleep?	0	1	2	3
How often do you have feelings of dependency on others?	0	1	2	3
How often do you feel more susceptible to pain?	0	1	2	3
How often do you have feelings of unprovoked anger?	0	1	2	3
How much are you losing interest in life?	0	1	2	3
SECTION 2 - D				
How often do you have feelings of hopelessness?	0	1	2	3
How often do you have self-destructive thoughts?	0	1	2	3
How often do you have an inability to handle stress?	0	1	2	3
How often do you have anger and aggression while under stress?	0	1	2	3
How often do you feel you are not rested even after long hours of sleep?	0	1	2	3
How often do you prefer to isolate yourself from others?	0	1	2	3
How often do you have unexplained lack of concern for family and friends?	0	1	2	3
How easily are you distracted from your tasks?	0	1	2	3
How often do you have an inability to finish tasks?	0	1	2	3
How often do you feel the need to consume caffeine to stay alert?	0	1	2	3
How often do you feel your libido has been decreased?	0	1	2	3
How often do you lose your temper for minor reasons?	0	1	2	3
How often do you have feelings of worthlessness?	0	1	2	3
SECTION 3 - G				
How often do you feel anxious or panic for no reason?	0	1	2	3
How often do you have feelings of dread or impending doom?	0	1	2	3
How often do you feel knots in your stomach?	0	1	2	3
How often do you have feelings of being overwhelmed for no reason?	0	1	2	3
How often do you have feelings of guilt about everyday decisions?	0	1	2	3
How often does your mind feel restless?	0	1	2	3
How difficult is it to turn your mind off when you want to relax?	0	1	2	3
How often do you have disorganized attention?	0	1	2	3
How often do you worry about things you were not worried about before?	0	1	2	3
How often do you have feelings of inner tension and inner excitability?	0	1	2	3
SECTION 4 - ACH	0	1	2	3
Do you feel your visual memory (shapes & images) is decreased?	0	1	2	3
Do you feel your verbal memory is decreased?	0	1	2	3
Do you have memory lapses?	0	1	2	3
Has your creativity been decreased?	0	1	2	3
Has your comprehension been diminished?	0	1	2	3
Do you have difficulty calculating numbers?	0	1	2	3
Do you have difficulty recognizing objects & faces?	0	1	2	3
Do you feel like your opinion about yourself has changed?	0	1	2	3
Are you experiencing excessive urination?	0	1	2	3
Are you experiencing slower mental response?	0	1	2	3

Medication History

Please circle any of the following medication you have been or are currently taking.

Acetylcholine Receptor Antagonist – Antimuscarinic Agents Atropine, Ipratopium, Scopolamine, Tiotropium

Acetylcholine Receptor Antagonist - Ganlionic Blockers Mecamylamine, Hexamethonium, Nicotine (high doses), Trimethaphan

Acetylcholinesterase Reactivators Pralidoxime

Acetylcholine Receptor Antagonist - Neuromuscular Blockers
Atracurium, Cisatracurium, Doxacurium, Metocurine, Mivacurium, Pancuronium, Rocuronium, Uccinylcholine, Tubocurarine, Vecuronium, Hemicholine

Agonist Modulator of GABA Receptor (benzodiazpines)
Xanax, Lexotanil, Lexotan, Librium, Klonopin, Valium, ProSon, Rohypnol, Dalmane, Ativan, Loramet, Sedoxil, Dormicum, Megadon, Serax , Restoril, Halcion

Agonist Modulator of GABA Receptors (nonbenzodiazpines)
Ambien, Sonata, Lunesta, Imovane

Cholinesterase Inhibitors (irreversible)
Echotiophate, Isoflurophate, Organophosphate Insecticides, Organophosphate-containing nerve agents

Cholinesterase Inhibitors (reversible)
Donepezil, Galatamine, Rivastigmine, Tacrine, THC, Erophonium, Neostigmine, Phystigimine, Pyridostigmine, Carbamate Insecticidses

Dopamine Reuptake Inhibitors Wellbutrin (Bupropion)

Dopamine Receptor Agonists Mirapex, Sifrol, Requip

D2 Dopamine Receptor Blockers (antipsychotics)
Thorazine, Prolixin, Trilafon, Compazine, Mellaril, Stelazine, Vesprin, Nozinan, Depixol, Navane, luanxol, Clopixol, Acuphase, Haldol, Orap, Clozaril, Zyprexa, Zydis, Seroquel, Geodon, Solian, Invega, Abilify

GABA Antagonist Competitive binder Flumazenil

Monoamine Oxidase Inhibitor (MAOI)
Marplan, Aurorix, Maneric, Moclodura, Nardil, Adlegiine, Elepryl, Azilect, Marsilid, Iprozid, Ipronid, Rivivol, Popilniazida, Zyvox, Zyvoxid

Noradrenergic and Specifi c Sertonergic Antidepressants (NaSSas)
Remeron, Zispin, Avanza, Norset, Remergil, Axit

Selective Serotonin Reuptake Inhibitor
Paxil, Zoloft, Prozac, Celexa, Lexapro, Luvox, Cipramil , Emocal, Serpam, Seropram, Cipralex, Esteria, Fontex, Seromex, Seronil, Sarafem, Fluctin, Faverin, Seroxat, Aropax, Deroxat, Rexetin, Xentor, Paroxat, Lustral, Serlain, Dapoxetine

Selective Serotonin Reuptake Enhancers Stablon, Coaxil, Tatinol

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
Effexor, Pristiq, Meridia, Serzone, Dalcipran, Despramine, Duloxetine

Tricylic Antidepressants (TCAs)
Elavil, Endep, Tryptanol, Trepiline, Asendin, Asendis, Defanyl, Demolox, Moxadil, Anafranil, Norpramin, Pertofrane, Prothiadin,Thanden, Adapin, Sinequan, Trofranil, Janamine, Gamanil, Aventyl, Pamelor, Opipramol, Vivactil, Rhotrimine, Surmontil

Metabolic Assessment Form

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

Category I	0	1	2	3
Feeling that bowels do not empty completely	☐	☐	☐	☐
Lower abdominal pain relief by passing stool or gas	☐	☐	☐	☐
Alternating constipation and diarrhea	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Hard dry or small stool	☐	☐	☐	☐
Coated tongue or "fuzzy" debris on tongue	☐	☐	☐	☐
Pass large amount of foul smelling gas	☐	☐	☐	☐
More than 3 bowel movements daily	☐	☐	☐	☐
Do you use laxatives frequently	☐	☐	☐	☐

Category II	0	1	2	3
Excessive belching burping or bloating	☐	☐	☐	☐
Gas immediately following a meal	☐	☐	☐	☐
Offensive breath	☐	☐	☐	☐
Difficult bowel movements	☐	☐	☐	☐
Sense of fullness during and after meals	☐	☐	☐	☐
Difficulty digesting fruits and vegetables; undigested foods found in stools	☐	☐	☐	☐

Category III	0	1	2	3
Stomach pain, burning or aching 1- 4 hours after eating	☐	☐	☐	☐
Do you frequently use antacids	☐	☐	☐	☐
Feeling hungry an hour or two after eating	☐	☐	☐	☐
Heartburn when lying down or bending forward	☐	☐	☐	☐
Temporary relief from antacids, food, milk, carbonated beverages	☐	☐	☐	☐
Digestive problems subside with rest and relaxation	☐	☐	☐	☐
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	☐	☐	☐	☐

Category IV	0	1	2	3
Roughage and fiber cause constipation	☐	☐	☐	☐
Indigestion and fullness lasts 2-4 hours after eating	☐	☐	☐	☐
Pain, tenderness, soreness on left side	☐	☐	☐	☐
Under rib cage bloated	☐	☐	☐	☐
Excessive passage of gas	☐	☐	☐	☐
Nausea and/or vomiting	☐	☐	☐	☐
Stool undigested, foul smelling, mucous -like, greasy or poorly formed	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐
Increased thirst and appetite	☐	☐	☐	☐
Difficulty losing weight	☐	☐	☐	☐

Category V	0	1	2	3
Greasy or high fat foods cause distress	☐	☐	☐	☐
Lower bowel gas and or bloating	☐	☐	☐	☐
several hours after eating	☐	☐	☐	☐
Bitter metallic taste in mouth, especially in the morning	☐	☐	☐	☐
Unexplained itchy skin	☐	☐	☐	☐
Yellowish cast to eyes	☐	☐	☐	☐
Stool color alternates for clay colored to normal brown	☐	☐	☐	☐
Reddened skin, especially palms	☐	☐	☐	☐
Dry or flaky skin and/or hair	☐	☐	☐	☐
History of gallbladder attacks or stones	☐	☐	☐	☐
Have you had your gallbladder removed?				

Category VI	0	1	2	3
Crave sweets during the day	☐	☐	☐	☐
Irritable if meals are missed	☐	☐	☐	☐
Depend on coffee to keep yourself going or started	☐	☐	☐	☐
Get lightheaded and if meals are missed	☐	☐	☐	☐
Eating relieves fatigue	☐	☐	☐	☐
Feel shaky, jittery, tremors	☐	☐	☐	☐
Agitated, easily upset, nervous	☐	☐	☐	☐
Poor memory, forgetful	☐	☐	☐	☐
Blurred vision	☐	☐	☐	☐

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

Category VIII	0	1	2	3
Cannot stay asleep	☐	☐	☐	☐
Crave salt	☐	☐	☐	☐
Slow starter in the morning	☐	☐	☐	☐
Afternoon fatigue	☐	☐	☐	☐
Dizziness when standing up quickly	☐	☐	☐	☐
Afternoon headaches	☐	☐	☐	☐
Headaches with exertion or stress	☐	☐	☐	☐
Weak nails	☐	☐	☐	☐

Category IX	0	1	2	3
Cannot fall asleep	☐	☐	☐	☐
Perspire easily	☐	☐	☐	☐
Under high amounts of stress	☐	☐	☐	☐
Weight gain when under stress	☐	☐	☐	☐
Wake up tired even after 6 or more hours of sleep	☐	☐	☐	☐
Excessive perspiration or perspiration with little or no activity	☐	☐	☐	☐

Category X	0	1	2	3
Tired, sluggish	☐	☐	☐	☐
Feel cold – hands, feel, all over .	☐	☐	☐	☐
Require excessive amounts of sleep to function properly	☐	☐	☐	☐
Increase in weight gain even with low-calorie diet	☐	☐	☐	☐
Gain weight easily	☐	☐	☐	☐
Difficult, infrequent bowel movements	☐	☐	☐	☐
Depression, lack of motivation	☐	☐	☐	☐
Morning headaches that wear off as the day progresses	☐	☐	☐	☐
Outer third of eyebrow thins	☐	☐	☐	☐
Thinning of hair on scalp, face or genitals or excessive falling hair	☐	☐	☐	☐
Dryness of skin and/or scalp				
Mental sluggishness	☐	☐	☐	☐

Category XI	0	1	2	3
Heart palpations	☐	☐	☐	☐
Inward trembling	☐	☐	☐	☐
Increased pulse even at rest	☐	☐	☐	☐
Nervousness and emotional	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐
Night sweats	☐	☐	☐	☐
Difficulty gaining weight	☐	☐	☐	☐

Category XII	0	1	2	3
Diminished sex drive	☐	☐	☐	☐
Menstrual disorders of lack of menstruation	☐	☐	☐	☐
Increased ability to eat sugars without symptoms	☐	☐	☐	☐

Category XIII	0	1	2	3
Increased sex drive	☐	☐	☐	☐
Tolerance to sugars reduced	☐	☐	☐	☐
Splitting" type headaches	☐	☐	☐	☐

Category XIV (Male Only)	0	1	2	3
Urination difficulty or dribbling	☐	☐	☐	☐
Urination frequent	☐	☐	☐	☐
Pain inside of legs or heels	☐	☐	☐	☐
Feeling of incomplete bowel evacuation	☐	☐	☐	☐
Leg nervousness at night	☐	☐	☐	☐

Category XV (Males Only)	0	1	2	3
Decrease in libido	☐	☐	☐	☐
Decrease in spontaneous morning erections	☐	☐	☐	☐
Decrease in fullness of erections	☐	☐	☐	☐
Difficulty in maintain morning erections	☐	☐	☐	☐
Spells of mental fatigue	☐	☐	☐	☐
Inability to concentrate	☐	☐	☐	☐
Episodes of depression	☐	☐	☐	☐
Muscle soreness	☐	☐	☐	☐
Decrease in physical stamina	☐	☐	☐	☐
Unexplained weight gain	☐	☐	☐	☐
Increase in fat distribution around chest and hips	☐	☐	☐	☐
Sweating attacks	☐	☐	☐	☐
More emotional than in the past	☐	☐	☐	☐

Category XVI (Menstruating Females Only)	0	1	2	3
Are you a menopausal ?		Yes	No	
Alternating menstrual cycle lengths ?		Yes	No	
Extended menstrual cycle, greater than 32 days?		Yes	No	
Shortened menses, less than every 24 days?		Yes	No	
Pain and cramping during periods	☐	☐	☐	☐
Scanty blood flow	☐	☐	☐	☐
Heavy blood flow	☐	☐	☐	☐
Breast pain and swelling during menses	☐	☐	☐	☐
Pelvic pain during menses	☐	☐	☐	☐
Irritable and depressed during menses	☐	☐	☐	☐
Acne break outs	☐	☐	☐	☐
Facial hair growth	☐	☐	☐	☐
Hair loss/thinning	☐	☐	☐	☐

Category XVII (Menopausal Females only)	0	1	2	3
How many years have you been menopausal? ________				
Do you ever have uterine bleeding since menopause?		Yes	No	
Hot flashes	☐	☐	☐	☐
Mental fogginess	☐	☐	☐	☐
Disinterest in sex	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Painful intercourse	☐	☐	☐	☐
Shrinking breast	☐	☐	☐	☐
Facial hair growth	☐	☐	☐	☐
Acne	☐	☐	☐	☐
Increased vaginal, pain, dryness or itching	☐	☐	☐	☐

PART II

How many alcohol beverages they consume per week? ______

How many times do you eat out per week? ___________

How many times a week do you eat fish? ___________

How many caffeinated beverages do you consume per day? ____

How many times a week do you eat raw nuts or seeds? ________

How many times a week do you workout? ___________

List the three worst foods you eat during the average week: 1. ______________ 2. ______________ 3. ______________

List the three healthiest foods you eat during the average week: 1. ______________ 2. ______________ 3. ______________

Do you smoke?_______ If yes, how many times a day ___________, how many times a week ___________.

Rate your stress levels on a scale of 1-10 during the average week. ______________

What do you eat for the following meals on a typical day?

Breakfast: ____

Lunch: ____

Dinner: ____

PERSONAL OPINION QUESTIONS

Please do not answer, "I don't know" to any of these questions

1. Why do you think healthcare practitioners have failed with your case? ______
2. Do you think your condition can be cured, or improved? ______
3. What do you consider a realistic time frame to see changes in your health under our care? ______
4. What are your expectations from us? ______
5. Is there anyone you blame for your health condition? ______
6. What specific improvements in your health would you consider a successful outcome in your case? ______
7. Are you emotionally and spiritually able to handle further investigation and management of your case? ______

   Is there anything you feel you should tell us about yourself or your case? ______

   Is there anything in what you believe about health and the body that you may think is holding back your health? ______
8. Are you willing to change what you believe about health and the body to gain more health? ______
9. Are there any emotional experiences that can be affecting to your health condition? ______
10. Do you have a distinct purpose in life? ______
11. Are there any patterns in childhood or adulthood that has contributed to your health problems? ______
12. Is your spouse and/or family unit supportive of you with your health condition? ______
13. Are your spouse and/or family unit supportive of you seeking care at our office? ______
14. How did you feel about answering all of these questions and the case review process? ______

We thank you for your patience and cooperation in filling out these forms.

Patient Signature ______ Date ______

BE SURE TO COMPLETE THE LAST THREE PAGES OF THIS CASE HISTORY – IT IS A 3 DAY DIET RECORD AND MUST BE COMPLETED.

*****Write down EVERYTHING you eat & drink for 3 days. What you're eating and when you're eating can have a HUGE NEGATIVE EFFECT on your health.****

Day 1

Breakfast	Lunch	Dinner
Time: Snack Time:	Time: Snack Time:	Time: Snack Time:

Day 2

Breakfast	Lunch	Dinner
Time: Snack Time:	Time: Snack Time:	Time: Snack Time:

Day 3

Breakfast	Lunch	Dinner
Time: Snack Time:	Time: Snack Time:	Time: Snack Time: