A Dr. Hallowell Protocol

SHINE *for* Doctors

Special Help Integrating Neurological Experience™

ADULT HEALTH HISTORY

Name of Patient		Date	
Gender ☐ Male ☐ Female		Date of Birth / /	Age
Address		Phone Numbers:	Home
Address			Work
			Cell
Occupation			
Emergency Contact			

FAMILY HISTORY

Family history can often be helpful in understanding an individual's problems.

Please check any box that applies:

Mother's highest education level:

Father's highest education level:

Please check any box that applies:

Has anyone in the family had:	*Siblings*	*Parents*	*Extended Family*
Motor problems			
Reading problems			
Speech/language problems			
School/learning problems			
Alcohol/drug problems			
Anxiety, depression, other psychological disorders			
Seizures/epilepsy			
Attention problems/hyperactivity			

Please list all family members (in or out of house) and other people currently in the house:

NAME	RELATIONSHIP	AGE	CURRENTLY IN HOUSE?

Parents are: Married ☐ Living together ☐ Divorced ☐ Separated ☐ Widowed ☐

BIRTH HISTORY

Do you have any information with regard to your birth history? _____

DEVELOPMENTAL HISTORY:

Do you have any information with regard to your infant health status?
For example, were you hospitalized, or had any serious health issues?

MEDICAL HISTORY

Are you regularly checked by the following:

☐ Medical Doctor ☐ Chiropractor ☐ Osteopath ☐ Naturopath ☐ Dentist ☐ Other

Do you have/had braces on your teeth? ☐ Yes ☐ No
Do you have any amalgam fillings? How many? ☐ Yes ☐ No
Do you complain of any ongoing physical pains? (headaches, stomach aches, muscle/joint aches, or growing pains) ☐ Yes ☐ No
Do you suffer from dry skin, dandruff, hard skin on elbows, bumps on the outside of the arms, cracked heels, excessive thirst/urination? ☐ Yes ☐ No

Please list all of your medical and/or psychological diagnoses, past and present:

Please list all current prescription medications:

Are you exposed to a toxic environment (including passive smoking or industrial chemicals)? ☐ Yes ☐ No

Have you had any serious falls, physical traumas, or physical injuries? ☐ Yes ☐ No
Please list:

Have you ever been involved in a motor vehicle accident? ☐ Yes ☐ No
Please list:

Has your hearing been tested? ☐ Yes ☐ No
When was your last hearing test?
Has your vision been tested? ☐ Yes ☐ No
When did you last visit the optometrist?
Do you wear glasses/contact lenses? ☐ Yes ☐ No

Have you been hospitalized? ☐ Yes ☐ No
If Yes, for what? _____

Have you had any surgeries? ☐ Yes ☐ No
If Yes, for what reason? _____

Have you had any surgeries recommended to you that have not been performed? ☐ Yes ☐ No
If Yes, for what? _____

Have you had prior psychotherapy or counseling? ☐ Yes ☐ No
If Yes, for what issue? _____

BEHAVIOUR/MENTAL HEALTH

On a scale of 1 to 10, describe your stress level (circle one).

Personal	1	2	3	4	5	6	7	8	9	10
Occupational	1	2	3	4	5	6	7	8	9	10

Describe any sports or activities you are involved in. _____

Indicate the number of hours a week of "screen time" you use:

Computer _____ Smart Device (phone, iPad, etc.) _____
Computer games (DS, etc.) _____ Television _____

Describe your family relationships; with parents and siblings.

Do you have many friends? _____

Do you excel at, or struggle to build relationships with your peers? ☐ Excel ☐ Struggle ☐ Neither

If you struggle, why do you think that is?

What problems do you have with peers, if any?

☐ None ☐ Bragging to peers ☐ Being Teased
☐ Being physically attacked ☐ Rejected by peers ☐ Overly physically affectionate
☐ Being bullied ☐ Jealous of peers

Do you have self-esteem issues? ☐ Yes ☐ No

Do you feel that you exhibit any of the following symptoms more often than is typical? (Please put a check in front of any that apply)

- ☐ Often touchy/easily annoyed
- ☐ Often defies rules
- ☐ Often angry/resentful
- ☐ Often argues with adults
- ☐ Often loses temper
- ☐ Blames other for mistakes
- ☐ Deliberately annoys
- ☐ Often spiteful/vindictive
- ☐ Refuses to go to work
- ☐ Repeated nightmares
- ☐ Unusual fears
- ☐ Panic attacks
- ☐ Self-conscious/clings
- ☐ Excessive need for reassurance
- ☐ Self-injurious behaviour
- ☐ Worry of future events
- ☐ Repeats certain actions
- ☐ Somatic complaints (headache/stomach)
- ☐ Difficulty maintaining friendships
- ☐ Often bullies/threatens
- ☐ Initiates physical fights
- ☐ Ever been arrested
- ☐ Physically cruel to others
- ☐ Physically cruel to animals
- ☐ Motor or vocal tics
- ☐ Destroys property
- ☐ Deliberately sets fires
- ☐ Lies often
- ☐ Steals
- ☐ Has run away
- ☐ Extreme mood swings
- ☐ Does not show emotions
- ☐ Overreacts to touch/noise
- ☐ Strange or bizarre ideas
- ☐ Used drugs in the past
- ☐ Poor social interactions
- ☐ Gets upset by changes in routine
- ☐ Often irritable
- ☐ Changes in appetite
- ☐ Diminished interest
- ☐ Sleep problems
- ☐ Restlessness or slowed down
- ☐ Fatigues/low energy
- ☐ Feels worthless
- ☐ Becomes tearful easily
- ☐ Often sad
- ☐ Indecisive/can't think
- ☐ Thinks about death
- ☐ Talks about suicide
- ☐ Hurts self
- ☐ Currently uses drugs
- ☐ Currently drinks beer or alcohol
- ☐ Used beer or alcohol in the past
- ☐ Can't stop thinking about things
- ☐ Excessive preoccupation with objects or ideas

Please place a check mark in the column which best describes you:	Not at all	Just a little	Pretty much	Very much
Often fails to give close attention to details or makes careless mistakes in work or other activities.				
Often has difficulty sustaining attention in tasks or activities.				
Often does not seem to listen when spoken to directly.				
Often does not follow through on instructions and fails to finish tasks (not due to oppositional behavioral failure to understand directions).				
Often has difficulty organizing tasks and activities.				
Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort				
Often loses things necessary for tasks or activities				
Is often easily distracted by extraneous stimuli				
Is often forgetful in daily activities				
Often fidgets with hands or feet or squirms in seat				
Often leaves seat in situations in which remaining seated is expected				
Often moves about excessively in situations where it is inappropriate (may be limited to subjective feelings of restlessness)				
Often has difficulty playing or engaging in leisure activities quietly				
Is often "on the go" or often acts as if "driven by a motor"				
Often talks excessively				
Often blurts out answers before questions have been completed				
Often has difficulty waiting turn				
Often interrupts or intrudes on others (butts into conversations or activities)				

Childhood conditions had, please check:

☐ measles	☐ mumps	☐ chicken pox	☐ whooping cough
☐ scarlet fever	☐ diphtheria	☐ rheumatic fever	☐ typhoid fever
☐ ear infections	☐ tubes in ears	☐ chronic illness	

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

O = Occasional F = Frequent C = Constant

O	F	C		O	F	C		O	F	C	
☐	☐	☐	Allergy	☐	☐	☐	Tonsillitis	☐	☐	☐	Skin rash
☐	☐	☐	Chills	☐	☐	☐	Eye pain	☐	☐	☐	Varicose veins
☐	☐	☐	Convulsions	☐	☐	☐	Failing vision	**Genito-Urinary**			
☐	☐	☐	Dizziness	☐	☐	☐	Far sighted	☐	☐	☐	Bed wetting
☐	☐	☐	Fainting	☐	☐	☐	Gum trouble	☐	☐	☐	Blood in urine
☐	☐	☐	Fevers	☐	☐	☐	Hay fever	☐	☐	☐	Frequent urination
☐	☐	☐	Headaches	☐	☐	☐	Hoarseness	☐	☐	☐	Loss control urine
☐	☐	☐	Loss of sleep	☐	☐	☐	Nasal obstruction	☐	☐	☐	Kidney infection
☐	☐	☐	Nervousness	☐	☐	☐	Near sighted	☐	☐	☐	Painful urination
☐	☐	☐	Depression	☐	☐	☐	Nosebleeds	☐	☐	☐	Prostate trouble
☐	☐	☐	Neuralgia	**Cardio-Vascular**				☐	☐	☐	Pus in urine
☐	☐	☐	Numbness	☐	☐	☐	Rapid heart beat	☐	☐	☐	Smell of urine
☐	☐	☐	Sweats	☐	☐	☐	Slow heart beat	**Pain or Numbness in:**			
☐	☐	☐	Loss of weight	☐	☐	☐	Swelling of ankles	☐	☐	☐	Shoulders
☐	☐	☐	tremors	☐	☐	☐	Hardening of arteries	☐	☐	☐	Arms
Muscle & Joint				☐	☐	☐	High blood pressure	☐	☐	☐	Hands
☐	☐	☐	Arthritis	☐	☐	☐	Low blood pressure	☐	☐	☐	Hips
☐	☐	☐	Bursitis	☐	☐	☐	Pain over heart	☐	☐	☐	Legs
☐	☐	☐	Foot trouble	☐	☐	☐	Poor circulation	☐	☐	☐	Knees
☐	☐	☐	Hernia	**Gastro Intestinal**				☐	☐	☐	Ankles
☐	☐	☐	Low back pain	☐	☐	☐	Excessive hunger	☐	☐	☐	Feet
☐	☐	☐	Neck pain	☐	☐	☐	Burping or gas	☐	☐	☐	Painful tail bone
☐	☐	☐	Neck stiffness	☐	☐	☐	Liver trouble	☐	☐	☐	Sciatica
☐	☐	☐	Pain between shoulders	☐	☐	☐	Colitis	☐	☐	☐	Swollen joints
Respiratory				☐	☐	☐	Colon trouble	**For Women Only**			
☐	☐	☐	Chest pain	☐	☐	☐	Constipation	☐	☐	☐	Cramps
☐	☐	☐	Chronic cough	☐	☐	☐	Diarrhea	☐	☐	☐	Heavy flow
☐	☐	☐	Difficulty breathing	☐	☐	☐	Difficult digestion	☐	☐	☐	Light flow
☐	☐	☐	Spitting blood	☐	☐	☐	Distension of abdomen	☐	☐	☐	Irregular cycle
☐	☐	☐	Throat phlegm	☐	☐	☐	Stomach pain	☐	☐	☐	Painful cycle
☐	☐	☐	wheezing	☐	☐	☐	Gall bladder trouble	☐	☐	☐	Discharge
EYes, Ears, Nose & Throat				☐	☐	☐	Hemorrhoids	☐	☐	☐	Sore breasts
☐	☐	☐	Colds	☐	☐	☐	Intestinal worms				
☐	☐	☐	Crossed eYes	☐	☐	☐	Jaundice	Menopausal: ☐ Yes ☐ No			
☐	☐	☐	Deafness	☐	☐	☐	Poor appetite	Last Menstruation Date: _____			
☐	☐	☐	Dental decay	☐	☐	☐	Nausea				
☐	☐	☐	Asthma	☐	☐	☐	Vomiting	Pregnant: ☐ Yes ☐ No			
☐	☐	☐	Ear aches	☐	☐	☐	Vomit blood	Due Date: _____			
☐	☐	☐	Ear discharges	**Skin**							
☐	☐	☐	Ear noises	☐	☐	☐	Boils				
☐	☐	☐	Sinus infections	☐	☐	☐	Bruise easily				
☐	☐	☐	Enlarged glands	☐	☐	☐	Dryness				
☐	☐	☐	Enlarged thyroid	☐	☐	☐	Hives or allergy				
☐	☐	☐	Sore throat	☐	☐	☐	itching				

HABITS OF LIFESTYLE

Do you smoke? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No

Exercise Indoor Activities: _____

Exercise Outdoor Activities: _____

Rate your sleep hours per night: ☐ 4-6 ☐ 6-8 ☐ 8-10 ☐ 12+

Do you wake rested? ☐ Yes ☐ No

Rate your appetite: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent

Rate your diet: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent

Do you eat regularly: ☐ Breakfast ☐ Lunch ☐ Dinner

Do you eat per day: ☐ 1 meal ☐ 2 meals ☐ 3 Meals ☐ 4 meals ☐ More than 4 Meals

Do you take vitamins and minerals? ☐Yes ☐No

If Yes, please list: _____

Do you take any recreational drugs? ☐Yes ☐No

If so, what? _____

Have you ever been knocked unconscious: ☐ Yes ☐ No ☐ Don't Know

If so, for how long? _____

REASON FOR ASSESSMENT

Please describe in your own words what concerns you have. Also, please add any additional information that you feel is important and may be helpful in our assessment.

What specific **question** do you have that you hope an evaluation will answer?

SIGNATURE _____ Date:___/_____/_____