Caplan Chiropractic

Registration & History

Who referred you?_____

PATIENT INFORMATION

Date_____

Patient Name_____

Address_____

_____

City State Zip

Patient Phone – Home_____

Work_____Cell_____

Best time and place to call_____

Patient Email_____

Sex: ☐M ☐F Age_____ Birth Date_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Spouse's Employer_____

EMERGENCY CONTACT

Name_____

Relationship_____

Phone _____

PATIENT INFORMATION

Is condition due to an auto accident? ☐Yes ☐No

If yes, date of accident_____

To whom have you made a report of your accident?

☐Auto Insurance ☐Health Insurance ☐Other__

Attorney Name (if applicable)_____

Insurance Co. Name_____

Insurance Co. Contact_____

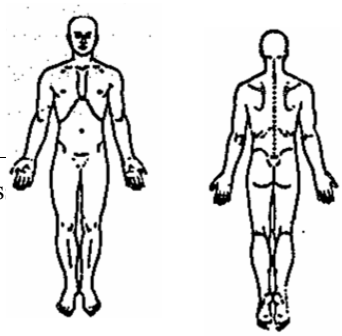
Insurance Co. Contact Phone_____

PATIENT CONDITION

When did your symptoms appear?_____

Is this condition getting progressively worse(circle one)? Yes No Unknown

Mark an X on the picture where you continue to have symptoms or discomfort.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of discomfort (circle all that apply): Sharp Dull Throbbing Aching Numbnes Burning

Tingling Cramps Stiffness Swelling Other _____

How often do you have these symptoms appear? _____

_____

Is it constant or does it come and go? _____

Does it interfere with your (circle all that apply)? Work Sleep Daily Routine Recreation

Activities that are difficult to perform (circle all that apply): Sitting Standing Walking Bending Lying Down

6015 Lehman Dr., Suite 202
Colorado Springs, CO 80918
Phone 719-357-6040

MEDICAL HISTORY & EVALUATION

SUBJECTIVE

Patient Goals: _____

Chief Complaint: _____

_____

Onset: _____

Descriptors: _____

Aggravating Factors: _____

Relieving Factors: _____

Yellow Flags: _____

_____ Night Pain _____ Sitting _____ Sit to Stand _____ Worse A.M. _____ Worse P.M.

PATIENT EDUCATION

Readiness to Learn: Ready & Motivated Limitations (see below)

Limitations to Learning: _____

MEDICAL HISTORY

Past Medical History: _____

_____

_____

Medications: _____

Treatment to Date: _____

PSYCHOSOCIAL (Occupation, recreation, support systems, etc)

_____

_____

_____

_____

_____

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PATIENT NAME_____DATE_____

HEALTH QUESTIONNAIRE

Height _____ ***Weight*** _____

Health Habits...

Current exercise (Type/ # Times per week): _____

Tobacco Usage (Type/ weekly use)?: _____

Alcohol Consumption (Type/ weekly): _____

Caffeine Intake (Type/ weekly): _____

Orthotic(s) Usage (Type/ how long): _____

Current Medications (please list both prescription & over-the-counter):_____

_____

Current Vitamins or Supplements (please list): _____

Health Conditions...

Please check any of the following diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan, and the possibility of being accepted for care.

___ Severe or Frequent Headaches	___ Ulcers / Colitis	___ Diabetes
___ Sinus Problems	___ Heart Attack / Stroke	___ Tuberculosis
___ Allergies	___ Blood Clots	___ PID
___ Dizziness	___ Congenital Heart Defect	___ Shingles
___ Concussion/Head Injury	___ Varicose Veins	___ Vision Impairment
___ Loss of Sleep/Irregular Sleep Patterns	___ Heart Surgery/Pacemaker	___ Hearing Impairment
___ Jaw Discomfort	___ Heart Murmur	___ Fatigue
___ Pain Between the Shoulders	___ High / Low Blood Pressure	___ Hepatitis
___ Frequent Neck Pain	___ Difficulty Breathing	___ Cancer
___ Numbness/Pain in Arm/Hand/Legs	___ Osteo/Rheumatoid Arthritis	___ Joint Dislocation
___ Muscle Spasms / Cramps	___ Tendonitis / Bursitis	___ Fracture
___ Sprains (please specify)	___ Surgeries (please specify)	___ Asthma
___ Lower Back Problems	___ Bone or Joint Disease	___ Anxiety
___ Digestive Problems	___ Rheumatic Fever	___ Depression
___ Skin Disorders	___ Anemia	___ Weight Change
___ Memory Loss (Short/Long Term)	___ Alcohol/Drug Abuse	___ Kidney Problems
___ Chemotherapy	___ HIV / AIDS	___ Venereal Disease
___ Psychiatric Problems	___ Vaccinations Type/Last)_____	

For Women: ___ Pregnancy (trimester_____) ___ Nursing ___ Birth Control (Type)_____

___ Painful Periods ___ Irregular Cycles ___ Breast Implants / Reduction

Previous Chiropractic: Yes No Good Bad _____

Diagnostic Tests: X-ray MRI CT Scan EMG Other_____

Caplan Chiropractic 6015 Lehman Dr., Suite 202, Colorado Springs, CO 80918
(719) 357-6064

Caplan Chiropractic

Office Policies & Information

WELCOME to our office. Please read these policies to ensure your understanding and assist us in providing you with quality care. We will be happy to answer any questions that may arise.

SERVICE Based on our assessment, we will design a program we feel best suited to reach your goals. Treatment includes Chiropractic care, Active Release Techniques® therapy, possible diet &/or lifestyle re-education based on recommendations for exercise, ergonomics and nutrition. Your first appointment will include both exam and initial treatment and will be approximately 55 minutes. Subsequent appointments are approximately 25 minutes. We will do our best to facilitate your healing process with thorough and effective treatment.

PAYMENT – CASH, CHECK, or CREDIT CARD (MC/VISA) IS DUE AT TIME OF SERVICE. We do not direct bill for any insurance carriers. However, we would be happy to submit an insurance claim to your insurance company upon request. Depending on your policy, you may receive re-imbursement of your out of pocket expenses. Any and all payments received from your insurance company must be payable to Caplan Chiropractic. Once Caplan Chiropractic has processed these payments you will receive any re-imbursement that is due to you. Your insurance company may mail payments for insurance claims originated by Caplan Chiropractic to you (the subscriber). In this case, you (the subscriber) are responsible for bringing any checks received to the Caplan Chiropractic to be processed.

Initial _____

☐ I would like Caplan Chiropractic to submit claims to my insurance on my behalf and I agree to bring any checks in to their office to be processed.

☐ No, thank you. I will not need a claim for insurance reimbursement.

Our cash rates are as follows : $199.00 initial visit, $65.00 subsequent visits.

MISSED APPOINTMENTS & CANCELLATIONS – If you are unable to keep your appointment, please let us know 24 hours in advance so we can make it available to other patients. MISSED APPOINTMENTS/CANCELLATIONS with less than a 24-hour notice will result in a full charge.

I have read, understand and agree to the above policies. I agree to be treated at Caplan Chiropractic.

Name:

Signature:

_____

I authorize Caplan Chiropractic to charge my credit card for my appointments:

Name on Card:
Credit Card #:
Exp Date:

Authorized Signature:

Caplan Chiropractic
6015 Lehman Ave., Suite 202
Colorado Springs, CO 80918
Phone 719-357-6064

Caplan Chiropractic

Notice of Use of Your Chiropractic & Medical Information

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Caplan Chiropractic we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a specific form please advise us in writing as to your preferences.

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Colorado Springs, CO 80918
719-357-6064

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:
Caplan Chiropractic

If you would like further information about our privacy policies and practices please contact:
Caplan Chiropractic

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of November 9th 2016. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed)	Signature	Date

If you are a minor, or if you are being represented by another party

Personal Representative (Printed)	Personal Representative Signature	Date

Please state the description of the authority to act on behalf of the patient.

CAPLAN CHIROPRACTIC

Patient Authorization Regarding Chiropractic Care Being Provided In An "Open-Door" Adjusting Environment

It is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open. As a result patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open door" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure and requesting your authorization.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care. If you choose not to be adjusted in an open-door adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from Dr. Caplan or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____	_____	_____
Name (printed)	Signature	Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

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719-357-6064

Caplan Chiropractic

Informed Consent

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures – please initial each one indicating your consent:

___ spinal manipulative therapy
___ active release techniques (ART)
___ range of motion testing
___ muscle strength testing
___ kinesiotaping
___ hot/cold therapy
___ palpation
___ orthopedic testing
___ postural anaylsis
___ basic neurological testing
___ dietary supplements
___ ultrasound
___ radiographic studies
___ EMS

_____

_____

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing serious complications including stroke.

Complications of ART include local bruising, fainting, temporary pain or discomfort and the possible temporary aggravation of prior existing symptoms. If you receive dietary supplements the risks include, but are not limited to allergic reactions to supplements.

Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibly to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for

Caplan Chiropractic

Informed Consent

during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain- medications

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set ip a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] (initial here) or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Michelle Caplan and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____ Patient's Name

_____ Signature

_____ Signature of Parent or Guardian (if a minor)

Dated: _____

Dr. Michelle Caplan, DC
Doctor's Name

_____
Signature

Metabolic Assessment Form™

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____

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

Category I

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

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

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

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Lowered gastrointestinal motility, constipation	0	1	2	3
Raised gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	Yes	No		

Category VIII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes	No		

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category XI

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

SMGEMAF04(121614)Version 2

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

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 XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a 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 XIV

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 XV

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

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(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 XVIII *(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 XIX *(Menstruating Females Only)*

Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

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

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

Health Questionnaire (NTAF)

Name: _____Age: _____ Sex: _____ Date:_____

*** Please circle 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 find it difficult to get regular exercise? 0 1 2 3
- Do you feel uncared for by the people in your life? 0 1 2 3
- Do you feel you are not accomplishing your life's purpose? 0 1 2 3
- Is sharing your problems with someone difficult for you? 0 1 2 3

SECTION C

SECTION C1

- 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 difficulty 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

- 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

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.

Medication History*

Please check any of the following medications 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, ☐Succinylcholine, ☐Tubocurarine, ☐Vecuronium, ☐Hemicholinium

Agonist Modulator of GABA Receptor (benzodiazepines)
☐Xanax®, ☐Lexotanil, ☐Lexotan®, ☐Librium, ☐Klonopin®, ☐Valium®, ☐ProSom®, ☐Rohypnol, ☐Dalmane, ☐Ativan, ☐Loramet®, ☐Sedoxil, ☐Dormicum, ☐Megalodon, ☐Serax®, ☐Restoril, ☐Halcion

Agonist Modulator of GABA Receptors (nonbenzodiazepines)
☐Ambien CR®, ☐Sonata®, ☐Lunesta®, ☐Imovane

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

Cholinesterase Inhibitors (reversible)
☐Donepezil, ☐Galatamine, ☐Rivastigmine, ☐Tacrine, ☐THC, ☐Edrophonium, ☐Neostigmine, ☐Physostigmine, ☐Pyridostigmine, ☐Carbamate Insecticides

Dopamine Reuptake Inhibitors
☐Wellbutrin XL® (Bupropion)

Dopamine Receptor Agonists
☐Mirapex®, ☐Sifrol®, ☐Requip®

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

GABA Antagonist Competitive binder
☐Flumazenil

Monoamine® Oxidase Inhibitors (MAOI)
☐Marplan®, ☐Aurorix®, ☐Manerix®, ☐Moclodura, ☐Nardil, ☐Adeline®, ☐Eldepryl®, ☐Azilect®, ☐Marsilid®, ☐Iprozid®, ☐Ipronid®, ☐Rivivol, ☐Popilniazida®, ☐Zyvox®, ☐Zyvoxid®

Noradrenergic® and Specific Sertonergic® Antidepressants (NaSSaa)
☐Remeron®, ☐Zispin®, ☐Avanza®, ☐Norset®, ☐Remergil®, ☐Axit®

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

Selective Serotonin Reuptake Enhancers
☐Stablon®, ☐Coaxil, ☐Tatinol®

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
☐Effexor®, ☐Pristiq®, ☐Meridia, ☐Serzone®, ☐Dalcipran®, ☐Despiramin, ☐Duloxetine

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

***Please refer to prescribing physician for nutritional interactions with any medications you may be taking.**

Brain Function Assessment Form™ (BFAF)

Name: _____ Age: _____ Sex: _____ Date:_____

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

SECTION 1

- A decrease in attention span **0 1 2 3**
- Mental fatigue **0 1 2 3**
- Difficulty learning new things **0 1 2 3**
- Difficulty staying focused and concentrating for extended periods of time **0 1 2 3**
- Experiencing fatigue when reading sooner than in the past **0 1 2 3**
- Experiencing fatigue when driving sooner than in the past **0 1 2 3**
- Need for caffeine to stay mentally alert **0 1 2 3**
- Overall brain function impairs your daily life **0 1 2 3**

SECTION 2

- Twitching or tremor in your hands and legs when resting **0 1 2 3**
- Handwriting has gotten smaller and more crowded together **0 1 2 3**
- A loss of smell to foods **0 1 2 3**
- Difficulty sleeping or fitful sleep **0 1 2 3**
- Stiffness in shoulders and hips that goes away when you start to move **0 1 2 3**
- Constipation **0 1 2 3**
- Voice has become softer **0 1 2 3**
- Facial expression that is serious or angry **0 1 2 3**
- Episodes of dizziness or light-headedness upon standing **0 1 2 3**
- A hunched over posture when getting up and walking **0 1 2 3**

SECTION 3

- Memory loss that impacts daily activities **0 1 2 3**
- Difficulty planning, problem solving, or working with numbers **0 1 2 3**
- Difficulty completing daily tasks **0 1 2 3**
- Confusion about dates, the passage of time, or place **0 1 2 3**
- Difficulty understanding visual images and spatial relationships (addresses and locations) **0 1 2 3**
- Difficulty finding words when speaking **0 1 2 3**
- Misplacement of things and inability to retrace steps **0 1 2 3**
- Poor judgment and bad decisions **0 1 2 3**
- Disinterest in hobbies, social activities, or work **0 1 2 3**
- Personality or mood changes **0 1 2 3**

SECTION 4

- Reduced function in overall hearing **0 1 2 3**
- Difficulty understanding language with background or scatter noise **0 1 2 3**
- Ringing or buzzing in the ear **0 1 2 3**
- Difficulty comprehending language without perfect pronunciation **0 1 2 3**
- Difficulty recognizing familiar faces **0 1 2 3**
- Changes in comprehending the meaning of sentences, written or spoken **0 1 2 3**
- Difficulty with verbal memory and finding words **0 1 2 3**
- Difficulty remembering events **0 1 2 3**
- Difficulty recalling previously learned facts and names **0 1 2 3**
- Inability to comprehend familiar words when read **0 1 2 3**
- Difficulty spelling familiar words **0 1 2 3**
- Monotone, unemotional speech **0 1 2 3**
- Difficulty understanding the emotions of others when they speak (nonverbal cues) **0 1 2 3**
- Disinterest in music and a lack of appreciation for melodies **0 1 2 3**
- Difficulty with long-term memory **0 1 2 3**
- Memory impairment when doing the basic activities of daily living **0 1 2 3**
- Difficulty with directions and visual memory **0 1 2 3**
- Noticeable differences in energy levels throughout the day **0 1 2 3**

SECTION 5

- Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach for objects **0 1 2 3**
- Difficulty comprehending written text **0 1 2 3**
- Floaters or halos in your visual field **0 1 2 3**
- Dullness of colors in your visual field during different times of the day **0 1 2 3**
- Difficulty discriminating similar shades of color **0 1 2 3**

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Brain Function Assessment Form™ (BFAF)

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

SECTION 6

- Difficulty with detailed hand coordination **0 1 2 3**
- Difficulty with making decisions **0 1 2 3**
- Difficulty with suppressing socially inappropriate thoughts **0 1 2 3**
- Socially inappropriate behavior **0 1 2 3**
- Decisions made based on desires, regardless of the consequences **0 1 2 3**
- Difficulty planning and organizing daily events **0 1 2 3**
- Difficulty motivating yourself to start and finish tasks **0 1 2 3**
- A loss of attention and concentration **0 1 2 3**

SECTION 7

- Hypersensitivities to touch or pain **0 1 2 3**
- Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall **0 1 2 3**
- Frequently bumping into the wall or objects **0 1 2 3**
- Difficulty with right-left discrimination **0 1 2 3**
- Handwriting has become sloppier **0 1 2 3**
- Difficulty with basic math calculations **0 1 2 3**
- Difficulty finding words for written or verbal communication **0 1 2 3**
- Difficulty recognizing symbols, words, or letters **0 1 2 3**

SECTION 8

- Difficulty swallowing supplements or large bites of food **0 1 2 3**
- Bowel motility and movements slow **0 1 2 3**
- Bloating after meals **0 1 2 3**
- Dry eyes or dry mouth **0 1 2 3**
- A racing heart **0 1 2 3**
- A flutter in the chest or an abnormal heart rhythm **0 1 2 3**
- Bowel or bladder incontinence, resulting in staining your underwear **0 1 2 3**

SECTION 9

- A decrease in movement speed **0 1 2 3**
- Difficulty initiating movement **0 1 2 3**
- Stiffness in your muscles (not joints) **0 1 2 3**
- A stooped posture when walking **0 1 2 3**
- Cramping of your hand when writing **0 1 2 3**

SECTION 10

- Abnormal body movements (such as twitching legs) **0 1 2 3**
- Desires to flinch, clear your throat, or perform some type of movement **0 1 2 3**
- Constant nervousness and a restless mind **0 1 2 3**
- Compulsive behaviors **0 1 2 3**
- Increased tightness and tone in specific muscles **0 1 2 3**

SECTION 11

- Difficulty with balance, or balance that is noticeably worse on one side **0 1 2 3**
- A need to hold the handrail or watch each step carefully when going down stairs **0 1 2 3**
- Episodes of dizziness **0 1 2 3**
- Nausea, car sickness, or seasickness **0 1 2 3**
- A quick impact after consuming alcohol **0 1 2 3**
- A slight hand shake when reaching for something **0 1 2 3**
- Back muscles that tire quickly when standing or walking **0 1 2 3**
- Chronic neck or back muscle tightness **0 1 2 3**

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Brain Health and Nutrition Assessment Form™ (BHNAF)

Name: _____ Age: _____ Sex: _____ Date:_____

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

SECTION 1

- Low brain endurance for focus and concentration **0 1 2 3**
- Cold hands and feet **0 1 2 3**
- Must exercise or drink coffee to improve brain function **0 1 2 3**
- Poor nail health **0 1 2 3**
- Fungal growth on toenails **0 1 2 3**
- Must wear socks at night **0 1 2 3**
- Nail beds are white instead of pink **0 1 2 3**
- The tip of the nose is cold **0 1 2 3**

SECTION 2

- Irritable, nervous, shaky, or light-headed between meals **0 1 2 3**
- Feel energized after meals **0 1 2 3**
- Difficulty eating large meals in the morning **0 1 2 3**
- Energy level drops in the afternoon **0 1 2 3**
- Crave sugar and sweets in the afternoon **0 1 2 3**
- Wake up in the middle of the night **0 1 2 3**
- Difficulty concentrating before eating **0 1 2 3**
- Depend on coffee to keep going **0 1 2 3**

SECTION 3

- Fatigue after meals **0 1 2 3**
- Sugar and sweet cravings after meals **0 1 2 3**
- Need for a stimulant, such as coffee, after meals **0 1 2 3**
- Difficulty losing weight **0 1 2 3**
- Increased frequency of urination **0 1 2 3**
- Difficulty falling asleep **0 1 2 3**
- Increased appetite **0 1 2 3**

SECTION 4

- Always have projects and things that need to be done **0 1 2 3**
- Never have time for yourself **0 1 2 3**
- Not getting enough sleep or rest **0 1 2 3**
- Difficulty getting regular exercise **0 1 2 3**
- Feel that you are not accomplishing your life's purpose **0 1 2 3**

SECTION 5

- Dry and unhealthy skin **0 1 2 3**
- Dandruff or a flaky scalp **0 1 2 3**
- Consumption of processed foods that are bagged or boxed **0 1 2 3**
- Consumption of fried foods **0 1 2 3**
- Difficulty consuming raw nuts or seeds **0 1 2 3**
- Difficulty consuming fish (not fried) **0 1 2 3**
- Difficulty consuming olive oil, avocados, flax seed oil, or natural fats **0 1 2 3**

SECTION 6

- Difficulty digesting foods **0 1 2 3**
- Constipation or inconsistent bowel movements **0 1 2 3**
- Increased bloating or gas **0 1 2 3**
- Abdominal distention after meals **0 1 2 3**
- Difficulty digesting protein-rich foods **0 1 2 3**
- Difficulty digesting starch-rich foods **0 1 2 3**
- Difficulty digesting fatty or greasy foods **0 1 2 3**
- Difficulty swallowing supplements or large bites of food **0 1 2 3**
- Abnormal gag reflex **Yes or No**

SECTION 7

- Brain fog (unclear thoughts or concentration) **Yes or No**
- Pain and inflammation **Yes or No**
- Noticeable variations in mental speed **Yes or No**
- Brain fatigue after meals **0 1 2 3**
- Brain fatigue after exposure to chemicals, scents, or pollutants **0 1 2 3**
- Brain fatigue when the body is inflamed **0 1 2 3**

SECTION 8

- Grain consumption leads to tiredness **0 1 2 3**
- Grain consumption makes it difficult to focus and concentrate **0 1 2 3**
- Feel better when bread and grains are avoided **0 1 2 3**
- Grain consumption causes the development of any symptoms **0 1 2 3**
- A 100% gluten-free diet **Yes or No**

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Brain Health and Nutrition Assessment Form™ (BHNAF)

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

SECTION 9

- A diagnosis of celiac disease, gluten sensitivity, hypothyroidism, or an autoimmune disease — Yes or No
- Family members who have been diagnosed with an autoimmune disease — Yes or No
- Family members who have been diagnosed with celiac disease or gluten sensitivity — Yes or No
- Changes in brain function with stress, poor sleep, or immune activation — 0 1 2 3

SECTION 10

- A loss of pleasure in hobbies and interests — 0 1 2 3
- Feel overwhelmed with ideas to manage — 0 1 2 3
- Feelings of inner rage or unprovoked anger — 0 1 2 3
- Feelings of paranoia — 0 1 2 3
- Feelings of sadness for no reason — 0 1 2 3
- A loss of enjoyment in life — 0 1 2 3
- A lack of artistic appreciation — Yes or No
- Feelings of sadness in overcast weather — 0 1 2 3
- A loss of enthusiasm for favorite activities — 0 1 2 3
- A loss of enjoyment in favorite foods — 0 1 2 3
- A loss of enjoyment in friendships and relationships — 0 1 2 3
- Inability to fall into deep, restful sleep — 0 1 2 3
- Feelings of dependency on others — 0 1 2 3
- Feelings of susceptibility to pain — 0 1 2 3

SECTION 11

- Feelings of worthlessness — 0 1 2 3
- Feelings of hopelessness — 0 1 2 3
- Self-destructive thoughts — 0 1 2 3
- Inability to handle stress — 0 1 2 3
- Anger and aggression while under stress — 0 1 2 3
- Feelings of tiredness, even after many hours of sleep — 0 1 2 3
- A desire to isolate yourself from others — 0 1 2 3
- An unexplained lack of concern for family and friends — 0 1 2 3
- An inability to finish tasks — 0 1 2 3
- Feelings of anger for minor reasons — 0 1 2 3

SECTION 12

- A decrease in visual memory (shapes and images) — Yes or No
- A decrease in verbal memory — 0 1 2 3
- Occurrence of memory lapses — 0 1 2 3
- A decrease in creativity — 0 1 2 3
- A decrease in comprehension — 0 1 2 3
- Difficulty calculating numbers — 0 1 2 3
- Difficulty recognizing objects and faces — 0 1 2 3
- A change in opinion about yourself — 0 1 2 3
- Slow mental recall — 0 1 2 3

SECTION 13

- A decrease in mental alertness — 0 1 2 3
- A decrease in mental speed — 0 1 2 3
- A decrease in concentration quality — 0 1 2 3
- Slow cognitive processing — 0 1 2 3
- Impaired mental performance — 0 1 2 3
- An increase in the ability to be distracted — 0 1 2 3
- Need coffee or caffeine sources to improve mental function — 0 1 2 3

SECTION 14

- Feelings of nervousness or panic for no reason — 0 1 2 3
- Feelings of dread — 0 1 2 3
- Feelings of a “knot” in your stomach — 0 1 2 3
- Feelings of being overwhelmed for no reason — 0 1 2 3
- Feelings of guilt about everyday decisions — 0 1 2 3
- A restless mind — 0 1 2 3
- An inability to turn off the mind when relaxing — 0 1 2 3
- Disorganized attention — 0 1 2 3
- Worry over things never thought about before — 0 1 2 3
- Feelings of inner tension and inner excitability — 0 1 2 3

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