CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. 'While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address;

b. The nature of the treatment;

c. The risks and benefits of that treatment; and

d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with ______________________________ (health care providers name).

Dated this __________ day of ____________ 20___

____
Patient signature (or Legal Guardian)
Print Name:____________________

____
Signature of Witness
Print Name:______________

Health History

Date: ___________________

Patient name: ________________________________ Date of Birth: _______________

Address: ____

Drivers License #/State: ____

Sex: Male ☐ Female ☐ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Occupation: ________________________ Employer: _______________________

Email: ______________________________ Spouses Name: ___________________

Who may we thank for referring you? ____

Phone number: Cell __________________ Home _____________________________

Emergency Contact: _________________________ Phone # _____________________

Reason for visit: ____

Is this due to an accident? ____

☐ Auto ☐ Work related ☐ Home

If so, has it been reported to: ☐ Insurance company ☐ Employer ☐ Work Comp?

When did the symptoms appear? ____

Is the condition getting worse? ____

How often do you have this pain? ____

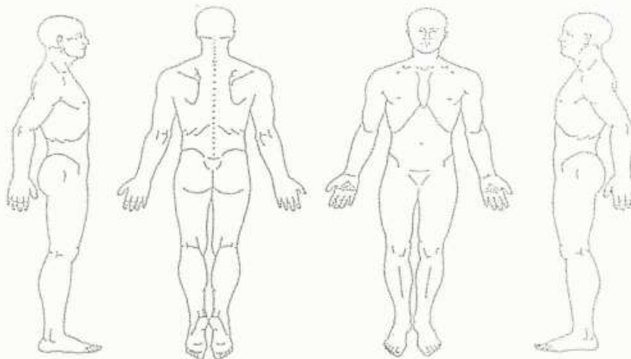
Is it constant or does it come and go? _______________________________________

Does it interfere with your ☐ Work ☐ Sleep ☐ Recreation ☐ Daily routine ☐ __________

Are the following painful or difficult? ☐ Sitting ☐ Standing ☐ Walking ☐ Lying ☐ Bending

☐ Lifting ☐ Other _______________

Where do you feel the pain:



Rate your pain 1-10 __________

☐ Burning ☐ Swelling ☐ Stiffness

☐ Cramps

Do you feel the following:

☐ Numbness ☐ Tingling ☐ Weakness

☐ Sharp ☐ Dull ☐ Ache ☐ Throbbing

How does your condition make you feel? _______________________________________

What would you be able to do/enjoy that you can't currently if this condition was gone?

____

Have you been treated for this condition previously? ☐ Yes ☐ No

☐ Medication ☐ Surgery ☐ Chiropractic ☐ Nutrition ☐ Acupuncture ☐ _______

Date of last exam: Physical __________ Blood work __________ Urine __________

X-Rays__________ MRI/CT/Ultrasound __________

Have you had or have any on the following:

AIDS	☐ Yes ☐ No	Alcoholism	☐ Yes ☐ No	Allergy shots	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Anorexia	☐ Yes ☐ No	Appendicitis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Autoimmune	☐ Yes ☐ No
Bleeding disorder	☐ Yes ☐ No	↑ Blood pressure	☐ Yes ☐ No	Breast lump	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Bulimia	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Chemical	☐ Yes ☐ No	Chicken pox	☐ Yes ☐ No
Crohns	☐ Yes ☐ No	Dependency		Diabetes	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Goiter	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Hashimoto's	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No
Herniated Disc	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	High	☐ Yes ☐ No
Hypo-	☐ Yes ☐ No	IBS	☐ Yes ☐ No	Cholesterol	
thyroiditis		Jaundice	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	Leaky Gut	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No
Lupus	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No
Mumps	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Multiple	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Sclerosis	
Parkinson's	☐ Yes ☐ No	Pinched nerve	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Prostate problem	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No
Psychiatric care	☐ Yes ☐ No	Scarlet fever	☐ Yes ☐ No	Rheumatoid	☐ Yes ☐ No
Rheumatic fever	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Arthritis	
Suicide attempt	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No	Thyroid	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Tumors	☐ Yes ☐ No	Problem	
Typhoid fever	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No	Vaginal	☐ Yes ☐ No
Venereal disease	☐ Yes ☐ No	Whooping cough	☐ Yes ☐ No	infections	

Other: ____

Do you get headaches? ☐ Yes ☐ No How often ______________ How would you describe them?

☐ Migraine ☐ Visual disturbance ☐ Nausea ☐ Tension ☐ Vomiting ☐ Related to allergies

☐ Aura ☐ Light sensitive ☐ Related to allergies ☐ Ocular migraine

Are you pregnant? ☐ Yes ☐ No Due Date______________

Have you ever take antibiotics? ☐ Yes ☐ No When______________

Are you taking birth control ☐ Yes ☐ No

Have you used hormone replacement therapy ☐ Yes ☐ No

Are you Vegetarian □ Yes □ No   Do you skip meals □ Yes □ No

How much sugar do you eat □ Little □ Moderate □ High   Do you crave sugar □ Yes □ No

____

Injuries/Surgeries you have had	Description	Date
Falls	______________________________	______________
Head injuries	______________________________	______________
Broken Bones	______________________________	______________
Auto Accidents	______________________________	______________
Surgeries	______________________________	______________

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

© 2013 Datis Kharrazian. All Rights Reserved.

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

© 2013 Datis Kharrazian. All Rights Reserved.
SMGEBFAF32(082013)

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

Metabolic Assessment Form

Name: ______________________ **Age:** ______ **Sex:** _____ **Date:** __________

PART I

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

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

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 movement	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 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

Category VI (continued)				
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous 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				
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 VIII				
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 IX				
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 X				
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

Copyright © 2012, Datis Kharrazian. All Rights Reserved.
SMGEMAF04(052212)

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

Category XI

Symptom	Rating
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

Symptom	Rating
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

Symptom	Rating
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

Symptom	Rating
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 XV

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

Category XVI

Symptom	Rating
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

Symptom	Rating
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)*

Symptom	Rating
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)*

Symptom	Rating
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)*

Symptom	Rating
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 XXI *(Menopausal Females Only)*

Symptom	Rating
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:

____

Copyright © 2012, Datis Kharrazian. All Rights Reserved.
SMGEMAF04(052212)

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

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