Welcome to the Healing Center

We Provide People Access to Their Full Potential

Records Request

The most effective way for Dr. Starling to provide the best possible care is for you to bring the last 3-5 years of the following:

- ☐ Blood/Lab Work
- ☐ X-Ray Reports
- ☐ MRI Reports
- ☐ Other Testing

Dr. Name _____ Phone _____
Dr. Name _____ Phone _____
Dr. Name _____ Phone _____

* It is important to bring these to the first visit. If there are any records that you can't bring to the first visit, please note your Doctor's name and phone number and we will retrieve them for you.

www.TheHealingCenterDenver.com

Phone: 303-721-9800
6300 S. Syracuse Way Suite 280 Centennial, CO 80111
Fax: 303-721-8853

The Healing Center - Patient History

Name: _____ Sex: M F Date: _____

Street: _____ City/State/Zip: _____

Phone: C: _____ H: _____ W: _____ Email: _____

DOB: _____ Age: _____ Ht: _____ Wt: _____ Blood Type: O A B AB

Martial Status: M D S W SSN: _____

Emergency Contact Name/#: _____

Spouse's Name/#: _____

Childrens' Name/Ages: _____

Occupation: _____

Occupational Stressors (Chemical, Physical, Structural, Psych): _____

List All Known Allergies: _____

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

_____

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

_____

_____

Past Medications and Supplements (3-6 months): _____

_____

Recent Exams (give dates): Physical: _____ Eye: _____

Dental: _____ Ob/Gyn: _____ Specialist: _____

Referred By: _____ Physcian: _____ Phone: _____

Your **Pain** level now feels: (pain) 10 ---------- 1 (no pain)

Your **Physical** health status now feels: (poor) 1 ---------- 10 (ideal)

Your **Mental** health status now feels: (poor) 1 ---------- 10 (ideal)

Your **Daily Work** stress levels now feels: (poor) 1 ---------- 10 (ideal)

Your **Home Life** stress levels now feels: (poor) 1 ---------- 10 (ideal)

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

1. _____

2. _____

3. _____

4. _____

5. _____

Name: _____ Date: _____

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

Category I: Colon

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief 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: Intestinal Integrity

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: Chemical Tolerance

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: Stomach - Hypochlorhydria

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 - Hyperacidity

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: Small Intesting/Pancreas

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, 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: Biliary

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 AM	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: Hepatic Detox

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: Sugar Metabolism

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: Peripheral Utilization of Sugars

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 & appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category XI: Adrenal Hypofunction

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 w/ exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Name: _____ Date: _____

Category XII: Adrenal Hyperfunction

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 w/ little or no activity	0	1	2	3

Category XIII: Electrolyte & pH Balance

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: Hypothyroid

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 gain 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: Thyroid Hyperfunction

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 (Male Only): Prostate

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3

Category XVI (Male Only): Prostate (Cont.)

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 XVII (Males Only): Andropause

Decreased libido	0	1	2	3
Decreased # 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 XVIII (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 XIX (Menopausal Females only)

How many years have you been menopausal?	_____			
Do you ever have uterine bleeding since menopause?	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

How many alcoholic beverages do you consume per week? ____ Rate your stress level on a scale of 1-10 during the average week: _____

How many caffeinated beverages do you consume per day? ____ How many times do you eat fish per week? _____

How many times do you eat out per week? _____ How many times do you work out per week? _____

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

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

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

Dietary Habits: List typical examples of daily meals (use Ø if you usually skip a meal).

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

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 Specific Sertonergic Antidepressants (NaSSaa)
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 Antidepresseants (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

Name: _____ 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 1 - Serotonin

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 - Dopamine

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 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 - GABA

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

Name: _____ Date: _____

Please answer all questions as completely and thoroughly as you can. Though some questions may not seem to pertain, they all are very important to help diagnosis and formulate a treatment plan specifically for you and make proper referrals. If needed, list number, then use spaces or back of page to explain more detail.

For Medical History: Current = C Past = P (greater than 6 months) include dates if possible for both

Healthcare

Independent or Concurrent Therapies:

1. ____ Chiropractic
2. ____ Chiro for family, pets
3. ____ Acupuncture
4. ____ Therapeutic Massage
5. ____ Naturopathic
6. ____ Oriental Medicine
7. ____ Nutritional Consult
8. ____ Medical Treatment
9. ____ Specialist
10. ____ Natural Healer
11. ____ Spiritual Healer
12. ____ Energy Work

_____

_____

_____

Diagnostic or Routine Exams: Please list area, Dr. and reason ordered, date and location of exam if known.

13. ____ X-rays
14. ____ MRI
15. ____ CAT Scan
16. ____ Blood draw
17. ____ Ultrasound
18. ____ Upper/lower GI
19. ____ DEXA Scan
20. ____ Breast Exam
21. ____ Prostate Exam
22. ____ Eye Exam
23. ____ Dental Exam
24. ____ Colonoscopy
25. ____ Other_____
26. ____ Other_____
27. ____ Other_____

_____

_____

_____

Significant Illnesses

28. ____ Allergies
39. ____ Arthritis
30. ____ Asthma
31. ____ Cancer
32. ____ Depression
33. ____ Diabetes
34. ____ Hepatitis A / B / C
35. ____ Heart disease
36. ____ High blood pressure
37. ____ Low blood pressure
38. ____ Lung disease
39. ____ Neurological
40. ____ Psychological
41. ____ Rheumatic Fever
42. ____ Seizures
43. ____ Thyroid disease
44. ____ Vascular disease
45. ____ Other

_____

_____

_____

Name: _____ Date: _____

Illness/Injuries/Surgeries/Hospitalizations:

46. ____ Broken bones
47. ____ Burns
48. ____ Car accidents
49. ____ Concussion
50. ____ Fallen down/upstairs
51. ____ Fallen from any height
52. ____ Fallen on ice
53. ____ Feeling un-coordinated
54. ____ Fevers
55. ____ Flu/colds
56. ____ Frequent accidents Sports injuries
57. ____ Frequent Illness
58. ____ Frequent Infections
59. ____ Head trauma
60. ____ Hospitalizations
61. ____ Infected wounds
62. ____ Loss of consciousness
63. ____ Psychological Hospitalization
64. ____ Recreational Injuries
65. ____ Serious cuts
66. ____ Serious Depression
67. ____ Significant trauma
68. ____ Surgeries
69. ____ Transfusions
70. ____ Transplants
71. ____ Tripping/Stumbling
72. ____ Wounds slow to heal

Childhood:

73. ____ Illnesses
74. ____ Traumatic events
75. ____ Immunizations
76. ____ Injuries
77. ____ Other
78. ____ Other

General Health: List times of day or any correlating factors

79. ____ Poor appetite
80. ____ Heavy appetite
81. ____ Change in appetite
82. ____ Unexplained Weight gain/loss
83. ____ Poor sleep
84. ____ Wake feeling tired
85. ____ Decreased sleep
86. ____ Heavy sleep
87. ____ Insomnia
88. ____ Apnea/Narcolepsy
89. ____ Sudden awakening at night time
90. ____ Hours of sleep/night
91. ____ Day napping ____ amt
92. ____ Night sweats
93. ____ Sudden energy drop
94. ____ Strong thirst hot/cold
95. ____ Fatigue
96. ____ Chills
97. ____ Sudden temp changes
98. ____ Localized weakness
99. ____ Tremors
100. ____ Poor circulation
101. ____ Peculiar tastes/smells
102. ____ Night pain
103. ____ Radiating pain
104. ____ Numbness/tingling
105. ____ Pins and needles
106. ____ Sweats easily
107. ____ Excessive sweating
108. ____ Body odor change
109. ____ Stress
110. ____ Bowel/bladder changes
111. ____ Bleed/bruise easily Where?_____

Musculoskeletal: List location and type of pain, i.e. sharp, dull, radiating, traveling, etc…

112. ____ Neck Pain
113. ____ Muscle Pain
114. ____ Back Pain
115. ____ Joint Pain
116. ____ Other muscle or joint problems?
117. ____ Irretractable night pain
118. ____ Scar tissue adhesions

Name: _____ Date: _____

Head, Eyes, Ears, Nose and Throat: List any noticeable correlation and frequency these conditions occur

119. ____ Dizziness
120. ____ Migraines Auras, Sounds, Smells
121. ____ Headaches
122. ____ Vision problems
123. ____ Near/Far sighted
124. ____ Blurry vision
125. ____ Night Blindness
126. ____ Eye strain/pain
127. ____ Color blindness
128. ____ Cataracts
129. ____ Glaucoma
130. ____ Spots in eyes
131. ____ Ringing in ears high/low
132. ____ Poor hearing
133. ____ Earaches
134. ____ Ear Pain
135. ____ Ear discharge
136. ____ Heavy ear wax
137. ____ Nose bleeds
138. ____ Sinus problems
139. ____ Mucus
140. ____ Dry throat/mouth
141. ____ Copious saliva (lots)
142. ____ Mouth/tongue sores
143. ____ Sore throats
144. ____ Other

Skin, Hair, and Nails:

145. ____ Rashes
146. ____ Eczema
147. ____ Hair/skin texture change
148. ____ Ulcerations
149. ____ Pimples
150. ____ Purpura (red or purple discoloration of the skin)
151. ____ Hives
152. ____ Dandruff
153. ____ Itching
154. ____ Loss of hair
155. ____ new moles/growth
156. ____ white spots on nails
157. ____ Absent half moons or ridged nails
158. ____ Other
159. ____ Other

Dental:

160. ____ Teeth problems
161. ____ Cavities
162. ____ Braces
163. ____ Bridges
164. ____ Fillings/amalgams
165. ____ Crowns gold/porcelain
166. ____ Tooth pain
167. ____ Head pain
168. ____ Jaw pain
169. ____ Molars
170. ____ Extractions
171. ____ Surgeries
172. ____ Jaw clicks
173. ____ Grinding teeth
174. ____ Facial pain
175. ____ Implants
176. ____ Dentures
177. ____ Swollen/bleeding gums
178. ____ Periodontal Tx
179. ____ Sealants
180. ____ Fluoride Tx
181. ____ Dry mouth
182. ____ Other_____
183. ____ Other_____

Neurologic:

184. ____ Balance problems
185. ____ Vertigo
186. ____ Nausea
187. ____ Vomiting
188. ____ Sudden blurry vision
189. ____ Loss of consciousness
190. ____ Loss of strength
191. ____ Weakness limb/body
192. ____ Feel un-coordinated
193. ____ Stumbling/tripping
194. ____ "Running into walls or things"
195. ____ Frequently dropping things
196. ____ Loss of hand grip
197. ____ Loss of fine motor skills
198. ____ Other_____
199. ____ Other_____

Name: _____ Date: _____

Cardio Vascular:

200. ____ High blood pressure
201. ____ Dizziness
202. ____ Blood Clots
203. ____ Low blood pressure
204. ____ Fainting
205. ____ Phlebitis
206. ____ Chest Pain
207. ____ Cold hands/feet
208. ____ Difficulty breathing
209. ____ Irregular heartbeat
210. ____ Hand/feet swelling
211. ____ Rapid pulse
212. ____ Heaviness in chest
213. ____ Other _____
214. ____ Other_____

Respiratory and Lungs:

215. _____Persistent Cough
216. ____ Coughing Blood
217. ____ Difficulty breathing while lying down
218. ____ Asthma
219. ____ Production of phlegm Y /N _____Color
220. ____ Tight chest
221. ____ COPD
222. ____ Bronchitis
223. ____ Pneumonia
224. ____ Asthma
225. ____ Other

Genito-Urinary:

226. ____ Pain w/urination
227. ____Loss of bladder function
228. ____Wake to urinate ____ x's/ night; time_____
229. ____ Kidney stones
230. ____ Frequent Urination _____ color _____odor
231. ____ Blood in urine
232. ____ Venereal disease/STD
233. ____ Urgency to urinate
234. ____ Impotency
235. ____ Prostate problems
236. ____ Other _____

Gastrointestinal:

237. ____ Pain or cramps
238. ____ Vomiting
239. ____ Rectal pain
240. ____ Bloody stools bright/dark red
241. ____ Sensitive abdomen
242. ____ Hemorrhoids
243. ____ Laxative use: ___wk; type_____
244. ____ Bowel Changes
245. Bowel movements _____Frequency/day/wk _____Color _____Odor (foul) _____Form (loose, compact) Texture (smooth, segmented)

Gynecology and pregnancy:

246. ____ Age of 1st menses
247. ____ Flow (describe)
248. ____ Period ___ days
249. ____ Clots
250. ____ Vaginal Sores
251. ____ Vaginal discharge _____odor _____color _____appearance
252. ____ Irregular Periods
253. ____ Last Menses
254. ____ Birth Control type and duration _____
255. ____ Number of pregnancies
256. ____ Number of births
257. ____ Live births
258. ____ Premature births; duration of pregnancy?_____
259. ____ Miscarriages; What month? _____
260. ____ Breast Lumps (tender?)
261. ____ PMS
262. ____ Mood Changes
263. ____ Body Changes
264. ____ Cramps
265. ____ Bloating
266. ____ Nausea
267. ____ Vomiting
268. ____ Menopause _____

Name: _____ Date: _____

Appliances or Aids:Cardio Vascular:

269. ____ Glasses/Prisms
270. ____ Contacts
271. ____ Orthotics
272. ____ Joint replacement
273. ____ Prosthetics
274. ____ Implants of any kind
275. ____ Braces
276. ____ Splints
277. ____ Pace Maker
278. ____ Hearing Aids
279. ____ Other
280. ____ Other

Neuropsychological:

281. ____ Seizures
282. ____ Depression
283. ____ Anxiety
284. ____ Poor memory
285. ____ Foggy thinking
286. ____ Bad Temper
287. ____ Concussions
288. ____ Easily stressed
289. ____ Considered/attempted suicide
290. ____ Treated for emotional concerns
291. ____ Antidepressant medications
292. ____ Other neurological or psychological concerns

Lifestyle and Social History:

Stress Screening: (Y/N)

293. ____ Can you relax when you want?
294. ____ Have trouble dealing with stress?
295. ____ Are you in therapy or counseling? Does it help?
296. ____ Is your family safe to express true emotions?
297. ____ Are romantic relationships fulfilling?
298. ____ Does stress leads to digestive problems?
299. ____ Do you abuse food/alcohol/tobacco to deal w/unpleasant feelings?
300. ____ Do you vent unpleasant emotions in a satisfying way?
301. ____ Do you avoid conflicts at your expense?
302. ____ Do you feel your health is out of your hands?
303. ____ Have you tried to deal with stress, but couldn't succeed?
304. ____ Do you feel capable of resolving your problems, but simply need to know how?
305. ____ How much do you love yourself? 0----------100%

Do you find any dysfunction or concern in the following areas? (Y/N)

306. ____ Relationship with Family
307. ____ Relationships with friends
308. ____ Social Skills
309. ____ Career
310. ____ Work
311. ____ Leisure Time
312. ____ Hobbies
313. ____ Past time activities
314. ____ Intimate relationships
315. ____ Sex
316. ____ Religious Life_____
317. ____ Spiritual Path_____
318. ____ Childhood Religious teachings
319. ____ Past relationships
320. ____ Childhood
321. ____ School

Name: _____ Date: _____

Lifestyle Habits: List type and quantities where valid

322. ____ Exercise: type_____
frequency/week_____
323. ____ Sports_____
324. ____ Walks: frequency/week_____
325. ____ Smoke/chew tobacco
326. ____ Recreational drugs use
327. ____ Un-protected sex
328. ____ Un-necessary risk taking
329. ____ Road Rage
330. ____ Seek conflict

Family History: Medical, psychological, social

331. ____ History of Chief Complaint
332. ____ Anemia
333. ____ Alcoholism
334. ____ Allergies
335. ____ ALS (Lou Gerhig's)
336. ____ Arthritis
337. ____ Asthma
338. ____ Back/spine problems
339. ____ Cancer
340. ____ Dementia/Alzheimer's
341. ____ Depression
342. ____ Diabetes
343. ____ Family violence
344. ____ Headaches
345. ____ Heart Disease
346. ____ High blood pressure
347. ____ High cholesterol
348. ____ Low cholesterol
349. ____ Lung disease
350. ____ Mental abuse
351. ____ Mental illness
352. ____ Migraines
353. ____ Multiple Sclerosis
354. ____ Muscular Dystrophy
355. ____ Neglect
356. ____ Neuropathy (numbness, tingling, pain, burning)
357. ____ Neuromuscular disease
358. ____ Parkinson's
359. ____ Physical abuse
360. ____ Sexual abuse
361. ____ Seizures
362. ____ Rigid upbringing
363. ____ Rigid Religious beliefs
364. ____ Stroke
365. ____ Suicide (or attempted)
366. ____ Thyroid disease
367. ____ Tremors
368. ____ Vascular disease
369. ____ Other_____
370. ____ Other_____

Cancellation Notice: Please Read and Initial

I understand that The Healing Center has a 24-hour Advance Cancellation Policy. Patients canceling with less than 24 hours notice will be charged for their visit. Initials _____

Authorization: Please Read and Sign

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation and provide treatment.

I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment.

I understand that I am responsible for all fees for services not covered by Medicare or insurance. I understand that I am ultimately responsible for all fees for services rendered and that fees are payable when services are rendered.

Signature_____ **Date:** _____

Authorization for Care of Minor

I hereby authorize this office and it's doctor(s) to administer care as they so deem necessary to my son/daughter.

Signed: _____ Witnessed: _____ Date: _____

Brain Region Localization Form

INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please answer every question, do not skip any questions. Follow the 0 to 4 key, and select which best fits for all of your answers.

KEY:

0 = I never have symptoms (0% of the time)
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NAME: DATE:

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

Frontal Lobe Precentral and Supplementary Motor Areas (Area 4 and 6)		Level
18.	Initiating movements with your arm or leg has become more difficult	0 1 2 3 4
19.	Feeling of arm or leg heaviness, especially when tired	0 1 2 3 4
20.	Increased muscle tightness in your arm or leg	0 1 2 3 4
21.	Reduced muscle endurance in your arm or leg	0 1 2 3 4
22.	Noticeable difference in your muscle function or strength from one side to the other	0 1 2 3 4
23.	Noticeable difference in your muscle tightness from one side to the other	0 1 2 3 4
Frontal Lobe Broca's Motor Speech Area (Area 44 and 45)		**Level**
24.	Difficulty producing words verbally, especially when fatigued	0 1 2 3 4
25.	Find the actual act of speaking difficult at times	0 1 2 3 4
26.	Notice word pronunciation and speaking fluency change at times	0 1 2 3 4
Parietal Somatosensory Area and Parietal Superior Lobule (Areas 3,1,2 and 7)		**Level**
27.	Difficulty in perception of position of limbs	0 1 2 3 4
28.	Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall	0 1 2 3 4
29.	Frequently bumping body or limbs into the wall or objects accidently	0 1 2 3 4
30.	Reoccurring injury in the same body part or side of the body	0 1 2 3 4
31.	Hypersensitivities to touch or pain perception	0 1 2 3 4

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Parietal Inferior Lobule (Area 39 and 40)		Level
32.	Right/left confusion [L]	0 1 2 3 4
33.	Difficulty with math calculations [L]	0 1 2 3 4
34.	Difficulty finding words [L]	0 1 2 3 4
35.	Difficulty with writing [L]	0 1 2 3 4
36.	Difficulty recognizing symbols or shapes [R]	0 1 2 3 4
37.	Difficulty with simple drawings [R]	0 1 2 3 4
38.	Difficulty interpreting maps [R]	0 1 2 3 4
Temporal Lobe Auditory Cortex (Areas 41, 42)		**Level**
39.	Reduced function in overall hearing	0 1 2 3 4
40.	Difficulty interpreting speech with background or scatter noise	0 1 2 3 4
41.	Difficulty comprehending language without perfect pronunciation	0 1 2 3 4
42.	Need to look at someone's mouth when they are speaking to understand what they are saying	0 1 2 3 4
43.	Difficulty in localizing sound	0 1 2 3 4
44.	Dislike of left predictable rhythmic, repeated tempo and beat music [L]	0 1 2 3 4
45.	Dislike of non-predictable rhythmic with multiple instruments [R]	0 1 2 3 4
46.	Noticeable ear preference when using your phone	right, left, no preference
Temporal Lobe Auditory Association Cortex (Area 22)		**Level**
47.	Difficulty comprehending meaning of spoken words [L]	0 1 2 3 4
48.	Tend toward monotone speech without fluctuations or emotions [R]	0 1 2 3 4

Medial Temporal lobe and Hippocampus		Level
49.	Memory less efficient	0 1 2 3 4
50.	Memory loss that impacts daily activities	0 1 2 3 4
51.	Confusion about dates, the passage of time, or place	0 1 2 3 4
52.	Difficulty remembering events	0 1 2 3 4
53.	Misplacement of things and difficulty retracing steps	0 1 2 3 4
54.	Difficulty with memory of locations (addresses) [R]	0 1 2 3 4
55.	Difficulty with visual memory [R]	0 1 2 3 4
56.	Always forgetting where you put items such as keys, wallet, phone, etc. [R]	0 1 2 3 4
57.	Difficulty remembering faces [R]	0 1 2 3 4
58.	Difficulty remembering names with faces [L]	0 1 2 3 4
59.	Difficulty with remembering words [L]	0 1 2 3 4
60.	Difficulty remembering numbers [L]	0 1 2 3 4
61.	Difficulty remembering to stay or be on time (reduced left) [L]	0 1 2 3 4
Occipital Lobe (Area, 17, 18, and 19)		**Level**
62.	Difficulty in discriminating similar shades of color	0 1 2 3 4
63.	Dullness of colors in visual field	0 1 2 3 4
64.	Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach out for objects	0 1 2 3 4
66.	Floater or halos in visual field	0 1 2 3 4

Brain Region Localization Form

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Cerebellum - Spinocerebellum		Level
67.	Difficulty with balance, or balance that is worse on one side	0 1 2 3 4
68.	A need to hold the handrail or watch each step carefully when going down stairs	0 1 2 3 4
69.	Feeling unsteady and prone to falling in the dark	0 1 2 3 4
70.	Proness to sway to one side when walking or standing	0 1 2 3 4
Cerebellum - Cerebrocerebellum		**Level**
71.	Recent clumsiness in hands	0 1 2 3 4
72.	Recent clumsiness in feet or frequent tripping	0 1 2 3 4
73.	A slight hand shake when reaching for something at the end of movement	0 1 2 3 4
Cerebellum - Vestibulocerebellum		**Level**
74.	Episodes of dizziness or disorientation	0 1 2 3 4
75.	Back muscles that tire quickly when standing or walking	0 1 2 3 4
76.	Chronic neck or back muscle tightness	0 1 2 3 4
77.	Nausea, car sickness, or sea sickness	0 1 2 3 4
78.	Feeling of disorientation or shifting of the environment	0 1 2 3 4
79.	Crowded places cause anxiety	0 1 2 3 4
Basal Ganglia Direct Pathway		**Level**
80.	Slowness in movements	0 1 2 3 4
81.	Stiffness in your muscles (not joints) that goes away when you move	0 1 2 3 4
82.	Cramping of hands when writing	0 1 2 3 4
83.	A stooped posture when walking	0 1 2 3 4
84.	Voice has become softer	0 1 2 3 4
85.	Facial expression changed leading people to frequently ask if you are upset or angry	0 1 2 3 4
Basal Ganglia Indirect Pathway		**Level**
86.	Uncontrollable muscle movements	0 1 2 3 4
87.	Intense need to clear your throat regularly or contract a group of muscles	0 1 2 3 4
88.	Obsessive compulsive tendencies	0 1 2 3 4
89.	Constant nervousness and restless mind	0 1 2 3 4
Autonomic Reduced Parasympathetic Activity		**Level**
90.	Dry mouth or eyes	0 1 2 3 4
91.	Difficulty swallowing supplements or large bites of food	0 1 2 3 4
92.	Slow bowel movements and tendency for constipation	0 1 2 3 4
93.	Chronic digestive complaints	0 1 2 3 4
94.	Bowel or bladder incontinence resulting in staining your underwear	0 1 2 3 4
Autonomic Increased Sympathetic Activity		**Level**
95.	Tendency for anxiety	0 1 2 3 4
96.	Easily startled	0 1 2 3 4
97.	Difficulty relaxing	0 1 2 3 4
98.	Sensitive to bright or flashing lights	0 1 2 3 4
99.	Episodes of racing heart	0 1 2 3 4
100.	Difficulty sleeping	0 1 2 3 4

Brain Region Localization Form

INSTRUCTIONS:

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Epileptiform Activity	Yes / No
Have you ever been diagnosed with a seizure disorder?	Yes / No
Have you ever been diagnosed with epilepsy?	Yes / No
Have you ever been told that you seemed frozen, absent, or tuned out at times without any recollection of the event?	Yes / No
Have you ever experienced sudden muscle stiffness and rigidity throughout your body?	Yes / No
Have you ever experienced sudden muscle jerks throughout your body?	Yes / No
Have you ever experienced a total loss of your muscle tone that lead to loss of control of your muscles or a fall?	Yes / No
Have you ever been told that you stare into space while you're lip smacking, chewing, or fidgeting that you are not aware of?	Yes / No
Do you ever experience sudden emotional responses such as anxiety, sadness, cry, or laugh for no real reason?	Yes / No
Do you ever experience sudden racing heart rate, sudden loss of bladder function, intestinal spasm, respiration, sweating, or any other sudden changes of function?	Yes / No
Do you ever experience sudden involuntary muscle contractures or jerks in any individual parts of your limbs or face?	Yes / No
Do you ever experience sudden involuntary head rotation and your eyes move forcefully to one side?	Yes / No
Do you ever experience sudden involuntary shift in your eyes to the side or upwards?	Yes / No
Do you ever experience sudden vocalization of random words or notice a sudden inability to speak?	Yes / No
Do you ever experience any spontaneous sensations of tingling, pins and needles" numbness, coldness, burning or other random sensations in any region of your body?	Yes / No
Do you ever experience a ringing sensation in your ears (tinnitus), sounds, or voices spontaneously?	Yes / No
Do you ever experience spontaneous perception of smells such as burning rubber, foul smells, or other odors without finding the source of the odor?	Yes / No
Do you ever experience flashing lights, stars, or jagged lines in your visual field?	Yes / No

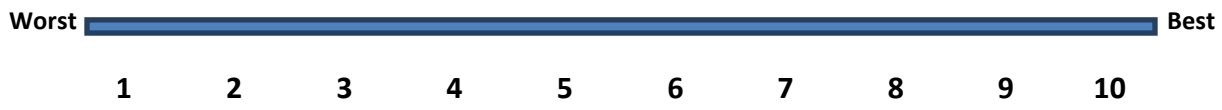
SIGNATURE: DATE:

Date:_____

GOAL SHEET

List top 3 symptoms & rate *current* severity below. Below each rating help us understand what your personal goal/s are for this symptom. Examples to consider are listed at the bottom of this page.

1) _____



Goal you want to achieve:

2) _____

Goal you want to achieve:

3) _____

Goal you want to achieve:

Goal Example: Information that would be helpful in following your progress, would include answering questions like: 1.) What changes do you want to see? 2.) How much change have you seen since beginning treatment?

- Symptom based (i.e ↓ anxiety, ↑ sleep, ↑ energy, ↓ px, ↓ bloating, etc.)
- Functional (i.e. ↑ range of motion, able to touch toes, able to move without pain, etc.)
- Lifestyle (can hike/run, clothes fit better, ↑ motivation to do things you love, etc.)