Van Harding L.Ac.
Neuro-Acupuncture & Natural Medicinals

NEW PATIENT REGISTRATION & MEDICAL HISTORY PACKET
COMPLEX CASE

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INTRODUCTION

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2990 South Sepulveda Blvd Suite 310 Los Angeles, Ca 90064 310-310-8096 tel/fax
www.vanharding.com

Van Harding L.Ac.

Acupuncture & Medicinals

New Patient Instructions – Complex Case

Thank you for your interest in becoming a patient. The documents you have downloaded are for assessing a Complex Case:

1) You have an autoimmune disease and are seeking managed care of your health,
2) You suspect you have an autoimmune condition and seek a diagnostic work-up and prospective treatment plan,
3) You have a condition which has not been successfully diagnosed and are seeking a thorough work-up and investigation of your case,
4) You have a diagnosis but the treatments have not been yielding positive results or not the desired improvements and are seeking a thorough work-up and investigation,
5) You are seeking assistance to recover from a Heart Attack or are seeking assistance to prevent a future Heart Attack.
6) You are seeking assistance for the recovery from a stroke/TIAs, brain injury or are seeking assistance to prevent a future stroke/TIAs.

Successful management of any complicated case requires proper testing, extensive investigation of health history, diagnosis, financial commitments and realistic patient expectations. Our extensive information gathering and the advanced, cutting-edge lab tests are key to managing your case.

The starting step of your case is completion of our detailed forms and questionnaires. These must be completed and submitted to our office before scheduling an appointment. Van will review all of this information before meeting with you for the first time at the initial consultation. The preview of these forms and questionnaires is included in the fees for your initial consultation.

The second step is acquiring copies of your medical records of the specific condition, disease or disorder that you seek our care, including lab work and diagnostic testing, are required before scheduling an appointment It is necessary to review those past medical records prior to your initial consultation. The preview of those records is included in the fees for your initial consultation. Section A contains instructions and appropriate forms to request copies of your medical records.

The initial consultation lasts approximately 60-90 minutes. It is Van's goal during the visit to gather the remaining necessary details about you and your medical condition so he can order any additional testing to determine root causes. If your case does not require any additional laboratory tests Van will discuss with you the proposed treatment plan and recommendations for your health.

Additional laboratory tests and Report of Findings consultation. Additional laboratory tests may be required, if so Van will discuss the necessity at the initial consultation and with your approval will then order those tests. Once Van has received the result(s) of that (those) laboratory test(s) you'll be notified to schedule the Report of Findings consultation appointment. At this appointment he will review the lab results, present a specific treatment plan and recommendations pertaining to your health. Expect this appointment to last 60 to 90 minutes or longer depending on the complications of your case and the number of questions you may have. Van's hourly rate is $300 per hour billed at 15 minute increments.

(continued)

New Patient Instructions – Complex Case (continued)

Getting Started: How to complete the forms and questionnaires. There are two sections of this document, Section A and Section B. All of the documents are to filled-in electronically. There are two types of documents: pdf and MSWord. There is a detailed list of documents within the Table of Contents located on the next page.

Section A contains the terms, conditions and policies of service and appropriate forms to request you medical documents. This section uses fill-in pdf forms. Allow 1 hour to complete these forms. To complete the forms:

1) Fill-in your answers,
2) Save a copy for your records,
3) Print a hard copy, provide your initials and signatures were required
4) Mail the signed hardcopy to our office at:

Van Harding L.Ac.
2990 South Sepulveda Blvd
Suite 310
Los Angeles, CA 90046

5) Confirm receipt of your documents. We will notify you via Email when we have received these documents. If you have given sufficient time for delivery by mail and have not received a notification from our office, please contact us for clarification. At your initial consultation we will provide you with original signed copies for your records.

Section B contains the forms and questionnaires of your medical history and chief complaint. The single most important criteria of a comprehensive assessment is the gathering of extensive and detailed health history. Please answer the following forms and questionnaires with as much detail as possible because it is vital that Van know everything about you and your case to better assess your condition. The amount of time needed to complete these forms will vary depending upon the complexity of your case. A minimum allowable time is about 4-6 hours spread across 2-3 days. This section uses both fill-in pdf forms and editable MSWord documents. To complete the forms:

1) Fill-in your answers
2) Save a copy for your records
3) Email the completed copies to our office at: info@vanharding.com
4) Confirm receipt of your documents. We will notify you via Email when we have received these documents. If you have not received a notification from our office, please contact us for clarification via email or phone.

Gathering prior medical records. We strongly recommend that you submit your requests to the appropriate physicians and medical care facilities as soon as possible because some offices may take 1-2 weeks to copy and release those documents.

Thank you in advance for your time and effort in completing these forms and questionnaires. The information derived from them will provide us invaluable data allowing for the appropriate course of treatment. If you have any questions please contact the office. I look forward to working with you.

Sincerely,

Van Harding L.Ac.
Acupuncture & Medicinals

Van Harding L.Ac.
Acupuncture & Medicinals

Establishing Health Goals

Before we begin our journey together, I want to discuss something very important that will have a major impact on your ability to recover and achieve maximum improvement. After many years I have had the opportunity to work with hundreds of patients and have seen many achieve significant improvement while others have become frustrated and failed in their attempts to get well. After careful review, I have discovered the reasons why some people succeed and why others fail, hence this questionnaire, Establishing Health Goals, explores those very reasons. It is my intention to do my best to assist you to achieve your health goal(s). You may be here to recover and regain function post a major injury or illness. For some of you it's about living free from debilitating pain, or relief from emotional distress, or enhanced cognitive functions to be connect to the word and for some of you it is living a life of vibrant health or maximizing your potential.

I've discovered that the correct way to attain one's health goal no matter 'what it may be', is to clearly define your needs and abilities to achieve your health goals. Therefore, to help you make significant changes in your health please review the following question and dig deep inside yourself for the answers. Please read through these questions before proceeding to other sections of the New Patient Registration & Medical History Packet. You will answer these questions in Section B. Thank you for your cooperation.

1) Have you made the decision to do what it takes to get well?
2) What health goal do you want to achieve under care provided by Van?
3) If you had a magic wand and could erase three health problems, what would they be?
4) If so, why do you think past health care practitioners have failed with your case?
5) Do you think your condition can be cured or improved?
6) What qualities are you looking for in a health care practitioner?
7) What things do you dislike about health care practitioners?
8) What do you consider a realistic amount of time to see changes in your health under the care by Van?
9) How much time are you willing to participate without improvement before you discontinue care?
10) Is there anyone you blame for your health condition?
11) What specific improvements in your health would you consider a successful outcome in your case?
12) Are you prepared to handle the financial costs of further assessments?
13) Do you think our practice fee ($300 per hour) is fair and appropriate?
14) Are you emotionally and spiritually at this time able to handle additional care efforts?
15) How would your feel if you spent considerably more time, energy and money under the care of Van than any other health care provider and had no improvements in your case?
16) As a vegetarian, are you willing to eat meat?
17) Are there any emotional experiences that can be contributing to your health condition?
18) Does your spouse and/or family provide you with support of your health condition? Are your spouse and/or family supportive of you seeking care with Van?
19) In order to improve your health, are you willing to:
    a) significantly modify your diet and/or life style?
    b) take several supplements each day?
    c) to receive acupuncture more than 3 times per week?
    d) receive low-current or microcurrent therapy?
    e) receive aromatherapy, or essential oils, sound and/or light therapy?
    f) receive massage, Myofascial Release, CranialSacral Therapy and/or deep tissue massage?
    g) participate in Qi Gong, exercise, yoga, stretching, meditation?
    h) keep a daily journal of how you feel physically and emotionally?

End

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Frequently Asked Questions About Lab Testing

Can you help me with my health problem?

Our clinic uses an innovative approach to assessing and treating your health. Perhaps you have been examined by your doctor, had blood tests done, x-rays or other diagnostic tests taken, only for your doctor to report back that all your tests are normal! Both you and your doctor know that your symptoms are anything but normal! Unfortunately this experience is all too common.

Most physicians are trained to look only in specific places for answers, using the same familiar labs or diagnostic tests. Yet, many causes of illness cannot be found this way. The usual tests do not look for food allergies, hidden infections, environmental toxins, mold exposures, nutritional deficiencies, and metabolic imbalances that our evaluation and testing uncover. Our practice also utilizes new laboratory testing to detect underlying gluten sensitivity and autoimmune activity that can be modified through diet, lifestyle, supplements or medications. Also, we utilize computer analysis of acupoints and acupuncture meridians to detect variants of Qi causing imbalances and disorders.

We use a variety of assessment techniques and procedures to help our patients recover from many chronic and difficult to treat conditions fibromyalgia, fatigue syndromes, autoimmune diseases, inflammatory disorders, mood and behavior disorders, memory problems and other chronic, complex conditions. We also focus on the prevention and treatment of heart disease, stroke, diabetes, dementia, neurodegenerative disorders, hormonal imbalances and digestive disorders. For a complete list of our areas of specialization visit out website “What We Treat”.

Will I need a blood test and where do I get that done?

During your consultation, we will determine which tests are needed to evaluate your health and review the testing recommendations, instructions (e.g. fasting or non-fasting, etc.), and costs.

Most of the testing requires you to go to an outside facility to draw blood (an order form is provided to take to the facility). Some tests are only available through specialty laboratories and others can be done at home such as collecting urine, saliva, or stool samples. In all cases, we assist you in coordinating initial and follow-up testing.

Do you take insurance for laboratory tests?

Cash pricing has been negotiated on most of our diagnostic testing. The cash prices are up to an 80% discount off list pricing and often are less expensive than submitting a bill to insurance. We use the newest, most advanced and cutting-edge tests, therefore they not accepted by most insurance companies because they are not considered "routine, conventional or mainstream”. .

Nutritional consultation services are typically not covered by insurance or Medicare. However, we provide a detailed receipt for services performed and you can submit that to your PPO insurance carriers or Health Savings Account as some carriers partially cover medical services and laboratory tests. Payment in full by cash, check, credit card, or any combination is due when services and tests are provided.

What credit cards do you accept?

We accept the following credit cards: Visa ,Master Card, Discover and American Express. An active credit card is kept on file at the office to bill follow-up consultations, laboratory testing, and other services.

Van Harding L.Ac.
Acupuncture & Medicinals

Instructions for Requesting Medical Records

Your medical records are very important in Van's evaluation of your case. Gather as much information as possible, going as far back as possible, even if you saw a doctor only once. Diagnostic testing, including blood tests, MRI's and CAT scans, medications, treatment notes and reports are just a few examples. You may have been told that your test results were "normal" but Van may see something different in the results as his evaluation methods are far different than other practitioners.

Here are six tips to help you gather your medical records:

1. IT IS YOUR RIGHT to obtain a copy of your medical records. On the next page is a Medical Records Release Authorization form. Print out a copy for each doctor you have seen and complete each form with their information.

2. Enclose or send a copy of your driver's license, government I.D. or your passport with the Medical Records Request Authorization form.

3. It is recommended that you go into the doctor's office personally to submit the form. Have the records sent directly to you, this way you know which records have been released and which records you need to follow up on to get them released. If you have records sent directly to us, please follow up with us to make sure we have received ALL your records.

4. Often a request for records will be put on the "back burner" and forgotten. Follow up frequently with each doctor's office until they sent your records.

5. If you are having a difficult time obtaining any records, please do not hesitate to contact our office for assistance.

6. If you request the records to be sent directly to our office they must be printed hard copies or electronic documents sent by email. Given the high volume of pages within a medical record we do not accept faxes.

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www.vanharding.com

MEDICAL RECORD RELEASE FORM

Doctor / Hospital: _____

Address: _____

Date: _____

Patient Information:

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS TO:

☐ Van Harding L.Ac.
2990 South Sepulveda Blvd Suite 310
Los Angeles, CA 90046

Phone: 310-310-8096

☐ Me personally and send them to:

_____

_____

Delivery Method: ☐Mail Copy ☐ Fax ☐Discuss Medical Information
Purpose of Request: ☐Medical Care ☐Personal ☐Continuing Care ☐Legal

Information to be released:

☐ Please provide complete copy of my medical history including all diagnostic and laboratory test results.

☐ Please provide complete copy of my diagnostic test results only.

☐ Other: _____

Authorization to Release Protected Information:

☐ I DO ☐ I Do NOT want Mental Health information released. Initials: _____

☐ I DO ☐ I Do NOT want information about HIV Tests & Related information released. Initials: _____

☐ I DO ☐ I Do NOT want information about Alcohol and/or Substance Abuse released. Initials: _____

☐ I DO ☐ I Do NOT want information about Genetic Testing released. Initials: _____

☐ I DO ☐ I Do NOT want information about _____ released. Initials: _____

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

Patient's Signature: _____ Date: _____

MEDICAL RECORD RELEASE FORM

Doctor / Hospital: _____

Address: _____

Date: _____

Patient Information: Minor under age 16

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS TO:

☐ Van Harding L.Ac.
2990 South Sepulveda Blvd Suite 310
Los Angeles, CA 90046

Phone: 310-310-8096

☐ Me personally and send them to:

_____

_____

Delivery Method: ☐ Mail Copy ☐ Fax ☐ Discuss Medical Information
Purpose of Request: ☐ Medical Care ☐ Personal ☐ Continuing Care ☐ Legal

Information to be released:

☐ Please provide complete copy of my medical history including all diagnostic and laboratory test results.

☐ Please provide complete copy of my diagnostic test results only.

☐ Other: _____

Authorization to Release Protected Information:

☐ I DO ☐ I Do NOT want Mental Health information released. Initials: _____

☐ I DO ☐ I Do NOT want information about HIV Tests & Related information released. Initials: _____

☐ I DO ☐ I Do NOT want information about Alcohol and/or Substance Abuse released. Initials: _____

☐ I DO ☐ I Do NOT want information about Genetic Testing released. Initials: _____

☐ I DO ☐ I Do NOT want information about _____ released. Initials: _____

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

Parent or Guardian Name: _____ Phone _____
Print

Signature: _____ Date: _____
Parent or Guardian

Van Harding L.Ac.

Acupuncture & Medicinals

A Message to Our Patients About Arbitration

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by California courts.

By signing this agreement you are changing the place where your claim will be presented. You still can call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. This agreement generally helps to limit the legal costs for both patients and physicians. This is because the time to conduct an arbitration hearing is far less than for a jury trial. Further, both parties are spared some of the rigors of trial and the publicity which may accompany judicial proceedings.

Our goal, of course, is to provide you with quality medical care which fully meets your health care needs. We know that most problems begin with communication. Therefore, if you have any questions about your care, please contact us.

Please sign the Arbitration Agreement after first reading it carefully and asking any questions you may have. Submit this document via postal mail with the other documents in Section A.

Sincerely,

Van Harding LAc

2990 South Sepulveda Blvd Suite 310 Los Angeles, CA 90064 310.310.8096 info@vanharding.com
www.vanharding.com

Van Harding L.Ac.

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Patient Acceptance Policy – Complex Case

In order to better serve you, the Patient Acceptance Policy should be carefully reviewed so you understand our expectations and clinical procedures. To prevent any misunderstandings or confusion on what to expect, please read the following steps and provide your signature.

1. **Completion of the following forms**:

Section A:

- Patient Acceptance Policy
- General Patient Information
- Notice of Privacy Practices
- Credit Card Authorization
- Arbitration Agreement
- Acupuncture Informed Consent to Treat

It is very important for you to carefully read and thoroughly complete all of these forms and questionnaires.

Section B:

- Chief Complaint Description
- Current-Past Medical History
- Review of Systems
- Family Medical History
- Symptom Assessment Form
- Medication History
- Family Medical History
- Dietary Evaluation
- Life Style & Environment Evaluation
- Health History Timeline, Goals & Protocols

2. **Prior Medical Records** from all physicians since you were first diagnosed with your health condition MUST be obtained prior to scheduling an appointment.

3. Initial Consultation will be scheduled once our office has received your completed forms & questionnaires, and copies of all your medical records. This 1- hour appointment will be scheduled to review your case. Van will conduct a thorough history and case assessment at that time. The cost for the I-hour appointment as well as Van's time for reviewing your medical questionnaire, medical records and written medical history is $300. Any lab work provided to our office less than 3 days prior to your initial consultation is billed at an additional review fee of $300 per hour. A cancellation fee of $275 is charged if you cancel your initial consultation appointment with less than 24-hours notice.

4. Comprehensive Blood Chemistry tests may be necessary to obtain based on the review of all your medical information at the conclusion of your initial consultation. This blood chemistry test includes:

- Comprehensive Executive Metabolic Panel: this includes 24 important disease markers such as Glucose, Hemoglobin Ale (Blood Sugar), SOOT, SGPT, GGT, Bilirubin (Liver), BUN, Creatinine, Phosphorus, Uric Acid (Kidney), Alkaline Phosphatase (Bone), and others
- Cardiovascular Panel: Cholesterol, Triglycerides, LDL, VLDL, HDL, Cholesterol/HDL Ratio, LDL/ HDL Ratio, C-Reactive Protein (hs-CRP), Homocysteine, and Fibrinogen
- Thyroid Panel: TSH, Total T4, Total T3, Free T4, Free T3, T3 uptake, and FTI
- CBC with differential: White Blood Cells and Red Blood Cells, Platelets
- Vitamin D & RBC Magnesium

5. Medical laboratory tests to our specifications may be ordered based on your health condition and you will be presented with detailed information on why the specific tests are recommended. **The cost for your initial laboratory tests will be discussed at that time and is different for every patient.**

Patient Acceptance Policy – Complex Case (continued)

6. The results of your lab tests may take approximately 2 to 6 weeks. An appointment to review your lab results takes approximately 1 to 2 hours, or longer, depending on the complications of your case. You will be presented with a written report detailing the results of your tests, the possible causes of your health problems, and the recommended treatment protocol. Your cooperation in taking "personal responsibility" for your health care will be vital for treatment success. It is suggested that you have your spouse or a supportive family member attend this appointment to help you on your health journey.

7. Your treatment may consist of dietary and lifestyle changes as well as prescribed Natural Pharmaceuticals, nutritional supplements, herbs, acupuncture ear seeds or magnets, microcurrent topical patches and essential oils. Unopened product returns will be accepted if returned within 10 days of purchase. There are no returns on refrigerated supplements.

8. **It is strongly recommended that you have access to a computer and an Internet connection**. A medical progress questionnaire will be posted to your e-mail one week before your next scheduled appointment. Completion of the questionnaires are required to monitor your progress. If you do not have access to the Internet, a copy of the progress questionnaire will be mailed or faxed to you.

9. **Correspondence by e-mail is strongly encouraged and is Free.** Please keep emails short and to the point. Responses will be made within a few days. Should you need an immediate response, please call the office at 310-310-8096. To speak directly with Van for detailed assistance you may schedule an appointment.

10. **Follow-up consultations** are scheduled approximately every 3, 6 or 12 weeks so you can discuss your progress and any concerns with Van. At these times, Van will determine what alterations to your treatment plan and/or medicinal protocols are necessary to help you progress. Consultations can be conducted either by phone, Skype or in person at the office.

11. **Additional lab tests are necessary to re-evaluate prior abnormal laboratory test results**. Laboratory fees can vary depending on what needs to be re-tested. The success of your treatment will not only be measured by the reduction or elimination of your physical symptoms, but also on abnormal laboratory tests returning to or progressing towards a normal status. *For example:*

Many physicians will prescribe Lipitor for individuals suffering with high cholesterol and will require periodic cholesterol blood tests to monitor the activity of the medication.

12. **Follow-up acupuncture treatments** are determined at the initial consultation. Certain conditions require weekly, twice weekly or at two week intervals.

13. **Appointments are scheduled online** through our website. Confirmations are emailed within 24 hours of your request. If you do not have access to the internet you can fax us with several dates and times of your availability.

Patient Acceptance Policy – Complex Case (continued)

14**. Appointment Late Arrivals for Acupuncture:** Notify our office by telephone if you are going to be more than 10 minutes late. If you are more than 10 minutes late to your appointment you are subject to the cancellation fee. Our office understands that traffic can cause delays and that there many reasons that may require you to be late to your appointment. However, we have requested that you select an appointment time which allows you to arrive 15-20 minutes early to stabilize your heart rate and blood pressure as well as to drink water.

15. Making Changes to your Appointment: Our offices must be notified 48 hours in advance to reschedule your appointment. Any notifications that are less than 48 hours are subject to a rescheduling fee. The rescheduling fee is 25% of the appointment fee that is being rescheduled. Our offices will do our best to work with you to accommodate unexpected circumstances that prevent you from making your appointment. We respectfully request that you state your reasons for rescheduling.

16. Cancellation of or No Show at your Appointment: Our office must be notified via email or phone 48 hours in advance to cancel your appointment. Failure to notify our offices or no show to your appointment will result with the full payment of the missed appointment being charged to your credit card. Our offices will do our best to work with you to accommodate unexpected circumstances that prohibit you from attending your appointment. We respectfully request that you state your reasons for the cancellation.

17. Arbitration is the agreed upon method for dispute resolution. We believe that the method of resolving disputes by arbitration is one of the fairet systems for both patients and physicians.

18. Payment is made at the time services are rendered and tests are ordered. Payments can be made via cash, check and/or credit card. We accept Visa, Master Card, Discover and American Express. A valid credit card must remain on file at all times.

19. Insurance companies have recently added acupuncture to their polies. Currently we will provide you with a Superbill to submit to your insurance company for reimbursement. Some policies are providing coverage for pain due to arthritis, post dental surgery, TMJ and all types of pain throughout the body. Other disorders sometimes included are women's reproductive, insomnia, anxiety, depression and nausea. Check your policy or speak with your Human Resources manager to determine if you have coverage.

I, _____have read and fully understand the **Patient Acceptance Policy**.
Print Patient Name

_____ _____
Patient Signature Date

Van Harding L.Ac.

Acupuncture & Medicinals

General Patient Information (Adult)

Name_____ Preferred Name _____
First Middle Last

Driver License/ID _____ Insurance _____
State Number Carrier Policy or ID Number

Address_____ _____ _____ _____
Street City State Zip Code

Home Phone_____ Work Phone _____

Cell Phone_____ Email _____

Occupation:_____ Employer:_____

Best time to reach you: ☐Morning ☐Afternoon ☐Evening Best phone to reach you: ☐Cell ☐Home ☐Work

In case of an EMERGENCY who should we contact? _____ _____
Name Relationship

Cell Phone _____ Home Phone _____ Work Phone _____

Social Security# _____ Language_____ USA Citizen: ☐Yes ☐No

Date of Birth _____ Age _____ Place of Birth _____ Sex ☐Female ☐Male ☐TS
Month Day Year City & State or Country

Genetic background (Please check appropriate boxes) Number of generations in USA: _____

☐African N.American	☐Asian Chinese	☐Caucasian Scandinavian	☐Middle East	☐Russia-Ukraine
☐Native N.American	☐Asian Japanese	☐Caucasian W. European	☐Mediterranean	☐India
☐Central American	☐Asian Korean	☐Caucasian British Isles	☐N. Africa	☐Pacific Islands
☐South American	☐Southeast Asia	☐Caucasian E. European	☐Central Africa	☐Australia – NZ

☐Adopted ☐Unknown Other:_____

Status: ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed ☐Emancipated Minor

Spouse's name:_____ Age:_____ Occupation:_____

Please check the highest level of education: ☐High School ☐VoTech ☐Bachelor ☐Master ☐Doctorate

Military:☐Army ☐Navy ☐Marine ☐Air Force Rank:_____ Discharge:_____
Date

Do you have any learning challenges?☐Yes ☐No If Yes, describe _____

Do you have a disability or a handicap? ☐Yes ☐No If yes, describe_____

Van Harding L.Ac.

Acupuncture & Medicinals

General Patient Information (Minor)

Name_____ Preferred Name _____
First Middle Last

Parent(s) or Guardian(s) name _____ _____
Mother's Father's

Address_____ _____ _____ _____
Street City State Zip Code

Home Phone_____ Work Phone _____

Cell Phone_____ Email _____

Occupation _____ Employer _____

Best time to reach you: ☐Morning ☐Afternoon ☐Evening Best phone to reach you: ☐Cell ☐Home ☐Work

In case of an EMERGENCY who should we contact? _____ _____
Name Relationship

Cell Phone_____ Home Phone_____ Work Phone_____

Social Security# _____ Language _____ USA Citizen: ☐Yes ☐No

Date of Birth _____ Age _____ Place of Birth _____ Sex ☐Female ☐Male ☐GD
Month Day Year City & State or Country

Genetic background (Please check appropriate boxes) Number of generations in USA: _____

☐African N.American	☐ Asian Chinese	☐ Caucasian Scandinavian	☐ Middle East	☐ Russia-Ukraine
☐Native N.American	☐Asian Japanese	☐Caucasian W. European	☐ Mediterranean	☐ India
☐Central American	☐ Asian Korean	☐Caucasian British Isles	☐ N. Africa	☐ Pacific Islands
☐South American	☐Southeast Asia	☐ Caucasian E. European	☐ Central Africa	☐ Australia – NZ

☐ Adopted ☐ Unknown ☐ Other:_____

Parental Status: ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Re-married ☐Widowed

Sibling status: ☐Biological ☐Step-by remarriage ☐Adopted ☐Foster-care ☐None ☐Deceased

Living at home with both parents? ☐Yes ☐No If no, describe living arrangements _____

_____

School grade level _____ Extra Activity _____
Team Sports Music Private Sports Additional Academics

Do you have any learning challenges? ☐Yes ☐No If Yes, describe _____

Do you have a disability or a handicap? ☐Yes ☐No If yes, describe_____

_____

Van Harding L.Ac.

Acupuncture & Medicinals

Notice of Privacy Practices

The privacy of your medical information is important to us and we are committed to protecting it. This notice describes how information about you may be used and disclosed, as well as, how you can get access to this information. Please read this information carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations. These include emergency care, quality assurance activities, payment, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a written request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

In the future we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. We have the right to make changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the information to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Office for Civil Rights
U.S. Department of Health and Human Services
50 United Nations Plaza - Room 322
San Francisco, CA 94102
415-437-8310 (VOICE); 415-437-8311 (TDD); 415437-8329 (FAX)

Contact Person:
Van Harding
2990 South Sepulveda Blvd
Suite 310
Los Angeles, CA 90046

I,_____hereby acknowledge my receipt of the Notice of Privacy Practices given to me.

Signed: _____ Date: _____

Van Harding L.Ac.

Acupuncture & Medicinals

Credit Card Authorization

I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. also understand that fees for professional services, products and shipping charges rendered to me will be immediately due and payable. If there is any unpaid balance on my account at any time, it will be charged to my credit card if no other payment arrangements have been agreed upon.

Authorization to debit a credit card:

Patient's Name: _____ File# _____

Visa Mastercard Discover American Express

Name on Credit Card: _____

16 Digit Card Number: _____ Expiration: ___ /___ cvv2: _____

Billing Address: _____

Street Apt or Unit#

_____

City State Zip Code

Please bill charges I incur to the card listed above for services, supplies, lab tests and shipping. I understand written notification of the dates of service and itemized charges will be sent to me for my records.

I have read and understand the above.

_____ _____

Credit Card Holder Signature Date

2990 South Sepulveda Blvd Suite 310 Los Angeles, Ca 90046 310-310-8096 tel/fax

www.vanharding.com

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X**

(Or Patient Representative) (Date) (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X**

. (Date) (Print Name of signor for Office)

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME: Van Harding LAc	2990 South Sepulveda Blvd Suite 310 Los Angeles, CA 90064	2554 Lincoln Blvd #211 Venice, CA 90291

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship to patient) DATE

Van Harding L.Ac.

Acupuncture & Medicinals

Section B: Medical History

Fill-In Forms & Questionnaires

The single most important criteria of a comprehensive and detailed health assessment is the gathering of information and it begins with your medical history and your description of the chief complaint or primary health concern.

Please complete the following forms and questionnaires with as much detail as possible. It is vital for the success of your case that Van knows everything about you and your case to better assess your condition. You may need family members to help supply information. We know that when a patient is in the doctor's office's there is a tendency of the patient to not mention too many symptoms out of fear that the doctor will think of you as a hypochondriac. We are interested in odd or unusual "message" (symptom) your body or mind expresses even if it seems irrelevant to you. These messages may be very useful clues in our type of medical detective work.

Questions are intentionally repeated in several areas of these forms and questionnaires to assist our evaluation process. Please do **NOT** skip a question because you have answered it somewhere else in this extensive packet of forms and questionnaires.

The amount of time needed to complete these forms will vary depending upon the complexities of your case and the amount of time needed to reflect and recall details.

We strongly recommend that after you complete these forms and questionnaires that you await 24 hours and then review all of your answers to determine if there has been any information unrecorded. Please allow a minimum of 4-6 hours spread across 2-3 days to complete these forms.

These are electronic documents in pdf and MSWord formats.

The first questionnaire is the Chief Complaint which is a pdf Fill-In form. You can add information by submitting an additional MSWord document and name the file with your name and Chief Complaint.
Example: Jane_Doe_Chief_Complaint

The second group contains several pdf forms which have boxes to be 'checked' and fields to 'filled-in' with a short answer. Hereto, you can add information by submitting an additional MSWord document and name the file with your name and subject title of the page located at the top of the document.
Example: John_Doe_Systems_Review

The third and last group has two MSWord documents: 1) Establishing Health Goals which was reviewed in the Introduction and 2) Health History Timeline Questionnaire which is reviewed in Section B. You may write as much information as you choose because there is no limit of space for any question.

Please send all of your documents after you have thoroughly reviewed them and cannot think of anything that needs to be included. Email these documents to our office and we will notify you when we have received them.

Summary: To complete the forms

1) Fill-in your answers
2) Save a copy for your records
3) Email the completed copies to our office at: info@vanharding.com
4) Confirm receipt of your documents. We will notify you via Email when we have received these documents. If you have not received a notification from our office within 24 hours, please contact us for clarification via email or phone.

Thank you for your cooperation and I look forward to reviewing ALL of your case.

Sincerely,
Van Harding L.Ac.

Name:_____ Date_____

Chief Complaint - Part 1

Primary Health Concern

Instructions: There are two (2) documents for the Chief Complaint. The first is a 'Fill-In' pdf which is seen below and the second is a MSWord document. Please provide as much information as possible - this is your opportunity to tell me what is occurring for you now, in the past as well as concerns you have for your future should this condition continue.

Name most significant issue:_____

If previously diagnosed condition please name or from the group below identify your main complaint.

Indicate all abnormalities that occur simultaneously with your main complaint:

- ☐ Balance
- ☐ Hearing
- ☐ Smell
- ☐ Speech
- ☐ Swallowing
- ☐ Taste
- ☐ Touch
- ☐ Vision
- ☐ Appetite
- ☐ Defecation
- ☐ Digestion
- ☐ Thirst
- ☐ Urination
- ☐ Bleeding
- ☐ Mucus flow
- ☐ Swelling
- ☐ Blood pressure
- ☐ Cardio
- ☐ Respiratory
- ☐ Skin
- ☐ Energy
- ☐ Libido
- ☐ Menses
- ☐ Semen flow
- ☐ Sleep
- ☐ Excess naps
- ☐ Addiction
- ☐ Attitude change
- ☐ Behavior change
- ☐ Cravings
- ☐ Emotions
- ☐ Mental function
- ☐ Memory
- ☐ Pain & Emotions
- ☐ Injury (Past)
- ☐ Injury (Recent)
- ☐ Fertility
- ☐ Weight
- ☐ Pain (physical)
- ☐ Twitching-Ticks
- ☐ Hiccups

Is the current episode the first time this primary complaint has occured? ☐ Yes ☐ No, it has occurred _____

When did the primary complaint become disruptive to your Activites of Daily Living or caused significant impairment?

_____

How many days, weeks, months or years ago or the date.

When did the primary complaint or associated symptoms begin before the condition became disruptive to your Activities of Daily Living or caused significant impairment?

_____

Indicate the number of days, weeks, months or years or the date.

How frequently does the primary complaint or associated symptoms interfere with Activities of Daily Living?

_____

Indicate number of minutes, hours in a day or number of days/weeks

What do you think is the origin or cause of the primary complaint? _____

_____

What provides relief to the primary complaint? _____

_____

_____

_____

Type of Pain or Sensation:

- ☐ Sharp
- ☐ Shooting
- ☐ Throbbing
- ☐ Burning
- ☐ Dull
- ☐ Aching
- ☐ Tingling
- ☐ Numbness
- ☐ Cramping
- ☐ Tightening
- ☐ Stiffness
- ☐ Swelling
- ☐ Heat
- ☐ Cold
- ☐ Crawling
- ☐ Itching

Quality.of Primary Complaint:

- ☐ Constant
- ☐ Intermittent

Trigger or Aggrivates PC:

- ☐ Cold ☐ Heat
- ☐ Physical activity
- ☐ Emotional upset
- ☐ Stress ☐ Weather

What provides relief of Pain or sensation? _____

_____

Rate your pain at it's most and least painfulness:

- ☐ 0 None
- ☐ 1 Mild - nagging, annoying, interferes little with ADLs
- ☐ 2 Mild - nagging, annoying, interferes little with ADLs
- ☐ 3 Mild - nagging, annoying, interferes little with ADLs
- ☐ 4 Moderate - Interfere's significantly with ADLs
- ☐ 5 Moderate - Interfere's significantly with ADLs
- ☐ 6 Moderate - Interfere's significantly with ADLs
- ☐ 7 Severe - Disabling, unable to perform ADLs (need med's)
- ☐ 8 Severe - Disabling, unable to perform ADLs (need med's)
- ☐ 9 Severe - Disabling, unable to perform ADLs (need meds)
- ☐ 10 Severe - Disabling, unable to perform ADLs (need hospital)

Name:_____ Date_____

Use the next four (4) pages to embellish upon the details of your Primary Complaint and Life Experiences.

Chief Complaint - Part 2

Primary Health Concern

Instructions: The Day Your Primary Complaint became disruptive to your ADL or caused significant impairment

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order starting with the morning of and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

Please identify the date. This does not have to be an exact calendar date – it can be 'mid-November 2011', or sometime in the summer of 2009, or it might be as specific as the morning of New Year's Day 2012. Then describe the following:

- where you were located when you noticed the problem (or a medical diagnosis that was given),
- how you felt and any pain and/or emotional responses
- what ADL you could not do or what bodily functions were significantly impaired
- the duration of the symptom(s) and characteristics (qualities)
- anything that seemed to make it worsen or improve it
- any observations by other people of your behavior, emotions or physical condition

Date your Primary Complaint or associated symptoms became disruptive to your ADL or caused significant impairment:

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Chief Complaint Part 2

Name:_____ Date_____

Chief Complaint - Part 3

Primary Health Concern

Instructions: Your Life Prior to the Day the Primary Complaint became disruptive to your ADL or caused significant impairment cited in Part 2.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Reflect back to the earliest date when you noticed the Chief Complaint and/or associated symptoms. Please identify the date. This does not have to be an exact calendar date – it can be 'mid-November 2011', or sometime in the summer of 2009, or it might be as specific as the morning of New Year's Day 2012.
- Next, list the events of your life that occurred between that earliest date of symptoms and the day your Primary Complaint became disruptive to your ADL or caused significant impairment. These events include:
  travel in or outside the USA or Canada moving your home changing jobs marriage divorce separation pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters child rearing problems children leaving home for college child custody illness accidents incarceration institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Date of earliest recall of Primary Complaint or associated symptoms:

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Chief Complaint Part 3

Name:_____ Date_____

Chief Complaint - Part 4

Primary Health Concern

Instructions: Your Life 1 year Prior to the Earliest Date you noticed the Primary Complaint or associated symptoms cited in Part 3.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Reflect back 1 year prior to the earliest date when you noticed the Chief Complaint and/or associated symptoms. Please identify the date. This does not have to be an exact calendar date – it can be 'mid-November 2011', or sometime in the summer of 2009, or it might be as specific as the morning of New Year's Day 2012.
- Next, list the events of your life that occurred between that earliest date of symptoms and the day your Primary Complaint became disruptive to your ADL or caused significant impairment. These events include:
  travel in or outside the USA or Canada moved your home changing jobs marriage divorce separation pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters child rearing problems children leaving home for college child custody illness accidents incarcerated institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Date 1 year prior to the earliest recall of the Primary Complaint or associated symptoms:

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Chief Complaint Part 4

Name:_____ Date_____

Chief Complaint - Part 5

Primary Health Concern

Instructions: Your Symptoms and Actions since the day your Primary Complaint or associated symptoms became disruptive to your ADL or caused significant impairment cited in Part 2.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Describe to best of you abilities the chronological sequences of the following starting from the Day the Primary Complaint or associated symptoms became disruptive to your ADL or caused significant impairment through to today. Include the following:
  - changes of the symptoms over time (duration, intensity, improvements, worsening, etc)
  - the actions you have employed to treat the problem via MD, ND, DO, DC, LAc, PT and other therapists as well as home remedies. Include the diagnosis, therapies, medications and natural remedies (herbs, homeopathy, nutritional) that have been used. Include any and all improvements or worsening of the problem/condition due to any of the actions you employed.
- Include the events of your life that occurred during this tme period. These events include:
  travel in or outside the USA or Canada moved your home changing jobs marriage divorce separation pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters child rearing problems children leaving home for college child custody illness accidents incarcerated institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Symptoms and Actions since the Primary Complaint or associated symptoms became disruptive to ADL or causative to significant impairment:

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Chief Complaint Part 5

Name_____ Date_____

Safety Screening

Current or most recent Primary Care Provider:

Name _____ Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain on bottom of page.	☐	☐
3. Are you taking any medication(s) including nonprescription medicine? If yes, please list on bottom of page.	☐	☐
4. Have you ever taken Phen-Fen/Redux?	☐	☐
5. Do you smoke tobacco? Describe usage below.	☐	☐
6. Do you use controlled substances or alcohol? Describe usage below.	☐	☐
7. Women Only: Are you pregnant or think you may be pregnant? Are you nursing? Are you taking oral contraceptives?	☐ ☐ ☐	☐ ☐ ☐

8. Are you allergic to or have you had any reactions to the following:	Yes	No
Local Anesthetics (eg. Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (eg. Nickel, mercury, etc)	☐	☐
Latex Rubber	☐	☐
Other _____		

9. If you allergic to the following, mark and explain below.

☐ Pollen ☐ Mold ☐ Grass ☐ Foods ☐ Animals

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pain	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Short of Breath	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Mitral Valve Prolapse	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Bleeding tendency	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Work-related Injuries	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other Injuries	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐	Other Implants or prosthetics, list:	☐	☐

_____

_____

Family Medical History: Has your father or mother ever had the following?

	Yes	No		Yes	No
Stroke	☐	☐	Mental Disorder	☐	☐
Asthma	☐	☐	High Blood Pressure	☐	☐
Allergies	☐	☐	Diabetes	☐	☐
Cancer	☐	☐	Multiple Sclerosis	☐	☐

Other(s) Parental Health Issues:

_____

_____

_____

List below medications, prior surgeries with dates, and/or current therapy:

_____

_____

_____

_____

_____

_____

_____

_____

Describe usage of tobacco, controlled substances and/or alcohol: Quantity per day, week, etc.

_____

_____

_____

_____

_____

_____

_____

_____

Name _____ Date _____

Current & Past Medical History

Illness	Timing	Comments
Chicken Pox	☐ Current ☐ Past	
German Measles	☐ Current ☐ Past	
Measles	☐ Current ☐ Past	
Mumps	☐ Current ☐ Past	
Polio	☐ Current ☐ Past	
Whooping cough	☐ Current ☐ Past	
Anemia	☐ Current ☐ Past	
Arthritis	☐ Current ☐ Past	
Asthma	☐ Current ☐ Past	
Bronchitis	☐ Current ☐ Past	
Cancer	☐ Current ☐ Past	
Chronic Fatigue Syndrome	☐ Current ☐ Past	
Crohn's Disease or Ulcerative Colitis	☐ Current ☐ Past	
Diabetes/Insulin Resistance	☐ Current ☐ Past	
Emphysema	☐ Current ☐ Past	
Epilepsy, convulsions	☐ Current ☐ Past	
Gallstones	☐ Current ☐ Past	
Gout	☐ Current ☐ Past	
Heart attack/Angina	☐ Current ☐ Past	
Heart failure	☐ Current ☐ Past	
Hepatitis	☐ Current ☐ Past	
High blood pressure	☐ Current ☐ Past	
Irritable bowel	☐ Current ☐ Past	
Kidney stones/disease	☐ Current ☐ Past	
Liver disease	☐ Current ☐ Past	
Pneumonia	☐ Current ☐ Past	
Rheumatic fever	☐ Current ☐ Past	
Sinusitis	☐ Current ☐ Past	
Sleep apnea	☐ Current ☐ Past	
Stroke	☐ Current ☐ Past	
Thyroid disease	☐ Current ☐ Past	
Head Injury	☐ Current ☐ Past	
Neck Injury	☐ Current ☐ Past	
Back Injury	☐ Current ☐ Past	
Fracture	☐ Current ☐ Past	
Other (describe)	☐ Current ☐ Past	

Name_____ Date _____

Review of Systems

Check only those items you identify with currently or in the past. Ignore anything that does not apply to you.

Current Past

GENERAL:
- ☐ ☐ Fevers
- ☐ ☐ Chills/Cold all over
- ☐ ☐ Aches/Pains
- ☐ ☐ General Weakness
- ☐ ☐ Difficulty sweating
- ☐ ☐ Excessive Sweating
- ☐ ☐ Swollen Glands
- ☐ ☐ Fatigue
- ☐ ☐ Nightmares
- ☐ ☐ No dream recall
- ☐ ☐ Early waking
- ☐ ☐ Daytime sleepiness

SKIN:
- ☐ ☐ Cuts Heal slowly
- ☐ ☐ Bruise Easily
- ☐ ☐ Rash
- ☐ ☐ Pigmentation
- ☐ ☐ Changing Moles
- ☐ ☐ Eczema
- ☐ ☐ Psoriasis
- ☐ ☐ Dryness
- ☐ ☐ Oiliness
- ☐ ☐ Itching
- ☐ ☐ Acne
- ☐ ☐ Boils
- ☐ ☐ Hives
- ☐ ☐ Fungus on Nails
- ☐ ☐ Cracking skin
- ☐ ☐ Shingles
- ☐ ☐ Athletes Foot
- ☐ ☐ Cellulite
- ☐ ☐ Have bumps on the back of arms
- ☐ ☐ Skin Cancer
- ☐ ☐ Strong body odor

HEAD:
- ☐ ☐ Poor Concentration
- ☐ ☐ Confusion
- ☐ ☐ Headaches:
  - ☐ ☐ After Meals
  - ☐ ☐ Migraine
  - ☐ ☐ Frontal
  - ☐ ☐ Morning
  - ☐ ☐ Afternoon
  - ☐ ☐ Evening
  - ☐ ☐ Occipital
  - ☐ ☐ Relieved by eating
- ☐ ☐ Concussion/Whiplash
- ☐ ☐ Mental Sluggishness
- ☐ ☐ Forgetfulness
- ☐ ☐ Face Twitch
- ☐ ☐ Poor Memory

Current Past

EYES:
- ☐ ☐ Sand in Eyes
- ☐ ☐ Double Vision
- ☐ ☐ Blurred Vision
- ☐ ☐ Poor Night Vision
- ☐ ☐ Bright Flashes
- ☐ ☐ Halo around Lights
- ☐ ☐ Eye Pains
- ☐ ☐ Dark Circles under Eyes
- ☐ ☐ Strong Light Irritates
- ☐ ☐ Cataracts
- ☐ ☐ Floaters in Eyes
- ☐ ☐ Visual hallucinations

EARS:
- ☐ ☐ Aches
- ☐ ☐ Wax buildup
- ☐ ☐ Pains
- ☐ ☐ Ringing
- ☐ ☐ Deafness/Hearing loss
- ☐ ☐ Itching
- ☐ ☐ Pressure
- ☐ ☐ Wear a hearing aid
- ☐ ☐ Frequent infections
- ☐ ☐ Tubes in ears
- ☐ ☐ Sensitive to loud noises
- ☐ ☐ Hearing Hallucinations

NOSE/SINUSES
- ☐ ☐ Stuffy
- ☐ ☐ Bleeding
- ☐ ☐ Running
- ☐ ☐ Congested
- ☐ ☐ Infection
- ☐ ☐ Polyps
- ☐ ☐ Acute smell (sensitive to scents)
- ☐ ☐ Drainage
- ☐ ☐ Sneezing spells
- ☐ ☐ Post nasal drip
- ☐ ☐ No sense of smell

MOUTH:
- ☐ ☐ Coated Tongue
- ☐ ☐ Sore Tongue
- ☐ ☐ Teeth Problems
- ☐ ☐ Bleeding Gums
- ☐ ☐ Canker Sores
- ☐ ☐ TMJ
- ☐ ☐ Cracked lips/ corners
- ☐ ☐ Chapped lips
- ☐ ☐ Fever blisters
- ☐ ☐ Wear dentures
- ☐ ☐ Grind teeth when sleeping
- ☐ ☐ Bad breath
- ☐ ☐ Dry mouth

Current Past

THROAT:
- ☐ ☐ Mucus
- ☐ ☐ Difficulty Swallowing
- ☐ ☐ Frequent Hoarseness
- ☐ ☐ Tonsillitis
- ☐ ☐ Enlarged Glands
- ☐ ☐ Constant clearing of throat
- ☐ ☐ Throat closes up

NECK:
- ☐ ☐ Stiffness
- ☐ ☐ Swelling
- ☐ ☐ Lumps
- ☐ ☐ Neck glands swell

CIRCULATION/RESPIRATION:
- ☐ ☐ Swollen Ankles
- ☐ ☐ Sensitive to Hot
- ☐ ☐ Sensitive to Cold
- ☐ ☐ Extremities Cold or Clammy
- ☐ ☐ Hands/Feet go to sleep/numb
- ☐ ☐ High Blood Pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Chest Pain
- ☐ ☐ Pain between shoulders
- ☐ ☐ Dizziness upon standing
- ☐ ☐ Fainting Spells
- ☐ ☐ High Cholesterol
- ☐ ☐ High Triglycerides
- ☐ ☐ Wheezing
- ☐ ☐ Irregular Heartbeat
- ☐ ☐ Palpitations
- ☐ ☐ Low exercise tolerance
- ☐ ☐ Frequent coughs
- ☐ ☐ Breathing heavily
- ☐ ☐ Frequently Sighing
- ☐ ☐ Shortness of breath
- ☐ ☐ Night Sweats
- ☐ ☐ Varicose Veins
- ☐ ☐ Mitral valve prolapse
- ☐ ☐ Murmurs
- ☐ ☐ Skipped heartbeat
- ☐ ☐ Heart enlargement
- ☐ ☐ Angina pain
- ☐ ☐ Bronchitis/Pneumonia
- ☐ ☐ Emphysema
- ☐ ☐ Croup
- ☐ ☐ Frequent colds
- ☐ ☐ Heavy/tight chest
- ☐ ☐ Past Heart Attack
- ☐ ☐ Phlebitis (inflamed veins)
- ☐ ☐ Spider Veins

(Continued on next page)

Review of Systems

GASTROINTESTINAL

Current / Past

- ☐ ☐ Peptic/Duodenal Ulcer
- ☐ ☐ Poor Appetite
- ☐ ☐ Excessive Appetite
- ☐ ☐ Gallstones
- ☐ ☐ Gallbladder pain
- ☐ ☐ Nervous Stomach
- ☐ ☐ Full Feeling after meal
- ☐ ☐ Indigestion
- ☐ ☐ Heartburn
- ☐ ☐ Acid Reflux
- ☐ ☐ Hiatal Hernia
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Vomiting Blood
- ☐ ☐ Abdominal Pains/Cramps
- ☐ ☐ Gas
- ☐ ☐ Diarrhoea
- ☐ ☐ Constipation
- ☐ ☐ Changes in Bowels
- ☐ ☐ Rectal Bleeding
- ☐ ☐ Tarry Stools
- ☐ ☐ Rectal Itching
- ☐ ☐ Use laxatives
- ☐ ☐ Bloating
- ☐ ☐ Belch frequently
- ☐ ☐ Anal itching
- ☐ ☐ Anal fissures
- ☐ ☐ Bloody stools
- ☐ ☐ Undigested food in stools

MEN'S HISTORY (for men only)

Have you had a PSA done? ◯Yes ◯No

PSA Level:

- ☐ 0 – 2
- ☐ 2 – 4
- ☐ 4 – 10
- ☐ >10

- ☐ ☐ Prostate enlargement
- ☐ ☐ Prostate infection
- ☐ ☐ Change in libido
- ☐ ☐ Impotence
- ☐ ☐ Diminished libido
- ☐ ☐ Poor libido
- ☐ ☐ Infertility
- ☐ ☐ Lumps in testicles
- ☐ ☐ Sore on penis
- ☐ ☐ Genital pain
- ☐ ☐ Hernia
- ☐ ☐ Prostate cancer
- ☐ ☐ Low sperm count
- ☐ ☐ Difficulty Obtaining Erection
- ☐ ☐ Difficulty Maintaining an Erection
- ☐ ☐ Nocturia (urination at night)
  How many times at night? _____
- ☐ ☐ Urgency/Change in Urinary Stream
- ☐ ☐ Loss of Control of Urine

WOMEN'S HISTORY (for women only)

Current / Past

- ☐ ☐ Fibrocystic Breasts
- ☐ ☐ Lumps in breast
- ☐ ☐ Fibroid Tumors/Breast
- ☐ ☐ Spotting
- ☐ ☐ Heavy Periods
- ☐ ☐ Fibroid Tumors/Uterus
- ☐ ☐ Painful periods
- ☐ ☐ Change in period
- ☐ ☐ Breast soreness before period
- ☐ ☐ Endometriosis
- ☐ ☐ Non-period bleeding
- ☐ ☐ Breast soreness during period
- ☐ ☐ Vaginal Dryness
- ☐ ☐ Vaginal discharge
- ☐ ☐ Had partial/total hysterectomy
- ☐ ☐ Hot Flashes
- ☐ ☐ Mood Swings
- ☐ ☐ Breast cancer
- ☐ ☐ Ovarian cysts
- ☐ ☐ Infertility
- ☐ ☐ Decreased Libido
- ☐ ☐ Loss of Control of Urine

- ☐ Are you pregnant? _____ (Due Date)

Contraception Type? _____

Age at first period? _____

Duration of cycle? _____ (Between 28-45 days)

Duration of Flow? _____ (Between 1-7 days)

Number of Pregnancies? _____

Number of Births? _____

Number of Miscarriages? _____

Number of Abortions? _____

Last Period? _____

Last Pap Smear? _____

Last Mammogram? _____

KIDNEY/URINARY TRACT:

- ☐ ☐ Burning during urination
- ☐ ☐ Frequent Urination
- ☐ ☐ Blood in Urine
- ☐ ☐ Night time Urination
- ☐ ☐ Problem Passing Urine
- ☐ ☐ Kidney Pain
- ☐ ☐ Kidney Stones
- ☐ ☐ Painful Urination
- ☐ ☐ Bladder infections
- ☐ ☐ Kidney infections
- ☐ ☐ Syphilis
- ☐ ☐ Bed-wetting
- ☐ ☐ Trichomonas infection

JOINT/MUSCLES/TENDONS

Current / Past

- ☐ ☐ Pain wakes me up
- ☐ ☐ Weakness in Legs and arms
- ☐ ☐ Balance problems
- ☐ ☐ Muscle cramping
- ☐ ☐ Head injury
- ☐ ☐ Muscle Stiffness in Morning
- ☐ ☐ Damp weather bothers you

EMOTIONAL:

- ☐ ☐ Convulsions
- ☐ ☐ Dizziness
- ☐ ☐ Fainting Spells
- ☐ ☐ Blackouts
- ☐ ☐ Amnesia
- ☐ ☐ Had shock therapy
- ☐ ☐ Frequently keyed up and jittery
- ☐ ☐ Shaky
- ☐ ☐ Startled by sudden noises
- ☐ ☐ Often feel suddenly scared
- ☐ ☐ Go to pieces easily
- ☐ ☐ Forgetful
- ☐ ☐ Withdrawn feeling
- ☐ ☐ Feel "lost" in time
- ☐ ☐ Had nervous breakdown
- ☐ ☐ Had "burnout"
- ☐ ☐ Feel groggy
- ☐ ☐ Unable to concentrate
- ☐ ☐ Short attention span
- ☐ ☐ Vision changes
- ☐ ☐ Unable to reason
- ☐ ☐ Considered a nervous person
- ☐ ☐ Worried over little things
- ☐ ☐ Anxiety
- ☐ ☐ Unusual tension
- ☐ ☐ Frustration
- ☐ ☐ Numbness
- ☐ ☐ Often break out in cold sweats
- ☐ ☐ Profuse sweating
- ☐ ☐ Depressed
- ☐ ☐ Been admitted for psychiatric care
- ☐ ☐ Often awakened by frightening dreams
- ☐ ☐ Family member had nervous breakdown
- ☐ ☐ Use tranquillizers
- ☐ ☐ Aggressive
- ☐ ☐ Misunderstood by others
- ☐ ☐ Irritable
- ☐ ☐ Easily flare in anger
- ☐ ☐ Feelings of hostility
- ☐ ☐ Hyperactive
- ☐ ☐ Restless leg syndrome
- ☐ ☐ Considered clumsy
- ☐ ☐ Unable to coordinate muscles
- ☐ ☐ Have difficulty falling asleep
- ☐ ☐ Have difficulty staying asleep
- ☐ ☐ Daytime sleepiness
- ☐ ☐ I am a workaholic
- ☐ ☐ Have you had hallucinations
- ☐ ☐ Have you considered suicide

Name_____ Date_____

Review of Systems

Are you allergic to wheat and/or other grains? ☐No ☐Yes, list other grains_____
_____
Do you have other food allergies or sensitivities? ☐No ☐Yes, please list the foods_____
_____
Do you have sensitivity to gluten? ☐No ☐Yes, what do you do to manage it?_____
_____
Do you have dairy sensitivities? ☐No ☐Yes, describe_____
Are you lactose intolerant? ☐No ☐Yes

How often are you affected by airborne allergies? ☐Never ☐Daily ☐Weekly ☐Monthly ☐Seasons
List allergens_____
How often do you experience hives or itching? ☐Never ☐Daily ☐Weekly ☐Monthly ☐Seasons
How often do you have sinus congestion upon waking? ☐Never ☐Daily ☐Weekly ☐Monthly ☐Seasons
How often do you have sinus congestion/stuffiness? ☐Never ☐Daily ☐Weekly ☐Monthly ☐Seasons
How often do you have sinus infections? ☐Never ☐Once per year ☐Several per year

How often do you eat soy? ☐Never ☐Daily ☐Weekly ☐Monthly ☐Less than 4 times per year
Do you crave bread and/or pasta? ☐No ☐Yes
Are there specific foods that make you tired, bloated or foggy thinking? ☐No ☐Yes, please list them_____
_____

Do you often feel spacey or unreal? ☐No ☐Yes, how often?_____
Sensation of something stuck in the throat? ☐No ☐Yes, how often and is there any specific trigger?_____
_____

Do you have alternating constipation and diarrhea? ☐No ☐Yes, how often?_____
Does your pulse increase speed after eating? ☐No ☐Yes, how often and how rapid is the pulse?_____
_____

Do you have bizarre, vivid dreams or nightmares? ☐No ☐Yes, how often?_____

Do you have episodic anger outbursts, intense frustration or easily irritable? ☐No ☐Yes, how often?_____
_____

Which of the following best describes your emotions, thoughts or actions you most frequently experience each day?
Limit your selection to 3 of the following:

☐ Constantly Worry	☐ Overly concerned	☐ Easily startled/frightened
☐ Sadness or Loss	☐ Brood, Bummed-out or disappointment	☐ Procrastinate
☐ Respond with Fear	☐ Hypersensitivity to criticism	☐ Fault-finding, Blaming
☐ Express Anger	☐ Easily Frustrated	☐ Optimistic
☐ Feel slightly 'High'	☐ Seek/Indulge in Pleasure	☐ Pessimistic

Symptom 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 check 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

Category VI *(Cont.)*				
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

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

Category XI

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

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 XIII

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

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

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 XV *(Cont.)*

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

Category XVI *(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 XVII *(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 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? _____ **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: _____ _____ _____

Symptom Assessment Form™ (BFAF)

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

Please check the appropriate box on ALL questions. "0" indicates least/never to "3" indicates most/always.

SECTION 1

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

SECTION 2

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

SECTION 3

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

SECTION 4

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

SECTION 5

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

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

Symptom 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 6

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

SECTION 7

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

SECTION 8

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

SECTION 9

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

SECTION 10

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

SECTION 11

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

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

Name _____ Date _____

Medication History Form

Please check any of the following phycotrophic medications you have taken in the past or are currently taking. (Please note that these are only phycotrophic medications)

- ☐ Abilify
- ☐ Acuphase
- ☐ Adapin
- ☐ Adlegiine
- ☐ Ambien
- ☐ Anafranil
- ☐ Aropax
- ☐ Asendin
- ☐ Asendis
- ☐ Ativan
- ☐ Atracurium
- ☐ Atropine
- ☐ Aurorix
- ☐ Avanza
- ☐ Aventyl
- ☐ Axit
- ☐ Azilect
- ☐ Carbamate Insecticides
- ☐ Celexa
- ☐ Cipralex
- ☐ Cipramil
- ☐ Cisatracurium
- ☐ Clopixol
- ☐ Clozaril
- ☐ Coaxil
- ☐ Compazine
- ☐ Dalcipran
- ☐ Dalmane
- ☐ Dapoxetine
- ☐ Defanyl
- ☐ Demolox
- ☐ Depixol
- ☐ Deroxat
- ☐ Despiramin
- ☐ Donepezil
- ☐ Dormicum
- ☐ Doxacurium
- ☐ Duloxetine
- ☐ Echotiophate
- ☐ Edrophonium
- ☐ Effexor
- ☐ Elavil
- ☐ Elepryl
- ☐ Emocal
- ☐ Endep
- ☐ Esteria
- ☐ Fluanxol
- ☐ Fluetin
- ☐ Flumazenil
- ☐ Fontex
- ☐ Galatamine
- ☐ Gamanil
- ☐ Geodon
- ☐ Halcion
- ☐ Haldol
- ☐ Hemicholinium
- ☐ Hexamethonium
- ☐ Imovane
- ☐ Invega
- ☐ Ipratopium
- ☐ Ipronid
- ☐ Iprozid
- ☐ Isoflurophate
- ☐ Janamine
- ☐ Klonopin
- ☐ Laxapro
- ☐ Lexotanil
- ☐ Lexotanil
- ☐ Librium
- ☐ Loramet
- ☐ Lunesta
- ☐ Lustral
- ☐ Luvox
- ☐ Manerix
- ☐ Marplan
- ☐ Marsilid
- ☐ Mecamylamine
- ☐ Megadon
- ☐ Mellaril
- ☐ Meridia
- ☐ Metocurine
- ☐ Mirapex
- ☐ Mivacurium
- ☐ Moclodura
- ☐ Moxadil
- ☐ Nardil
- ☐ Navane
- ☐ Neostigmine
- ☐ Nicotine (high dose)
- ☐ Norpramin
- ☐ Norset
- ☐ Nozinan
- ☐ Opipramol
- ☐ Orap
- ☐ Organophosphate Insecticides
- ☐ Organophosphate nerve agents
- ☐ Pamelor
- ☐ Pancuronium
- ☐ Paroxat
- ☐ Paxil
- ☐ Pertofrane
- ☐ Physostigmine
- ☐ Popilniazida
- ☐ Pralidoxime
- ☐ Pristiq
- ☐ Prolixin
- ☐ ProSom
- ☐ Prothiaden
- ☐ Prozac
- ☐ Pyridostigmine
- ☐ Remergil
- ☐ Remeron
- ☐ Requip
- ☐ Restoril
- ☐ Rexetin
- ☐ Rhotrimine
- ☐ Rivastigmine
- ☐ Rivivol
- ☐ Rocuronium
- ☐ Rohypnol
- ☐ Sarafem
- ☐ Scopolamine
- ☐ Sedoxil
- ☐ Serax
- ☐ Serlain
- ☐ Seromex
- ☐ Seronil
- ☐ Seropram
- ☐ Seroquel
- ☐ Seroxat
- ☐ Serzone
- ☐ Sifrol
- ☐ Sinequan
- ☐ Solian
- ☐ Sonata
- ☐ Stablon
- ☐ Stelazine
- ☐ Succinylcholine
- ☐ Surmontil
- ☐ Tacrine
- ☐ Tatinol
- ☐ THC
- ☐ Thorazine
- ☐ Tiotropium
- ☐ Tofranil
- ☐ Trepiline
- ☐ Trilafon
- ☐ Trimethaphan
- ☐ Tryptanol
- ☐ Tubocurarine
- ☐ Valium
- ☐ Vecuronium
- ☐ Vesprin
- ☐ Vivactil
- ☐ Wellbutrin (bupropion)
- ☐ Xanax
- ☐ Zispin
- ☐ Zoloft
- ☐ Zydis
- ☐ Zyprexa
- ☐ Zyvox
- ☐ Zyvoxid

Name _____ **Date** _____

Family Medical History

Many health problems are hereditary in nature and may be handed down generation after generation.

Please review the below-listed diseases and conditions and indicate those that are recurrent health problems of a family member. Leave blank those that do not apply.

	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age at death (if deceased)												
Heart Disease												
Stroke												
Uterine Cancer												
Colon Cancer												
Breast Cancer												
Ovarian Cancer												
Prostate Cancer												
Skin Cancer												
ADD/ADHD												
ALS or other Motor Neuron Diseases												
Alzheimer's												
Anemia												
Anxiety												
Arthritis												
Asthma												
Autism												
Autoimmune Diseases (such as Lupus, Hashimoto's, Multiple Sclerosis, etc.)												
Bipolar Disease												
Bladder disease												
Blood clotting problems												
Celiac disease												
Dementia												
Depression												
Diabetes												
Digestive Disturbances												
Eczema												
Emphysema												
Epilepsy												

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2990 South Sepulveda Blvd Suite 310 Los Angeles, CA 90064 310.310.8096 tel/fax info@vanharding.com

Name _____ Date _____

Family Medical History (Continued)

	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Environmental Sensitivities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Food Intolerances, Allergies, Sensitivities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Headache	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Bowel Disease (IBD)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome (IBS)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Nervous breakdown	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Parkinson's	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pneumonia/Bronchitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Smoking addiction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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2990 South Sepulveda Blvd Suite 310 Los Angeles, CA 90064 310.310.8096 tel/fax info@vanharding.com

Name_____ Date_____

Family Medical History

Off-spring Inquiry

This next section is specific to your biological off-spring and children that you are living with you. If you do not have off-spring or do not have children living with you please check the following box:

☐ Yes, I did not have off-spring & children do not live with me

Some genetic traits can skip a generation hence the abnormality may be expressed in your children without having any expression in you. Knowing that you are a carrier can be of significance to your health care decision. These questions are not intended to replace genetic testing but they can be a determinant that a genetic test is warranted.

The questions also collect information about your life experience and insight of your health during pregnancy (which may have manifest as congenital issues in your offspring) which maybe of relevance insight to your health today. Also, the past and current health of your children and their psychological states may have been or are factors influencing your health.

Child #1 Name_____ Sex_____ Birth Year_____

☐Alive ☐Deceased Date of death:_____ Cause of death:_____

Genetic Birth Defect: ☐No ☐Yes, please describe_____

Congenital Issue: ☐No ☐Yes, please describe_____

Pregnancy difficulties ☐No ☐Yes, please describe_____

Delivery difficulties: ☐No ☐Yes, please describe_____

Major Infectious Disease(s) your child had that you were exposed: ☐No ☐Yes, list_____

_____

Mental, Emotional, Psychological Disorders: ☐No ☐Yes, list_____

_____

Current physical health: ☐Without disease ☐With disease, please indicate_____

_____

Child #2 Name_____ Sex_____ Birth Year_____

☐Alive ☐Deceased Date of death:_____ Cause of death:_____

Genetic Birth Defect: ☐No ☐Yes, please describe_____

Congenital Issue: ☐No ☐Yes, please describe_____

Pregnancy difficulties ☐No ☐Yes, please describe_____

Delivery difficulties: ☐No ☐Yes, please describe_____

Major Infectious Disease(s) your child had that you were exposed: ☐No ☐Yes, list_____

_____

Mental, Emotional, Psychological Disorders: ☐No ☐Yes, list_____

_____

Current physical health: ☐Without disease ☐With disease, please indicate_____

_____

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Name_____ Date_____

Family Medical History

Off-spring Inquiry

Child #3 Name_____ Sex_____ Birth Year_____

☐Alive ☐Deceased Date of death:_____ Cause of death:_____

Genetic Birth Defect: ☐No ☐Yes, please describe_____

Congenital Issue: ☐No ☐Yes, please describe_____

Pregnancy difficulties ☐No ☐Yes, please describe_____

Delivery difficulties: ☐No ☐Yes, please describe_____

Major Infectious Disease(s) your child had that you were exposed: ☐No ☐Yes, list_____

_____

Mental, Emotional, Psychological Disorders: ☐No ☐Yes, list_____

_____

Current physical health: ☐Without disease ☐With disease, please indicate_____

_____

Child #4 Name_____ Sex_____ Birth Year_____

☐Alive ☐Deceased Date of death:_____ Cause of death:_____

Genetic Birth Defect: ☐No ☐Yes, please describe_____

Congenital Issue: ☐No ☐Yes, please describe_____

Pregnancy difficulties ☐No ☐Yes, please describe_____

Delivery difficulties: ☐No ☐Yes, please describe_____

Major Infectious Disease(s) your child had that you were exposed: ☐No ☐Yes, list_____

_____

Mental, Emotional, Psychological Disorders: ☐No ☐Yes, list_____

_____

Current physical health: ☐Without disease ☐With disease, please indicate_____

_____

Child #5 Name_____ Sex_____ Birth Year_____

☐Alive ☐Deceased Date of death:_____ Cause of death:_____

Genetic Birth Defect: ☐No ☐Yes, please describe_____

Congenital Issue: ☐No ☐Yes, please describe_____

Pregnancy difficulties ☐No ☐Yes, please describe_____

Delivery difficulties: ☐No ☐Yes, please describe_____

Major Infectious Disease(s) your child had that you were exposed: ☐No ☐Yes, list_____

_____

Mental, Emotional, Psychological Disorders: ☐No ☐Yes, list_____

_____

Current physical health: ☐Without disease ☐With disease, please indicate_____

_____

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Name _____ Date _____

Dietary Evaluation

Please indicate how often you consume the following:

Fast Food:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Fried Foods:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Luncheon Meats:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Canned Meats:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Soda / Diet Soda:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Natural Soda:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Juice:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Tea / Coffee:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Energy Drinks:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Water:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Sugar, Candy, Desserts:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Chocolate:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Artificial Sweeteners:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Margarine:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Milk:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Butter:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Yogurt:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Cottage Cheese:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Cream Cheese:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Cheese:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Ice Cream:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Other Milk based products:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Gluten:				
White Flour:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Wheat Flour:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Oats / Oatmeal:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Rye:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Barley:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Spelt:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Gluten Free Products:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Fresh Vegetables:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Frozen Vegetables:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Canned Vegetables:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Fish:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Shell Fish:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Raw nuts or Seeds:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Avocados:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Flaxseed / Flaxseed Oil:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Fish Oils:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Olive Oil:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Coconut Oil:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Fruit:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Soy:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Corn:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily
Vitamins / Supplements:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily

List the three healthiest foods you consume on a regular basis:

Healthy Food #1: _____

Healthy Food #2: _____

Healthy Food #3: _____

List the three worst foods you consume on a regular basis:

Worst Food #1: _____

Worst Food #2: _____

Worst Food #3: _____

Are you a vegetarian or vegan? ☐ Yes ☐ No
If Yes, are you willing to change? ☐ Yes ☐ No

Has there ever been a food that you have craved or really "pigged-out" on over a period of time? ☐ Yes ☐ No

List those foods: _____

_____

Do you have an aversion to certain foods? ☐ Yes ☐ No

List those foods: _____

_____

Do you have symptoms **immediately after** eating, such as burping, belching, sneezing, bloating, hives, etc.? ☐ Yes ☐ No

If yes, explain: _____

_____

Do you feel **worse** when you consume a lot of:

- ☐ High fat foods
- ☐ High protein foods
- ☐ Fried foods
- ☐ Alcoholic drinks
- ☐ Refined Sugar (Junk Food)
- ☐ Other _____
- ☐ High carbohydrate foods (breads, pasta, potatoes) _____

Do you feel **better** when you consume a lot of:

- ☐ High fat foods
- ☐ High protein foods
- ☐ Fried foods
- ☐ Alcoholic drinks
- ☐ Refined Sugar (Junk Food)
- ☐ Other _____
- ☐ High carbohydrate foods (breads, pasta, potatoes) _____

Does skipping meals greatly affect your symptoms? ☐ Yes ☐ No

Do you eat snacks between breakfast & lunch? ☐ Yes ☐ No

Do you eat snacks between lunch & dinner? ☐ Yes ☐ No

Do you eat snacks after you eat dinner? ☐ Yes ☐ No

Name_____ Date _____

Life Style & Environment

What type of housing do you live in? ☐Apartment ☐Townhome/Condo ☐High-rise Bldg ☐Single Family
Was the structure built before 1980? ☐No ☐Yes If yes, when _____
Is it more than one-story tall (stairs)? ☐No ☐Yes How many times daily do you climb the stairs? _____
Do you have ☐ carpeting ☐ draperies ☐Central Heating & AC ☐Window A/C ☐Hardwood floors
Is it located ☐ beachside ☐in city ☐ in canyon ☐ near high power transmission ☐ near freeway

With whom do you live? ☐ Spouse ☐Children ☐Parent ☐Sibling ☐Other _____
Do you have pets or livestock? ☐No ☐ Yes If yes, list _____
_____
Where do the animals live? ☐ Inside Home ☐ Outside Home ☐Boarding Facility
If you have horses or livestock how many hours per week do you spend at their facility? _____

How many hours of sleep do you get nightly? _____ What time do you go to sleep at night? _____
Do you feel rested upon awakening? ☐ Yes ☐ No Do you snore? ☐Yes ☐No Use sleep aids? ☐Yes ☐No
Do you require daytime naps to feel rested? ☐No ☐ Yes, explain_____
Do you have any difficulty falling asleep or remaining asleep? ☐No ☐ Yes, explain_____
What type of mattress do you sleep on? ☐Box spring w/ mattress ☐water ☐futon ☐tatami
Other, describe _____

What currently stresses you the most? _____
Rate your stress 0 to 10 _____ How many days per week does this occur? _____
0=no impact 3=slight distracting 5=distracts from work/can relax afterwards
7=very difficult to focus/cannot relax on own effort 10=cannot function/feel you need to be hospitalized

Exercise: ☐Never ☐Hours per week _____ Type _____
Physical work ☐Never ☐Hours per week _____ Type _____
Mental work: ☐Never ☐Hours per week _____ Type _____
TV & Movies: ☐Never ☐Hours per week _____ Practice musical instrument: ☐Never ☐Hours per week _____
Drive car: ☐Never ☐Hours per week _____ Standard shift/clutch: ☐Yes ☐No

In the past 8 weeks have you donate the following? ☐ blood ☐ plasma ☐ platelets
Have you donated the following? ☐Tissue ☐Organ
In the past 8 weeks have you received a vaccination or other injection? ☐No ☐Yes
In the past 8 weeks have you been in contact with smallpox vaccination site of anyone else? ☐No ☐ Yes
In the past 16 weeks have you donated a double unit of RBCs using an apheresis machine? ☐No ☐ Yes
In the past 12 months have you had an accidental needle stick or contact with someone else's blood? ☐No ☐ Yes
In the past 12 months have you had close contact with a person with yellow jaundice of viral hepatitis? ☐No ☐ Yes
In the past 12 months have you had a tattoo applied or removed? ☐No ☐Yes
In the past 12 months have you had ear or body piercing? ☐No ☐Yes
Have you ever used a needle to take drugs that were not prescribed for you by a medical doctor? ☐No ☐Yes
In the past 12 months have you been treated for gonorrhea or syphilis? ☐No ☐Yes

In the past 12 months have you been in jail or prison? ☐No ☐Yes
In the past 3 years have you been outside the USA or Canada? ☐No ☐Yes
Since 1980 have you ever lived in or travelled to Europe that equaled or exceeded 90 days duration? ☐No ☐Yes
Please list the countries you have live in or traveled to. _____
_____

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Acupuncture & Medicinals

Health History Timeline Questionnaire

The following questions are to collect information that was not reviewed in the previous forms. This section has been replicated as a MSWord for you to write your answers. The MSWord replicated document can be downloaded from our website under Clinic Forms. Look for the document named "MSWord Health History Timeline Questionnaire". Please take a few minutes to read through ALL of these questions before you begin your answers.

1) Provide your health history using a timeline sequence (from earliest age to most recent). It should include:
   - all diagnosis given to you in a timeline and your opinions about each diagnosis
   - treatments, supplements and medications to those diagnosis
   - any medical procedures (botox, set a broken bone) or surgeries you have had
   - any head injuries* (see notes below for details)
   - any significant laboratory or imaging results
   - notable irregularities of menses (timing, flow, clots or pain)
   - exposure to environmental, industrial, or toxic compounds
   - history of infections (excluding common colds, sinus infections, seasonal allergy reactions)
   - your travels within and outside the USA
   - major life changes (marriage, child birth, divorce, financial, deaths, job change, moved homes, etc)
   - periods when you felt healthy, good physically or emotionally well
2) When was the last time you felt well? What do you think has happened to your health since then?
3) List all health care providers you have consulted, their opinions and their treatments.
4) List any treatments, medications, or supplements that have improved your health.
5) List any treatments, medications, or supplements that have caused reactions or decreased your health.
6) List all medicationss and dosages you are currently taking.
7) List all supplements & dosages you are currently taking.
8) Is there anything you feel you should tell Van about yourself or your case not covered so far?
9) How did you feel about answering all of these questions and the extensive intake forms?

***Head Injuries** that cause an underlying health problem are more common than most of us are aware of because there does not have to be a bleeding cut, residual local pain, a bruise, swelling or contusion on the head surface to indicate that the brain was injured. A mild concussion or the whiplash from the car accident or hitting your head against the kitchen cabinet can have long-term effects that have a very slow and insidious onset. Hence you may not be aware that the symptoms you have today are related to the "that seemingly insignificant bump to your head" several months or a year or more ago. As well, if you bumped your head and it resulted with dizziness, being stunned and you were not diagnosed with a concussion please include these events in the timeline. Include any incident of whiplash and/or the hit to head that did not leave a mark or result with a diagnosed concussion.

Van Harding L.Ac.
Acupuncture & Medicinals

Health History Timeline Questionnaire

This is the MSWord document for you to write the answers to the following questions. Please save a copy for your records and email a copy to our office when you are satisfied with the completeness of your answers.

Be certain to give extra attention to the information requested with regards to Head Injuries. Recall that head injuries that cause an underlying health problem are more common than most of us are aware of because there does not have to be a bleeding cut, residual local pain, a bruise, swelling or contusion on the head surface to indicate that the brain was injured. A mild concussion or the whiplash from the car accident or hitting your head against the kitchen cabinet can have long-term effects that have a very slow and insidious onset. Hence you may not be aware that the symptoms you have today are related to the "that seemingly insignificant bump to your head" several months or a year or more ago. As well, if you bumped your head and it resulted with dizziness, being stunned and you were not diagnosed with a concussion please include those events in the timeline. Include any incident of whiplash and/or the hit to head that did not leave a mark or result with a diagnosed concussion.

Please take a few minutes to read through ALL nine(9) questions before you begin your answers. We recognize that you may not remember how you felt years ago or the actual sequences of events. Do the best you can to construct the timeline of your health. This exercise may take you considerable time depending upon the complexities of your health history. If you are dealing with impaired memory you may need to ask family and friends for assistance. It is best to not rush through the assignment.

1) Provide your health history using a timeline sequence (from earliest age to most recent). It should include:
   - all diagnosis given to you in a timeline and your opinions about each diagnosis
   - treatments, supplements and medications to those diagnosis
   - any medical procedures (botox, set a broken bone) or surgeries you have had
   - any head injuries* (see notes below for details)
   - any significant laboratory or imaging results
   - notable irregularities of menses (timing, flow, clots or pain)
   - exposure to environmental, industrial, or toxic compounds
   - history of infections (excluding common colds, sinus infections, seasonal allergy reactions)
   - your travels within and outside the USA
   - major life changes (marriage, child birth, divorce, financial, deaths, job change, moved homes, etc)
   - periods when you felt healthy, good physically and/or emotionally
2) When was the last time you felt well? What do you think has happened to your health since then?
3) List all health care providers you have consulted, their opinions and their treatments.
4) List any treatments, medications, or supplements that have improved your health.
5) List any treatments, medications, or supplements that have caused reactions or decreased your health.
6) List all medications and dosages you are currently taking.
7) List all supplements & dosages you are currently taking.
8) Is there anything you feel you should tell Van about yourself or your case not cover so far?
9) How did you feel about answering all of these questions and the extensive intake forms?

Van Harding L.Ac.
Neuro-Acupuncture & Natural Medicinals

Establishing Health Goals

I've discovered that the correct way to attain one's health goal no matter 'what it may be', is to clearly define your needs and abilities to achieve your health goals. Therefore, to help you make significant changes in your health please review the following questions and dig deep inside yourself for the answers.

PLEASE ANSWER ALL QUESTIONS INDEPENDENT OF EACH OTHER (for example, do not combine questions 2 and 3 below, but answer each one individually). Please do not leave any answers blank or answer with "I don't know". Start your answer at the end of the question. You can type as much information as you choose, there is no limit.

1) Have you made the decision to do what it takes to get well?
2) What do you want to achieve from the care Van can provide?
3) If you had a magic wand and could erase three health problems, what would they be?
4) If so, why do you think health care practitioners have failed with your case?
5) Do you think your condition can be cured or improved?
6) What are you looking for in a health care practitioner?
7) What things do you dislike about health care practitioners?
8) What do you consider a realistic amount of time to see changes in your health under the care by Van?
9) How much time are you willing to participate without improvement before you discontinue care?
10) Is there anyone you blame for your health condition?
11) What specific improvements in your health would you consider a successful outcome in your case?
12) Are you prepared to handle the financial costs of further assessments?
13) Do you think our practice fee ($300 per hour) is fair and appropriate?
14) Are you emotionally and spiritually at this time able to handle additional care efforts?
15) How would your feel if you spent considerably more time, energy and money under the care of Van than any other health care provider and had no improvements in your case?
16) As a vegetarian, are you willing to eat meat?
17) Are there any emotional experiences that can be contributing to your health condition?
18) Does your spouse and/or family provide you with support of your health condition?
19) Are your spouse and/or family supportive of you seeking care with Van?
20) Are you willing to participate in telephone and email follow-up inquires?
21) In order to improve your health, are you willing to

    a) significantly modify your diet?

    b) significantly modify your lifestyle?

    c) take several supplements each day?

    d) to receive acupuncture more than 3 times per week?

    e) receive low-current or microcurrent therapy?

f) receive aromatherapy or essential oils?

g) participate I sound and/or light therapy?

h) receive massage, Myofascial Release, CranialSacral Therapy and/or deep tissue massage?

i) participate in Qi Gong, exercise, and/or stretching?

j) participate in meditation?

k) keep a daily journal of how you feel physically and emotionally?

End

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**

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For nutritional purposes only.

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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

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

Child Neurotransmitter & Nutrition Questionnaire (CNNQ)

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: GENERAL

- Does your child have any food sensitivities or allergies? (please list)
  _____
  _____
- List your child's 4 healthiest foods eaten regularly.
  _____, _____,
  _____, _____
- List your child's 4 unhealthiest foods eaten regularly.
  _____, _____,
  _____, _____
- How many times a week does your child eat candy? _____
- How many times a week does your child drink soda pop? _____
- Please list the top 4 foods your child craves regularly?
  _____, _____,
  _____, _____
- List the medication(s) your child is currently prescribed and over the counter.
  _____
  _____
- Do you find it difficult as a parent to have your child on a special diet?
  _____

SECTION: A (K52)

- Does your child eat pasta, breads, and breaded foods? **0 1 2 3**
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating wheat foods? **0 1 2 3**
- Does your child eat dairy products? **0 1 2 3**
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating dairy products? **0 1 2 3**

SECTION: B (K53)

- Does your child eat fried fish? **0 1 2 3**
- Does your child eat roasted nuts or seeds? **0 1 2 3**
- Is your child **missing** essential fatty acid rich foods in his/her diet? (for example: avocadoes, flax seeds, olives) *(mark "0" if present, "3" if missing)* **0 1 2 3**
- Does your child eat *fried* foods? **0 1 2 3**

SECTION: C (K34)

- Is your child's mental speed slow? **0 1 2 3**
- Does your child have difficulty with learning or memory? **0 1 2 3**
- Does your child have difficulty with balance and coordination? **0 1 2 3**

SECTION: D (K16)

- Does your child have stress? **0 1 2 3**
- Does your child **not** have enough sleep and rest? *(mark "3" if not enough)* **0 1 2 3**
- Does your child **not** have regular exercise? *(mark "3" if no exercise)* **0 1 2 3**
- Does your child feel overly worried and scared? **0 1 2 3**

SECTION: E (K16, K51)

- Does your child have temper tantrums? **0 1 2 3**
- Does your child exhibit wild behavior? **0 1 2 3**
- Does your child frequently yell or scream for unnecessary reasons? **0 1 2 3**
- Does your child have an **inability** to nap or sleep when physically exhausted? *(mark "3" if unable)* **0 1 2 3**
- Is your child overly talkative? **0 1 2 3**
- Does your child fidget and squirm when seated? **0 1 2 3**
- Does your child run and climb excessively when it is inappropriate? **0 1 2 3**
- Does your child have difficulty playing quietly or engaging in leisure activities? **0 1 2 3**

SECTION: F (K51)

- Does your child get excited easily? **0 1 2 3**
- Does your child have anxiousness and panic for minor reasons? **0 1 2 3**
- Does your child feel overwhelmed for minor reasons? **0 1 2 3**
- Does your child find it difficult to relax when she/he is awake? **0 1 2 3**
- Does your child have disorganized attention? **0 1 2 3**

SECTION: G (K50)

- Does your child seem depressed? **0 1 2 3**
- Does your child have mood changes with overcast weather? **0 1 2 3**
- Does your child have symptoms of inner rage? **0 1 2 3**
- Does your child seem uninterested in games or hobbies? **0 1 2 3**
- Does your child have difficulty falling into deep restful sleep? **0 1 2 3**
- Does your child seem uninterested in friendships? **0 1 2 3**
- Does your child have symptoms of unprovoked anger? **0 1 2 3**
- Does your child seem uninterested in eating? **0 1 2 3**

SECTION: H (K49)

- Does your child have difficulty handling stress? **0 1 2 3**
- Does your child have anger and aggression while being challenged? **0 1 2 3**
- Does your child feel tired even after long sleeps? **0 1 2 3**
- Does your child tend to isolate from others? **0 1 2 3**
- Does your child get distracted easily? **0 1 2 3**
- Does your child have constant need and desire for candy and sugar? **0 1 2 3**
- Does your child have disorganized attention? **0 1 2 3**

SECTION: I (K48)

- Does your child have difficulty with visual memory? **0 1 2 3**
- Does your child have difficulty remembering locations? **0 1 2 3**
- Does your child have fatigue or low endurance for learning activities? **0 1 2 3**
- Does your child have difficulty with attention or low attention span or endurance? **0 1 2 3**
- Does your child have slow or difficult speech? **0 1 2 3**
- Does your child have uncoordinated or slow movement? **0 1 2 3**

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For nutritional purposes only

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