



Office Use Only

Practitioner: AM DB JT MM RL

Appt Type: CHIRO FUNC MASS

Appt Date \_\_\_\_\_

CT

C

Thank You

**PERSONAL INFORMATION**

|                                   |             |   |                                     |
|-----------------------------------|-------------|---|-------------------------------------|
| <b>Name:</b>                      |             | <b>Guardian's Name (if minor):</b>                      |                                     |
| <b>Today's Date:</b>              |             | <b>Date of Birth:</b>                                   | <b>Age:</b>                         |
| <b>Address:</b>                   |             | <b>Height:</b>  | <b>Weight:</b>                      |
| <b>City:</b>                      |             | <b>Email Address:</b>                                   |                                     |
| <b>State:</b>                     | <b>Zip:</b> | <b>Ph: H/C</b>  |                                     |
| <b>Preferred Contact:</b>         | Phone       | Email   | <b>Do you have MEDICARE?</b> Yes No |
| <b>Marital Status (Dropdown):</b> |             | <b>Would you like to receive our newsletter?</b> Yes No |                                     |

**EMERGENCY CONTACT INFORMATION**

| Name of Emergency Contact | Relationship to Patient | Phone Number |
|---------------------------|-------------------------|--------------|
|                           |                         |              |

**REFERRAL INFORMATION**

**How were you referred to our office? (Dropdown)**

**Name of referrer or event (so that we can thank them):**

**GOALS FOR MY CARE**

People see health care practitioners for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others to correct whatever the core malfunction may be. Your practitioner will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we may be guided by your wishes.

- Relief Care: Symptomatic relief of pain or discomfort
- Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms
- Comprehensive Care: Address the entire system and bring your body to the highest state of health possible.

Any other goals you'd like to share?

**THE BEGINNING YEARS**

| Birth to 17 years of age   | NO | YES | EXPLAIN |
|--|----|-----|---------|
| Did you have any serious childhood illness?                            |    |     |         |
| Did you have any serious falls as a child?                             |    |     |         |
| Was there prolonged use of medicine such as antibiotics or an inhaler? |    |     |         |
| Were you vaccinated?   |    |     |         |
| <b>Adult: 18 YO to Present</b>   |    |     |         |
| Are you pregnant? If yes, when are you due?                            |    |     |         |
| Do you have a pacemaker?   |    |     |         |
| Do you have any metal in your body?                                    |    |     |         |
| Do you exercise regularly?   |    |     |         |
| Do you have any scars?   |    |     |         |

**HEALTH CONCERNS - List according to severity. Rate from 1 (mild) to 10 (unbearable)**

| Health Concern   | Severity       | Episode Start Date? | Had this before? When?  | Constant or Intermittent? |
|--|----------------|---------------------|---|---------------------------|
|  |                |                     |   |                           |
|  |                |                     |   |                           |
|  |                |                     |   |                           |
| <b>Since the problem started, is it (Please Check):</b>  |                |                     | <b>Does it travel/radiate?</b>  |                           |
| Same   | Improving      | Worse               | No  | Yes, where?               |
| <b>What makes it better?</b>   |                |                     | <b>What makes it worse?</b>   |                           |
|  |                |                     |   |                           |
| <b>Do you have a family history of this or similar symptoms?</b>   |                |                     | <b>Have you seen other doctors for this condition?</b>  |                           |
| No   | Yes/explain:   |                     | No  | Yes                       |
|  |                |                     | Medical   | Chiropractor              |
|  |                |                     | Other:  |                           |
|  |                |                     | If yes, what Yes, diagnosis:  |                           |
|  |                |                     | What was done?  |                           |
| <b>Do you have allergies/sensitivities to fragrances or oils?</b>  |                |                     | <b>Do you have any known allergies?</b>   |                           |
| No   | Yes, explain:  |                     | No  | Yes, explain:             |
|  |                |                     |   |                           |
| <b>How have you taken care of your health in the past?</b>   |                |                     | <b>How have the previous method(s) work out for you?</b>                                      |                           |
| Medications  | Emergency Room | Routine Medical     | Bad results   | Some results              |
| Exercise   | Nutrition/Diet | Holistic Care       | No change   | Still trying              |
| Vitamins   | Chiropractic   | Other:              |   | Great Results             |
|  |                |                     |   | Other:                    |
| <b>Are you concerned that this condition is or will negatively affect any of the following?</b>              |                |                     | <b>Are you concerned that your health conditions(s) might turn into any of the following?</b> |                           |
| Job  | Marriage       | Kids                | Future Ability  | Family health problems    |
| Sleep  | Self-esteem    | Freedom             | Finances  | Heart Disease             |
| Time   | Other          |                     |   | Cancer                    |
|  |                |                     |   | Chronic Fatigue           |
|  |                |                     |   | Diabetes                  |
|  |                |                     |   | Arthritis                 |
|  |                |                     |   | Other                     |
| <b>Have your health condition(s) affected your job, finances, relationships, family or other activities?</b> |                |                     | <b>If you have health issues, what have they cost you?</b>                                    |                           |
| No   | Yes, explain:  |                     | Time  | Money                     |
|  |                |                     | Sleep   | Freedom                   |
|  |                |                     |   | Hope                      |
|  |                |                     |   | Happiness                 |
|  |                |                     |   | Please explain:           |

**PAST ACCIDENTS/SURGERIES/INJURIES/PROCEDURES: List all (auto/work), x-rays, trauma (physical/emotional)**

| Type | Date | Doctor/Hospitalization/x-rays/Procedure |
|------|------|---|
|      |      |   |
|      |      |   |
|      |      |   |
|      |      |   |

**List all prescription drugs, over-the-counter drugs, and all supplements you are currently taking**

| Name of drug or supplement | Taken for how long? | For what purpose? | How much? |
|----------------------------|---------------------|-------------------|-----------|
|                            |                     |                   |           |
|                            |                     |                   |           |
|                            |                     |                   |           |
|                            |                     |                   |           |

## HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Valeo Health & Wellness Center's Notice of Privacy Practices. Valeo is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request. Signing below acknowledges that you have access to this notice via internet or the copy in our office for your review at any time.

Client Name: \_\_\_\_\_

Signature of patient (or parent, if minor): \_\_\_\_\_ Date \_\_\_\_\_

## VALEO PAYMENT POLICY

**RETURNED CHECK POLICY** - If you pay with a check that is returned due to insufficient funds, we will require immediate payment in another form plus a \$35.00 returned check fee and any bank charges. If there is no response from you, we must send this to collections.

**SERVICE AGREEMENT** - I clearly understand and agree that all services and products rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. Valeo will work with you regarding payment plans if necessary. There will be an 18% APR charged on balances over 30 days past due. Anything older than 120 days will be sent to collections. Please contact us if you have any questions regarding this policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**INSURANCE PAYMENT AGREEMENT - FOR PERSONAL INJURY, WORK COMP OR MEDICARE ONLY:**

I understand that insurance will be billed for Valeo services and I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### POLICIES AND PROCEDURES

1. The practitioners design specific health plans in order for you to get better in the shortest amount of time. It is to your benefit to maintain your visit schedule and care plan as explained to you in the Report of Findings. The practitioners take your health very seriously and we ask that you do the same.

2. If you need to cancel or reschedule an appointment, please provide the office with at least a 24-hour notice. Our goal is to stay on time; however, occasionally emergencies or unforeseen circumstances arise where the practitioner will spend more time with a patient. We will do our best to inform you if the practitioner is running behind schedule.

# Metabolic Assessment Form™

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

## PART I

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

1. \_\_\_\_\_ 4. \_\_\_\_\_  
 2. \_\_\_\_\_ 5. \_\_\_\_\_  
 3. \_\_\_\_\_

## PART II

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

|   |   |
|---|---|
| <p><b>Category I</b></p> <p>Feeling that bowels do not empty completely      0 1 2 3</p> <p>Lower abdominal pain relieved by passing stool or gas      0 1 2 3</p> <p>Alternating constipation and diarrhea      0 1 2 3</p> <p>Diarrhea      0 1 2 3</p> <p>Constipation      0 1 2 3</p> <p>Hard, dry, or small stool      0 1 2 3</p> <p>Coated tongue or “fuzzy” debris on tongue      0 1 2 3</p> <p>Pass large amount of foul-smelling gas      0 1 2 3</p> <p>More than 3 bowel movements daily      0 1 2 3</p> <p>Use laxatives frequently      0 1 2 3</p> <p><b>Category II</b></p> <p>Increasing frequency of food reactions      0 1 2 3</p> <p>Unpredictable food reactions      0 1 2 3</p> <p>Aches, pains, and swelling throughout the body      0 1 2 3</p> <p>Unpredictable abdominal swelling      0 1 2 3</p> <p>Frequent bloating and distention after eating      0 1 2 3</p> <p><b>Category III</b></p> <p>Intolerance to smells      0 1 2 3</p> <p>Intolerance to jewelry      0 1 2 3</p> <p>Intolerance to shampoo, lotion, detergents, etc      0 1 2 3</p> <p>Multiple smell and chemical sensitivities      0 1 2 3</p> <p>Constant skin outbreaks      0 1 2 3</p> <p><b>Category IV</b></p> <p>Excessive belching, burping, or bloating      0 1 2 3</p> <p>Gas immediately following a meal      0 1 2 3</p> <p>Offensive breath      0 1 2 3</p> <p>Difficult bowel movements      0 1 2 3</p> <p>Sense of fullness during and after meals      0 1 2 3</p> <p>Difficulty digesting proteins and meats; undigested food found in stools      0 1 2 3</p> <p><b>Category V</b></p> <p>Stomach pain, burning, or aching 1-4 hours after eating      0 1 2 3</p> <p>Use of antacids      0 1 2 3</p> <p>Feel hungry an hour or two after eating      0 1 2 3</p> <p>Heartburn when lying down or bending forward      0 1 2 3</p> <p>Temporary relief by using antacids, food, milk, or carbonated beverages      0 1 2 3</p> <p>Digestive problems subside with rest and relaxation      0 1 2 3</p> <p>Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine      0 1 2 3</p> <p><b>Category VI</b></p> <p>Difficulty digesting roughage and fiber      0 1 2 3</p> <p>Indigestion and fullness last 2-4 hours after eating      0 1 2 3</p> <p>Pain, tenderness, soreness on left side under rib cage      0 1 2 3</p> <p>Excessive passage of gas      0 1 2 3</p> <p>Nausea and/or vomiting      0 1 2 3</p> <p>Stool undigested, foul smelling, mucus like, greasy, or poorly formed      0 1 2 3</p> <p>Frequent loss of appetite      0 1 2 3</p> | <p><b>Category VII</b></p> <p>Abdominal distention after consumption of fiber, starches, and sugar      0 1 2 3</p> <p>Abdominal distention after certain probiotic or natural supplements      0 1 2 3</p> <p>Decreased gastrointestinal motility, constipation      0 1 2 3</p> <p>Increased gastrointestinal motility, diarrhea      0 1 2 3</p> <p>Alternating constipation and diarrhea      0 1 2 3</p> <p>Suspicion of nutritional malabsorption      0 1 2 3</p> <p>Frequent use of antacid medication      0 1 2 3</p> <p>Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/Diverticulitis, or Leaky Gut Syndrome?      Yes No</p> <p><b>Category VIII</b></p> <p>Greasy or high-fat foods cause distress      0 1 2 3</p> <p>Lower bowel gas and/or bloating several hours after eating      0 1 2 3</p> <p>Bitter metallic taste in mouth, especially in the morning      0 1 2 3</p> <p>Burpy, fishy taste after consuming fish oils      0 1 2 3</p> <p>Unexplained itchy skin      0 1 2 3</p> <p>Yellowish cast to eyes      0 1 2 3</p> <p>Stool color alternates from clay colored to normal brown      0 1 2 3</p> <p>Reddened skin, especially palms      0 1 2 3</p> <p>Dry or flaky skin and/or hair      0 1 2 3</p> <p>History of gallbladder attacks or stones      0 1 2 3</p> <p>Have you had your gallbladder removed?      Yes No</p> <p><b>Category IX</b></p> <p>Acne and unhealthy skin      0 1 2 3</p> <p>Excessive hair loss      0 1 2 3</p> <p>Overall sense of bloating      0 1 2 3</p> <p>Bodily swelling for no reason      0 1 2 3</p> <p>Hormone imbalances      0 1 2 3</p> <p>Weight gain      0 1 2 3</p> <p>Poor bowel function      0 1 2 3</p> <p>Excessively foul-smelling sweat      0 1 2 3</p> <p><b>Category X</b></p> <p>Crave sweets during the day      0 1 2 3</p> <p>Irritable if meals are missed      0 1 2 3</p> <p>Depend on coffee to keep going/get started      0 1 2 3</p> <p>Get light-headed if meals are missed      0 1 2 3</p> <p>Eating relieves fatigue      0 1 2 3</p> <p>Feel shaky, jittery, or have tremors      0 1 2 3</p> <p>Agitated, easily upset, nervous      0 1 2 3</p> <p>Poor memory, forgetful between meals      0 1 2 3</p> <p>Blurred vision      0 1 2 3</p> <p><b>Category XI</b></p> <p>Fatigue after meals      0 1 2 3</p> <p>Crave sweets during the day      0 1 2 3</p> <p>Eating sweets does not relieve cravings for sugar      0 1 2 3</p> <p>Must have sweets after meals      0 1 2 3</p> <p>Waist girth is equal or larger than hip girth      0 1 2 3</p> <p>Frequent urination      0 1 2 3</p> <p>Increased thirst and appetite      0 1 2 3</p> <p>Difficulty losing weight      0 1 2 3</p> |
|---|---|

|  |   |   |   |   |
|--|---|---|---|---|
| <b>Category XII</b>  |   |   |   |   |
| 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 |
| <b>Category XIII</b>   |   |   |   |   |
| 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 |
| <b>Category XIV</b>  |   |   |   |   |
| 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 |
| <b>Category XV</b>   |   |   |   |   |
| 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 |
| <b>Category XVI</b>  |   |   |   |   |
| 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 |

|   |     |    |   |             |
|---|-----|----|---|-------------|
| <b>Category XVI (Cont.)</b>                         |     |    |   |             |
| Night sweats  | 0   | 1  | 2 | 3           |
| Difficulty gaining weight                           | 0   | 1  | 2 | 3           |
| <b>Category XVII (Males Only)</b>                   |     |    |   |             |
| 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           |
| <b>Category XVIII (Males Only)</b>                  |     |    |   |             |
| 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           |
| <b>Category XIX (Menstruating Females Only)</b>     |     |    |   |             |
| 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           |
| <b>Category XX (Menopausal Females Only)</b>        |     |    |   |             |
| 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 foginess                                     | 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? \_\_\_\_\_

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

How many caffeinated beverages do you consume per day? \_\_\_\_\_

How many times do you eat fish per week? \_\_\_\_\_

How many times do you eat out per week? \_\_\_\_\_

How many times do you work out per week? \_\_\_\_\_

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

List the three worst foods you eat during the average week: \_\_\_\_\_

List the three healthiest foods you eat during the average week: \_\_\_\_\_

### **PART IV**

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

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



# Brain Region Localization Form

## INSTRUCTIONS:

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

## KEY:

- 0 = I never have symptoms (0% of the time)
- 1 = I rarely have symptoms (Less than 25% of the time)
- 2 = I often have symptoms (Half of the time)
- 3 = I frequently have symptoms (75% of the time)
- 4 = I always have symptoms (100% of the time)

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

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

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



# Brain Region Localization Form

## INSTRUCTIONS:

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

## KEY:

- 0 = I never have symptoms (0% of the time)
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- 3 = I frequently have symptoms (75% of the time)
- 4 = I always have symptoms (100% of the time)

| Parietal Inferior Lobule<br>(Area 39 and 40)        |  | Level                      | Medial Temporal lobe and<br>Hippocampus  |  | Level     |
|---|--|----------------------------|--|--|-----------|
| 32.   | Right/left confusion <input type="checkbox"/> L  | 0 1 2 3 4                  | 49.                                      | Memory less efficient  | 0 1 2 3 4 |
| 33.   | Difficulty with math calculations <input type="checkbox"/> L                                   | 0 1 2 3 4                  | 50.                                      | Memory loss that impacts daily activities  | 0 1 2 3 4 |
| 34.   | Difficulty finding words <input type="checkbox"/> L  | 0 1 2 3 4                  | 51.                                      | Confusion about dates, the passage of time, or place   | 0 1 2 3 4 |
| 35.   | Difficulty with writing <input type="checkbox"/> L   | 0 1 2 3 4                  | 52.                                      | Difficulty remembering events  | 0 1 2 3 4 |
| 36.   | Difficulty recognizing symbols or shapes <input type="checkbox"/> R                            | 0 1 2 3 4                  | 53.                                      | Misplacement of things and difficulty retracing steps  | 0 1 2 3 4 |
| 37.   | Difficulty with simple drawings <input type="checkbox"/> R                                     | 0 1 2 3 4                  | 54.                                      | Difficulty with memory of locations (addresses) <input type="checkbox"/> R   | 0 1 2 3 4 |
| 38.   | Difficulty interpreting maps <input type="checkbox"/> R  | 0 1 2 3 4                  | 55.                                      | Difficulty with visual memory <input type="checkbox"/> R   | 0 1 2 3 4 |
| Temporal Lobe Auditory Cortex<br>(Areas 41, 42)     |  | Level                      | 56.                                      | Always forgetting where you put items such as keys, wallet, phone, etc. <input type="checkbox"/> R                       | 0 1 2 3 4 |
| 39.   | Reduced function in overall hearing  | 0 1 2 3 4                  | 57.                                      | Difficulty remembering faces <input type="checkbox"/> R  | 0 1 2 3 4 |
| 40.   | Difficulty interpreting speech with background or scatter noise                                | 0 1 2 3 4                  | 58.                                      | Difficulty remembering names with faces <input type="checkbox"/> L   | 0 1 2 3 4 |
| 41.   | Difficulty comprehending language without perfect pronunciation                                | 0 1 2 3 4                  | 59.                                      | Difficulty with remembering words <input type="checkbox"/> L   | 0 1 2 3 4 |
| 42.   | Need to look at someone's mouth when they are speaking to understand what they are saying      | 0 1 2 3 4                  | 60.                                      | Difficulty remembering numbers <input type="checkbox"/> L  | 0 1 2 3 4 |
| 43.   | Difficulty in localizing sound   | 0 1 2 3 4                  | 61.                                      | Difficulty remembering to stay or be on time (reduced left) <input type="checkbox"/> L                                   | 0 1 2 3 4 |
| 44.   | Dislike of left predictable rhythmic, repeated tempo and beat music <input type="checkbox"/> L | 0 1 2 3 4                  | Occipital Lobe<br>(Area, 17, 18, and 19) |  | Level     |
| 45.   | Dislike of non-predictable rhythmic with multiple instruments <input type="checkbox"/> R       | 0 1 2 3 4                  | 62.                                      | Difficulty in discriminating similar shades of color   | 0 1 2 3 4 |
| 46.   | Noticeable ear preference when using your phone  | right, left, no preference | 63.                                      | Dullness of colors in visual field   | 0 1 2 3 4 |
| Temporal Lobe Auditory Association Cortex (Area 22) |  | Level                      | 64.                                      | Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach out for objects | 0 1 2 3 4 |
| 47.   | Difficulty comprehending meaning of spoken words <input type="checkbox"/> L                    | 0 1 2 3 4                  | 66.                                      | Floater or halos in visual field   | 0 1 2 3 4 |
| 48.   | Tend toward monotone speech without fluctuations or emotions <input type="checkbox"/> R        | 0 1 2 3 4                  |  |  |           |



# Brain Region Localization Form

## INSTRUCTIONS:

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

## KEY:

- 0 = I never have symptoms (0% of the time)
- 1 = I rarely have symptoms (Less than 25% of the time)
- 2 = I often have symptoms (Half of the time)
- 3 = I frequently have symptoms (75% of the time)
- 4 = I always have symptoms (100% of the time)

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



# Is Your Life Out Of Balance?

**DIRECTIONS:** On a scale from 1-10, where (10) is the highest and (1) is the lowest, please rate your current "health level" in each significant area of your life.

### Relationship / Family Life

Are you in a loving relationship? Do you feel like you spend enough quality time with your family? Do you have a close connection with your children, parents, and relatives? Do you have poor family relationships from the past or present that negatively impact your health?

### Leisure

Are you taking regular vacations without bringing work with you? Do you have time set aside each week to relax and enjoy life? Do you have a healthy routine at the end of the day that helps you wind down?

### Social Health

Do you have a connection with at least one other person, outside your family, who you can turn to in difficult and good times? Are you able to maintain long-term friendships? Are you comfortable in social settings?

### Environmental

Do you regularly enjoy time out in nature? Do you spend time doing outdoor activities such as sports, camping, fishing, hiking, etc.? Are you aware of toxins in your environment? If you are aware of certain environmental toxins, do you limit your exposure to them?

### Intellectual

Are you open to new ideas? What is the quality of the information and entertainment that you allow into your mind? Do you challenge yourself to learn new things and hobbies?

### Spiritual

Do you feel that you have a close/strong relationship with God? Do you regularly study, meditate, pray or worship? Do you regularly attend fellowship with others whom share the same beliefs as yourself?

### Physical

Do you have plenty of energy? Do you exercise, eat healthy and drink plenty of water on a regular basis? Are you limited in what you can do because of physical ailments?

### Job / Career

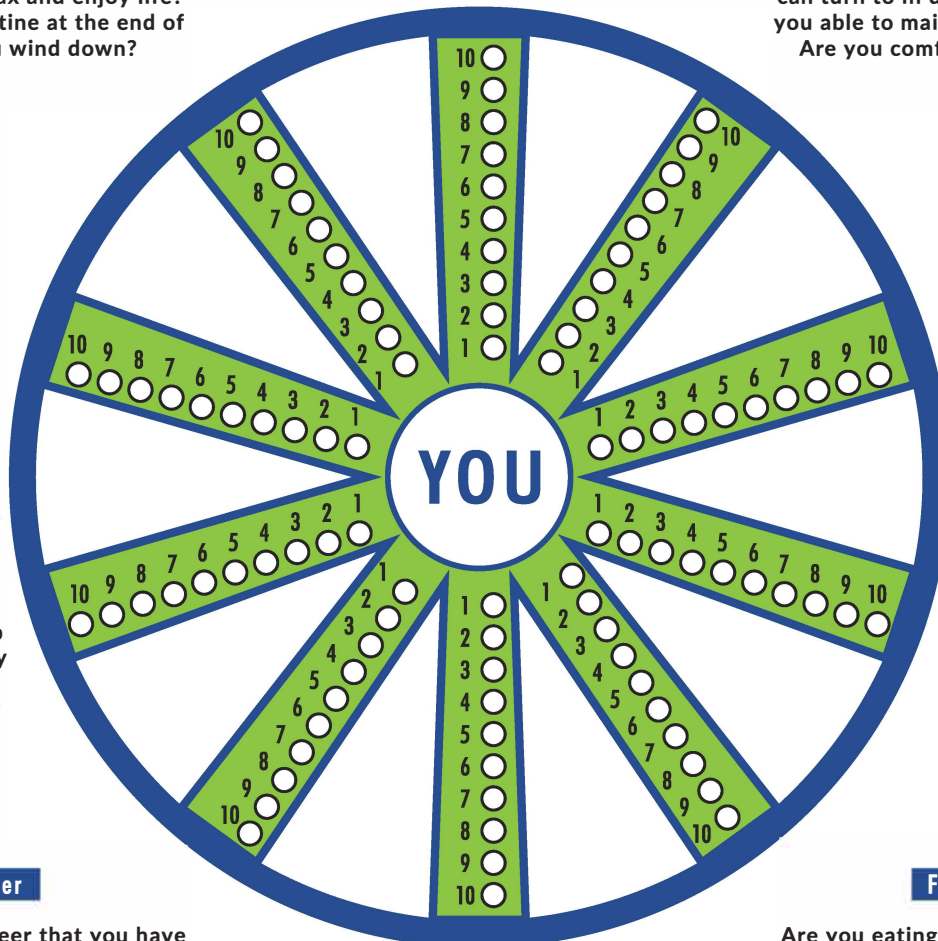
Are you working in the career that you have always wanted to be working in? Does your job stimulate you, give you energy or drain your energy? Does your career allow you to live the lifestyle you desire? Are you working in a position or towards a career that you feel God has planned for you?

### Food / Nutrition

Are you eating natural/organic foods? Are you skipping meals? Do you plan out your meals ahead of time? Do you take whole-food supplements?

### Psychological / Emotional / Stress

Do you have a positive attitude even during stressful times? Does your stress level overwhelm you? Do you have peace in your life?



Name:

Date:

SCORE:



Is Your Life  
Out Of Balance?

## Your Well Score

1. Copy your score from the front and write it here \_\_\_\_\_ / 100.
2. Knowing the score you wrote down, what would you like your total score to be? \_\_\_\_\_
3. What do you think the time frame will be to achieve that number? \_\_\_\_\_
4. Of the ten categories on the front, what area of your life would you like to change the most?  
\_\_\_\_\_
5. What changes in your life do you think will need to be made in order for you to achieve your goal(s)? Please check all that apply below.

- Exercise    Diet Changes    Supplements    Body Cleanse    Chiropractic Care
- Massage Therapy    Medical Treatment    Counseling    Spiritual Healing
- Other \_\_\_\_\_

6. How will your life improve as a result of making these changes?

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