

Name _____ Date of Birth _____

Address _____ City/State/Zip _____

Email _____

Telephone: Home _____ Work _____ Cell _____

Place of Employment _____ Occupation _____

Married ____ Single ____ Divorced ____ Widow(er) ____ # of Children ____

Spouse's Name _____ Place of Employment _____

In Case of Emergency, who should we contact?

Name _____ Phone _____ Relationship _____

How did you hear about our office? _____

Please describe in complete detail your health concerns and health history: (What, how long, how it started, when it started, what treatments tried, what you hope to gain from your visit today, etc.) If additional space is needed, please attach the remainder of your health history in a typed format.

[illegible]

I hereby authorize Dr. Way to examine me as she deems appropriate.

Date _____

Date _____

Date _____

HEALTH HISTORY

Name _____ Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: _____ Date began: _____

List current health problems for which you are being treated: _____

What types of therapies have you tried for these problem(s) or to improve your health over-all:

☐ diet modification ☐ fasting ☐ vitamins/minerals ☐ herbs ☐ homeopathy ☐ chiropractic ☐ acupuncture ☐ conventional drugs

☐ other _____

Do you experience any of these general symptoms EVERY DAY?

☐ Debilitating fatigue ☐ Shortness of breath ☐ Insomnia ☐ Constipation ☐ Chronic pain/inflammation

☐ Depression ☐ Panic attacks ☐ Nausea ☐ Fecal incontinence ☐ Bleeding

☐ Disinterest in sex ☐ Headaches ☐ Vomiting ☐ Urinary incontinence ☐ Discharge

☐ Disinterest in eating ☐ Dizziness ☐ Diarrhea ☐ Low grade fever ☐ Itching/rash

Current medications (prescription or over-the-counter): _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

Outcome _____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ☐ underweight ☐ overweight ☐ just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)? _____

What are your current health goals: _____

Medical History

- ☐ Arthritis
☐ Allergies/hay fever
☐ Asthma
☐ Alcoholism
☐ Alzheimer's disease
☐ Autoimmune disease
☐ Blood pressure problems
☐ Bronchitis
☐ Cancer
☐ Chronic fatigue syndrome
☐ Carpal tunnel syndrome
☐ Cholesterol, elevated
☐ Circulatory problems
☐ Colitis
☐ Dental problems
☐ Depression
☐ Diabetes
☐ Diverticular disease
☐ Drug addiction
☐ Eating disorder
☐ Epilepsy
☐ Emphysema
☐ Eyes, ears, nose, throat problems
☐ Environmental sensitivities
☐ Fibromyalgia
☐ Food intolerance
☐ Gastroesophageal reflux disease
☐ Genetic disorder
☐ Glaucoma
☐ Gout
☐ Heart disease
☐ Infection, chronic
☐ Inflammatory bowel disease
☐ Irritable bowel syndrome
☐ Kidney or bladder disease
☐ Learning disabilities
☐ Liver or gallbladder disease (stones)
☐ Mental illness
☐ Mental retardation
☐ Migraine headaches
☐ Neurological problems (Parkinson's, paralysis)
☐ Sinus problems
☐ Stroke
☐ Thyroid trouble
☐ Obesity
☐ Osteoporosis
☐ Pneumonia
☐ Sexually transmitted disease
☐ Seasonal affective disorder
☐ Skin problems
☐ Tuberculosis
☐ Ulcer
☐ Urinary tract infection
☐ Varicose veins
 Other _____

Medical (Men)

- ☐ Benign prostatic hyperplasia
☐ Prostate cancer

- ☐ Decreased sex drive
☐ Infertility
☐ Sexually transmitted disease
 Other _____

Medical (Women)

- ☐ Menstrual irregularities
☐ Endometriosis
☐ Infertility
☐ Fibrocystic breasts
☐ Fibroids/ovarian cysts
☐ Premenstrual syndrome (PMS)
☐ Breast cancer
☐ Pelvic inflammatory disease
☐ Vaginal infections
☐ Decreased sex drive
☐ Sexually transmitted disease
 Other _____
 Date of last GYN exam _____
 Mammogram ☐ + ☐ -
 PAP ☐ + ☐ -
 Form of birth control _____
 # of children _____
 # of pregnancies _____
☐ C-section _____
 Age of first period _____
 Date - last menstrual cycle _____
 Length of cycle _____ days
 Interval of time between cycles _____ days
 Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____
☐ Surgical menopause
☐ Menopause

Family Health History (Parents and Siblings)

- ☐ Arthritis
☐ Asthma
☐ Alcoholism
☐ Alzheimer's disease
☐ Cancer
☐ Depression
☐ Diabetes
☐ Drug addiction
☐ Eating disorder
☐ Genetic disorder
☐ Glaucoma
☐ Heart disease
☐ Infertility
☐ Learning disabilities
☐ Mental illness
☐ Mental retardation
☐ Migraine headaches
☐ Neurological disorders (Parkinson's, paralysis)
☐ Obesity
☐ Osteoporosis
☐ Stroke
☐ Suicide
 Other _____

Health Habits

- ☐ Tobacco:
 Cigarettes: #/day _____
 Cigars: #/day _____
☐ Alcohol:
 Wine: #glasses/d or wk _____
 Liquor: #ounces/d or wk _____
 Beer: #glasses/d or wk _____
☐ Caffeine:
 Coffee: #6 oz cups/d _____
 Tea: #6 oz cups/d _____
 Soda w/caffeine: #cans/d _____
 Other sources _____
☐ Water: #glasses/d _____

Exercise

- ☐ 5-7 days per week
☐ 3-4 days per week
☐ 1-2 days per week
☐ 45 minutes or more duration per workout
☐ 30-45 minutes duration per workout
☐ Less than 30 minutes
☐ Walk - #days/wk _____
☐ Run, jog, other aerobic - #days/wk _____

- ☐ Weight lift - #days/wk _____
☐ Stretch - #days/wk _____
☐ Other _____

Nutrition & Diet

- ☐ Mixed food diet (animal and vegetable sources)
☐ Vegetarian
☐ Vegan
☐ Salt restriction
☐ Fat restriction
☐ Starch/carbohydrate restriction
☐ The Zone Diet
☐ Total calorie restriction
 Specific food restrictions:
☐ dairy ☐ wheat ☐ eggs
☐ soy ☐ corn ☐ all gluten
 Other _____

Food Frequency

- Number of servings per day:
 Fruits (citrus, melons, etc.) _____
 Dark green or deep yellow/orange vegetables _____
 Grains (unprocessed) _____
 Beans, peas, legumes _____
 Dairy, eggs _____
 Meat, poultry, fish _____

Eating Habits

- ☐ Skip meals - which ones _____
☐ One meal/day
☐ Two meals/day
☐ Three meals/day
☐ Graze (small frequent meals)
☐ Generally eat on the run
☐ Eat constantly whether hungry or not

Current Supplements

- ☐ Multivitamin/mineral
☐ Vitamin C
☐ Vitamin E
☐ EPA/DHA
☐ Evening Primrose/GLA
☐ Calcium, source _____
☐ Magnesium
☐ Zinc
☐ Minerals, describe _____
☐ Friendly flora (acidophilus)
☐ Digestive enzymes
☐ Amino acids
☐ CoQ10
☐ Antioxidants (e.g., lutein, resveratrol, etc.)
☐ Herbs
☐ Homeopathy
☐ Protein shakes
☐ Superfoods (e.g., bee pollen, phytonutrient blends)
☐ Liquid meals (Ensure)
 Others _____

I Would Like To:ENERGY - VITALITY

- ☐ Feel more vital
☐ Have more energy
☐ Have more endurance
☐ Be less tired after lunch
☐ Sleep better
☐ Be free of pain
☐ Get less colds and flu
☐ Get rid of allergies
☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
☐ Stop using laxatives and stool softeners
☐ Improve sex drive

BODY COMPOSITION

- ☐ Loose weight
☐ Burn more body fat
☐ Be stronger
☐ Have better muscle tone
☐ Be more flexible

STRESS, MENTAL, EMOTIONAL

- ☐ Learn how to reduce stress
☐ Think more clearly and be more-focused
☐ Improve memory
☐ Be less depressed
☐ Be less moody
☐ Be less indecisive
☐ Feel more motivated

LIFE ENRICHMENT

- ☐ Reduce my risk of degenerative disease
☐ Slow down accelerated aging
☐ Maintain a healthier life longer
☐ Change from a "treating-illness" orientation to creating a wellness lifestyle

Metabolic Assessment Form

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

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

1. _____
2. _____
3. _____
4. _____
5. _____

Please circle the appropriate number “0 - 3” 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 relief by passing stool or gas . 0 1 2 3
 Alternating constipation and diarrhea 0 1 2 3
 Diarrhea 0 1 2 3
 Constipation 0 1 2 3
 Hard, dry, or small stool 0 1 2 3
 Coated tongue of “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

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 foods found in stools 0 1 2 3

Category III

Stomach pain, burning, or aching 1- 4
 hours after eating 0 1 2 3
 Do you frequently use antacids? 0 1 2 3
 Feeling hungry an hour or two after eating 0 1 2 3
 Heartburn when lying down or bending forward . . . 0 1 2 3
 Temporary relief from antacids, food,
 milk, 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 IV

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

Category V

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
 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 VI

Crave sweets during the day 0 1 2 3
 Irritable if meals are missed 0 1 2 3
 Depend on coffee to keep yourself going or started . . 0 1 2 3
 Get lightheaded if meals are missed 0 1 2 3
 Eating relieves fatigue 0 1 2 3
 Feel shaky, jittery, 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 VII

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

Category VIII

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 IX

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts 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 X

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

Category XI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

Category XIV (Males only)

Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males only)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintain 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
Decrease in 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 XVI (Menstruating Females Only)

Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 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 break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Females Only)

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

How many alcohol beverages do you consume per week? _____

How many times do you eat out per week? _____

How many times a week do you eat fish? _____

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

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

Do you smoke? _____ If yes, how many times a day: _____

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

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

Health Questionnaire (NTAF)

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

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

SECTION A

- Is your memory noticeably declining? 0 1 2 3
- Are you having a hard time remembering names and phone numbers? 0 1 2 3
- Is your ability to focus noticeably declining? 0 1 2 3
- Has it become harder for you to learn things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament getting worse in general? 0 1 2 3
- Are you losing your attention span endurance? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you fatigue when driving compared to the past? 0 1 2 3
- How often do you fatigue when reading compared to the past? 0 1 2 3
- How often do you walk into rooms and forget why? 0 1 2 3
- How often do you pick up your cell phone and forget why? 0 1 2 3

SECTION B

- How high is your stress level? 0 1 2 3
- How often do you feel that you have something that must be done? 0 1 2 3
- Do you feel you never have time for yourself? 0 1 2 3
- How often do you feel you are not getting enough sleep or rest? 0 1 2 3
- Do you find it difficult to get regular exercise? 0 1 2 3
- Do you feel uncared for by the people in your life? 0 1 2 3
- Do you feel you are not accomplishing your life's purpose? 0 1 2 3
- Is sharing your problems with someone difficult for you? 0 1 2 3

SECTION C

SECTION C1

- How often do you get irritable, shaky, or have lightheadedness between meals? 0 1 2 3
- How often do you feel energized after eating? 0 1 2 3
- How often do you have difficulty eating large meals in the morning? 0 1 2 3
- How often does your energy level drop in the afternoon? 0 1 2 3
- How often do you crave sugar and sweets in the afternoon? 0 1 2 3
- How often do you wake up in the middle of the night? 0 1 2 3
- How often do you have difficulty concentrating before eating? 0 1 2 3
- How often do you depend on coffee to keep yourself going? 0 1 2 3
- How often do you feel agitated, easily upset, and nervous between meals? 0 1 2 3

SECTION C2

- Do you get fatigued after meals? 0 1 2 3
- Do you crave sugar and sweets after meals? 0 1 2 3
- Do you feel you need stimulants such as coffee after meals? 0 1 2 3
- Do you have difficulty losing weight? 0 1 2 3
- How much larger is your waist girth compared to your hip girth? 0 1 2 3
- How often do you urinate? 0 1 2 3
- Have your thirst and appetite been increased? 0 1 2 3
- Do you have weight gain when under stress? 0 1 2 3
- Do you have difficulty falling asleep? 0 1 2 3

SECTION 1 - S

- Are you losing your pleasure in hobbies and interests? 0 1 2 3
- How often do you feel overwhelmed with ideas to manage? 0 1 2 3
- How often do you have feelings of inner rage (anger)? 0 1 2 3
- How often do you have feelings of paranoia? 0 1 2 3
- How often do you feel sad or down for no reason? 0 1 2 3
- How often do you feel like you are **not** enjoying life? 0 1 2 3

- How often do you feel you lack artistic appreciation? 0 1 2 3
- How often do you feel depressed in overcast weather? 0 1 2 3
- How much are you losing your enthusiasm for your favorite activities? 0 1 2 3
- How much are you losing enjoyment for your favorite foods? 0 1 2 3
- How much are you losing your enjoyment of friendships and relationships? 0 1 2 3
- How often do you have difficulty falling into deep restful sleep? 0 1 2 3
- How often do you have feelings of dependency on others? 0 1 2 3
- How often do you feel more susceptible to pain? 0 1 2 3
- How often do you have feelings of unprovoked anger? 0 1 2 3
- How much are you losing interest in life? 0 1 2 3

SECTION 2 - D

- How often do you have feelings of hopelessness? 0 1 2 3
- How often do you have self-destructive thoughts? 0 1 2 3
- How often do you have an inability to handle stress? 0 1 2 3
- How often do you have anger and aggression while under stress? 0 1 2 3
- How often do you feel you are not rested even after long hours of sleep? 0 1 2 3
- How often do you prefer to isolate yourself from others? 0 1 2 3
- How often do you have unexplained lack of concern for family and friends? 0 1 2 3
- How easily are you distracted from your tasks? 0 1 2 3
- How often do you have an inability to finish tasks? 0 1 2 3
- How often do you feel the need to consume caffeine to stay alert? 0 1 2 3
- How often do you feel your libido has been decreased? 0 1 2 3
- How often do you lose your temper for minor reasons? 0 1 2 3
- How often do you have feelings of worthlessness? 0 1 2 3

SECTION 3 - G

- How often do you feel anxious or panic for no reason? 0 1 2 3
- How often do you have feelings of dread or impending doom? 0 1 2 3
- How often do you feel knots in your stomach? 0 1 2 3
- How often do you have feelings of being overwhelmed for no reason? 0 1 2 3
- How often do you have feelings of guilt about everyday decisions? 0 1 2 3
- How often does your mind feel restless? 0 1 2 3
- How difficult is it to turn your mind off when you want to relax? 0 1 2 3
- How often do you have disorganized attention? 0 1 2 3
- How often do you worry about things you were not worried about before? 0 1 2 3
- How often do you have feelings of inner tension and inner excitability? 0 1 2 3

SECTION 4 - ACH

- Do you feel your visual memory (shapes & images) is decreased? 0 1 2 3
- Do you feel your verbal memory is decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity been decreased? 0 1 2 3
- Has your comprehension been diminished? 0 1 2 3
- Do you have difficulty calculating numbers? 0 1 2 3
- Do you have difficulty recognizing objects & faces? 0 1 2 3
- Do you feel like your opinion about yourself has changed? 0 1 2 3
- Are you experiencing excessive urination? 0 1 2 3
- Are you experiencing slower mental response? 0 1 2 3

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

Medication History

Please circle any of the following medication you have been or are currently taking.

Acetylcholine Receptor Antagonist – Antimuscarinic Agents

Atropine, Ipratropium, Scopolamine, Tiotropium

Acetylcholine Receptor Antagonist - Ganglionic 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 (benzodiazepines)

Xanax, Lexotanil, Lexotan, Librium, Klonopin, Valium, ProSom, Rohypnol, Dalmane, Ativan, Loramet, Sedoxil, Dormicum, Megadon, Serax, Restoril, Halcion

Agonist Modulator of GABA Receptors (nonbenzodiazepines)

Ambien, Sonata, Lunesta, Imovane

Cholinesterase Inhibitors (irreversible)

Echtiophate, Isoflurophate, Organophosphate Insecticides, Organophosphate-containing nerve agents

Cholinesterase Inhibitors (reversible)

Donepezil, Galatamine, Rivastigmine, Tacrine, THC, Erophonium, Neostigmine, Physostigmine, Pyridostigmine, Carbamate Insecticides

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, Iloxol, 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, Adlegine, Elepryl, Azilect, Marsilid, Iprozid, Ipronid, Rivivol, Popilniazida, Zyvox, Zyvoxid

Noradrenergic and Specific Serotonergic Antidepressants (NaSSa)

Remeron, Zispin, Avanza, Norset, Remergil, Axit

Selective Serotonin Reuptake Inhibitor

Paxil, Zoloft, Prozac, Celexa, Lexapro, Luvox, Cipramil, Emocal, Serpam, Seropram, Cipralext, 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

Tricyclic Antidepressants (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.**

Life Impact Questionnaire

Name: _____

Date: _____

Please take several minutes to answer these questions so Dr. Way can help you get better faster. **(Please circle as many that apply)**

1. How have you taken care of your health in the past?
 - a. Medications
 - b. Emergency Room
 - c. Routine Medical
 - d. Exercise
 - e. Nutrition/Diet
 - f. Holistic Care
 - g. Vitamins
 - h. Chiropractic
 - i. Other (please specify): _____
2. How did the previous method(s) work out for you?
 - a. Bad results
 - b. Some results
 - c. Great results
 - d. Nothing changed
 - e. Did not get worse
 - f. Did not work very long
 - g. Still trying
 - h. Confused
3. How have others been affected by your health condition?
 - a. No one is affected
 - b. Haven't noticed any problem
 - c. They tell me to do something
 - d. People avoid me
4. What are you afraid this might be (or beginning) to affect (or will affect)?
 - a. Job
 - b. Kids
 - c. Future ability
 - d. Marriage
 - e. Self-esteem
 - f. Sleep
 - g. Time
 - h. Finances
 - i. Freedom

5. Are there health conditions you are afraid this might turn into?

- a. Family health problems
- b. Heart disease
- c. Cancer
- d. Diabetes
- e. Arthritis
- f. Fibromyalgia
- g. Depression
- h. Chronic Fatigue
- i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples _____

What are you most concerned with regarding your problem? _____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific _____

What would be different/better without this problem? Please be specific _____

What do you desire most to get from working with us? _____

What is that worth to you? _____

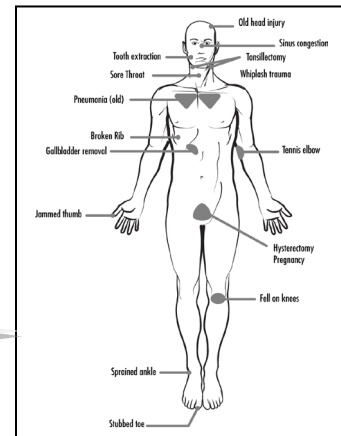
Body Injury Sheet [PLEASE LABEL AND WRITE CLEARLY]

Name: _____ Date: _____

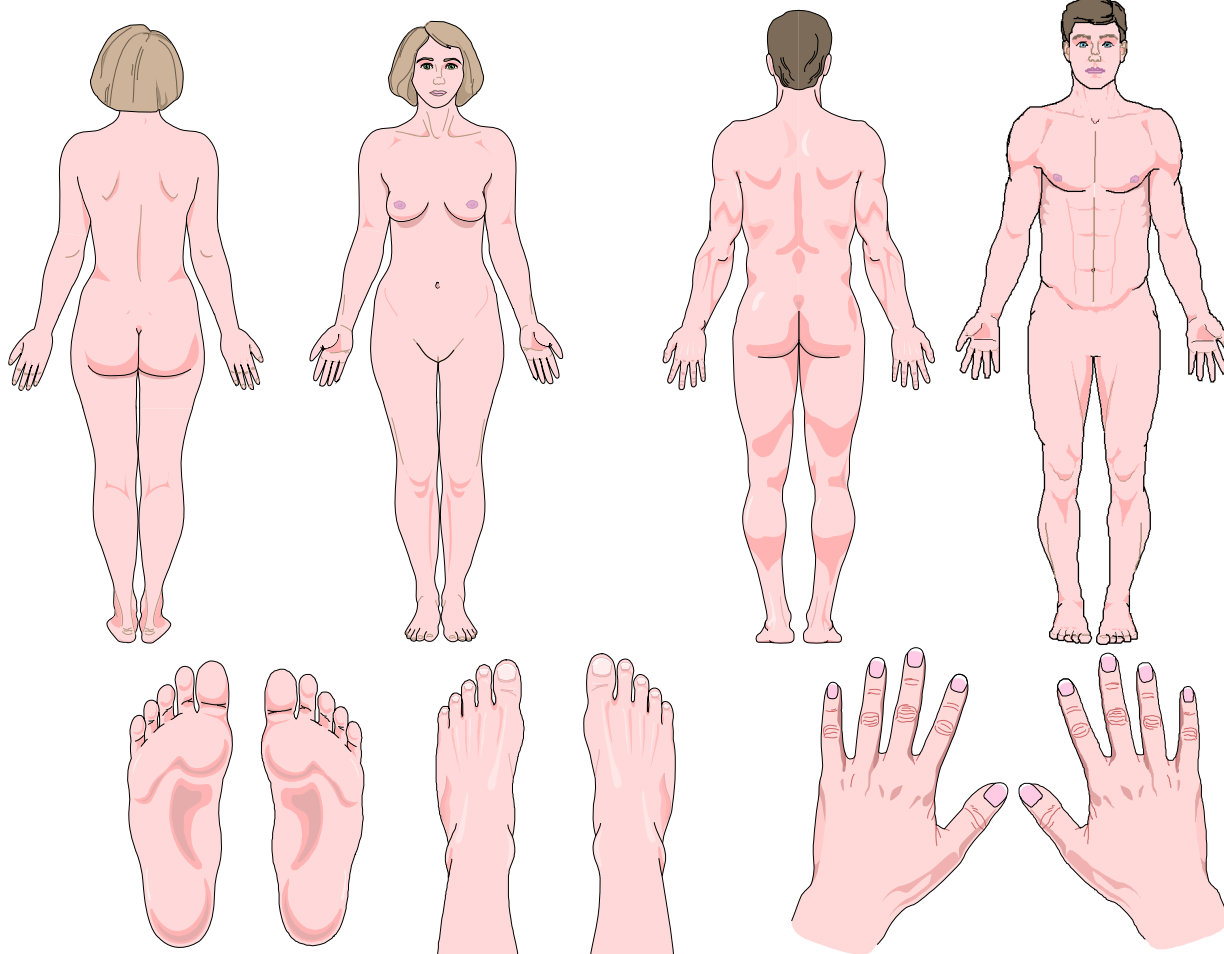
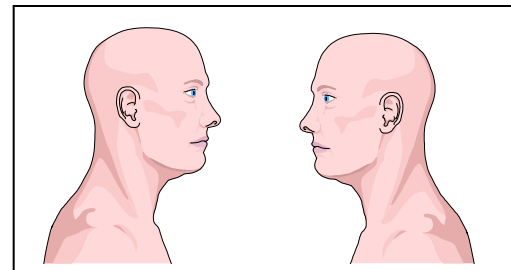
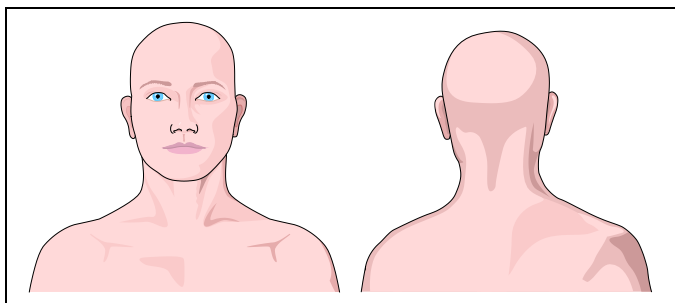
LABEL AREAS of old injuries, pain and location in body of past infection.

Examples: scars, whiplash from auto accident injuring neck or chin hitting dashboard, head injury, blows to the body from falls or hits (ex. falling on your tail bone, hit in the nose or on the head), surgeries, broken bones (ex. broke rib, toe, arm), muscle, tendon or ligament tears, organs removed, etc. *Examples:* sore throat, tonsils swollen, ear infections, lung infection, bronchial infections, bladder infections, sinus infection, appendix, etc.

SEE EXAMPLE TO THE RIGHT



Example:



Practitioner Signature/or Health Coach: _____