**VCM Patient Information**

**Name Date**

**Address \_ City State Zip Code**

**Home Phone Cell Phone** **Work Phone Email Date of Birth / / Occupation Person who referred you Cell**

**Please state if it is a previous or current condition on each line that applies**

**Heart Disease**

**Epilepsy**

**Fibromyalgia**

**Lupus**

# Osteoarthritis Migraine Headaches Graves Disease

**Kidney Disease**  **Irritable Bowel Syndrome Diabetes**

**Human Papilloma Virus**

**Shingles**

**Low Blood Pressure**

**High Cholesterol**

**Panic Disorder**

**Breast Cysts**

**Ovarian Cysts**

**Enlarged prostate**

**Lymes Disease**

**Bartonella**

# Cancer

**High Blood Pressure**

**Psoriasis**

**Rheumatoid Arthritis**

**Osteopenia**

**Multiple Sclerosis**

**Hashimoto’s Disease**

**Liver Disease**

**Crohn’s Disease**

**Hepatitis**

**Epstein Barr Virus**

**Herpes Virus**

**Heart Arrythmia**

**Depression**

**Polycystic Ovaries**

**Uterine Fibroids**

**Ovarian Fibroids**

**Erectile Dysfunction**

**Babesia**

**Erlichiosis**

PATIENT NAME:

### ARBITRATION AGREEMENT For Vienna Complimentary Medicine

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to 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 , 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 spouses(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 or preceptorship interns who now o in the future threat 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.

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 of 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 loses, 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 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 ARTIBRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

|  |  |
| --- | --- |
| PATIENT SIGNATURE | **X** (Date) |
| (Or Patient Representative) | (Indicate relationship if signing for patient) |
| OFFICE SIGNATURE | **X** (Date) |

AAC-FED ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

**Informed Consent**

I hereby agree to receive some of the following services by Stuart Saltzman, aka Shep Saltzman, Barbara Balsamo, and or VCM,LLC, and any staff or Independent Contractors or therapists at VCM,LLC:

Acupuncture, Chinese Herbs, Homeopathy, Nutritional coaching, Well Being Assessments, Physical Examination, Consultation for determination of future services, review of lab tests from a nutritional perspective, allergy testing, nutritional coaching, massage, facial rejuvenation.

I understand I may receive recommendations for: Nutritional supplements, Herbal supplements, Homeopathic remedies, Acupuncture treatments, facial rejuvenation, and skin care products.

**ACUPUNCTURE**:I understand that if I get Acupuncture, I understand it is possible to experience bruising, numbness, or tingling near the needle site that might last a few days, or dizziness. I may also feel feint for a few days. Infections is also a risk, even though we only use sterile needles and practice clean needle techniques approved by the NCCAOM. Our Chinese Medical Practitioners are all approved by the NCCAOM for Acupuncture and Chinese Herbs

**Supplements, Remedies, Nutritional food- ­ ‐** I understand that If I agree to use any recommended supplements or remedies, or skin care products, I may experience side effects. Our products come from plant, mineral and animal sources, and are considered safe by traditional standards in the practice of Chinese Medicine, nutrition and Homeopathy, and skin care. I understand the products or supplements and remedies not may be safe during pregnancy, and I agree to inform VCM,LLC AND IT’S STAFF OR PRACTITIONERS THAT I AM PREGANT ONCE I KNOW .

**SIDE EFFECTS** Some possible side effects of remedies and supplements and skin care used are: nausea, vomiting, headaches, rashes, hives, tingling, headaches, bloating, gas. I agree to inform one of the practitioners of VCM,LLC of my side effects immediately, and stop using any supplements or remedies, or skin care products until I speak directly with whoever recommended the remedy or supplement or skin care product.

**CONFIDENTIALITY:** I UNDERSTAND MY RECORDS AND INFORMATION WILL REMAIN CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE WITHOUT MY PERMISSION.

**Medical Supervision** It is the position of VCM,LLC that’s you seek medical supervision of your health for any condition you come to VCM,LLC., by a medical doctor

VCM,LLC and any of it’s practitioners is not a replacement for seeing a medical doctor or medical attention and supervision. We are complementary, and adjunctive. We do not provide primary care, and we do not practice medicine. Our primary focus is the prevention of disease, the improvement of function and the correction of energetic and nutritional imbalances.

By voluntarily signing below, I show I have read this notice, which is also posted on the website [www.vcmedicine.com.](http://www.vcmedicine.com/) I have been told about the risks and benefits of Acupuncture, and other services at VCM,LLC and I have had the opportunity to ask questions about any services I agree to. 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 and support

Sign Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Date of Birth

VIENNA COMPLEMENTARY MEDICINE

380 Maple Avenue West, Suite 304

Vienna, Virginia 22180

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to you past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

Vienna Complementary Medicine Privacy Practices and HIPPA Consent Form

VIENNA COMPLEMENTARY MEDICINE

380 Maple Avenue West, Suite 304

Vienna, Virginia 22180

Patient Name

DOB / /

I HEREBY ACKNOWLEDGE THAT I RECEIVED, AND HAVE BEEN GIVEN AN OPPORTUNITY TO READ A COOPY OF VIENNA COMPLEMENTARY MEDICINE’S PRIVACY PRACTICES. I UNDERSTAND THAT IF I HAVE ANY QUESTIONS REGARDING THENOTICE OR MY PRIVACY RIGHTS, I CAN CONTACT THE

PRIVACY OFFICER AT: 380 Maple Avenue, Suite 304, Vienna, Virginia 22180.

Signature of Patient

Signature of Parent, Guardian or Personal Representative\*

 / /

date

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Office, Stuart Saltzman at 345 Maple Avenue, Suite 332, Vienna, VA 22180

* Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost- based fee for copies.
* Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
* Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one account in any 12- month period.
* Right to Request Restrictions. You have the right to request a restriction or limitation on the use of disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
* Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
* Right to a Copy of this Notice. You have the right to a copy of this Notice.
* Electronic Transactions Standards.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Stuart Saltzman, our Privacy officer, at 345 Maple Avenue, Suite 332, Vienna, VA 22180 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257.

We will not retaliate against you for filing a complaint. The effective date of this Notice is

 .

**Prescription Medications**

**Name of Drug/Hormone Dosage Purpose**

**Non-­‐Prescription Medication**

**Name of Medication Dosage Purpose**

**Supplements**

**Name Of Supplement Dosage Purpose**

**Surgeries or Child Births**

**Description Date**

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

**Injuries**

**Description Date**

1.

2.

3.

4.

5.

6.

7.

**Nutritional Assessment Questionnaire**

Name:

Date:

/ /

Birthdate: \_ Gender: \_

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

1. -----------------------------------------------

**2.**-----------------------------------------------

3.-----------------------------------------------

**4.**-----------------------------------------------

5.

**PARTI**

Read the following questions and fill in the number that applies:

KEY: 0 (or leave blank) = Do not consume or use 1 = Con sume or use 2-3 times/month

2 = Consume or use weekly

3 = Consume or use daily

|  |  |
| --- | --- |
| **DIET** |  |
| 1.  | Alcohol | 8.  | Coffee | 15.  | Refined flour/ Baked goods |
| 2.  | Artificial sweeteners | 9.  | Eat fast food regularly | 16.  | Refined sugar |
| 3.  | candy or other sweets | 10.  | Fried foods | 17.  | Vitamins andminerals |
| 4.  | Carbonated beverages | 11.  | Luncheon meats/ hot dogs | 18.  | Water, distilled |
| 5.  | Chewing tobacco | 12.  | Margarine | 19.  | water, Tap |
| 6.  | Cigarettes | 13.  | **Milk** products | 20.  | Water, well |
| 7.  | Cigars/pipes | 14.  | Non-herbal tea | 21.  | Diet often |

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**LIFESTYLE**

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., ....\_, ···- ···-··- ·····- ·.·.···- ·-···- ······-

22.

23.

24.

25.

Times you exercise per week (1 = once a week, 2 = 2-4 times/week, 3 = 5 times a week) Changed jobs (3= within last 2 months, 2= within last 6 months, 1= within last 12 months.)

Divorced (3= within last 6 months, 2= within last year, 1= within last 2 years)

Work over 60 hours/week (3= always, 2= usually, 1= occasionally, 0= never)

- ·····- ·-·-·- -·--- ·- - - ······- ·-·-·- -··--····-·- ···-·- ···-·- ···-·- ·-·- -·· -····-·- ······-.·.·•-•·- ••-···- ·-···-\_,-\_... , . .. , .\_...... .\_.,,...\_, ,.\_. .. ,\_.... ..

**MEDICAT IONS**

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**Indicate with a checkmark or circle anymedications you're currently taking or have taken in the lastmonth:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 26. |   | Antacids | 32.  | Asthma inhalers | 38.  | Estrogen/Progesterone | 44.  | oral/implant contraceptives |
| 27. |   | Antibiotics | 33.  | Beta blockers | 39.  | Heart medications | 45.  | Radiation exposure |
| 28. |   | Anticonvulsants | 34.  | Chemotherapy | 40.  | High blood pressure | 46.  | Recreational drugs |
| 29. |   | Antidepressants | 35.  | Cortisone | 41.  | Hormone Therapy | 47.  | Relaxants/Sleeping pills |
| 30. |   | Antifungals | 36.  | Diabetic medications | 42.  | Laxatives | 48.  | Thyroid medication |
| 31. |   | Aspirin/Ibuprofen | 37.  | Diuretics | 43.  | Insulin | 49.  | Tylenol/acetaminophen |
|  |  |  |  |  |  |  | 50.  | Ulcer medications |

##### ot her medicatio ns and dosages (if known): - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

**PART** II

Read the following questions and fill in the number that applies:

**Please Answer Each**

**Section Carefully**

**They relate to different body systems.**

(How significant is the symptom? How true is the statement? 0 means not at all, 3 means extremely true.)

KEY: 0 (or leave blank) = No or Do not have the symptom, the symptom does not occtu· 1 = Yes or It is a minor or mild symptom or it rarely occurs (oncea month or less) 2 = It is a moderate symptom or it occasionally occurs (weekly)

3 = It is a seve1·esymptom or it frequently occurs (daily)

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**Section 1**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 51.  | Belching or gas within 1 hr. of a meal | 60. |   | Do you feel like skipping breakfast? |
| 52.  | Heartburn or acid reflux | 61. |   | Do you feel better if you don't eat? |
| 53.  | Bloating shortly after eating | 62. |   | Sleepy after meals |
| 54.  | Are you a vegan (no dairy, meat, fish or eggs) | 63. |   | Fingernails chip, peel or break easily |
| 55.  | Bad breath (halitosis) | 64. |   | Anemia unresponsive to iron |
| 56.  | Loss of taste for meat | 65. |   | stomach pains or cramps |
| 57.  | Sweat has a strong odor | 66. |   | Diarrhea, chronic |
| 58.  | Stomach upset by taking vitamins | 67. |   | Diarrhea shortly after meals |
| 59.  | Sense of excess fullness after meals | 68. |   | Black or tarry stools |
|  |  | 69. |   | Undigested food in stool |



**Section 2**

1. Pain between shoulder blades
2. Stomach upset by greasy foods
3. Greasy or shiny stools
4. Nausea
5. Sea, car or airplane sickness, motion sickness
6. History of morning sickness (1 = yes, 0 = no)
7. Light or clay colored stools
8. Dry skin, itchy feet and/or skin peels on feet
9. Headache over the eye
10. Gallbladder attacks (past or present)
11. Gallbladder removed (1 = yes, 0 = no)
12. Bitter taste in mouth, especially after meals
13. Become sick if drinking wine
14. If drinking alcohol, easily intoxicated

**Section 3**

1. Food allergies
2. Abdominal bloating 1 to 2 hours after eating
3. Specific foods make you tired or bloated (1= yes, 0= no)
4. Pulse speeds after eating
5. Airborne allergies
6. Experience hives
7. Sinus congestion, "stuffy head"
8. Crave bread or noodles
9. Alternating constipation and diarrhea

#### Section 4

1. Anus itches
2. Coated tongue
3. Feel worse in moldy or musty place
4. Taken any antibiotic for a combined time of (1 = < 1 mo., 2 = < 3 mos., 3 = > 3 mos.)
5. Fungus or yeast infections
6. Ring worm, "jock itch", "athletes foot", nail fungus
7. Eating sugar, starch or drinking alcohol increases yeast symptoms
8. Stools hard or difficult to pass
9. History of parasites (1 = yes, 0 = no)

#### Section 5

1. History of Carpal Tunnel Syndrome (1 = yes, 0 = no)
2. History of lower right abdominal pain (1 = yes, 0 = no)
3. History of stress fractures
4. Bone loss (reduced density on bone scan)
5. Are you shorter than you used to be? (1 = yes, 0 = no)
6. Calf, foot or toe cramps at rest
7. Cold sores, fever blisters or herpes lesions
8. Frequent fevers
9. Frequent skin rashes and / or hives
10. Have you ever had a herniated disc? (1 = yes, 0 = no)
11. Excessively flexible joints, "double jointed"
12. Joints pop or click
13. Pain or swelling in joints
14. Bursitis or tendonitis
15. History of bone spurs (1 = yes, 0 = no)
16. Alcoholic beverages per week (0 = < 3/ week, 1 = < 7/ week, 2 = < 14/ week, 3 = > 14/week)
17. Recovering alcoholic (1 = yes, 0 = no)
18. Hangovers after drinking alcohol
19. History of drug or alcohol abuse (1 = yes, 0 = no)
20. History of hepatitis (1 = yes, 0 = no)
21. Long term use of prescription medications (1 = yes, 0 =no)
22. Sensitive to chemicals (perfume, cleaning solvents, insecticides, exhaust, etc.)
23. Sensitive to tobacco smoke
24. Exposure to diesel fumes
25. Pain under right side of rib cage
26. Hemorrhoids or varicose veins
27. Nutrasweet (aspartame) consumption
28. Bothered by aspartame (Nutrasweet)
29. Chronic fatigue or Fibromyalgia
30. Crohn’s disease (1 = yes, 0 = no)
31. Wheat or grain sensitivity
32. Dairy sensitivity
33. Are there foods you could not give up (1 = yes, 0 = no)
34. Asthma, sinus infections, stuffy nose
35. Bizarre vivid or nightmarish dreams
36. Use over-the-counter pain medications
37. Feel spacey or unreal
38. Less than one bowel movement per day
39. Stools have corners or edges are flat or ribbon shaped
40. Stools are not well formed (loose)
41. Irritable bowel or mucus colitis
42. Blood in stool
43. Mucus in stool
44. Excessive foul smelling lower bowel gas
45. Bad breath or strong body odors
46. Painful to press along outer sides of thighs (Iliotibial Band)
47. Cramping in lower abdominal region
48. Dark circles under eyes
49. Morning stiffness
50. Vomiting or nausea
51. Crave chocolate
52. Feet have a strong odor
53. Tendency to anemia
54. Whites of eyes (sclera) blue tinted
55. Hoarseness
56. Difficulty swallowing
57. Lump in throat
58. Dry mouth, eyes and / or nose
59. Gag easily
60. White spots on fingernails
61. Cuts heal slowly and / or scar easily
62. Decreased sense of taste or smell

#### Section 6

1. Aspirin is an effective pain reliever (1 = yes, 0 = no)
2. Crave fatty or greasy foods
3. Low or reduced fat diet (past or present)
4. Tension headaches at base of skull

#### Section 7

1. Awaken a few hours after falling asleep, hard to get back to sleep
2. Crave sweets
3. Eat desserts or sugary snacks
4. Binge or uncontrolled eating
5. Excessive appetite
6. Crave coffee or sugar in the afternoon
7. Sleepy in afternoon

#### Section 8

1. Muscles become easily fatigued
2. Feel worse, sore after moderate exercise
3. Vulnerable to insect bites
4. Loss of muscle tone, heaviness in arms / legs
5. Enlarged heart, or heart failure
6. Pulse slow / below 65 (1 = yes, 0 = no)
7. Ringing in the ears / Tinnitus
8. Numbness, tingling or itching in extremities
9. Depressed
10. Fear of impending doom
11. Worrier, apprehensive, anxious
12. Nervous or agitated
13. Feelings of insecurity
14. Heart races

#### Section 9

1. Tend to be a "night person"
2. Difficulty falling asleep
3. Slow starter in the morning
4. Keyed up, trouble calming down
5. High blood pressure (normal 120/80)
6. Headache after exercising
7. Feeling wired or jittery if drinking coffee
8. Clench or grind teeth
9. Calm on the outside, troubled inside
10. Chronic low back pain, worse with fatigue
11. Become dizzy when standing up suddenly
12. Difficult maintaining manipulative correction
13. Pain after manipulative correction

#### Section 10

1. Over 6’ 6" tall (Mature height)
2. Early sexual development (before age 10) (1 = yes, 0 = no)
3. Increased libido
4. Splitting type headache
5. Memory failing
6. Ability to tolerate sugar
7. Headaches when out in the hot sun
8. Sunburn easily or suffer sun poisoning
9. Muscles easily fatigued
10. Dry flaky skin and or dandruff
11. Fatigue that is relieved by eating
12. Headache if meals are skipped or delayed
13. Irritable before meals
14. Shaky if meals delayed
15. Family members with diabetes (0 = none, 1 = 2 or less, 2 = Between 2 - 4, 3 = More than 4)
16. Frequent thirst
17. Frequent urination
18. Can hear heart beat on pillow at night
19. Whole body or limb jerk as falling asleep
20. Night sweats
21. Restless leg syndrome
22. Cheilosis (cracks at corner of mouth)
23. Fragile skin, easily chaffed, as in shaving
24. Polyps or warts
25. MSG sensitivity
26. Wake up without remembering dreams
27. Take birth control pills
28. Small bumps on back of arms
29. Strong light at night irritates eyes
30. Nose bleeds and / or tend to bruise easily
31. Bleeding gums especially when brushing teeth
32. Arthritic tendencies
33. Crave salty foods
34. Salt foods before tasting
35. Perspire easily
36. Chronic fatigue, or get drowsy often
37. Afternoon yawning
38. Afternoon headache
39. Asthma, wheezing or difficulty breathing
40. Pain on the medial or inner side of the knee
41. Tendency to sprain ankles or "shin splints"
42. Tendency to need to wear sunglasses
43. Allergies and / or hives
44. Weakness, dizziness
45. Under 4’ 10" (Mature height)
46. Decreased libido
47. Abnormal thirst
48. Weight gain around hips or waist
49. Menstrual disorders
50. Delayed (after age 13) sexual development (1 = yes, 0 = no)
51. Tendency to ulcers or colitis

#### Section 11

1. Allergic to iodine
2. Difficulty gaining weight, even with large appetite
3. Nervous, emotional, can’t work under pressure
4. Inward trembling
5. Flush easily
6. Fast pulse at rest
7. Intolerance to high temperatures
8. Difficulty losing weight

#### Section 12 – Men Only

1. Prostrate Problem
2. Urination difficult or dribbling
3. Difficult to start and stop urine stream
4. Pain or burning with urination

#### Section 13 – Women Only

1. Depression During Period
2. Mood swings associated with periods (PMS)
3. Crave chocolate around periods
4. Breast tenderness associated with cycle
5. Excessive menstrual flow
6. Scanty blood flow during periods
7. Occasional skipped periods
8. Variations in menstrual cycles
9. Endometriosis
10. Uterine fibroids

#### Section 14

1. Aware of heavy and / or irregular breathing
2. Discomfort at high altitudes
3. "Air hunger" and / or yawn frequently
4. Compelled to open windows in a closed room
5. Shortness of breath with moderate exertion

#### Section 15

1. Pain in mid back region
2. Dark circles under eyes and / or puffy eyes
3. History of kidney stones (1 = yes, 0 = no)

#### Section 16

1. Runny or drippy nose
2. Catch colds at the beginning of winter
3. Mucus producing cough
4. Frequent infections (ear, sinus, lung, skin, bladder, kidney, etc.)
5. Frequent colds or flu
6. Never get sick (3 = not in last 7 yrs., 2 = not in last 4 yrs., 1 = not in last 2 yrs.)
7. Mentally sluggish, reduced initiative
8. Easily fatigued, sleepy during the day
9. Sensitive to cold, poor circulation (cold hands and feet)
10. Constipation, chronic
11. Excessive hair loss and / or coarse hair
12. Morning headaches, wear off during the day
13. Loss of lateral 1/3 of eyebrow
14. Seasonal sadness
15. Waking to urinate at night
16. Interruption of stream during urination
17. Pain on inside of legs or heels
18. Feeling of incomplete bowel evacuation
19. Decreased sexual function
20. Breast fibroids, benign masses
21. Painful intercourse (dyspareunia)
22. Vaginal discharge
23. Vaginal dryness
24. Vaginal itchiness
25. Gain weight around hips, thighs and buttocks
26. Excess facial or body hair
27. Hot flashes
28. Night sweats (in menopausal females)
29. Thinning skin
30. Ankles swell, especially at end of day
31. Cough at night
32. Blush or face turns red for no reason
33. Dull pain or tightness in chest and / or radiate into right arm, worse with exertion
34. Muscle cramps with exertion

311. Cloudy, bloody or darkened urine

312. Urine has a strong odor

1. Acne (adult)
2. Itchy skin / dermatitis
3. Cysts, boils, rashes
4. History of Epstein Bar, Mono, Herpes, Shingles,

Chronic Fatigue, Hepatitis or other chronic viral condition (1 = yes, 0 = no)

# Metabolic Assessment Form

### Name: Age: Sex: Date:

**PART I**

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

**1.**

**2.**

**3.**

**4.**

**5.**

###### **PART II** Please circle the appropriate number on all questions below. 0 as the least/never up to 3 as the most/always.

|  |  |
| --- | --- |
| **Category 1**Feeling that bowels do not empty completely 0 1 2 3Lower abdominal pain relieved by passing stool or gas 0 1 2 3Alternating constipation and diarrhea 0 1 2 3Diarrhea 0 1 2 3Constipation 0 1 2 3Hard, dry, or small stool 0 1 2 3Coated tongue or “fuzzy” debris on tongue 0 1 2 3Pass large amount of foul-smelling gas 0 1 2 3More than 3 bowel movements daily 0 1 2 3Use laxatives frequently 0 1 2 3**Category II**Increasing frequency of food reactions 0 1 2 3Unpredictable food reactions 0 1 2 3Aches, pains, and swelling throughout the body 0 1 2 3Unpredictable abdominal swelling 0 1 2 3Frequent bloating and distention after eating 0 1 2 3Abdominal intolerance to sugars and starches 0 1 2 3**Category III**Intolerance to smells 0 1 2 3Intolerance to jewelry 0 1 2 3Intolerance to shampoo, lotion, detergents, etc. 0 1 2 3Multiple smell and chemical sensitivities 0 1 2 3Constant skin outbreaks 0 1 2 3**Category IV**Excessive belching, burping, or bloating 0 1 2 3Gas immediately following a meal 0 1 2 3Offensive breath 0 1 2 3Difficult bowel movement 0 1 2 3Sense 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 3Use antacids 0 1 2 3Feel hungry an hour or two after eating 0 1 2 3Heartburn when lying down or bending forward 0 1 2 3 Temporary relief by using antacids, food, milk, orcarbonated beverages. 0 1 2 3Digestive problems subside with rest & 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 3Indigestion and fullness last 2-4 hours after eating 0 1 2 3Pain, tenderness, soreness on left side under rib cage 0 1 2 3 | **Category VI (continued)**Excessive passage of gas 0 1 2 3Nausea and/or vomiting 0 1 2 3Stool undigested, foul smelling, mucous like, greasyor poorly formed. 0 1 2 3Frequent urination 0 1 2 3Increased thirst and appetite 0 1 2 3Difficulty losing weight 0 1 2 3**Category VII**Greasy or high-fat foods cause distress 0 1 2 3 Lower bowel gas and/or bloating several hoursafter eating. 0 1 2 3Bitter metallic taste in mouth, especially in the morning 0 1 2 3Unexplained itchy skin 0 1 2 3Yellowish cast to eyes 0 1 2 3Stool color alternates from clay colored to normal brown 0 1 2 3Reddened skin, especially palms 0 1 2 3Dry or flaky skin and/or hair 0 1 2 3History of gallbladder attacks or stones 0 1 2 3Have you had your gallbladder removed? YES NO**Category VIII**Acne and unhealthy skin 0 1 2 3Excessive hair loss 0 1 2 3Overall sense of bloating 0 1 2 3Bodily swelling for no reason 0 1 2 3Hormone imbalances 0 1 2 3Poor bowel function 0 1 2 3Excessively foul-smelling sweat 0 1 2 3**Category IX**Crave sweets during the day 0 1 2 3Irritable if meals are missed 0 1 2 3Depend on coffee to keep going/get started 0 1 2 3Get light-headed if meals are missed 0 1 2 3Eating relieves fatigue 0 1 2 3Feel shaky, jittery, or have tremors 0 1 2 3Agitated, easily upset, nervous 0 1 2 3Poor memory/forgetful 0 1 2 3Blurred vision 0 1 2 3**Category X**Fatigue after meals 0 1 2 3Crave sweets during the day 0 1 2 3Eating sweets does not relieve cravings for sugar 0 1 2 3Must have sweets after meals 0 1 2 3Waist girth is equal or larger than hip girth 0 1 2 3Frequent urination 0 1 2 3Increased thirst and appetite 0 1 2 3Difficulty losing weight 0 1 2 3 |

|  |  |
| --- | --- |
| **Category XI**Cannot stay asleep 0 1 2 3Crave salt 0 1 2 3Slow starter in the morning 0 1 2 3Afternoon fatigue 0 1 2 3Dizziness when standing up quickly 0 1 2 3Afternoon headaches 0 1 2 3Headaches with exertion or stress 0 1 2 3Weak nails 0 1 2 3**Category XII**Cannot fall asleep 0 1 2 3Perspire easily 0 1 2 3Under high amount of stress 0 1 2 3Weight gain when under stress 0 1 2 3Wake up tired even after 6 or more hours of sleep 0 1 2 3 Excessive perspiration or perspiration with little orno activity. 0 1 2 3**Category XIII**Edema and swelling in ankles and wrists 0 1 2 3Muscle cramping 0 1 2 3Poor muscle endurance 0 1 2 3Frequent urination 0 1 2 3Frequent thirst 0 1 2 3Crave salt 0 1 2 3Abnormal sweating from minimal activity 0 1 2 3Alteration in bowel regularity 0 1 2 3Inability to hold breath for long periods 0 1 2 3Shallow, rapid breathing 0 1 2 3**Category XIV**Tired/Sluggish 0 1 2 3Feel cold - hands, feet, all over 0 1 2 3Require excessive amounts of sleep to function properly 0 1 2 3Increase in weight even with low-calorie diet 0 1 2 3Gain weight easily 0 1 2 3Difficult, infrequent bowel movements 0 1 2 3Depression / lack of motivation 0 1 2 3Morning headaches that wear off as the day progresses 0 1 2 3Outer third of eyebrow thins 0 1 2 3 Thinning of hair on scalp, face, or genitals, orexcessive hair loss. 0 1 2 3Mental sluggishness 0 1 2 3**Category XV**Heart palpitations 0 1 2 3Inward trembling 0 1 2 3Increased pulse even at rest 0 1 2 3Nervous and emotional 0 1 2 3Insomnia 0 1 2 3Night sweats 0 1 2 3Difficulty gaining weight 0 1 2 3**Category XVI**Diminished sex drive 0 1 2 3Menstrual disorders or lack of menstruation 0 1 2 3Increased ability to eat sugars without symptoms 0 1 2 3 | **Category XVII**Increased sex drive 0 1 2 3Tolerance to sugars reduced 0 1 2 3“Splitting” – type headaches 0 1 2 3**Category XVIII (Males Only)**Urination difficulty or dribbling 0 1 2 3Frequent urination 0 1 2 3Pain inside of legs or heels 0 1 2 3Feeling of incomplete bowel emptying 0 1 2 3Leg twitching at night 0 1 2 3**Category XIX (Males Only)**Decreased libido 0 1 2 3Decreased number of spontaneous morning erections 0 1 2 3Decreased fullness of erections 0 1 2 3Difficulty maintaining morning erections 0 1 2 3Spells of mental fatigue 0 1 2 3Inability to concentrate 0 1 2 3Episodes of depression 0 1 2 3Muscle soreness 0 1 2 3Decreased physical stamina 0 1 2 3Unexplained weight gain 0 1 2 3Increase in fat distribution around chest and hips 0 1 2 3Sweating attacks 0 1 2 3More emotional than in the past 0 1 2 3**Category XX (Menstruating Females Only)**Perimenopausal YES NOAlternating menstrual cycle lengths YES NOExtended menstrual cycle (greater than 32 days) YES NOShortened menstrual cycle (less than 24 days) YES NOPain and cramping during periods 0 1 2 3Scanty blood flow 0 1 2 3Heavy blood flow 0 1 2 3Breast pain and swelling during menses 0 1 2 3Pelvic pain during menses 0 1 2 3Irritable and depressed during menses 0 1 2 3Acne 0 1 2 3Facial hair growth 0 1 2 3Hair loss / thinning 0 1 2 3**Category XXI (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 3Mental fogginess 0 1 2 3Disinterest in sex 0 1 2 3Mood swings 0 1 2 3Depression 0 1 2 3Painful intercourse 0 1 2 3Shrinking breasts 0 1 2 3Facial hair growth 0 1 2 3Acne 0 1 2 3Increased vaginal pain, dryness, or itching 0 1 2 3 |

**PART III**

How many alcoholic beverages do you consume per week? How many caffeinated beverages do you consume per day? How many times do you eat out per week?

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

Rate your stress level on a scale of 1-10 during the average week: How many times do you eat fish per week?

How many times do you work out per week?

List the three worst foods you eat during the average week: , , List the three healthiest foods you eat during the average week: , , **PART IV**

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

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

**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 A**

SECTION C2

* How often do you get fatigued after meals?

**0 1 2 3**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * How often do you crave sugar and sweets after meals?
 | **0** | **1** | **2** | **3** |
| * How often do you feel you need stimulants, such as coffee, after meals?
 | **0** | **1** | **2** | **3** |
| * How often 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 increased?
 | **0** | **1** | **2** | **3** |
| * How often do you gain weight when under stress?
 | **0** | **1** | **2** | **3** |
| * How often do you have difficulty falling asleep?
 | **0** | **1** | **2** | **3** |

**SECTION 1**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * 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 new things?
 | **0** | **1** | **2** | **3** |
| * How often do you have a hard time remembering your appointments?
 | **0** | **1** | **2** | **3** |
| * Is your temperament generally getting worse?
 | **0** | **1** | **2** | **3** |
| * Is your attention span decreasing?
 | **0** | **1** | **2** | **3** |
| * How often do you find yourself down or sad?
 | **0** | **1** | **2** | **3** |
| * How often do you become fatigued when driving compared to in the past?
 | **0** | **1** | **2** | **3** |
| * How often do you become fatigued when reading compared to in 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** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Are you losing interest in hobbies?
 | **0** | **1** | **2** | **3** |
| * How often do you feel overwhelmed?
 | **0** | **1** | **2** | **3** |
| * How often do you have feelings of inner rage?
 | **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 your 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 B**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * How high is your stress level?
 | **0** | **1** | **2** | **3** |
| * How often do you feel 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** |

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

**SECTION 2**

* How often do you have feelings of hopelessness?
* How often do you have self-destructive thoughts?
* How often do you have an inability to handle stress?
* How often do you have anger and aggression while under stress?
* How often do you feel you are not rested, even after long hours of sleep?
* How often do you prefer to isolate yourself from others?
* How often do you have unexplained lack of concern for

family and friends?

* How easily are you distracted from your tasks?
* How often do you have an inability to finish tasks?
* How often do you feel the need to consume caffeine to stay alert?
* How often do you feel your libido has been decreased?
* How often do you lose your temper for minor reasons?
* How often do you have feelings of worthlessness?

**SECTION 3**

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

**SECTION 4**

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

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

**0 1 2 3**

mental function **0 1 2 3**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SECTION 5*** A decrease in mental alertness
 | **0** | **1** | **2** | **3** |
| * A decrease in mental speed
 | **0** | **1** | **2** | **3** |
| * A decrease in concentration quality
 | **0** | **1** | **2** | **3** |
| * Slow cognitive processing
 | **0** | **1** | **2** | **3** |
| * Impaired mental performance
 | **0** | **1** | **2** | **3** |
| * An increase in the ability to be distracted
* Need coffee or caffeine sources to improve
 | **0** | **1** | **2** | **3** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * How often do you feel anxious or panicked 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** |

## Name: Age: Sex: Date:

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

**SECTION 1**

* A decrease in attention span **0 1 2 3**
* Mental fatigue **0 1 2 3**
* Difficulty learning new things **0 1 2 3**
* Difficulty staying focused and concentrating

for extended periods of time **0 1 2 3**

* Experiencing fatigue when reading sooner

than in the past **0 1 2 3**

* Experiencing fatigue when driving sooner

than in the past **0 1 2 3**

* Need for caffeine to stay mentally alert **0 1 2 3**
* Overall brain function impairs your daily life **0 1 2 3**

**SECTION 2**

* Twitching or tremor in your hands and legs

when resting **0 1 2 3**

* Handwriting has gotten smaller and more

crowded together **0 1 2 3**

* A loss of smell to foods **0 1 2 3**
* Difficulty sleeping or fitful sleep **0 1 2 3**
* Stiffness in shoulders and hips that goes away

when you start to move **0 1 2 3**

* Constipation **0 1 2 3**
* Voice has become softer **0 1 2 3**
* Facial expression that is serious or angry **0 1 2 3**
* Episodes of dizziness or light-headedness

upon standing **0 1 2 3**

* A hunched over posture when getting up and walking **0 1 2 3**

SECTION 3

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Memory loss that impacts daily activities
 | **0** | **1** | **2** | **3** |
| * Difficulty planning, problem solving,

or working with numbers | **0** | **1** | **2** | **3** |
| * Difficulty completing daily tasks
 | **0** | **1** | **2** | **3** |
| * Confusion about dates, the passage of time, or place
 | **0** | **1** | **2** | **3** |
| * Difficulty understanding visual images and spatial

relationships (addresses and locations) | **0** | **1** | **2** | **3** |
| * Difficulty finding words when speaking
 | **0** | **1** | **2** | **3** |
| * Misplacement of things and inability to retrace steps
 | **0** | **1** | **2** | **3** |
| * Poor judgment and bad decisions
 | **0** | **1** | **2** | **3** |
| * Disinterest in hobbies, social activities, or work
 | **0** | **1** | **2** | **3** |
| * Personality or mood changes
 | **0** | **1** | **2** | **3** |

**SECTION 4**

* Reduced function in overall hearing **0 1 2 3**
* Difficulty understanding language with background

or scatter noise **0 1 2 3**

* Ringing or buzzing in the ear **0 1 2 3**
* Difficulty comprehending language without

perfect pronunciation **0 1 2 3**

* Difficulty recognizing familiar faces **0 1 2 3**
* Changes in comprehending the meaning of sentences,

written or spoken **0 1 2 3**

* Difficulty with verbal memory and finding words **0 1 2 3**
* Difficulty remembering events **0 1 2 3**
* Difficulty recalling previously learned facts and names **0 1 2 3**
* Inability to comprehend familiar words when read **0 1 2 3**
* Difficulty spelling familiar words **0 1 2 3**
* Monotone, unemotional speech **0 1 2 3**
* Difficulty understanding the emotions of others

when they speak (nonverbal cues) **0 1 2 3**

* Disinterest in music and a lack of appreciation

for melodies **0 1 2 3**

* Difficulty with long-term memory **0 1 2 3**
* Memory impairment when doing the basic activities

of daily living **0 1 2 3**

* Difficulty with directions and visual memory **0 1 2 3**
* Noticeable differences in energy levels throughout

the day **0 1 2 3**

SECTION 5

* Difficulty coordinating visual inputs

and hand movements, resulting in an inability

to efficiently reach for objects **0 1 2 3**

* Difficulty comprehending written text **0 1 2 3**
* Floaters or halos in your visual field **0 1 2 3**
* Dullness of colors in your visual field during different

times of the day **0 1 2 3**

* Difficulty discriminating similar shades of color **0 1 2 3**

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

**SECTION 6 SECTION 9**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| * Difficulty with detailed hand coordination
 | **0** | **1** | **2** | **3** | * A decrease in movement speed
 | **0** | **1** | **2** | **3** |
| * Difficulty with making decisions
 | **0** | **1** | **2** | **3** | * Difficulty initiating movement
 | **0** | **1** | **2** | **3** |
| * Difficulty with suppressing socially
 |  |  |  |  | * Stiffness in your muscles (not joints)
 | **0** | **1** | **2** | **3** |
| inappropriate thoughts **0 1 2 3*** Socially inappropriate behavior **0 1 2 3**
* Decisions made based on desires,

regardless of the consequences **0 1 2 3*** Difficulty planning and organizing daily events **0 1 2 3**
* Difficulty motivating yourself to start and finish tasks **0 1 2 3**
* A loss of attention and concentration **0 1 2 3**
 | * A stooped posture when walking **0 1 2 3**
* Cramping of your hand when writing **0 1 2 3**
 |
| **SECTION 7** |  |  |  |  | **SECTION 10** |  |  |  |  |
| * Hypersensitivities to touch or pain
 | **0** | **1** | **2** | **3** | * Abnormal body movements (such as twitching legs)
 | **0** | **1** | **2** | **3** |
| * Difficulty with spatial awareness when moving,
 |  |  |  |  | * Desires to flinch, clear your throat,
 |  |  |  |  |
| laying back in a chair, or leaning against a wall | **0** | **1** | **2** | **3** | or perform some type of movement | **0** | **1** | **2** | **3** |
| * Frequently bumping into the wall or objects
 | **0** | **1** | **2** | **3** | * Constant nervousness and a restless mind
 | **0** | **1** | **2** | **3** |
| * Difficulty with right-left discrimination
 | **0** | **1** | **2** | **3** | * Compulsive behaviors
 | **0** | **1** | **2** | **3** |
| * Handwriting has become sloppier
 | **0** | **1** | **2** | **3** | * Increased tightness and tone in specific muscles
 | **0** | **1** | **2** | **3** |
| * Difficulty with basic math calculations
 | **0** | **1** | **2** | **3** |  |  |  |  |  |
| * Difficulty finding words for written
 |  |  |  |  |  |  |  |  |  |
| or verbal communication | **0** | **1** | **2** | **3** |  |  |  |  |  |
| * Difficulty recognizing symbols, words, or letters
 | **0** | **1** | **2** | **3** |  |  |  |  |  |

**SECTION 8 SECTION 11**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Difficulty swallowing supplements

or large bites of food | **0** | **1** | **2** | **3** |
| * Bowel motility and movements slow
 | **0** | **1** | **2** | **3** |
| * Bloating after meals
 | **0** | **1** | **2** | **3** |
| * Dry eyes or dry mouth
 | **0** | **1** | **2** | **3** |
| * A racing heart
 | **0** | **1** | **2** | **3** |
| * A flutter in the chest or an abnormal heart rhythm
 | **0** | **1** | **2** | **3** |
| * Bowel or bladder incontinence,

resulting in staining your underwear | **0** | **1** | **2** | **3** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Difficulty with balance, or balance that is

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

**Stress Survey- Shep Saltzman – Vienna Complementary Medicine**

**Stress is the experience of the excess emotional toll of common life experiences. It is known as the “Stress Response”. We have the capacity to respond to emergencies, but chronic stress is different.**

**Stress can make us feel: tired, anxious, angry, frustrated, disappointed, worried, afraid, and confused.**

**No matter how hard we try, life can become very stressful due to circumstances in our control and out of our control.**

**People we love die, get into trouble, get sick, lose their jobs, get old, get sick, get cancer, have heart attacks and strokes, develop dementia. Our lives are affected by others: friends, family and pets.**

**We can also have our own problems, as we age and deal with our lives. Earning a living or dealing with our relationships can be very stressful. Aging can be stressful, and dealing with illness and health problems can be stressful.**

**Please complete the following stress survey to assess your stress level.**

**0-2 = limited stress 3-4 = minimal stress 5-6 = moderate stress 7-8 = significant stress 9-10 = unbearable stress. Your score is your perception of your stress.**

**Work**

* 1. **Stress with clients/patients**
	2. **Stress with professional associates**
	3. **Stress with co –workers**
	4. **Stress with managers and bosses**
	5. **Stress with assistants**
	6. **Too many hours of work stress**
	7. **Need training stress**
	8. **Technology stress**
	9. **Do not like what you do stress**
	10. **Not enough business or income stress**

**Total**

**Finances**

* 1. **Stress with earning money**
	2. **Stress with saving money**
	3. **Debt stress**
	4. **Retirement stress**
	5. **Conflict on how to spend what you have stress**
	6. **Spousal conflicts over money stress**
	7. **Conflict regarding helping kids with money stress**
	8. **Conflict helping parents with their money stress**
	9. **Estate and family business stress**
	10. **Bookkeeping and tax stress**

**Relationships**

1. **Spousal Stress**
2. **Significant other/partner stress**
3. **Children stress**
4. **Parent stress**
5. **Grandparent stress**
6. **Grandchildren stress**
7. **Friend stress**
8. **Sibling stress**
9. **Nephew/Niece/Cousin stress**
10. **Other family stress**

Total

**Health stress**

1. **Allergies (skin, asthma, sinus, joint pain, rashes, rosacea)**
2. **Depression or anxiety**
3. **Obesity/over weight**
4. **Hormone deficiency or excesses**
5. **Pain/inflammation, infections**
6. **Digestion (acid reflux, bloating, diarrhea, constipation)**
7. **Headaches, migraines**
8. **Hot flashes, night sweats, menopause**
9. **Insomnia (can’t stay asleep or fall asleep)**
10. **Feel cold, cold hands/feet**

**Total**

**Other stresses**

1. **Divorce or separation**
2. **Loss of loved ones**
3. **Loss of pet**
4. **Moving /relocating**
5. **Children moving in or out of your home**
6. **Parents moving into your home**
7. **Buying or selling a house**
8. **Fixing up a house**
9. **Retirement**
10. **Starting a new business or job**

**Illness stress**

1. **Cancer**
2. **Heart disease**
3. **High Blood Pressure**
4. **Diabetes**
5. **Lyme disease**
6. **Arthritis**
7. **Injuries (slipped disc, hip, knee, shoulder**
8. **Chronic fatigue /Fibromyalgia**
9. **Liver disease**
10. **Kidney disease Total**

**Emotional Stressors**

1. **Anxiety**
2. **Depression**
3. **Worry**
4. **Grief**
5. **Anger**

**Traumas or Abuse**

**These are extremely painful experiences that are life changing. If you are feel comfortable, please briefly describe them**

**Physical**

**Emotional**

**Spiritual**

**Stress and Traumas are important aspects of our health and are important to work on. Sometimes they are the most important areas to work on**

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 **Patient Signature**

 **Guardian/Parent Signature**

 **Date**