PATIENT INFORMATION

Name: ____

First M.I. Last Preferred Name

Address: ____

City: _______________________________ State: __________________ Zip Code: ____________________

Telephone numbers: home: __________________________ work/cell: _______________________________

Email Address: ___________________________________

Birth date: _______________Age: ________ Biological Gender (circle one): M F OTHER Number of children: ____

OCCUPATION:

Employer: ______________________________________ Hours per week: __________

Employer address: ____

Marital status: SINGLE MARRIED PARTNERSHIP SEPARATED DIVORCED

With whom do you live: SPOUSE PARTNER PARENTS FRIENDS CHILDREN ALONE

Spouse/parent name: ______________________________

Spouse/parent phone: ______________________________ Spouse/parent birth date: ____________________

Spouse/parent address: ____

Emergency contact: ____

Relationship: _____________ Telephone number: ________

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IF SOMEONE OTHER THAN CLIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE THE FOLLOWING:

Name of responsible party: ______________________________

Relationship to client: ___________________________________ Phone#: ____

I acknowledge that by completing this 'client intake form' that I fully authorize and consent to the wellness program at ASKDRSKIP.COM, PLLC. I have honestly, thoughtfully and completely filled out this form.

NOTICE THAT SERVICES ARE NOT PRIMARY CARE: I understand that no practitioner that I see at ASKDRSKIP.COM, PLLC is acting as my primary care physician. As such, emergency services are not offered. I understand that even though my holistic practitioners at ASKDRSKIP.COM, PLLC may address issues affecting my general health, the practice is focused on the complementary, holistic, least invasive approach to health and it is in my best interest to have a primary care physician to ensure that I am fully appraised of all available conventional means to address any medical conditions that I may have. I also understand that Dr. Skip, is a doctor of holistic medicine and NOT licensed to practice medicine or surgery in West Virginia. I further acknowledge that Dr. Skip is in no way recommending you discontinue any therapy or prescription prescribed by your Medical Doctor.

NO GUARANTEES: I understand that ASKDRSKIP.COM, PLLC does not make any representations, claims or guarantees that I will be helped with my medical problems or conditions by undergoing the program at ASKDRSKIP.COM, PLLC . However, ASKDRSKIP.COM, PLLC will do their best to help me accomplish my healthcare and wellness goals!

Signature: ____ **Date:** ____________________________

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How did you hear about our clinic: ____________________

Our ASKDRSKIP.COM, PLLC Health Programs and Naturopathic healthcare are most effective when the practitioners completely understand the client's physical, mental, and emotional concerns and conditions. The information you provide helps us to understand your needs and how to best help you reach your health goals. Your time, honesty, thoughtfulness and attention to detail in completing this form is appreciated and required. We will return an incomplete form and reschedule appointments if not done thoughtfully and completely. This could result in rescheduleing fees. See Square-up policy. Please feel free to mark anything you may have a question about and we can discuss it together. This information is completely confidential.

Why did you choose to come to this clinic? ____________________

Are you currently receiving healthcare? Y N

If yes, where and from whom and what type? If no, when and where did you last receive medical or health care?

____

____

What was the reason? ____________________

What are your most important health problems?
List them in order of importance.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

What three expectations do you have from **this** visit to our clinic?

1. ____________________
2. ____________________
3. ____________________

What expectations do you have of us during the program or protocol? ____________________

____

What is your present **level of commitment** to wellness programs and to addressing the underlying causes of your health problems listed above? *(Rate from 0 to 10 -- 0 being little commitment, 10 being 100% committed)*

0 1 2 3 4 5 6 7 8 9 10

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What behaviors or habits do you engage in regularly that you believe **support** your health? ____________________

____

What behaviors or habits do you engage in regularly that you believe **do not support** your health? ____________________

____

What do you love to do? ____________________

GENERAL INFORMATION

Weight: ________ lbs. Maximum Weight: ____________ lbs. Weight 1 year ago: ____________ lbs.

Height: ________ What is your Blood type? ____________________

When is your energy the best? ____________________

When is it the worst? ____________________

Do you have any medical devices in your body (i.e.: pace maker, artificial joints, organs, etc.)? Y N

If so what? ____________________

Childhood Illnesses

Scarlet Fever	Y	N	Diphtheria	Y	N
Rheumatic Fever	Y	N	Mumps	Y	N
Measles	Y	N	German Measles	Y	N
Other Diseases					

Hospitalization & Surgeries

What hospitalizations or surgeries have you had? Please include **year**:

____

____

X-Rays & Special Imaging Studies

Thermography, X-rays, CAT scans, MRI, Echocardiogram (heart), EKGs, or ECGs or other studies you have had: ____________

____________________ Year ____________

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Immunizations

Polio Y N Pertussis Y N Tetanus shot Y N Diphtheria Y N Measles/Mumps/Rubella Y N

Other immunizations: ____________________

Allergies

Hypersensitive or allergic to:

Any medications: ____________________

Any foods/herbs: ____________________

Supplements/Animals/Other: ____________________

Current Medications

Do you take or use:

Laxatives	Y	N	Pain Relievers	Y	N
Antacids	Y	N	Cortisone	Y	N
Appetite Suppressants	Y	N	Hormones	Y	N
Tranquilizers	Y	N	Thyroid Medication	Y	N
Sleeping Pills	Y	N			

Please list **ALL** prescription medications, over the counter medications, vitamins or other supplements you are currently taking:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________

Are there any cultural or religious practices we should be aware of when providing healthcare to you?____________________

____

Please list the five most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? *(Please include the date.)*

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

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REVIEW OF SYSTEMS

MENTAL/EMOTIONAL

Treated for emotional problems?	Y	N	N/A	Depression?	Y	N	N/A
Mood Swings?	Y	N	N/A	Anxiety or nervousness?	Y	N	N/A
Considered/Attempted suicide?	Y	N	N/A	Tension?	Y	N	N/A
Poor Concentration?	Y	N	N/A	Memory Problems?	Y	N	N/A

ENDOCRINE SYSTEM

Hypothyroid	Y	N	N/A	Heat or cold intolerance	Y	N	N/A
Low blood sugar	Y	N	N/A	Diabetes	Y	N	N/A
Excessive thirst	Y	N	N/A	Excessive hunger	Y	N	N/A
Fatigue	Y	N	N/A	Seasonal depression	Y	N	N/A

IMMUNE SYSTEM

Vaccinations	Y	N	N/A	Reactions to vaccinations	Y	N	N/A
Chronic Fatigue Syndrome	Y	N	N/A	Chronic infections	Y	N	N/A
Chronically swollen glands	Y	N	N/A	Slow wound healing	Y	N	N/A

NEUROLOGICAL SYSTEM

Seizures	Y	N	N/A	Paralysis	Y	N	N/A
Muscle weakness	Y	N	N/A	Numbness or tingling	Y	N	N/A
Loss of memory	Y	N	N/A	Dizziness	Y	N	N/A
Easily stressed	Y	N	N/A	Loss of balance	Y	N	N/A

SKIN

Rashes	Y	N	N/A	Eczema, Hives	Y	N	N/A
Acne, Boils	Y	N	N/A	Itching	Y	N	N/A
Color Change	Y	N	N/A	Unusual Hair Loss	Y	N	N/A
Lumps	Y	N	N/A	Night Sweats	Y	N	N/A

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HEAD

Headaches	Y	N	N/A	Head Injury	Y	N	N/A
Migraines	Y	N	N/A	Jaw/TMJ problems	Y	N	N/A

EYES

Spots in Eyes	Y	N	N/A	Cataracts	Y	N	N/A
Impaired Vision	Y	N	N/A	Glasses or Contacts	Y	N	N/A
Blurriness	Y	N	N/A	Eye pain/strain	Y	N	N/A
Color Blindness	Y	N	N/A	Tearing or Dryness	Y	N	N/A
Double Vision	Y	N	N/A	Glaucoma	Y	N	N/A

EARS

Impaired Hearing	Y	N	N/A	Ringing	Y	N	N/A
Earaches	Y	N	N/A	Dizziness	Y	N	N/A

SINUS & NASAL

Frequent Colds	Y	N	N/A	Nose Bleeds	Y	N	N/A
Stuffiness	Y	N	N/A	Hay Fever	Y	N	N/A
Sinus Problems	Y	N	N/A	Loss of Smell	Y	N	N/A

MOUTH & THROAT

Frequent Sore Throat	Y	N	N/A	Copious Saliva	Y	N	N/A
Teeth Grinding	Y	N	N/A	Sore Tongue/Lips	Y	N	N/A
Gum Problems	Y	N	N/A	Hoarseness	Y	N	N/A
Dental Cavities	Y	N	N/A	Jaw Clicks	Y	N	N/A

NECK

Lumps	Y	N	N/A	Swollen Glands	Y	N	N/A
Goiter	Y	N	N/A	Pain or stiffness	Y	N	N/A

RESPIRATORY SYSTEM

Cough	Y	N	N/A	Phlegm	Y	N	N/A
Spitting up blood	Y	N	N/A	Wheezing	Y	N	N/A

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Asthma	Y	N	N/A	Bronchitis	Y	N	N/A
Pneumonia	Y	N	N/A	Pleurisy	Y	N	N/A
Emphysema	Y	N	N/A	Difficulty Breathing	Y	N	N/A
Pain on Breathing	Y	N	N/A	Shortness of Breath – AM	Y	N	N/A
Tuberculosis	Y	N	N/A	Shortness of Breath – PM	Y	N	N/A
Shortness of breath – Lying Down	Y	N	N/A				

CARDIOVASCULAR SYSTEM

Heart Disease	Y	N	N/A	Angina	Y	N	N/A
High/Low Blood Pressure	Y	N	N/A	Murmurs	Y	N	N/A
Blood Clots	Y	N	N/A	Fainting	Y	N	N/A
Phlebitis	Y	N	N/A	Palpitations/Fluttering	Y	N	N/A
Rheumatic Fever	Y	N	N/A	Chest Pain	Y	N	N/A
Swelling in Ankles	Y	N	N/A				

GASTROINTESTINAL SYSTEM

Bowel Movements			PER DAY	Heartburn	Y	N	N/A
Is this a change	Y	N	N/A	Change in Appetite	Y	N	N/A
Trouble Swallowing	Y	N	N/A	Vomiting (Illness or Induced)	Y	N	N/A
Change in Thirst	Y	N	N/A	Constipation	Y	N	N/A
Nausea	Y	N	N/A	Diarrhea	Y	N	N/A
Vomiting Blood	Y	N	N/A	Gall Bladder Disease	Y	N	N/A
Blood in Stool	Y	N	N/A	Ulcer	Y	N	N/A
Pain or Cramps	Y	N	N/A	Hemorrhoids	Y	N	N/A
Belching or Passing Gas	Y	N	N/A	Black Stools	Y	N	N/A
Yellowing Skin or Eyes	Y	N	N/A	Liver Disease	Y	N	N/A

URINARY SYSTEM

Pain on Urination	Y	N	N/A	Increased Frequency	Y	N	N/A
Frequency at Night	Y	N	N/A	Inability to Hold Urine	Y	N	N/A
Frequent Infections	Y	N	N/A	Kidney Stones	Y	N	N/A

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MUSCULAR SKELETAL

Joint pain or stiffness	Y	N	N/A	Arthritis	Y	N	N/A
Broken Bones	Y	N	N/A	Weakness	Y	N	N/A
Muscle Spasms or Cramps	Y	N	N/A	Sciatica	Y	N	N/A

BLOOD/PERIPHERAL/VASCULAR

Easy Bleeding or Bruising	Y	N	N/A	Anemia	Y	N	N/A
Deep Leg Pain	Y	N	N/A	Cold Hands/Feet	Y	N	N/A
Varicose Veins	Y	N	N/A	Thrombophlebitis	Y	N	N/A

MEN

Hernias	Y	N	N/A	Testicular Masses	Y	N	N/A
Testicular Pain	Y	N	N/A	Prostate Issues	Y	N	N/A
Feminization/Hormonal Issues	Y	N	N/A	Discharge or Sores	Y	N	N/A
Are You Sexually Active	Y	N	N/A	Sexually Transmitted Illness	Y	N	N/A
Impotence	Y	N	N/A	Premature Ejaculation	Y	N	N/A
Sexual Orientation	HETEROSEXUAL			HOMOSEXUAL	BISEXUAL		
How often do you have to get up at night to urinate?				Has this increased in recent years?	Y	N	N/A
Any problems with impotency? (Getting or maintaining an erection)	Y	N	N/A	Do you have any abnormal discharge from the penis?	Y	N	N/A
Any sores on penis?	Y	N	N/A	Any venereal diseases?	Y	N	N/A
Are you currently sexual active?	Y	N	N/A	How often?			
Is this more or less than last year?	MORE	LESS		Do you use birth control?	Y	N	N/A
What type of birth control do you currently use?							
Have you ever been physically/sexually abused?	Y	N	N/A	How old and how often?			

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WOMEN

Age of First Menses				Age of Last Mense (if stopped)			
Sexual Orientation	HETEROSEXUAL		HOMOSEXUAL			BISEXUAL	
Length of Cycle			DAYS	Number of Pregnancies			
Duration of Menses			DAYS	Number of Live Births			
Painful Menses	Y	N	N/A	Number of Miscarriages			
Heavy or Excessive Flow	Y	N	N/A	Number of Abortions			
PMS	Y	N	N/A	What are the symptoms?			
Regular Cycles?	Y	N	N/A	Date of last pap			
Bleeding between cycles	Y	N	N/A	Ever had abnormal pap?	Y	N	N/A
Pain During Intercourse	Y	N	N/A	Birth Control	Y	N	N/A
Menopausal Symptoms	Y	N	N/A	Breast Lumps	Y	N	N/A
Ovarian Cysts	Y	N	N/A	Are you sexually active?	Y	N	N/A
Do you do breast self-exams?	Y	N	N/A	Infertility	Y	N	N/A
Breast Pain/Tenderness	Y	N	N/A	Nipple Discharge	Y	N	N/A
Cervical Dysplasia	Y	N	N/A	Fibroids	Y	N	N/A
Endometriosis	Y	N	N/A	Sexually Transmitted Diseases?	Y	N	N/A
If you do have STDs, which one(s)?							
Are your periods:	HEAVY		MEDIUM			LIGHT	
What color is the blood?	LIGHT RED		DARK RED		MEDIUM		CLOTS
Have you ever been physically/sexually abused?	Y	N	N/A	How old and how often?			
Do you use birth control?	Y	N	N/A	What type of birth control do you use?			

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PERSONAL HABITS

What do you enjoy most in your life? ______________________________

What are you main interests or hobbies? ______________________________

What do you worry most about in your life? ______________________________

On a scale of 1 to 10 (with 10 being great), how do you rate the quality of your sleep? 1 2 3 4 5 6 7 8 9 10

Do you wake up at night?	Y	N	N/A	How many hours do you sleep at night?			
Do you ever sweat while you are sleeping?	Y	N	N/A	How frequently and how much do you sweat?			
Do you wake up feeling refreshed?	Y	N	N/A	Do you ever nap or rest horizontally?	Y	N	N/A
What do you normally feel like temperature wise compared to others?	WARMER			COOLER		AVERAGE	
What are the temperatures of your hand and feet generally?	WARMER			COOLER		AVERAGE	
Do you enjoy your work?	Y	N	N/A	Do you take vacations?	Y	N	N/A
Are you currently in a happy, satisfying relationship with someone?	VERY MUCH		MOSTLY	SOMEWHAT		NO	
How often do you suffer from colds, the flu, sore throat, or yeast infections throughout the year?							
When you rise quickly from a sitting or lying position, do you ever get dizzy?	Y	N	N/A	How often?			

DIGESTION

Do you have any problems with gas, bloating or fullness after eating?					Y	N	N/A
How often?				How severe?			
Do you have gas in	UPPER ABDOMEN			LOWER ABDOMEN		BOTH AREAS	
How long have you had this problem?				How often do you have bowel movements?			
Do you ever have	BLOOD		MUCUS	UNDIGESTED FOOD		BLACK STOOLS	
Any rectal itching	Y	N	N/A	Do your stools tend to be	FORMED	LOOSE	
How often do you have diarrhea?				Do you ever experience alternating diarrhea and constipation?	Y	N	N/A
How often do you have thin, long & narrow stools?				How often do you have small and hard stools?			

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Do you ever have yellow or light-colored stools?	Y	N	N/A	If so, how often?			
How often do your stools have a strong, disagreeable odor?				Have you ever fasted?	Y	N	N/A
Juice or Water fast?	JUICE	WATER		For how long have you fasted?			
How did you feel while you were fasting?							
Have you traveled outside the US in the past 5 years?	Y	N	N/A	Have you been camping in the last 5 years?	Y	N	N/A

KIDNEY AND BLADDER

Have you had recurrent bladder infections?	Y	N	N/A	How were they treated?			
How many bladder infections have you had in the last 3 years?				Have you ever had any burning sensation during or after urination?	Y	N	N/A
What color is your urine?	DARK YELLOW	BRIGHT YELLOW		CLOUDY	PALE	CLEAR	
Does your urine have a strong odor?	Y	N	N/A	Do you have difficulty starting or stopping urination?	Y	N	N/A
Do you have difficulty perspiring?	Y	N	N/A	Do you perspire when you exercise?	LIGHTLY	MODERATELY	HEAVILY
Do you perspire when not exercising?	Y	N	N/A	If so, at what times?			
Does your perspiration have a strong odor?	Y	N	N/A				

Do you exercise?	Y	N	N/A	If yes, what type?			
How often do you exercise?				Spend time outside?	Y	N	N/A
Do you drink coffee?	Y	N	N/A	How many cups per day?			
Do you use tobacco?	Y	N	N/A	How many packs per day?			
Use recreational drugs?	Y	N	N/A	Smoked Previously	Y	N	N/A
Eat three meals a day?	Y	N	N/A	Treated for drug dependence?	Y	N	N/A
Treated for alcoholism?	Y	N	N/A	Use alcoholic beverages?	Y	N	N/A
How many alcoholic beverages do you consume per night/week?							
Do you go on diets often?	Y	N	N/A	How often?			

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OCCUPATIONAL/HOUSEHOLD

<table>
<tr><td>How long have you lived at your present address?</td><td colspan="7"></td></tr>
<tr><td>Where have you lived previously?</td><td colspan="7"></td></tr>
<tr><td>Please describe location, if old or new construction, damp or moldy conditions, etc.</td><td colspan="7"></td></tr>
<tr><td>Do you have specialized air filtration at home?</td><td>Y</td><td>N</td><td>N/A</td><td>Do you live in the city?</td><td>Y</td><td>N</td><td>N/A</td></tr>
<tr><td>Do you work in an office building?</td><td>Y</td><td>N</td><td>N/A</td><td>Do the windows open?</td><td>Y</td><td>N</td><td>N/A</td></tr>
<tr><td>Do you work in the presence of toxic fumes or chemicals?</td><td>Y</td><td>N</td><td>N/A</td><td>Do any of your hobbies involve toxic materials?</td><td>Y</td><td>N</td><td>N/A</td></tr>
<tr><td>Are you currently exposed to second hand smoke?</td><td>Y</td><td>N</td><td>N/A</td><td>Do you use/drink</td><td>BOTTLED WATER</td><td>FILTERED WATER</td><td>TAP WATER</td></tr>
</table>

Is there any information about your health you would like to add?____________________________________

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Please upload your completed form with any historical records and/or labs to our 'Contact Us' Form on ASKDRSKIP.COM/contact.

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T.C.M. DISCLOSURE STATEMENT & CONSENT FORM

The purpose of Oriental Medicine, Acupuncture, Functional Medicine, Natural Health, Mercier (Infertility) Gyno-visceral Manipulation Therapy, Point Puncture-Intravenous Nutritional Therapy, Manual Medicine, Supplements, Prescriptions, and/or any other services or therapies offered by:

'Dr. Skip' - Patrick W. Hart, Jr., O.M.D. | Acupuncture Physician
Diplomate in Naturopathic Medicine, NBENQA, Diplomate in Pastoral Medicine, Pastoral Medical Association

Is to help the whole person re-establish balance through removing obstacles to health and encouraging the body's natural healing process (this balance is known as "homeostasis").

I, (print your name here), ____, as a mature adult, of sound mind have read this 'disclosure statement' and understand the limit of these services and give my full voluntary and informed consent.

Non-Medical Nature of Services: I understand that Dr. Skip is not a medical doctor and that Oriental Medicine and Naturopathy are not a medical specialty but a separate and distinct health care tradition. Dr. Skip is trained extensively in Oriental Medicine and maintains a secular license in good standing in West Virginia since 2003.

If I believe that I have a medical condition, which requires medical care, I will consult my primary care physician or an appropriate specialist. I understand that Dr. Skip may, during his assessment, see evidence of a condition which should be diagnosed and treated by a medical physician or require laboratory or other testing to support good health care decision making, and in that event necessary referrals will be made. Dr. Skip is not my primary care physician, and I should understand that his work serves a supplemental purpose and I should not avoid any diagnostic work-ups or discontinue any medical treatment based upon my consultation with Dr. Skip. Any labs run through our office, should be considered educational in nature, and it is also understood they are not meant for diagnostic purposes, but for overall nutritional/functional health and wellness assessment.

If I believe that modifications may be sensible in the light of natural approaches to care, I agree to first discuss such changes with my primary care (prescribing) physician and any related specialists. My holistic doctor (Dr. Skip) will explain his assessment to me and describe the nature of his recommendations, the expected prognosis without such care, and the anticipated costs, risks, benefits and experience of following various options. I understand that a core approach taken by East Asian Medicine (aka T.C.M.: Traditional Chinese Medicine) is achieving better health status through improvements in mind, body, spirit, diet and the use of dietary

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supplements, herbs and other modalities to improve biological function, as well as exercise and other lifestyle modifications.

The focus of East Asian Medicine (aka T.C.M.) and naturopathic care is to alleviate the underlying conditions that bring about illness rather than the treatment of symptoms. While I may experience some immediate improvement from the use of herbs, homeopathic remedies and other botanical, T.C.M. and naturopathic methods, I understand that the most effective results occur when I make a long-term commitment to rebuild my health with the assistance of Dr. Skip.

I understand that Dr. Skip does not provide any medical or hospital-based services. If I have difficulty with any of remedies or other aspects of my work with Dr. Skip, I understand I can contact the office during business hours to discuss concerns I may have.

Potential Risks: As with any method of care, Oriental Medicine (aka T.C.M. or natural medicine) can involve some risk. I understand that I may experience aches, pains, or even new symptoms as the body responds by shifting its balance. This is generally a positive sign and shows the body is making positive movement. Some people may experience a healing crisis, a short period in which symptoms worsen or a period of a flu-like illness with mild fever, chills, dizziness, loss of appetite, or similar symptoms. Such an experience is a signal the body is detoxifying. While herbs and botanical products are generally available over-the-counter and are considered safe based upon their long history of use, many of them have not been widely tested. While statistically we have great results with the Mercier Therapy and as with anything there are 'no guarantees' and we cannot guarantee pregnancy or any specific outcomes. You have Dr. Skip's commitment that every effort will be made to achieve the expansion of your family and improve your wellness.

Negative reactions to prescriptions, therapies, techniques, natural remedies and services may include rare allergic reactions, including headaches, itching, hives, difficulty breathing, and very rarely, even shock or death. I understand that the interactions between herbs, and between herbs and drugs that might be prescribed, are not yet well known, and that while unlikely, I could have an adverse reaction or experience a reduction or increase in the effect of other medications. This can have serious consequences for some medications, such as for the control of high blood pressure or blood sugar.

I understand that I should let us and my medical primary care physician know what supplements I am taking, particularly prior to surgery or other procedures. Negative reactions are extremely rare given the doses used; an effective dose may result in a temporary increase in my symptoms or healing crisis. I understand that it is in my best interest to let my medical primary care physician know about my work with Dr. Skip to ensure my care is coordinated. I am aware that such consultations are an art and that no guarantees are made as to any outcomes.

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<u>Notice to Menstruating/Pregnant/Surgical Women</u>: All female clients must alert Dr. Skip if they know or suspect that they are pregnant or may become pregnant or if you are menstruating, now, or in the near future, or have had recent surgery as some of the techniques and remedies used could present a risk. PLEASE ALERT DR. SKIP IF YOU CURRENTLY HAVE AN IUD.

<u>Informed Consent for Consultation</u>: I hereby authorize Oriental Medical care (natural and holistic wellness services) assessment and consultation (whether Mercier Therapy or any other service offered at ASKDRSKIP.COM, PLLC) and certify that I understand the nature of this health care method, including the risks of possible adverse reactions and choices I may have about other approaches. I understand that no recommendations are being made to me to discontinue any treatment being provided by any other health care professional. I understand that Dr. Skip does not function as a conventional medical primary care physician, and that he offers his services in addition to other services I receive. I have been adequately informed, and questions I have asked to have been satisfactorily answered. I represent that I am seeking assessment, wellness service and consultation in order to further my own health and for no other reason and do not represent a third party. I am aware that I may withdraw this consent and discontinue following the recommendations at any time.

For all complaints, disagreements and grievances, the Parties (ASKDRSKIP.COM, PLLC and Client) agree to use their best efforts to resolve their dispute privately and if that effort fails, the sole recourse available shall be resolution through arbitration, and the decision pursuant to arbitration shall be final and binding. Arbitration may be sought through the National Center for Life and Liberty at www.ncll.org or through an arbitrator mutually agreed upon by the Parties. Jurisdiction for enforcement of arbitration decisions shall be the state/jurisdiction where services were or are provided. The Client also agrees to pursue relief and to resolve any disputes between the Parties only in the manner provided by this Agreement and not to file any verbal, recorded, or written complaint, grievance, or lawsuit with any medical licensing board, court or to make any disparaging comment or statement to or on a medical licensing board, better business bureau, newspaper, social media forum, blog, or any other internet medium or forum. Such action would result in dismissal from our care, office and wellness community. The arbitration provisions and non-disparagement provisions of this Agreement shall survive termination of services by ASKDRSKIP.COM, PLLC and termination of the doctor-client relationship.

All your personal and health related information is and always will be completely private and confidential.

The Food and Drug Administration have not evaluated the statements here. The recommendations/ prescriptions/therapies/products/consultations/services/techniques/education and any and all information presented here is not intended to diagnose, treat, cure or prevent any disease. Dr. Skip will not recommend discontinuation of any therapies or medication prescribed to me by another practitioner.

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I assume full responsibility for this decision and attest to signing and to the complete understanding of our **T.C.M. Disclosure Statement & Consent Form** as that is the only way I can be a patient of ASKDRSKIP.COM, PLLC, Dr. Skip and our wellness community.

Signature (Client or Legal Guardian)

Date

Chase Bank Building
1000 Fifth Avenue, Ste 110
Huntington, WV 25701
Office: (304) 634-9700

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TELEHEALTH COACHING | DISCLOSURE STATEMENT

Prior to establishing a virtual client relationship, it is important that you first review this disclosure statement completely and carefully. It will give you a better understanding of what to expect from me and the health coaching process. Should there be any confusion, my office is happy and willing to go over it together. Please do not hesitate to ask questions.

What is Telehealth Coaching?
Telehealth Coaching is similar to face to face, except sessions are conducted either over the telephone or over the internet using software that can be downloaded to your computer or mobile device.

Some of the benefits include:

1. Flexibility for individuals that work excessive hours and experience trouble meeting traditional business hours,
2. Accessibility for those that have barriers such as disabilities, transportation and child care
3. Increase in choice for those residing in rural areas,
4. Elimination of visibility entering/leaving an office.

Some limitations include:

1. Potential for connections to be disrupted or disconnected,
2. If you are out-of-state, jurisdictional laws (see example below*) often limit my ability to request disagnostic labs, and therefore, requires additional time, intake forms, and lengthier discussion to help us determine a root cause anlaysis in lieu of labs. In these instances, diagnosis is not provided as that is only accomplished via face to face appointments.

I assume full responsibility for this decision and attest to signing and the complete understanding as that is the only way I can be a Telehealth Coaching (aka Virtual) client of ASKDRSKIP.COM, PLLC and Dr. Skip.

______________________________ ______________________

Signature (Client or Legal Guardian) **Date**

*The only services offered in Texas are nutritional counseling services offered by telecommunications, as permitted by Section 701 of the Tex. Occupations Code. However, Dr. Partrick Hart, OM.D., is NOT a licensed or registered dietitian. In compliance with Texas Occupations Code Section 701.251 and 701.353, Dr. Hart does not use any titles that imply or indicate that he is a licensed or registered dietitian, nor does he use any seals to imply or indicate that he is a licensed or registered dietitian. For clients in the State of Texas, Dr. Hart does not make use of scientific laboratory tests to make nutritional recommendations or for any other purpose.

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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 to 3 as the most/always.**

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3

Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting proteins and meats; undigested food found in stools	0	1	2	3

Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI				
Difficulty digesting roughage and fiber	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII				
Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	Yes	No		

Category VIII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
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 IX				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful between meals	0	1	2	3
Blurred vision	0	1	2	3

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

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SMGEMAF(122215)Version 3

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

Category XII				
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 XIII				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV				
Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

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

Category XVI				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*				
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*				
Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*				
Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*				
Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

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

PART III

How many alcoholic beverages do you consume per week? _________

How many caffeinated beverages do you consume per day? _________

How many times do you eat out per week? _________

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

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

How many times do you eat fish per week? _________

How many times do you work out per week? _________

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

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

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:

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Neurotransmitter Assessment Form™ (NTAF)

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

- 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**

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**

SECTION C

SECTION C1

- How often do you get irritable, shaky, or have light-headedness 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

- 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

- 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 2

- 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

- 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**

SECTION 4

- Do you feel your visual memory (shapes & images) has decreased? **0 1 2 3**
- Do you feel your verbal memory has decreased? **0 1 2 3**
- Do you have memory lapses? **0 1 2 3**
- Has your creativity decreased? **0 1 2 3**
- Has your comprehension 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 a slower mental response? **0 1 2 3**

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SMGENTAF04(031513)

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

Medication History*

Please check any of the following medications you have taken in the past or are currently taking.

Noradrenergic and Specific Serotonergic Antidepressants (NaSSAs)

- ☐ Remeron®
- ☐ Zispin®
- ☐ Avanza®
- ☐ Norset®
- ☐ Remergil®
- ☐ Axit®

Tricyclic Antidepressants (TCAs)

- ☐ Elavil®
- ☐ Endep®
- ☐ Tryptanol®
- ☐ Trepiline®
- ☐ Asendin®
- ☐ Asendis®
- ☐ Defanyl®
- ☐ Demolox®
- ☐ Moxadil®
- ☐ Anafranil®
- ☐ Norpramin®
- ☐ Pertofrane®
- ☐ Thaden™
- ☐ Prothiaden®
- ☐ Adapin®
- ☐ Sinequan®
- ☐ Tofranil®
- ☐ Janamine®
- ☐ Gamanil®
- ☐ Aventyl®
- ☐ Pamelor®
- ☐ Opipramol®
- ☐ Vivactil®
- ☐ Rhotrimine®
- ☐ Surmontil®
- ☐ Norpramin®

Selective Serotonin Reuptake Inhibitors (SSRIs)

- ☐ Paxil®
- ☐ Zoloft®
- ☐ Prozac®
- ☐ Celexa®
- ☐ Lexapro®
- ☐ Esertia®
- ☐ Luvox®
- ☐ Cipramil®
- ☐ Emocal®
- ☐ Seropram®
- ☐ Cipralex®
- ☐ Fontex®
- ☐ Priligy®
- ☐ Seromex®
- ☐ Seronil®
- ☐ Sarafem®
- ☐ Fluctin®
- ☐ Faverin®
- ☐ Seroxat®
- ☐ Aropax®
- ☐ Deroxat®
- ☐ Rexetin®
- ☐ Paroxat®
- ☐ Lustral®
- ☐ Serlain®

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

- ☐ Effexor®
- ☐ Pristiq®
- ☐ Meridia®
- ☐ Serzone®
- ☐ Dalcipran®
- ☐ Cymbalta®

Selective Serotonin Reuptake Enhancers (SSREs)

- ☐ Stablon®
- ☐ Coaxil®
- ☐ Tatinol®

Monoamine Oxidase Inhibitors (MAOIs)

- ☐ Marplan®
- ☐ Aurorix®
- ☐ Manerix®
- ☐ Moclodura®
- ☐ Nardil®
- ☐ Adeline®
- ☐ Eldepryl®
- ☐ Azilect®
- ☐ Marsilid®
- ☐ Iprozid®
- ☐ Ipronid®
- ☐ Rivivol®
- ☐ Propilniazida®
- ☐ Zyvox®
- ☐ Zyvoxid®

Dopamine Receptor Agonists

- ☐ Mirapex®
- ☐ Sifrol®
- ☐ Requip®

Norepinephrine–Dopamine Reuptake Inhibitors (NDRIs)

- ☐ Wellbutrin XL®

D2 Dopamine Receptor Blockers (antipsychotics)

- ☐ Thorazine®
- ☐ Prolixin®
- ☐ Trilafon®
- ☐ Compazine®
- ☐ Mellaril®
- ☐ Stelazine®
- ☐ Vesprin®
- ☐ Nozinan®
- ☐ Depixol®
- ☐ Navane®
- ☐ Fluanxol®
- ☐ Clopixol®
- ☐ Acuphase®
- ☐ Haldol®
- ☐ Orap®
- ☐ Clozaril®
- ☐ Zyprexa®
- ☐ Zydis®
- ☐ Seroquel XR®
- ☐ Geodon®
- ☐ Solian®
- ☐ Invega®
- ☐ Abilify®

GABA Antagonist Competitive Binder

- ☐ Romazicon®

Agonist Modulators of GABA Receptors (benzodiazepines)

- ☐ Xanax®
- ☐ Lexotanil®
- ☐ Lexotan®
- ☐ Librium®
- ☐ Klonopin®
- ☐ Valium®
- ☐ Prosom®
- ☐ Rohypnol®
- ☐ Magadon®
- ☐ Dalmane®
- ☐ Ativan®
- ☐ Loramet®
- ☐ Sedoxil®
- ☐ Dormicum®
- ☐ Serax®
- ☐ Restoril®
- ☐ Halcion®

Agonist Modulators of GABA Receptors (non-benzodiazepines)

- ☐ Ambien CR®
- ☐ Sonata®
- ☐ Lunesta®
- ☐ Imovane®

Acetylcholine Receptor Agonists

- ☐ Urecholine®
- ☐ Evoxac®
- ☐ Salagen®
- ☐ Isopto®
- ☐ Nicotone

Acetylcholine Receptor Antagonists (antimuscarinic agents)

- ☐ AtroPen®
- ☐ Scopace®
- ☐ Atrovent®
- ☐ Spiriva®

Acetylcholine Receptor Antagonists (ganglionic blockers)

- ☐ Inversine®
- ☐ Nicotine (high doses)
- ☐ Hexamethonium
- ☐ Arfonad®

Acetylcholine Receptor Antagonists (neuromuscular blockers)

- ☐ Tracrium®
- ☐ Nimbex®
- ☐ Nuromax®
- ☐ Metubine®
- ☐ Mivacron®
- ☐ Pavulon®
- ☐ Zemuron®
- ☐ Anectine®
- ☐ Tubocurarine®
- ☐ Norcuron®
- ☐ Hemicholinium-3®

Acetylcholinesterase Reactivators

- ☐ Protopam®

Cholinesterase Inhibitors (reversible)

- ☐ Aricept®
- ☐ Razadyne®
- ☐ Exelon®
- ☐ Cognex®
- ☐ THC
- ☐ Carbamate insecticides
- ☐ Enlon®
- ☐ Prostigmin®
- ☐ Antilirium®
- ☐ Mestinon®

Cholinesterase Inhibitors (irreversible)

- ☐ Echothiophate
- ☐ Isoflurophate
- ☐ Organophosphate insecticides
- ☐ Organophosphate-containing nerve agents

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

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SMGENTAF04(031513)

Brain Health and Nutrition Assessment Form™ (BHNAF)

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

- Low brain endurance for focus and concentration **0 1 2 3**
- Cold hands and feet **0 1 2 3**
- Must exercise or drink coffee to improve brain function **0 1 2 3**
- Poor nail health **0 1 2 3**
- Fungal growth on toenails **0 1 2 3**
- Must wear socks at night **0 1 2 3**
- Nail beds are white instead of pink **0 1 2 3**
- The tip of the nose is cold **0 1 2 3**

SECTION 2

- Irritable, nervous, shaky, or light-headed between meals **0 1 2 3**
- Feel energized after meals **0 1 2 3**
- Difficulty eating large meals in the morning **0 1 2 3**
- Energy level drops in the afternoon **0 1 2 3**
- Crave sugar and sweets in the afternoon **0 1 2 3**
- Wake up in the middle of the night **0 1 2 3**
- Difficulty concentrating before eating **0 1 2 3**
- Depend on coffee to keep going **0 1 2 3**

SECTION 3

- Fatigue after meals **0 1 2 3**
- Sugar and sweet cravings after meals **0 1 2 3**
- Need for a stimulant, such as coffee, after meals **0 1 2 3**
- Difficulty losing weight **0 1 2 3**
- Increased frequency of urination **0 1 2 3**
- Difficulty falling asleep **0 1 2 3**
- Increased appetite **0 1 2 3**

SECTION 4

- Always have projects and things that need to be done **0 1 2 3**
- Never have time for yourself **0 1 2 3**
- Not getting enough sleep or rest **0 1 2 3**
- Difficulty getting regular exercise **0 1 2 3**
- Feel that you are not accomplishing your life's purpose **0 1 2 3**

SECTION 5

- Dry and unhealthy skin **0 1 2 3**
- Dandruff or a flaky scalp **0 1 2 3**
- Consumption of processed foods that are bagged or boxed **0 1 2 3**
- Consumption of fried foods **0 1 2 3**
- Difficulty consuming raw nuts or seeds **0 1 2 3**
- Difficulty consuming fish (not fried) **0 1 2 3**
- Difficulty consuming olive oil, avocados, flax seed oil, or natural fats **0 1 2 3**

SECTION 6

- Difficulty digesting foods **0 1 2 3**
- Constipation or inconsistent bowel movements **0 1 2 3**
- Increased bloating or gas **0 1 2 3**
- Abdominal distention after meals **0 1 2 3**
- Difficulty digesting protein-rich foods **0 1 2 3**
- Difficulty digesting starch-rich foods **0 1 2 3**
- Difficulty digesting fatty or greasy foods **0 1 2 3**
- Difficulty swallowing supplements or large bites of food **0 1 2 3**
- Abnormal gag reflex **Yes or No**

SECTION 7

- Brain fog (unclear thoughts or concentration) **Yes or No**
- Pain and inflammation **Yes or No**
- Noticeable variations in mental speed **Yes or No**
- Brain fatigue after meals **0 1 2 3**
- Brain fatigue after exposure to chemicals, scents, or pollutants **0 1 2 3**
- Brain fatigue when the body is inflamed **0 1 2 3**

SECTION 8

- Grain consumption leads to tiredness **0 1 2 3**
- Grain consumption makes it difficult to focus and concentrate **0 1 2 3**
- Feel better when bread and grains are avoided **0 1 2 3**
- Grain consumption causes the development of any symptoms **0 1 2 3**
- A 100% gluten-free diet **Yes or No**

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SMGEBHNAF34(082013)

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

Brain Health and Nutrition Assessment Form™ (BHNAF)

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

SECTION 9

- A diagnosis of celiac disease, gluten sensitivity, hypothyroidism, or an autoimmune disease **Yes or No**
- Family members who have been diagnosed with an autoimmune disease **Yes or No**
- Family members who have been diagnosed with celiac disease or gluten sensitivity **Yes or No**
- Changes in brain function with stress, poor sleep, or immune activation **0 1 2 3**

SECTION 10

- A loss of pleasure in hobbies and interests **0 1 2 3**
- Feel overwhelmed with ideas to manage **0 1 2 3**
- Feelings of inner rage or unprovoked anger **0 1 2 3**
- Feelings of paranoia **0 1 2 3**
- Feelings of sadness for no reason **0 1 2 3**
- A loss of enjoyment in life **0 1 2 3**
- A lack of artistic appreciation **Yes or No**
- Feelings of sadness in overcast weather **0 1 2 3**
- A loss of enthusiasm for favorite activities **0 1 2 3**
- A loss of enjoyment in favorite foods **0 1 2 3**
- A loss of enjoyment in friendships and relationships **0 1 2 3**
- Inability to fall into deep, restful sleep **0 1 2 3**
- Feelings of dependency on others **0 1 2 3**
- Feelings of susceptibility to pain **0 1 2 3**

SECTION 11

- Feelings of worthlessness **0 1 2 3**
- Feelings of hopelessness **0 1 2 3**
- Self-destructive thoughts **0 1 2 3**
- Inability to handle stress **0 1 2 3**
- Anger and aggression while under stress **0 1 2 3**
- Feelings of tiredness, even after many hours of sleep **0 1 2 3**
- A desire to isolate yourself from others **0 1 2 3**
- An unexplained lack of concern for family and friends **0 1 2 3**
- An inability to finish tasks **0 1 2 3**
- Feelings of anger for minor reasons **0 1 2 3**

SECTION 12

- A decrease in visual memory (shapes and images) **Yes or No**
- A decrease in verbal memory **0 1 2 3**
- Occurrence of memory lapses **0 1 2 3**
- A decrease in creativity **0 1 2 3**
- A decrease in comprehension **0 1 2 3**
- Difficulty calculating numbers **0 1 2 3**
- Difficulty recognizing objects and faces **0 1 2 3**
- A change in opinion about yourself **0 1 2 3**
- Slow mental recall **0 1 2 3**

SECTION 13

- 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 **0 1 2 3**
- Need coffee or caffeine sources to improve mental function **0 1 2 3**

SECTION 14

- Feelings of nervousness or panic for no reason **0 1 2 3**
- Feelings of dread **0 1 2 3**
- Feelings of a “knot” in your stomach **0 1 2 3**
- Feelings of being overwhelmed for no reason **0 1 2 3**
- Feelings of guilt about everyday decisions **0 1 2 3**
- A restless mind **0 1 2 3**
- An inability to turn off the mind when relaxing **0 1 2 3**
- Disorganized attention **0 1 2 3**
- Worry over things never thought about before **0 1 2 3**
- Feelings of inner tension and inner excitability **0 1 2 3**

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