****IMPORTANT****

PLEASE READ THIS PAGE CAREFULLY

In order for you to get better as fast as possible, we need the help of ALL persons significantly involved in your support system. Spouse, children and other family members all play a crucial role in your successful recovery. In short, it is extremely important that everyone is "on the same page."

Therefore, we require that all persons directly in your support system sign this affidavit. This form must be returned with your Case Review and Case History forms before Dr. Clark can examine you.

AFFIDAVIT

I (each) the undersigned individual certify that:

- I understand that Dr. Clark's methods and treatment are unique.
- I understand that Dr. Clark does not accept every person into his treatment program.

_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature
_____	_____
Print Name	Signature

Thank you for taking the time to make sure you get the best results possible in the fastest time.

Return this with your Case History forms.

NOTE: TYPE OUT the answers to the following questions in a separate document. MAKE SURE to return them with your packet. Dr. Clark cannot see you if any of your packet is incomplete.

HEALTH HISTORY QUESTIONS

1. Please list your education, profession, sports and hobbies
2. List your chief complaints in order of your importance
3. Provide a detailed narrative (story) of your health history in a timeline sequence
4. List all diagnoses given to you in a timeline sequence and your personal opinions about the diagnosis
5. List your opinion on what you think has happened to your health
6. List of all healthcare providers you have consulted and their opinions and treatments about your case
7. List any treatments, medications, or supplements that have improved your health
8. List any treatments, medications, or supplements that have caused reactions or decreased your health
9. List in a timeline sequence and medications you have taken
10. List in a timeline sequence any medical procedures or surgeries you have had
11. List in a timeline sequence any significant laboratory or imaging results
12. List in a timeline sequence any exposure to environmental, industrial, or toxic compounds.
13. List any history of infections (excluding common colds).
14. List ALL current medications, herbs, vitamins, supplements etc
15. Describe your family's medical history (mom, dad, grandparents, siblings)

PERSONAL OPINION QUESTIONS

Please do not answer, "I don't know" to any of these questions

1. Why do you think healthcare practitioners have failed with your case?
2. Do you think your condition can be cured, or improved?
3. What do you consider a realistic time frame to see changes in your health under our care?
4. What are your expectations from us?
5. Is there anyone you blame for your health condition?
6. What specific improvements in your health would you consider a successful outcome in your case?
7. Are you emotionally and spiritually able to handle further investigation and management of your case?
8. Is there anything you feel you should tell us about yourself or your case?
9. Is there anything in what you believe about health and the body that you may think is holding back your health?
10. Are you willing to change what you believe about health and the body to gain more health?
11. Are there any emotional experiences that can be affecting to your health condition?
12. Do you have a distinct purpose in life?
13. Are there any patterns in childhood or adulthood that has contributed to your health problems?
14. Is your spouse and/or family unit supportive of you with your health condition?
15. Are your spouse and/or family unit supportive of you seeking care at our office?
16. How did you feel about answering all of these questions?

Confidential Neuro-Metabolic Case History

Name _____

Address _____ City _____State_____ Zip_____

SSN#_____ Date of Birth _____ Marital Status: S M W D

Home Telephone _____ Cell _____ Work_____

Email: _____ Best Place To Reach You (circle one) Home / Work / Cell

Occupation _____ Employer _____

Spouse/Significant Other's Name _____ Phone_____

Emergency Contact: Name _____ Relationship_____Phone_____

I (signature) _____consent to allow Dr. Clark to speak with me and perform a consultation and examination in order to determine if further testing is necessary, to determine if he is willing to accept my case.

Please answer the following questions.

What are you hoping happens today as a result of your consultation with the Doctor?_____

_____

Since your problem began, what three things has it caused you to miss the most?

1. _____
2. _____
3. _____

Please list the most troubling symptoms you are suffering—even though you may be taking medication, and even though you have been told your labs are "normal."

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

What are you hoping Dr. Clark tells you today?_____

_____

Describe what you hope or think Dr. Clark might be able to do for you. _____

_____

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

Describe what will be different/better in your life if you can finally be relieved of these problems._____

_____

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

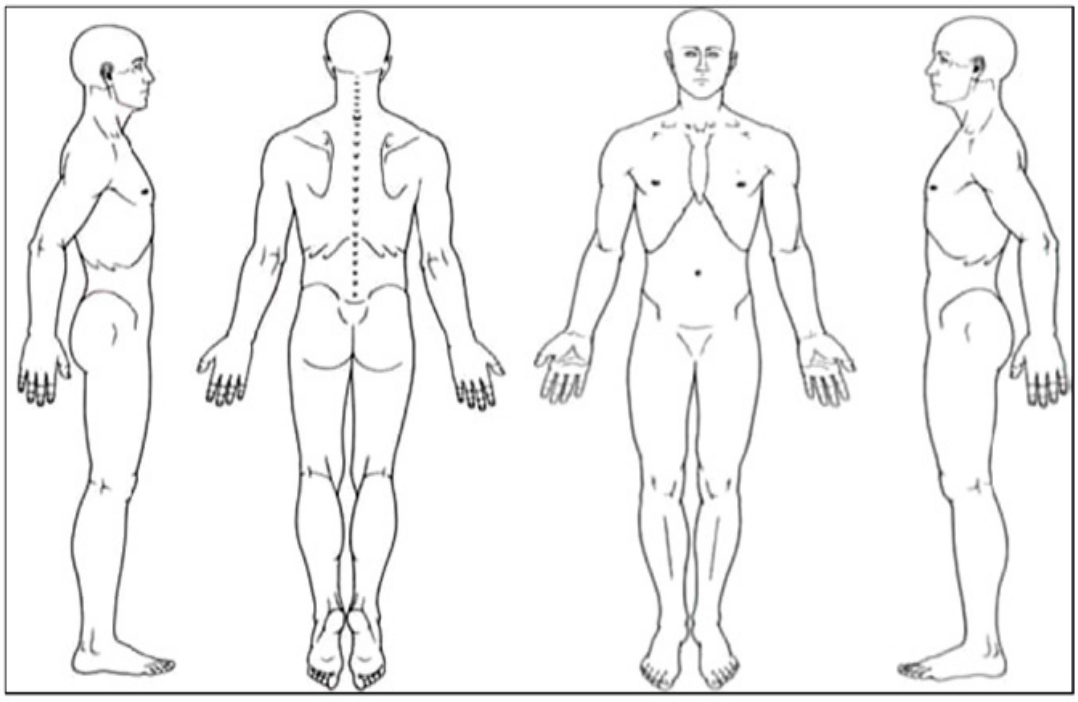
What is that worth to you? _____

What is your idea of the ideal doctor? _____

_____

Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the diagram to accurately describe what you feel..

PP = PAIN
WW = WEAKNESS
NN = NUMBNESS
HH = HEAT
TT = TINGLING
BB= BURNING
CC = CRAMPING
FF = STIFFNESS
RR = Pressure



Circle Y for "YES" or N for "NO" in the box next to each of the questions.

Weakness	Y N	Twitching muscles	Y N
Fatigue	Y N	Decrease in size or tone of your arms or legs	Y N
Pins & Needles feelings, electric shock feelings	Y N	Sensitivity to light	Y N
Racing heart beat	Y N	Difficulty talking?	Y N
Trouble controlling bowels or bladder	Y N	Sweat more on one side (armpit, face etc.)	Y N
Angina—chest pain or shortness of breath	Y N	You feel unsteady or you fall	Y N
Hair loss on the arms or legs	Y N	Dry mouth	Y N
Left arm pain	Y N	Dry eyes	Y N
Balance problems	Y N	Circle: Nausea , vomiting	Y N
Swelling in the lower legs	Y N	Circle: Cold arms, hands, legs, feet	Y N
Fingernails are brittle or have ridges	Y N	Numbness? If so, where?_____	Y N
Symptoms change with arm, leg or neck movement	Y N	Cramping pains in the legs that start after walking	Y N
Blackouts/loss of consciousness	Y N	Uncoordinated	Y N
Fainting	Y N	Poor exercise tolerance	Y N
Light-headedness	Y N	Muscle cramping	Y N
Double Vision	Y N	Men--Erectile Dysfunction Women---can't achieve orgasm	Y N

Have you had ANY of the following in the last 12 months, or are experiencing currently? Circle the appproiate choice, either "C" for currently, or "X" for in the last 12 months.

Unexplained weight loss	C X	Arthritis	C X
Seizures	C X	Alcoholism	C X
Dizziness	C X	Abdominal surgery	C X
Hand Trembling	C X	Bleeding disorder	C X
Weakness	C X	Blood clots	C X
Loss of memory	C X	Breathing difficulty	C X
Loss of coordination	C X	Asthma	C X
Numbness in BOTH hands AND feet	C X	Cancer	C X
High Blood Pressure	C X	Diabetes	C X
Low Blood Pressure	C X	Eczema	C X
Pain over heart	C X	Eating disorder	C X
Poor Circulation	C X	Glaucoma	C X
Rapid Heartbeat	C X	HIV +	Yes No
Slow Heartbeat	C X	Hernia	C X
Other heart condition?	C X	Headaches	C X
Describe _____		Influenza	C X
Stroke	When?_____	Kidney disease	C X
TIA (transient ischemic attack)	When? _____	Liver disease	C X
Varicose veins	C X	Mental illness	C X
Bruise easily	C X	Measles	C X
Aortic aneurysm	C X	Mumps	C X
Appendicitis	C X	Pleurisy	C X
Anemia	C X	Pneumonia	C X
Chest pain	C X	Polio	C X
Chronic cough	C X		
Coughing/spitting blood	C X		

Please circle the appropriate number for each item below:
0 as the least/never and 3 as the most/always

Sensitive to odors, perfumes, smoke	0	1	2	3
Sensitive to pollens, molds	0	1	2	3
Extreme sugar cravings	0	1	2	3
Genital rash (vaginal, “jock itch”)	0	1	2	3
Ringworm	0	1	2	3
Fungus on toenails or fingernails	0	1	2	3
Repeated use of antibiotics (even in distant past)	0	1	2	3
Repeated use of steroids	0	1	2	3
Mouth thrush (yeast infection)	0	1	2	3
Dark skin under eyes; looks like you might have a mild ‘black eye”	0	1	2	3
Bloating	0	1	2	3
Belching	0	1	2	3
Intestinal gas	0	1	2	3
Constipation	0	1	2	3
Diarrhea	0	1	2	3
Indigestion	0	1	2	3
Esophageal reflux	0	1	2	3
Asthma	0	1	2	3
Itching, tingling or burning	0	1	2	3
Hives, psoriasis or dandruff	0	1	2	3
Acne	0	1	2	3
Hair loss	0	1	2	3
Chronic infections (repeated infections)	0	1	2	3
Your symptoms/behaviors worse in the following weather: Damp, hot, misty, moldy, musty	0	1	2	3
Bronchitis	0	1	2	3
Congestion with changing seasons	0	1	2	3
Cough	0	1	2	3
Pneumonia	0	1	2	3
Post nasal drip	0	1	2	3
Sighing	0	1	2	3
Sinus fullness	0	1	2	3
Wheezing	0	1	2	3

Please circle the appropriate number for each item below:
0 as the least/never and 3 as the most/always

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**
Use laxatives frequently	**0**	**1**	**2**	**3**
Increasing frequency of food reactions	**0**	**1**	**2**	**3**
Unpredictable food reactions	**0**	**1**	**2**	**3**
Unpredictable abdominal swelling	**0**	**1**	**2**	**3**
Frequent bloating and distention after eating	**0**	**1**	**2**	**3**
Eating sugars and starches creates abdominal symptoms	**0**	**1**	**2**	**3**
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**
Belching, burping or bloating within 45 minutes of eating	**0**	**1**	**2**	**3**
Intestinal gas immediately following a meal	**0**	**1**	**2**	**3**
Food seems to sit heavy in your stomach like a rock	**0**	**1**	**2**	**3**
Sense of fullness during and after meals	**0**	**1**	**2**	**3**
Difficulty digesting fruits and vegetables; undigested food found in stools	**0**	**1**	**2**	**3**
Stomach pain, burning, or aching 1-4 hours after eating	**0**	**1**	**2**	**3**
Use antacids	**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**
Fruits, Vegetables (roughage & fiber) cause constipation	**0**	**1**	**2**	**3**
Indigestion and fullness last 2-4 hours after eating	**0**	**1**	**2**	**3**
Pain, tenderness, soreness on left side under rib cage	**0**	**1**	**2**	**3**

Excessive passage of gas	**0**	**1**	**2**	**3**
Nausea and/or vomiting	**0**	**1**	**2**	**3**
Stool has undigested food, foul smelling, mucous like, greasy, or poorly formed	**0**	**1**	**2**	**3**
Greasy or high-fat foods cause distress	**0**	**1**	**2**	**3**
Lower bowel gas and/or bloating several hours after eating	**0**	**1**	**2**	**3**
Bitter metallic taste in mouth, especially in the morning	**0**	**1**	**2**	**3**
Unexplained itchy skin	**0**	**1**	**2**	**3**
Yellowish cast to eyes	**0**	**1**	**2**	**3**
Stool color alternates from clay colored to normal brown	**0**	**1**	**2**	**3**
Reddened skin, especially palms	**0**	**1**	**2**	**3**
Dry or flaky skin and/or hair	**0**	**1**	**2**	**3**
History of gallbladder attacks or stones	**0**	**1**	**2**	**3**
Have you had your gallbladder removed?			**Y**	**N**
Burpy fishy taste after consuming fish oils	**0**	**1**	**2**	**3**
Acne and unhealthy skin	**0**	**1**	**2**	**3**
All over sense of bloating (not just abdomen)	**0**	**1**	**2**	**3**
Bodily swelling for no reason	**0**	**1**	**2**	**3**
Hormone imbalances	**0**	**1**	**2**	**3**
Symptoms are worse around menstrual period	**0**	**1**	**2**	**3**
Excessively foul-smelling sweat	**0**	**1**	**2**	**3**
If you go more 3 or 4 hours without eating you feel light-headed, irritable, headache-y, shaky	**0**	**1**	**2**	**3**
Irritable if meals are missed	**0**	**1**	**2**	**3**
Depend on coffee to get started or keep going	**0**	**1**	**2**	**3**
Get light-headed if meals are missed	**0**	**1**	**2**	**3**
Eating relieves fatigue	**0**	**1**	**2**	**3**
15 to 30 minutes after eating you get sleepy, tired or drowsy	**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 Frequent urination	**0**	**1**	**2**	**3**
Increased thirst and appetite	**0**	**1**	**2**	**3**
Difficulty losing weight	**0**	**1**	**2**	**3**
Numbness or tingling in the toes or feet	**0**	**1**	**2**	**3**
Women: difficulty or inability to achieve orgasm	**0**	**1**	**2**	**3**

Please circle the appropriate number for each item below:
0 as the least/never and 3 as the most/always

Cannot stay asleep at night	0	1	2	3
Crave salt	0	1	2	3
Afternoon fatigue	0	1	2	3
Afternoon headaches	0	1	2	3
Dizzy or light-headed when standing up quickly	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Cannot fall asleep	0	1	2	3
Perspire very easily	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
Edema and swelling in ankles or 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
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3
Tired/sluggish	0	1	2	3
Feel cold in hands, feet, or 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 or exercise	0	1	2	3
Gain weight easily	0	1	2	3
Difficulty or infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on: scalp, face, 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
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3
Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased sex drive	0	1	2	3
"Splitting" - type headaches	0	1	2	3
Males Only	0	1	2	3
Urination or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
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
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
Menstruating Females Only				
Perimenopausal	0	1	2	3
Alternating menstrual cycle lengths	0	1	2	3
Extended menstrual cycle (greater than 32 days)	0	1	2	3
Shortened menstrual cycle (less than 24 days)	0	1	2	3
Pain and cramping during periods	0	1	2	3
Scanty period	0	1	2	3
Heavy period	0	1	2	3
Breast pain and swelling during period	0	1	2	3
Pelvic pain during period	0	1	2	3
Irritable and depressed during period	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Menopausal Females Only				
How many years have you been menopausal?	_____			
Since menopause, do you ever have uterine bleeding?	Y	N		
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

Please circle the appropriate number for each item below:
0 as the least/never and 3 as the most/always

• Is your memory noticeably declining?	**0**	**1**	**2**	**3**
• How often do you have a hard time remembering names and phone numbers?	**0**	**1**	**2**	**3**
• Is your ability to focus noticeably declining?	**0**	**1**	**2**	**3**
• Has it become harder for you to learn things?	**0**	**1**	**2**	**3**
• How often do you have a hard time remembering your appointments?	**0**	**1**	**2**	**3**
• Is your temperament getting worse in general?	**0**	**1**	**2**	**3**
• Are you losing your attention span endurance?	**0**	**1**	**2**	**3**
• How often do you find yourself down or sad?	**0**	**1**	**2**	**3**
• How often do you fatigue when driving compared to the past?	**0**	**1**	**2**	**3**
• How often do you fatigue when reading compared to the past?	**0**	**1**	**2**	**3**
• How often do you walk into rooms and forget why?	**0**	**1**	**2**	**3**
• How often do you pick up your cell phone and forget why?	**0**	**1**	**2**	**3**
• How high is your stress level? (“3” is highest)	**0**	**1**	**2**	**3**
• How often do you feel that you have something that must be done?	**0**	**1**	**2**	**3**
• Do you feel you never have time for yourself?		**Y**	**N**	
• 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?		**Y**	**N**	
• How often do you find little to no pleasure in your hobbies and interests?	**0**	**1**	**2**	**3**
• How often do you feel overwhelmed with ideas to manage?	**0**	**1**	**2**	**3**
• How often do you have feelings of inner rage (anger)?	**0**	**1**	**2**	**3**
• How often do you have feelings of that things or people are out to get you?	**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 depressed in overcast weather?	**0**	**1**	**2**	**3**
• How often do you have feelings of sudden, unprovoked anger?	**0**	**1**	**2**	**3**

• How often do you have feelings of hopelessness?	**0**	**1**	**2**	**3**
• How often do you have feelings of worthlessness?	**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 prefer to isolate yourself from others?	**0**	**1**	**2**	**3**
• How often are you easily 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 lose your temper for minor reasons?	**0**	**1**	**2**	**3**
• How often do you feel anxious or panic for no reason?	**0**	**1**	**2**	**3**
• How often do you have feelings of dread or impending doom?	**0**	**1**	**2**	**3**
• How often do you feel knots in your stomach?	**0**	**1**	**2**	**3**
• How often do you have feelings of being overwhelmed for no reason?	**0**	**1**	**2**	**3**
• How often do you have feelings of guilt about everyday decisions?	**0**	**1**	**2**	**3**
• How often does your mind feel restless?	**0**	**1**	**2**	**3**
• How often is is difficult to turn your mind off when you want to relax?	**0**	**1**	**2**	**3**
• How often do you have feelings of inner tension, buzzing, vibration or excitability?	**0**	**1**	**2**	**3**
• How often do you have memory lapses?	**0**	**1**	**2**	**3**
• How often do you have difficulty finding the “right” word?	**0**	**1**	**2**	**3**
• Has your creativity been decreased?		**Y**	**N**	
• Has your ability to understand things been diminished?		**Y**	**N**	
• How often do you have difficulty calculating numbers?	**0**	**1**	**2**	**3**
• How often do you have difficulty recognizing remembering names and faces?	**0**	**1**	**2**	**3**
• How often do you feel you are thinking/reacting SLOWER than you used to?	**0**	**1**	**2**	**3**

Medication History

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

Acetylcholine Receptor Antagonist – Antimuscarinic Agents
Atropine, Ipratopium, Scopolamine, Tiotropium

Acetylcholine Receptor Antagonist - Ganlionic Blockers
Mecamylamine, Hexamethonium, Nicotine (high doses), Trimethaphan

Acetylcholinesterase Reactivators
Pralidoxime

Acetylcholine Receptor Antagonist - Neuromuscular Blockers
Atracurium, Cisatracurium, Doxacurium, Metocurine, Mivacurium, Pancuronium, Rocuronium, Uccinylcholine, Tubocurarine, Vecuronium, Hemicholine

Agonist Modulator of GABA Receptor (benzodiazpines)
Xanax, Lexotanil, Lexotan, Librium, Klonopin, Valium, ProSon, Rohypnol, Dalmane, Ativan, Loramet, Sedoxil, Dormicum, Megadon, Serax , Restoril, Halcion

Agonist Modulator of GABA Receptors (nonbenzodiazpines)
Ambien, Sonata, Lunesta, Imovane

Cholinesterase Inhibitors (irreversible)
Echotiophate, Isoflurophate, Organophosphate Insecticides, Organophosphate-containing nerve agents

Cholinesterase Inhibitors (reversible)
Donepezil, Galatamine, Rivastigmine, Tacrine, THC, Erophonium, Neostigmine, Phystigimine, Pyridostigmine, Carbamate Insecticidses

Dopamine Reuptake Inhibitors
Wellbutrin (Bupropion)

Dopamine Receptor Agonists
Mirapex, Sifrol, Requip

D2 Dopamine Receptor Blockers (antipsychotics)
Thorazine, Prolixin, Trilafon, Compazine, Mellaril, Stelazine, Vesprin, Nozinan, Depixol, Navane, luanxol, Clopixol, Acuphase, Haldol, Orap, Clozaril, Zyprexa, Zydis, Seroquel, Geodon, Solian, Invega, Abilify

GABA Antagonist Competitive binder
Flumazenil

Monoamine Oxidase Inhibitor (MAOI)
Marplan, Aurorix, Maneric, Moclodura, Nardil, Adlegiine, Elepryl, Azilect, Marsilid, Iprozid, Ipronid, Rivivol, Popilniazida, Zyvox, Zyvoxid

Noradrenergic and Specific Sertonergic Antidepressants (NaSSaa)
Remeron, Zispin, Avanza, Norset, Remergil, Axit

Selective Serotonin Reuptake Inhibitor
Paxil, Zoloft, Prozac, Celexa, Lexapro, Luvox, Cipramil , Emocal, Serpam, Seropram, Cipralex, Esteria, Fontex, Seromex, Seronil, Sarafem, Fluctin, Faverin, Seroxat, Aropax, Deroxat, Rexetin, Xentor, Paroxat, Lustral, Serlain, Dapoxetine

Selective Serotonin Reuptake Enhancers
Stablon, Coaxil, Tatinol

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
Effexor, Pristiq, Meridia, Serzone, Dalcipran, Despramine, Duloxetine

Tricylic Antidepresseants (TCAs)
Elavil, Endep, Tryptanol, Trepiline, Asendin, Asendis, Defanyl, Demolox, Moxadil, Anafranil, Norpramin, Pertofrane, Prothiadin, Thanden, Adapin, Sinequan, Trofranil, Janamine, Gamanil, Aventyl, Pamelor, Opipramol, Vivactil, Rhotrimine, Surmontil

Please circle the appropriate number for each item below:
0 as the least/never and 3 as the most/always

Trouble sustaining attention in routine situations, easily distracted	0	1	2	3
Difficulty remembering where things are Bad memory for directions	0	1	2	3
Bad memory for directions	0	1	2	3
Difficulty understanding body language	0	1	2	3
Don't understand the 'big picture' of words / phrases	0	1	2	3
Often don't get humor and metaphors	0	1	2	3
Not Able to "read between the lines"	0	1	2	3
Act compulsively	0	1	2	3
Difficulty with word problems	0	1	2	3
Not Able to focus	0	1	2	3
Difficulty following through or finishing things	0	1	2	3
Not Able to 'tune out' irrelevant stimuli	0	1	2	3
Trouble imagining or visualizing an activity or physical action	0	1	2	3
Not Able to speak without sounding monotone	0	1	2	3
Blurting out of answers before the question is completed	0	1	2	3
Hyperactive-move excessively	0	1	2	3
Not able to control what you say	0	1	2	3
Not able to cry or be spontaneous	0	1	2	3
Not able to predict what others will do	0	1	2	3
Irregular heart rate--If yes, describe _____	0	1	2	3
Not able to remember facts and figures	0	1	2	3
Not able to identify objects by name	0	1	2	3
Trouble with fine motor skills (small objects, handwriting, buttons)	0	1	2	3
Difficulty with calculations/math	0	1	2	3
Trouble reading (dyslexic)-even if past only	0	1	2	3
Trouble following multiple step directions	0	1	2	3
Truly upset if routine or plan changes	0	1	2	3
Irregular heart RHYTHM --If yes, describe _____	0	1	2	3
Have repetitive thoughts	0	1	2	3
Tend to write very small	0	1	2	3
Start things, but don't finish	0	1	2	3

Please circle the appropriate number for each item below:
0 as the least/never and 3 as the most/always

Feelings of sadness	0	1	2	3
Moodiness	0	1	2	3
Negativity	0	1	2	3
Low energy	0	1	2	3
Irritability	0	1	2	3
Suicidal thoughts	0	1	2	3
Low self-esteem	0	1	2	3
Forgetfulness	0	1	2	3
Repetitive movements of your face and lips	0	1	2	3
Feelings of helplessness or powerlessness	0	1	2	3
Feeling dissatisfied or bored	0	1	2	3
Excessive guilt	0	1	2	3
Crying easily	0	1	2	3
Low appetite	0	1	2	3
Very sensitive to smells or odors	0	1	2	3
Poor sense of smell	0	1	2	3
Auditory (sound) or visual hallucinations	0	1	2	3
Sudden fear	0	1	2	3
Sudden anger	0	1	2	3
Sudden sexual arousal	0	1	2	3
History of family violence or explosiveness	0	1	2	3
Extreme irritability	0	1	2	3
Dark thoughts or thoughts of homicide	0	1	2	3
Preoccupation with moral or religious ideas	0	1	2	3
Reading comprehension problems	0	1	2	3
Irritability that tends to build, then explode	0	1	2	3
Ringing (tinnitus) -- If yes, describe it _____	0	1	2	3

Please circle the appropriate number for each item below:
0 as the least/never and 3 as the most/always, or Circle "Yes" or "No"

Grind teeth	0	1	2	3
There is some action you feel you MUST do, and doing it gives you a sense of relief	Yes	No		
Muscle cramps **Where?** _____	0	1	2	3
You have certain muscles that are always tight. **Where?** _____	0	1	2	3
Restless legs	0	1	2	3
You have small jerks or "twitches" in your muscles. **Where?** _____	0	1	2	3
Tremors **Where?** _____	0	1	2	3
Pain in shoulder joint (or past shoulder joint problems) **Which shoulder?** _____	0	1	2	3
You bite or chew your fingernails	0	1	2	3
You have Obsessive thoughts	0	1	2	3
Song gets stuck in your head	0	1	2	3
Panic attacks	0	1	2	3
Handwriting gets smaller the more you write	0	1	2	3
Move slowly compared to how quickly you used to move	Yes	No		
Your walking speed is slow (especially compared to how fast you used to walk)	Yes	No		
You are Excessively motivated	0	1	2	3
You startle very very easily	0	1	2	3
You are Easily embarrassed	0	1	2	3
Feelings of nervousness or anxiety	0	1	2	3
Heart pounding, rapid heart rate	0	1	2	3
Feel like you can't take a deep breath	0	1	2	3
Avoidance of public places from fear or anxiety	0	1	2	3
Unexplained Periods of nausea and stomach upset	0	1	2	3
Tendency to predict the worst	0	1	2	3
Fear of being judged or scrutinized	0	1	2	3
Excessive worrying about what others think	0	1	2	3
Tendency to "freeze up" in stressful situations	0	1	2	3

Please circle the appropriate number for each item below:
0 as the least/never and 3 as the most/always, or Circle “Yes” or “No”

You see letters backwards (even if only as a child).				Yes	No
You have real difficulty with math.				Yes	No
You have difficulty with “word” problems in math.				Yes	No
Difficulty with “spatial” skills	0	1	2	3	
Hand or foot or leg or arm feels like it doesn’t belong to you. **Which one?**_____	0	1	2	3	
Feel odd sensations (bugs crawling, tingling, burning etc) **Where?**_____	0	1	2	3	
Get claustrophobic, tunnel vision, or feeling that the world is closing in	0	1	2	3	
You have difficulty understanding how others feel .	0	1	2	3	
Getting dressed is difficult	0	1	2	3	
Difficulty understanding people’s facial expressions	0	1	2	3	
Difficulty understanding the emotions in a verbal conversation	0	1	2	3	
You get your right and left confused.	0	1	2	3	
Speech is slurred	0	1	2	3	
You trip	0	1	2	3	
When driving, you bump into curbs or objects. **Which side of car?** _____	0	1	2	3	
You knock over or bump into objects when reaching for them. **Which arm?** _____	0	1	2	3	
You drop things. **When using which hand?** _____	0	1	2	3	

Write down EVERYTHING you eat drink for 48 hours.
What you're eating and when you're eating could make your symptoms WORSE.

Day 1		
Breakfast Time: Details:	**Lunch** Time: Details	**Dinner** Time: Details:
Snack Time: Details:	**Snack** Time: Details:	**Snack** Time: Details:
Day 2		
Breakfast Time: Details:	**Lunch** Time: Details:	**Dinner** Time: Details:
Snack Time: Details:	**Snack** Time: Details:	**Snack** Time: Details:

I certify that I have read and understand the information given in the health history questionnaire. I understand the importance of a truthful health history and that my doctor and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about the questionnaire have been answered to my satisfaction. I will not hold my doctor, or any other member of his staff, responsible for any action they take or do not take because of error or omissions that I may have made in completing the questionnaire.

Signature _____

Date _____

Checklist for Your Completed Packet

___ Affidavit signed by you and members of support system

___ Included your TYPED answers to the questions on page 1.

(Do NOT forget to include these when you mail back.)

___ All questions were answered—no blanks

___ Diet History was completed

___ Your signature in the box at the top of this page

Mail your completed packet to:

Dr. David Clark, DC

6015 Fayetteville Rd Suite 111

Durham, NC 27713

919-401-0444

or...

Scan all pages of packet (and typed answers) into one pdf file and email to:

support@doctordavidclark.com