Confidential Patient Intake Information

Please fill out the following form in as much detail as possible. All your health information is kept confidential.

Patient Information

Patient Name _____

Today's Date _____ Date of Birth _____

Social Security # _____

Address _____

City _____

State _____ Zip _____

Gender: ☐ Male ☐ Female Height _____ Weight _____

☐ Single ☐ Married ☐ Partnered ☐ Engaged
☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

How many children do you have? _____

Please list any family members being treated here _____

_____

Occupation _____

Employer/School _____

Employer/School Address _____

_____

Employer/School phone #: (_____) _____

Contact Information

Home Phone (_____) _____

Cell Phone (_____) _____

Email address _____

May we contact you via (please check for all applicable):

☐ Home phone ☐ Cell ☐ Work phone ☐ Email

☐ Check if you would like to receive Newsletters by email

In case of emergency please contact:

Name _____

Relationship _____

Home Phone (_____) _____

Alternate Phone (_____) _____

Spouse's/Partner's name _____

Spouse's/Partner's employer _____

Who referred you? _____

Patient Condition

What is your major complaint *(be as specific as possible)* _____

_____

When did you condition/symptoms/pain first appear? *(specific date, days ago, weeks, ago, etc.)* _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

When is it worse? ☐ Morning ☐ Afternoon ☐ Evening ☐ Changes time of day

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily routines ☐ Recreation ☐ Other _____

How long has it been since you really felt good? _____

Other doctors seen for this condition: ☐ MD ☐ DC ☐ DO ☐ DDS ☐ Other _____

Does the condition/symptom/pain radiate? ☐ Yes ☐ No

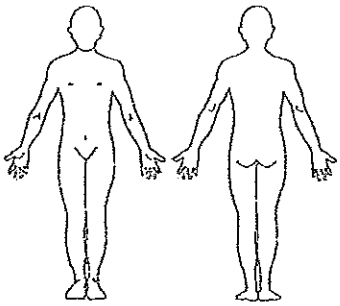
If yes, where and how frequently _____

How long/often does the radiation occur/last? _____

Do you have: ☐ Numbness ☐ Tingling ☐ Weakness

Describe _____

Mark all areas on the picture where your condition, symptoms and/or pain occur



List and mark the severity of your condition/symptoms/pain on the scale below:

Body part _____ _____

0 (None) 5 (Severe) 10

Body part _____ _____

0 (None) 5 (Severe) 10

Type of Pain:

☐ Sharp ☐ Dull ☐ Throbbing ☐ Tingling ☐ Other _____
☐ Shooting ☐ Burning ☐ Aching ☐ Numbness

What activities or positions aggravate your condition?

☐ Bending ☐ Coughing ☐ Getting up/down ☐ Driving ☐ Lifting ☐ Lying down
☐ Sneezing ☐ Standing ☐ Staining at stool ☐ Turning head ☐ Twisting ☐ Walking

Patient Condition

What activities or positions relieve your condition:

☐ Heat ☐ Lying down ☐ Sitting ☐ Sitting ☐ Stretching ☐ Other
☐ Ice ☐ Medication ☐ Massage ☐ Standing ☐ Exercise

Have you ever had this condition before? ☐ Yes ☐ No If yes, when? _____

Were you treated for this condition or a similar one before? ☐ Yes ☐ No If yes, when/by whom? _____

_____

Health History

Do you have any allergies? (food, contact, environmental) _____

List any prescribed medications, over the counter medications, vitamins, herbs and supplements _____

_____

When was your last: Physical examination _____ Blood/lab work _____ X-ray study _____

Injuries/Surgeries you've had and when? _____

_____

Have you had or do you have any of the following conditions or diseases? ***Please check yes or no for each one below***

☐ Ankylosing spondulitis
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bleeding disorder
☐ Blurred vision
☐ Bowel/Bladder problems
☐ Buzzing in ear
☐ Cancer
☐ Carpal tunnel
☐ Celiac disease (gluten)
☐ Chest pains
☐ Chronic fatigue
☐ Cold hands or feet
☐ Colitis/diverticulitis
☐ Compression fractures
☐ Connective tissue issues
☐ COPD (bronchitis/emphy)
☐ Depression
☐ Diabetes
☐ Digestive/bowel problems
☐ Dizziness or vertigo
☐ Fibromyalgia
☐ Fusions (spinal, joint)
☐ Gout
☐ Hear disease
☐ Hepatitis (A, B, C, etc.)
☐ Herpes
☐ High blood pressure
☐ Hip replacement
☐ HIV/AIDS
☐ Kidney disease
☐ Knee surgery
☐ Liver disease
☐ Marfan syndrome
☐ Multiple sclerosis
☐ Osteoporosis/penia
☐ Parkinson's disease
☐ Rotator cuff problem
☐ STI/STD
☐ Shoulder surgery
☐ Spinal surgery
☐ Stroke/TIA
☐ Thyroid problems
☐ Tuberculosis
☐ Other _____
☐ Other _____

Are there any conditions that run in your family? ☐ Yes ☐ No If yes, what condition(s) and which family member? _____

_____

Personal and Social Health History

Are you currently pregnant, or do you think you may be pregnant? ☐ Yes ☐ No If yes, how many weeks? _____

How many hours per week do you typically work/attend school? ☐ <20 hrs ☐ 20 hrs ☐ 30 hrs ☐ 40 hrs ☐ 40+ hrs

What are your typical duties and postures (sitting, standing, lifting, etc.)? _____

Do you exercise? ☐ Yes ☐ No If yes, how often and what type? _____

Do you or does anyone else ever "crack" you neck/back/joints? ☐ Yes ☐ No If yes, how often and what body parts? _____

How would you rate your eating habits? ☐ Excellent ☐ Pretty good ☐ Could be better ☐ Needs Improvement

How well do you sleep? ☐ Excellent ☐ Pretty good ☐ Restless ☐ Can't sleep ☐ Wake up often

How many hours of sleep do you get daily? _____ hours *and* Do you feel rested in the morning? ☐ Yes ☐ No

How is your energy overall? ☐ Full power ☐ OK ☐ Low ☐ Sporadic/Generally fatigued ☐ I depend on caffeine for energy

How do you feel your immune system is working? ☐ Strong ☐ OK ☐ Low

What do you hope to receive from our program? _____

Thank you for completing our health care questionnaire

INSURANCE INFORMATION

Name of Insured_____ Relationship _____ Birthdate _____
Name of Insurance Company _____ Phone _____
Policy or Group # _____ Group Name: _____

SECONDARY INSURANCE INFORMATION

Name of Insured_____ Relationship _____ Birthdate _____
Name of Insurance Company _____ Phone _____
Policy or Group # _____ Group Name: _____

FEES ARE PAYABLE AT THE TIME X-RAYS, EXAMS AND TREATMENTS ARE RECEIVED UNLESS OTHER ARRANGEMENTS ARE MADE

X _____ _____
PATIENT'S SIGNATURE TODAY'S DATE

IF THIS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS:

Date of accident: _____ Location: _____
How did accident occur? _____ Auto accident _____ On-the-job injury Other: _____
If hurt at work, did you report the injury to your foreman or employer? _____ Yes _____ No
Have you lost any days of work? _____ Yes _____ No Dates: _____
Please describe the circumstances: _____
_____
If an auto accident, were you: _____ Driver? _____ Passenger? _____ Pedestrian?
If an auto accident, were you struck from _____ Behind _____ Front _____ Driver Side _____ Passenger Side
Please list extent of the injuries as you know them: _____
_____

Circle symptoms you have noticed since the accident:

Headache	Irritability	Numbness in toes	Face Flushed	Cold Feet
Neck Pain	Chest Pain	Shortness of Breath	Buzzing in Ears	Hands Cold
Neck Stiff	Dizziness	Fatigue	Loss of Balance	Stomach Upset
Sleeping Problem	Heavy Head	Depression	Fainting Spells	Constipation
Back Pain	Tingling in Arms	Light bothers Eyes	Loss of Smell	Cold Sweats
Nervousness	Tingling in Legs	Loss of Memory	Loss of Taste	Fever
Tension	Numbness in Fingers	Ears Ring	Diarrhea	

Name of your insurance company involved: _____
Name of insurance company of person responsible for injuries: _____
Do you have an attorney who has advised you in this case? _____ Yes _____ No
Attorney's name: _____ Phone: _____

PATIENT CONSENT FOR US AND /OR DISCLOSURE OF PROTECTED HEALTHINFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to singing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my singing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me: and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and /or disclosed to carry out treatment, payment and /or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____ _____ _____
Name of Individual (printed) Signature of Individual Date Witness

Beyer Natural Health Solutions

17023 S Harlem Ave, Tinley Park, IL 60477
(708) 614-1222 office (708) 614-0470 fax
DR. EDWARD J. BEYER, CHIROPRACTIC PHYSICIAN

Dear New Patient,

We want to welcome you to Beyer Natural Health Solutions. Our mission is it improve your chronic health condition as much as possible in our time together and to teach you how to manage your own health for the rest of your life. There are a few requirements and an understanding that needs to be established before we enter our trusted doctor/patient relationship. Please initial after each point signifying that you understand:

1. This clinic does not always follow traditional medicine standard of care. This means that we may recommend labs/tests that are well beyond what your medical doctor would do. This is done because we are interested in looking at the body as a whole and when doing so we can identify underlying causes of illness. Many of our tests if any, may not be covered by our insurance.
   Initials: _____

2. Our clinic utilizes a functional medicine/laboratory approach along with functional neurology and traditional chiropractic. Any one of these disciplines may be used to help you regain your health.
   Initials: _____

3. It is extremely important that you fully understand the "why" behind what we do. For this reason we require that you watch our full length video/DVD or have attended our workshop pertaining to your condition in its entirety. The video length is approximately 45-55 minutes long. By initialing below, you are agreeing to have watched the full length video or attended a workshop.
   Initials: _____

4. In order for you to regain your health there will be dietary changes, neurological and/or traditional exercises to be done as well as lifestyle changes.
   Initials: _____

5. At the present time we will bill your insurance if there is any coverage. However, in almost all cases there will be an out-of-pocket expense to be met. Typically this cost will range from $200-$400 per month for 18-24 months if you chose to finance it. The exact cost of care and your options to pay for it will be explained in detail at the second visit.
   Initials: _____

I have read and fully understand all of the above. I desire to have an initial consultation and examination by the doctor today. I understand that in doing so I am under no obligation for future care.

Signature: _____ Date: _____

Sincerely,
Dr. Edward Beyer, D.C.

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
Abdominal intolerance to sugars and starches	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 movement	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

Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use 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				
Roughage and 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

Category VI (continued)				
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category VII				
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
Difficulty losing weight	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 VIII				
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 IX				
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	0	1	2	3
Blurred vision	0	1	2	3

Category X				
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

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

Category XI				
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 XII				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under 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 XIII				
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 XIV				
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 XV				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3
Category XVI				
Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XVII				
Increased sex drive	0	1	2	3
Tolerance 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	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 XIX *(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 XX *(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 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	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:

Brain Region Localization Form

INSTRUCTIONS:

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

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

NAME: DATE:

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

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

Brain Region Localization Form

INSTRUCTIONS:

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

KEY:

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

Parietal Inferior Lobule (Area 39 and 40)		Level
32.	Right/left confusion [L]	0 1 2 3 4
33.	Difficulty with math calculations [L]	0 1 2 3 4
34.	Difficulty finding words [L]	0 1 2 3 4
35.	Difficulty with writing [L]	0 1 2 3 4
36.	Difficulty recognizing symbols or shapes [R]	0 1 2 3 4
37.	Difficulty with simple drawings [R]	0 1 2 3 4
38.	Difficulty interpreting maps [R]	0 1 2 3 4
Temporal Lobe Auditory Cortex (Areas 41, 42)		**Level**
39.	Reduced function in overall hearing	0 1 2 3 4
40.	Difficulty interpreting speech with background or scatter noise	0 1 2 3 4
41.	Difficulty comprehending language without perfect pronunciation	0 1 2 3 4
42.	Need to look at someone's mouth when they are speaking to understand what they are saying	0 1 2 3 4
43.	Difficulty in localizing sound	0 1 2 3 4
44.	Dislike of left predictable rhythmic, repeated tempo and beat music [L]	0 1 2 3 4
45.	Dislike of non-predictable rhythmic with multiple instruments [R]	0 1 2 3 4
46.	Noticeable ear preference when using your phone	right, left, no preference
Temporal Lobe Auditory Association Cortex (Area 22)		**Level**
47.	Difficulty comprehending meaning of spoken words [L]	0 1 2 3 4
48.	Tend toward monotone speech without fluctuations or emotions [R]	0 1 2 3 4

Medial Temporal lobe and Hippocampus		Level
49.	Memory less efficient	0 1 2 3 4
50.	Memory loss that impacts daily activities	0 1 2 3 4
51.	Confusion about dates, the passage of time, or place	0 1 2 3 4
52.	Difficulty remembering events	0 1 2 3 4
53.	Misplacement of things and difficulty retracing steps	0 1 2 3 4
54.	Difficulty with memory of locations (addresses) [R]	0 1 2 3 4
55.	Difficulty with visual memory [R]	0 1 2 3 4
56.	Always forgetting where you put items such as keys, wallet, phone, etc. [R]	0 1 2 3 4
57.	Difficulty remembering faces [R]	0 1 2 3 4
58.	Difficulty remembering names with faces [L]	0 1 2 3 4
59.	Difficulty with remembering words [L]	0 1 2 3 4
60.	Difficulty remembering numbers [L]	0 1 2 3 4
61.	Difficulty remembering to stay or be on time (reduced left) [L]	0 1 2 3 4
Occipital Lobe (Area, 17, 18, and 19)		**Level**
62.	Difficulty in discriminating similar shades of color	0 1 2 3 4
63.	Dullness of colors in visual field	0 1 2 3 4
64.	Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach out for objects	0 1 2 3 4
66.	Floater or halos in visual field	0 1 2 3 4

Brain Region Localization Form

INSTRUCTIONS:

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

KEY:

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

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

Brain Region Localization Form

INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please select yes or no.

Epileptiform Activity	Yes / No
Have you ever been diagnosed with a seizure disorder?	Yes / No
Have you ever been diagnosed with epilepsy?	Yes / No
Have you ever been told that you seemed frozen, absent, or tuned out at times without any recollection of the event?	Yes / No
Have you ever experienced sudden muscle stiffness and rigidity throughout your body?	Yes / No
Have you ever experienced sudden muscle jerks throughout your body?	Yes / No
Have you ever experienced a total loss of your muscle tone that lead to loss of control of your muscles or a fall?	Yes / No
Have you ever been told that you stare into space while you're lip smacking, chewing, or fidgeting that you are not aware of?	Yes / No
Do you ever experience sudden emotional responses such as anxiety, sadness, cry, or laugh for no real reason?	Yes / No
Do you ever experience sudden racing heart rate, sudden loss of bladder function, intestinal spasm, respiration, sweating, or any other sudden changes of function?	Yes / No
Do you ever experience sudden involuntary muscle contractures or jerks in any individual parts of your limbs or face?	Yes / No
Do you ever experience sudden involuntary head rotation and your eyes move forcefully to one side?	Yes / No
Do you ever experience sudden involuntary shift in your eyes to the side or upwards?	Yes / No
Do you ever experience sudden vocalization of random words or notice a sudden inability to speak?	Yes / No
Do you ever experience any spontaneous sensations of tingling, pins and needles" numbness, coldness, burning or other random sensations in any region of your body?	Yes / No
Do you ever experience a ringing sensation in your ears (tinnitus), sounds, or voices spontaneously?	Yes / No
Do you ever experience spontaneous perception of smells such as burning rubber, foul smells, or other odors without finding the source of the odor?	Yes / No
Do you ever experience flashing lights, stars, or jagged lines in your visual field?	Yes / No

SIGNATURE: DATE: