Achieving Health Chiropractic and Wellness Center

1670 Sierra Avenue, Suite 302 Yuba City CA 95993
www.achievingit.com
530-671-4976

Welcome! Thank you for choosing **AHCWC** to assist you on your path to a healthier you.
To provide you with excellent service our staff will need to photo copy your driver's license and all available insurance cards.
Please fill in the information requested as completely as possible. (please print!)

Tell us about you!
Title: _____
First Name: _____
Middle Name: _____
Last Name: _____
Nickname: _____
Gender: M ☐ F ☐
Birth Date: ___/ _____/_____
Marital Status: M ☐ D ☐ S ☐ W ☐

Employment Status:
Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐
Student: Part-Time ☐ Full-Time ☐
Driver's License #: _____

Primary Contact Information
Home Address: _____
City: _____
State: _____ Zip: _____
Phone #: (__)____- _____
Phone #: (__)____- _____
Phone #: (__)____- _____
Email Hm: _____

Employment Information
Employer Name: _____
Occupation: _____
Date Started: ____/ _____/_____

Spouse Information
First Name: _____
Middle Name: _____
Last Name: _____
Phone #:(__)____- _____ __
Birth Date: ____/ _____/_____

Employment Information For Spouse
Employer Name: _____
Occupation: _____
Date Started: ____/ _____/_____
Phone #: (__)____- _____

Patient Billing
Primary
Who is the Member: Self ☐ Spouse ☐
Insurance Name: _____

Member #: _____
Group #: _____
Start Date : ____/ _____/_____

Secondary: _____
Insurance Name: _____
Member #: _____
Group #: _____
Start Date : ____/ _____/_____

Referral Source
Internet ☐ Phonebook ☐ Family ☐
Friend ☐ Other ☐
First Name: _____
Middle Name: _____
Last Name: _____
Relationship: _____
Phone #:(__) _____- _____

Parent / Guardian
First Name: _____
Middle Name: _____
Last Name: _____
Relationship _____
Phone #:(__)____- _____
Birth Date: ____/ _____/_____

Females Only
Last Menstrual Period: _____
Pregnant: Yes ☐ No ☐
Nursing: Yes ☐ No ☐

Signature : _____
Date : ____/ _____/_____

Achieving Health Chiropractic and Wellness Center

Patient Health Information (PHI) Regulations

We want you to know how your **Patient Health Information (PHI)** will be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your **PHI**, we encourage you to read the **HIPPA NOTICE** that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow the **Achieving Health Chiropractic & Wellness Center** to use his/her **Patient Health Information (PHI)** for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested **PHI** to Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all **PHI** to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of his/her **PHI**. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care. I hereby state and agree that a photocopy of this or any other document will be deemed as valid and binding on all parties involved as the original copy. I have read and understand how my **Patient Health Information** will be used and I agree to these policies and procedures.

8. We require a 24-hour notice for all missed, cancelled, or rescheduled appointments. Failure to give a 24-hour notice *may* result in a $25.00 missed appointment fee.

Patient's Signature _____ Date _____

Achieving Health Chiropractic & Wellness Center

NEW PATIENT INFORMATION

TREATMENT: What type of treatment are you looking for?

- ❑ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
- ❑ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
- ❑ I am looking take care of my problem and then go on to "achieve optimal health and wellness."

HEALTH CONCERNS: Please list your top health concerns in order of priority.

_____

_____

_____

COMPLAINT/PROBLEM: In relation to your *primary* complaint:

When did you first seek treatment for this problem: _____ Has another doctor(s) treated you for this condition: Y ☐ N ☐

If yes, who? _____ Treatment(s) _____

Have you had any intolerance or reaction to the treatments: Y ☐ N ☐ Describe: _____

If this is a recurrence, when was the first time you noticed this problem: _____

How did it originally occur? _____ Has it become changed recently: Y ☐ N ☐ Gradually Worse ☐ Better ☐ Same ☐

How frequent is the condition: Constant ☐ Daily ☐ Intermittent ☐ Night Only ☐ How long does it last: All Day ☐ Few Hours ☐ Minutes ☐

Is this condition interfering with your: Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other ❑ _____

How long has it been since you really felt good: Days ☐ Weeks ☐ Months ☐ Years ☐ More than ten years ☐

Describe the pain: Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing ☐ Other ❑ _____

What makes the problem worse: Standing ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting ☐ Other ❑ _____

Is there anything that you can do to relieve the problem: ☐ Y ☐ N If yes, describe: _____

If no, what have you tried to do that has not helped: _____

What do you believe is wrong with you: _____

Are there any other conditions or symptoms that may be related to your major symptom: ☐ Y ☐ N If yes, what: _____

Have you had a fall recently: ☐ Y ☐ N Have you fallen in the past: ☐ Y ☐ N If yes, when _____ Describe: _____

Have you broken any bones: ☐ Y ☐ N If yes, which one(s) _____

Have you been in an auto accident: ☐ Y ☐ N If yes, when _____ Describe: _____

Please check all of the symptoms that apply. (P=Past / C=Current)

Complaint	P	C	Complaint	P	C	Complaint	P	C
Headache			Rapid Heart Rate			Swollen Ankles		
Facial Pain			High Blood Pressure			Ankle/Foot Pain		
Eye Pain			Low Blood Pressure			Tingling in Feet		
Blurred Vision			Abdominal Pains			Walking Problems		
Dizziness			Nausea/Vomiting			Sore Muscles		
Earache			Poor Appetite			Weak Muscles		
Forgetfulness			Fullness of Bladder			Paralysis		
Confusion			Urination Difficulty			Shakiness		
Sinusitis			Frequent Urination			Sweating		
Teeth Grinding			Constipation			Insomnia		
Dry Mouth			Hemorrhoids			Fainting		
Excessive Thirst			Decreased Sex Drive			Convulsions		
Unpleasant Taste			Menstrual Irregularities			Irritability		
Neck Pain			Elbow/Hand Pain			Impatience		
Sore Throat			Tingling in Hands			Fatigue		
Lump in Throat			Clammy Hands			Feel Loss of Control		
Swallowing Pain			Low Back Pain			Other: _____		
Unsteady Voice			Hip Pain					
Shoulder Pain			Knee Pain					
Persistent Coughing			Poor Circulation					
Chest Pressure			Swollen Joints					
Slow Heart Rate			Joint Stiffness					

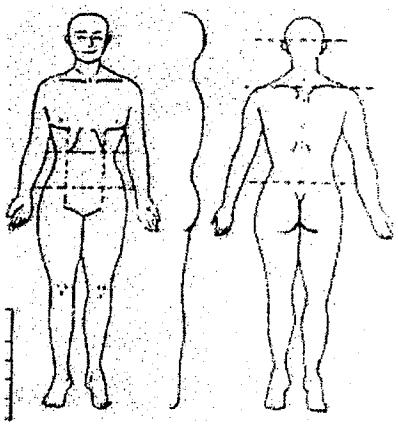
Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

Stabbing - ||| Tingling - :::

Burning - xxx Cramping - ^^^

Numbness - === Dull - ###

Scars – ooo



SCARS/SURGICAL PROCEDURES: List all scars and surgical procedures you have had and mark on drawings above: _____

HABITS:	Heavy	Moderate	Light	None
Alcohol				
Coffee	❑	❑	❑	❑
Soda/Diet Soda	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Drugs	❑	❑	❑	❑
Stress Level	❑	❑	❑	❑

	5-7 x/wk	3-5 x/2k	1-3 x/wk	None	Type	Time
Exercise						
Sleep	8+ hrs	7-8 hrs	6-7 hrs	5-6 hr	Less than 5 hrs	
			❑	❑	❑	
Meals/Day	5+	4	3	2		
				❑		
Water/Day	128 + oz	64+ oz	32-64 oz	Less than 8 oz		
				❑		

WORK ACTIVITY: Heavy Labor Light Labor Mostly Sitting Mostly Standing Walking/Moving Driving

SUPPLEMENTS: Do you take Vitamins/Supplements or Herbs: Y N If yes, who recommended them _____

ALLERGIES: Please check and list all allergies.

Food: _____

Medications: _____

Seasonal/Other: _____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	MEDICATION NAME	DATE STARTED
Antacids		
Antibiotics		
Antidepressants		
Anti-Diabetics		
Anti-Inflammatory		
Blood Pressure Lowering Meds		
Cholesterol Lowering Meds		
Hormone Replacement		
Oral Contraceptives		
Other		

MEDICAL HISTORY: Identify any conditions that you or any of your family members have now or have had in the past.

G=Grandparent M=Mother F=Father S=Sibling X=Self

_____ Alcoholism	_____ Eczema	_____ Miscarriage(s)	_____ Tumor(s)
_____ Anemia	_____ Emphysema	_____ Mumps	_____ Ulcer(s)
_____ Cancer	_____ Epilepsy	_____ Pleurisy	_____ Other_____
_____ Cold Sores	_____ Goiter	_____ Pneumonia	_____
_____ Deep vein Thrombosis	_____ Gout	_____ Polio	_____
_____ Detached retina	_____ Heart Disease	_____ Rheumatic Fever	
_____ Diabetes	_____ HIV/AIDS	_____ Stroke	

Is there anything else you would like us to know? _____

Patient's Signature _____ Date _____

Please indicate the payment option that best suits your needs by marking an X in front of that option.

_____ Pay at the Time of Service.

If you pay at the time of service, you will receive a discount of approximately 20%. If you have health insurance, ***Achieving Health Chiropractic & Wellness Center*** will submit a claim to your insurance company, as a courtesy to you, and your insurance company will reimburse you directly the portion of the charge covered after payment of any deductibles or co-payments.

_____ Billed or Charged Service

If you choose not to pay at the time of service, you and/or your insurance company will be charged 100% of our fees. ***Achieving Health Chiropractic & Wellness Center*** will submit a claim to your insurance companies and wait for payment as a courtesy to you. We will accept assignment for payment of the insurance portions.

X-rays are not a covered service of ***Achieving Health Chiropractic & Wellness Center***. If X-rays are necessary, you will be referred to a facility of your choice. All fees are subject to change without notice.

Any financial arrangements are to be determined before services are rendered.

A service charge of 1.5% interest (18% per annum) will be charged for any balance due after 30 days.

Payment plans are available and are determined on an individual basis.

If you have any further questions, please feel free to ask.

I agree to the terms above and acknowledge that in the event that there is an outstanding balance, which fails to be cured within ninety (90) days, my account with ***Achieving Health Chiropractic & Wellness Center*** will be turned over to collections. I understand that should this happen,
I will remain responsible for any and all additional collection fees.

INSURANCE ASSIGNMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that ***Achieving Health Chiropractic & Wellness Center*** will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to ***Achieving Health Chiropractic & Wellness Center*** will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

Achieving Health Chiropractic & Wellness Center does not promise that my insurance company will pay the claims submitted. In the event that my insurance company disputes or rejects the claim, it is my responsibility to pay the charges and pursue reimbursement from my insurance company on my own.

I hereby authorize ***Achieving Health Chiropractic & Wellness Center*** to examine and treat my condition as the doctor deems appropriate through the use of Chiropractic Health Care, and I give authority for those procedures to be performed. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby agree that I am responsible for all bills incurred by me at ***Achieving Health Chiropractic & Wellness Center***. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Achieving Health Chiropractic & Wellness Center will submit a claim to your insurance company for the full service charge. We will accept payment from your insurance company for the insurance portion and we will attempt to bill any secondary or additional insurance company you may have.

I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

I understand and agree to the payment option that I have chosen as indicated by an X above.

_____ _____

Signature of Patient or Person Acting on Patient's Behalf Date

Thank you for choosing Foster Mc Manus, D.C., as your chiropractor and wellness care physician.

Billed or Charged Services			Payment at the Time of Service		
	$165.00	First Visit		$125.00	First Visit
99204	80.00	Extended Initial Visit Includes: History, Med/Legal Exam	99204	65.00	Extended Initial Visit Includes: History, Med/Legal Exam
99203	60.00	Intermediate Initial Visit Includes: History, Exam, Health Scan & BIA	99203	45.00	Intermediate Initial Visit Includes: History, Exam, Health Scan & BIA
99202	40.00	Basic Initial Visit Includes: History & Exam	99202	30.00	Basic Initial Visit Includes: History & Exam
98941	60.00	Adjustment: 1-3 Areas Includes: Laser & Percusser or ASERT	98941	45.00	Adjustment: 1-3 Areas Includes: Laser & Percusser or ASERT
98940	37.22	Medicare Adjustment: 1-3 Areas Includes: Laser & Percusser or ASERT	98940	37.22	Medicare Adjustment: 1-3 Areas Includes: Laser & Percusser or ASERT **(no discount)**
98940	50.00	Adjustment: 1-2 Areas Includes: Laser & Percusser	98940	40.00	Adjustment: 1-2 Areas Includes: Laser & Percusser
98940	26.54	Medicare Adjustment: 1-2 Areas—Includes: Laser & Percusser	98940	26.54	Medicare Adjustment: 1-2 Areas—Includes: Laser & Percusser **(no discount)**
99211	60.00	One-half Hour Office Visit	99211	45.00	One-half Hour Office Visit
99212	30.00	Re-Exam—Basic	99212	10.00	Re-Exam—Basic
99213	40.00	Re-Exam—Intermediate	99213	20.00	Re-Exam—Intermediate
99214	60.00	Re-Exam—Extended	99214	40.00	Re-Exam—Extended
99214-25	75.00	Extended Office Visit Includes: Adjustment with Mini NET Session	99214-25	60.00	Extended Office Visit Includes: Adjustment with Mini NET Session
97012	15.00	Intersegmental Traction	97012	5.00	Intersegmental Traction
97124	30.00	15-Minute Massage, TFH, Bodywork	97124	20.00	15-Minute Massage, TFH, Bodywork
97124	40.00	30-Minute Massage, TFH, Bodywork	97124	30.00	30-Minute Massage, TFH, Bodywork
97039	35.00	EB Detoxification Foot Bath	97039	25.00	EB Detoxification Foot Bath
97802	35.00	Health Scan	97802	25.00	Health Scan
99401	15.00	BIA	99401	10.00	BIA
97802-25	45.00	Health Scan & BIA	97802-25	35.00	Health Scan & BIA
97803	25.00	Check-Up	97803	15.00	Check-Up
97110	25.00	Neuromuscular Re-education Includes 15-Minute Laser or Percusser	97110	15.00	Neuromuscular Re-education Includes 15-Minute Laser or Percusser
97112	35.00	Neuromuscular Re-education Includes 30-Minute Laser or Percusser	97112	25.00	Neuromuscular Re-education Includes 30-Minute Laser or Percusser
			99214c	100.00	Couples Integration
			99214	200.00	NET Counseling — First Hour
				100.00	NET Counseling— Second Hour
99199	25.00	Missed Appointment	99199	25.00	Missed Appointment
99600	100.00	House Call	99600	100.00	House Call

Metabolic Detoxification Questionnaire

Part 1: Symptoms

Name _____ Date _____

Rate each of the following symptoms based on how you've been feeling for the: ☐ Past 48 hours ☐ Past week ☐ Past 30 days

Point Scale

0 — Never or almost never have the symptoms
1 — Occasionally have it; effect is not severe
2 — Occasionally have it; effect is severe
3 — Frequently have it; effect is not severe
4 — Frequently have it; effect is severe

Head
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia **Total** _____

Eyes
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision (does not include near- or farsightedness) **Total** _____

Ears
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss **Total** _____

Nose
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation **Total** _____

Mouth/Throat
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, or lips
_____ Canker sores **Total** _____

Skin
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating **Total** _____

Heart
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain **Total** _____

Lungs
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing **Total** _____

Digestive Tract
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain **Total** _____

Joints/Muscles
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness **Total** _____

Weight
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight **Total** _____

Energy/Activity
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness **Total** _____

Mind
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities **Total** _____

Emotions
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression **Total** _____

Other
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge **Total** _____

For Practitioner Use Only:
Urinary pH _____

Grand Total _____

FirstLine Therapy®
Lifestyle Medicine Programs by Metagenics

Metabolic Detoxification Questionnaire

Part 2: Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
☐ Yes (1 pt.) ☐ No (0 pt.)
If yes, how many are you currently taking? ____ (1 pt. each)

2. Are you presently taking one or more of the following over-the-counter drugs?
☐ Cimetidine (2 pts.) ☐ Acetaminophen (2 pts.) ☐ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
☐ Experience side effects; drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
☐ Experience side effects; drug(s) is (are) efficacious at usual dose(s) (2 pts.)
☐ Experience no side effects; drug(s) is (are) usually not efficacious (2 pts.)
☐ Experience no side effects; drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently within the last 6 months have you regularly used tobacco products?
☐ Yes (2 pts.) ☐ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine-containing products?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
☐ Yes (1 pt.) ☐ No (0 pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

10. Do you have a personal history of:
☐ Environmental and/or chemical sensitivities (5 pts.)
☐ Chronic fatigue syndrome (5 pts.)
☐ Multiple chemical sensitivity (5 pts.)
☐ Fibromyalgia (3 pts.)
☐ Parkinson's type symptoms (3 pts.)
☐ Alcohol or chemical dependence (2 pts.)
☐ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
☐ Yes (1 pt.) ☐ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite-containing foods such as wine, dried fruit, salad bar vegetables, etc.?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

Total _____

Part 3: Alkalizing Assessment

1. Do you have a history of or currently have kidney dysfunction?
☐ Yes (1 pt.) ☐ No (0 pt.)

2. Have you ever been diagnosed with hyperkalemia?
☐ Yes (1 pt.) ☐ No (0 pt.)

3. Are you currently taking diuretics or blood pressure medication?
☐ Yes (1 pt.) ☐ No (0 pt.)

Total _____

Overall Score Tabulation

For Practitioner Use Only:

Part 1: Symptoms Grand Total _____ (High >50; moderate 15-49; low <14)
Part 2: XTT Total _____ (High >10; moderate 5-9; low <4)
Part 3: Alkalizing Assessment Total _____ (High ≥1)
Urinary pH _____

Notes:

- Patients with high Symptoms but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered, such as inflammation/immune/allergic gastrointestinal dysfuntion, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.
- Recommend non-alkalizing nutrients if patient answers "yes" to any questions in the Alkalizing Assessment.

Identi-T™ Stress Assessment

Name _____ **Age** _____ **Sex** _____ **Date**_____

Stress is a normal part of life. Every day, we're faced with stimuli, called stressors, which can elicit the body's "fight or flight" response, setting off a cascade of physiological reactions and resulting in emotions ranging from mild to intense. But while occasional stress is natural and even healthy, chronic or acute stress can be harmful.

Please take a few moments to discover your body's response to situations you perceive as stressful. By honestly assessing how you feel, your healthcare provider can create a natural stress relief program for your individual needs.

Directions:
Please read each statement and circle the number 0, 1, 2, or 3 that best describes your feelings or reactions throughout the course of the day. Determine the subtotal score for each section, then determine the total scores for sections A-C and C-E. Some questions may appear redundant between sections. There's a reason for each question. Don't spend much time on any one question.

0 = Never true 1= Seldom true 2= Sometimes true 3= Often true

When under stress for two weeks or longer, I...

Section A:

1. Get wound up when I get tired and have trouble calming down 0 1 2 3
2. Feel driven, appear energetic but feel "burned out" and exhausted 0 1 2 3
3. Feel restless, agitated, anxious, and uneasy 0 1 2 3
4. Feel easily overwhelmed by emotion 0 1 2 3
5. Feel emotional — cry easily or laugh inappropriately 0 1 2 3
6. Experience heart palpitations or a pounding in my chest 0 1 2 3
7. Am short of breath 0 1 2 3
8. Am constipated 0 1 2 3
9. Feel warm, over-heated, and dry all over 0 1 2 3
10. Get mouth sores or sore tongue 0 1 2 3
11. Get hot flashes 0 1 2 3
12. Sleep less than seven hours a night 0 1 2 3
13. Have trouble falling asleep and staying asleep 0 1 2 3
14. Worry about high blood pressure, cholesterol, and triglycerides 0 1 2 3
15. Forget to eat and feel little hunger 0 1 2 3

Total points: _____

Section B:

1. Find myself worrying about things big and small 0 1 2 3
2. Feel like I can't stop worrying, even though I want to 0 1 2 3
3. Feel impulsive, pent up, and ready to explode 0 1 2 3
4. Get muscle spasms 0 1 2 3
5. Feel aggressive, unyielding, or inflexible when pressed for time 0 1 2 3
6. See, hear, and smell things that others do not 0 1 2 3
7. Stay awake replaying the events of the day or planning for tomorrow 0 1 2 3
8. Have upsetting thoughts or images enter my mind again and again 0 1 2 3
9. Have a hard time stopping myself from doing things again and again, like checking on things or rearranging objects over and over 0 1 2 3
10. Worry a lot about terrible things that could happen if I'm not careful 0 1 2 3

Total points: _____

Section C:

1. Have muscle and joint pains 0 1 2 3
2. Have muscle weakness 0 1 2 3
3. Crave salt or salty things 0 1 2 3
4. Have multiple points on my body that when touched are tender or painful 0 1 2 3
5. Have dark circles under my eyes 0 1 2 3
6. Feel a sudden sense of anxiety when I get hungry 0 1 2 3
7. Use medications to manage pain 0 1 2 3
8. Get dizzy when rising or standing up from a kneeling or sitting position 0 1 2 3
9. Have diarrhea or bouts of nausea with or without vomiting for no apparent reason 0 1 2 3
10. Have headaches 0 1 2 3

Total points: _____

Section D:

1.	Have trouble organizing my thoughts	0	1	2	3
2.	Get easily distracted and lose focus	0	1	2	3
3.	Have difficulty making decisions and mistrust my judgment	0	1	2	3
4.	Feel depressed and apathetic	0	1	2	3
5.	Lack the motivation and energy to stay on task and pay attention	0	1	2	3
6.	Am forgetful	0	1	2	3
7.	Feel unsettled, restless, and anxious	0	1	2	3
8.	Wake up tired and unrefreshed	0	1	2	3
9.	Experience heartburn and indigestion	0	1	2	3
10.	Catch colds or infections easily	0	1	2	3

Total points: _____

Section E:

1.	Feel tired for no apparent reason	0	1	2	3
2.	Experience lingering mild fatigue after exertion or physical activity	0	1	2	3
3.	Find it difficult to concentrate and complete tasks	0	1	2	3
4.	Feel depressed and apathetic	0	1	2	3
5.	Feel cold or chilled – hands, feet, or all over – for no apparent reason	0	1	2	3
6.	Have little or no interest in sex	0	1	2	3
7.	Sweat spontaneously during the day	0	1	2	3
8.	Feel puffy and retain fluids	0	1	2	3
9.	Sleep more than nine hours a night	0	1	2	3
10.	Have poor muscle tone	0	1	2	3
11.	Have trouble losing weight	0	1	2	3
12.	Wake up tired even though I seem to get plenty of sleep	0	1	2	3
13.	Have no energy and feel physically weak	0	1	2	3
14.	Am susceptible to colds and the flu	0	1	2	3
15.	Feel dragged down by multiple symptoms, such as poor digestion and body aches	0	1	2	3

Total points: _____

Add points from sections A, B & C	**Total for A, B & C:** _____
Add points from sections C, D & E	**Total for C, D & E:** _____

LIfestyle and Health Status:

1. Circle the level of stress you experience on the scale of 1-10, 10 being the worst:
   1 2 3 4 5 6 7 8 9 10
2. What do you consider to be the major causes of your stress (for example — spouse, family, friends, work, finances, wedding, pregnancy, legal, commute):
   _____
3. I eat breakfast _____ times a week. My typical breakfast is: _____
4. I take a multiple vitamin/mineral _____ days per week. I take a fish oil supplement _____ days per week.
5. I participate in 30 minutes of physical activity such as walking, aerobics (e.g., running), resistance training (e.g., weights, pilates), sports (e.g. biking), or yoga:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
6. I smoke _____ cigarettes daily.
7. I drink two or more 8 ounce cups of caffeinated coffee or other caffeinated beverages like energy/diet drinks, colas, or black or green teas:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
8. I drink two or more ounces of alcoholic beverages:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
9. List your current health problems and any over-the-counter or prescription medications that you are now taking:

Current health problem(s)	Date of onset	List all current medication(s)