Florida Functional Neurology Group

WWW.FFNG.ORG

Alexander C. Frank, D.C., D.A.C.N.B., F.A.B.E.S.

Board Certified Chiropractic Neurologist
Diplomate, American Chiropractic Neurology Board
Fellow, American Board of Electrodiagnostic Specialties

Confidential Patient Information

Name:_____ Date of Birth:_____

Address:_____ Home Phone:_____

_____ Cell Phone:_____

Email:_____

Occupation:_____ Work Phone:_____

Last 4 #s of SSN:_____Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

Referred by:_____

Is (are) your present issue(s) a result of any of the following: ☐No, Yes, if so, please indicate below

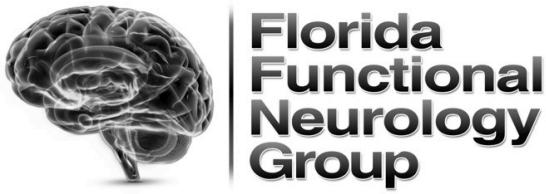
☐Automobile collision ☐Slip & Fall ☐Work-Related Injury ☐Scholastic Sports Injury ☐Other

Thank you for choosing Florida Functional Neurology Group (FFNG) and Dr. Alexander C. Frank for your health care needs. Dr. Frank is one (1) of five (5) board certified chiropractic neurologists in the S. Florida area, along with holding a Fellowship in Electrodiagnostic Specialties (NVC/EMG). He has interned and trained with some of the top chiropractic neurologists and functional medicine specialists in the world.Dr. Frank's advanced training allows him to be the only chiropractic practitioner in South Florida to be authorized to employ the ImPACT Computerized Neurocognitive Assessment, utilized by the NFL and other professional organizations for the assessment of concussions/mild traumatic brain injury.

It is in your best interest to provide Dr. Frank and FFNG with past medical records, diagnosis(es) such as X-rays, MRI, CT scans and the reports from the radiologist/physician, blood work, additional lab testing, and any other records/information in regard to your health ***at least one week prior to your first appointment***.

The initial office visit is dedicated ***to the examination***, with minimal time spent filling in any remaining past medical history not obtained in your new patient package. Please provide as much detail as possible, such as providing a synopsis of previous practitioners you treated with, current & past complaint(s), diagnosis(es), treatments, medication, supplementation, etc.

The following documents can be filled out on your computer. Use the TAB key to move from field to field, or use the mouse to select the field you want to fill in. Please save the document to your computer before emailing them back to FFNG.



WWW.FFNG.ORG

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The board certified chiropractic neurologist provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient, I am authorizing FFNG and its' staff to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

To the best of my knowledge I am pregnant_____ __ I am NOT pregnant_____

I give my permission to X-ray_____ I DO NOT give my permission to x-ray me for diagnostic interpretation. _____

Missed Appointments:

There is a possible $25 fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

_____being the parent or legal guardian of_____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

_____ None

May we mail postcards or leave messages on any answering device, i.e. home answering machines or voicemails? Yes_____ No_____

Acknowledgement:

I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon reques I will be given a copy.

I, _____, have read and fully understand the above statements.

Signature: _____ Date_____

Florida Functional Neurology Group

WWW.FFNG.ORG

Account Information

If you need any assistance completing this paperwork, please ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful and educational.

CONFIDENTIAL HEALTH INFORMATION
Clinic ID: Date:

Patient Information

Last name First name MI Prefer to be called

Are you here because you were injured while working, in a motor vehicle collision, or in another accident? ☐Yes ☐No

Health Complaints

*What is your **primary** complaint?*_____
*How long have you been experiencing this primary complaint?*_____

*Has this progressed over that time?*_____

*Using the scale below, rate how your **primary** complaint affects your life (mark only one box)*

1	2	3	4	5	6	7	8	9	10
Symptoms that do not affect life in any way	Symptoms that slightly affect life	Symptoms that don't affect daily activities	Symptoms that affect daily activities	Symptoms that prevent performing daily activities	Symptoms that limit work schedule	Symptoms that prevent attending work	Symptoms that prevent work and all personal activities	Symptoms that keep me from leaving home	Symptoms that cause thoughts of suicide

Do you have any additional symptoms (musculoskeletal, neurological, or otherwise) that are related to this?

*If yes, please list:*_____

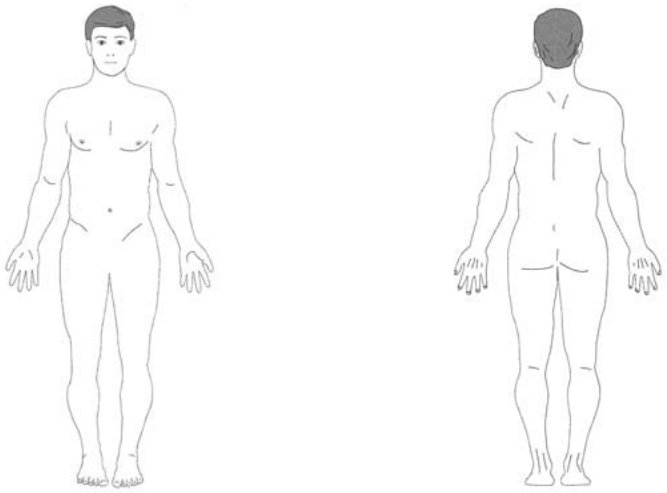
List any other health conditions/complaints you are currently experiencing on the following lines:

1) _____ 2) _____

3) _____ 4) _____

Please use the images on the right to mark the areas affected by your chief complaint and any of the associated symptoms listed above.

Include any additional descriptors or comments concerning your health complaints if necessary.



Last Name, First Initial:_____

Lifestyle & Nutritional Habits

❖ Occupational History:

Do you work? ☐ Yes ☐ No, unemployed ☐ Disability ☐ Retired

*Occupation (if working or worked previously):*_____

❖ Daily Habits:

On average how many hours of television do you watch per day?	☐ <1	☐ 1-3	☐ 3-5	☐ >5
On average, how many hours per day do you use a computer at work or home?	☐ <1	☐ 1-3	☐ 3-5	☐ >5
On average, how many hours per day do you ride in a car or other vehicle?	☐ <1	☐ 1-3	☐ 3-5	☐ >5
Do you exercise?	☐ Yes	☐ No		
If yes above, how often do you exercise?	☐ Daily	☐ 3-5x/wk	☐ 2x/wk	☐ 1x/wk
On average, how long do your workouts last?	☐ >1hr	☐ 1hr	☐ 30min	☐ <30min

What are your exercise activities? (mark all that apply)

☐ Walking	☐ Swimming	☐ Weight lifting
☐ Stretching/Flexibility	☐ Yoga/Pilates	☐ Resistance bands
☐ Running/elliptical/rowing/stairclimbing	☐ Group Exercise Class	☐ Athletics_____

Do you smoke tobacco?	☐ Yes	☐ No		
If yes to above	How often? _____		How much? _____	
Any recreational drug use	☐ Yes	☐ No		
How many servings of alcohol do you drink per week?	☐ 0	☐ 1-2	☐ 3-5	☐ >5
How many servings of coffee do you drink per week?	☐ 0	☐ 1-2	☐ 3-5	☐ >5
How many servings of soda do you drink per week?	☐ 0	☐ 1-2	☐ 3-5	☐ >5

❖ Dietary Habits:

What does your diet primarily consist of? (mark all that apply)

☐ Breads, cereals	☐ Pastas, rice	☐ Cookies, crackers, pretzels
☐ Lean protein (chicken, beef, fish)	☐ Dairy (milk, cheese, ice cream)	☐ Vegetables
☐ Processed meats (lunch meat, etc)	☐ Processed/packaged snacks/meals	☐ Fruits
☐ Candy	☐ Soda/energy & sugary drinks	☐ Coffee/tea
☐ Water		

❖ Dietary Habits cont'd:

What is your attitude about food/eating? (mark all that apply)

- ☐ Eat 3 full meals per day
- ☐ Eat less than 3 full meals per day
- ☐ Snack often throughout the day
- ☐ Eat balanced meals
- ☐ Do not eat balanced meals
- ☐ Very picky about foods
- ☐ Overeat at each meal
- ☐ Am hungry soon after each meal
- ☐ Prefer snacking over meals
- ☐ Enjoy eating
- ☐ Poor appetite for food in general

Family Health History

Mark the following conditions as they pertain to your family. Include family member (parents,siblings,children,grandparents)

Diabetes	_____	Cancer	_____
Heart problems	_____	Vascular problems (including stroke, embolism)	_____
Kidney problems	_____	Muscle diseases (myopathies)	_____
Gastrointestinal problems	_____	Nerve diseases (neuropathies)	_____
Autoimmune conditions	_____	Neurological conditions	_____
Respiratory conditions	_____	Psychiatric conditions (i.e. depression, bipolar, schizophrenia, etc)	_____
Musculoskeletal conditions	_____	Headaches	_____
Other	_____		

Does any member of your family have a condition/symptoms similar to yours? ☐ Yes ☐ No

*If yes, please explain:*_____

Medical History

Mark any of the following conditions as they pertain to you:

- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ HIV positive
- ☐ Measles
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Psychiatric Disorders
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Tuberculosis
- ☐ Venereal Infection
- ☐ Whooping Cough

Any cardiac conditions? *(if yes, please explain)*_____

Any significant illnesses or infections in your past? (if yes, please explain) _____

❖ Medical History cont'd:

Any recent illnesses or infections? (if yes, please explain) _____

Any known allergies or sensitivities? (please describe) _____

Any autoimmune conditions? (thyroid disorders, eczema, psoriasis, RA, Lupus, etc.) _____

List any broken bones or dislocations you have had (include locations, R/L) _____

Have you suffered any head injuries (including concussions)*?*	☐ Yes	Please explain:_____
Were you ever knocked unconscious?	☐ Yes	Please explain:_____
Have you ever had a lapse in memory?	☐ Yes	Please explain:_____
Have you ever had a spinal tap or injection?	☐ Yes	Please explain:_____

❖ Surgical History:

Do you have any implantable medical devices in your body? (including pacemakers, stents, plates, screws)

If yes, please explain: _____

Mark all of the following procedures as they pertain to you: *(for procedures listed in 3rd column, please describe on adjacent line)*

☐ Tonsillectomy	☐ Thyroid surgery	☐ Neurosurgery	_____
☐ Gall bladder removal	☐ Stomach surgery	☐ Spinal surgery	_____
☐ Appendectomy	☐ Rectal surgery	☐ Cardiac surgery	_____
☐ Hernia repair	☐ Abdominal surgery	☐ Orthopedic surgery	_____
☐ Breast implant surgery	☐ Tubes in ears	☐ Female surgery	_____
☐ Cesarean Section	☐ Knee/hip replacement	☐ Male Surgery	_____
		☐ Other	_____

❖ Medications, Vitamins, Supplements

Please list any *vitamins or supplements* you are currently taking:

_____ _____ _____

_____ _____ _____

Please list any *prescription or over-the-counter medications* you are currently taking and the condition for which you are taking them:

_____ _____ _____

_____ _____ _____

Injuries

❖ *List any (even minor) motor vehicle collisions (auto or otherwise), that you have been involved in as either driver or passenger, begin with most recent*

Type of collision	Injuries suffered & treatment received	Date of injury

❖ *List any job injuries that you have experienced. Begin with most recent*

Type of injury	Treatment received	Date of injury

❖ *List any athletic injuries that you have experienced below. Begin with the most recent*

Type of injury	Treatment received	Date of injury

❖ *List any other injuries that you have experienced below. Begin with most recent*

Type of injury	Treatment received	Date of injury

Last Name, First Initial:_____

Review of Systems

Mark any of the following conditions/symptoms that currently pertain to you

❖General

☐Consistent fainting	☐Chills	☐Convulsions	☐Depression	☐Dizziness
☐Loss of weight	☐Fatigue	☐Fever	☐Headaches	☐Loss of sleep
☐Weight gain	☐Neuralgia	☐Night sweats	☐Wheezing	☐Nervousness

❖ Gastro-Intestinal

☐Constipation	☐Diarrhea	☐Gall bladder issues	☐Hemorrhoids	☐Poor digestion
☐Liver problems	☐Nausea	☐Stomach pain	☐Poor appetite	☐Changes in urgency
☐Rectal bleeding	☐Vomiting	☐Vomiting blood	☐Jaundice	☐Changes in frequency

❖ Eye/Ear/Nose/Throat

☐Asthma	☐Sore throat	☐Tonsillitis	☐Blurry vision	☐Earache
☐Ear noises (tinnitus)	☐Enlarged thyroid	☐Crossed eyes	☐Double vision	☐Ear discharge
☐Nasal obstruction	☐Nose bleeds	☐Worsening vision	☐Eye pain	☐Deafness
☐Hay fever	☐Sinusitis	☐Hoarseness	☐Changes in sense of smell	☐Changes in sense of taste

❖ Respiratory

☐Chronic cough	☐Chest pain	☐Difficulty taking normal breath	☐Difficulty taking deep breath	☐Wheezing
☐Heaviness in chest	☐Coughing blood	☐Coughing phlegm		

❖Musculoskeletal

☐Backache	☐Foot pain	☐Pain between shoulder-blades	☐Painful tailbone	☐Neck stiffness
☐Spinal curvature	☐Loss of range of motion	☐Weakness	☐Changes in muscle tone	☐Muscle twitching
☐Muscle tremors	☐Swollen joints	☐Changes in gait		

❖Cardio-Vascular

☐Ankle swelling	☐Poor circulation	☐High blood pressure	☐Low blood pressure	☐Heart fluttering/ palpitations
☐Rapid heartbeat	☐Slow heartbeat	☐Pain over heart	☐Venous insufficiency	

❖Skin

☐Dryness	☐Bruise easily	☐Hives	☐Itching	☐Eczema
☐Sensitive skin	☐Skin discolorations	☐Thinning of skin		

❖Neurological

❑Attention problems	❑Mental fogginess	❑Mental fatigue	❑Mood changes	❑Lack of motivation
❑Incoordination	❑Difficulty with word retrieval	❑Difficulty remembering names	❑Difficulty remembering faces	❑Difficulty expressing feelings
❑Difficulty recalling memories	❑Difficulty understanding directions	❑Difficulty with simple math calculations	❑Difficulty with comprehension	❑Difficulty finishing tasks
❑ Abnormal sensations	❑Uncontrollable movements	❑Increased anxiety or panic	❑Increased sensitivity to light	❑Increased sensitivity to touch
❑Increased sensitivity to sound	❑Easily get annoyed/ frustrated			

❖*Please note any additional comments or concerns you would like us to know regarding your health*

❖*I understand and agree to the following:*

❖ *It is my responsibility to complete the clinic's forms accurately and provide the most up to date information*

❖ *It is my responsibility to notify the doctor if any of the information has changed or requires updating*

Signature of patient Date

Signature of Guardian Relationship to patient Date

RESET A FORM

Florida Functional Neurology Group
WWW.FFNG.ORG

Medication History*

Please check any of the following medications 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, ☐ Succinylcholine, ☐ Tubocurarine, ☐ Vecuronium, ☐ Hemicholinium

Agonist Modulator of GABA Receptor (benzodiazepines)
☐ Xanax®, ☐ Lexotanil, ☐ Lexotan®, ☐ Librium, ☐ Klonopin®, ☐ Valium®, ☐ ProSom®, ☐ Rohypnol, ☐ Dalmane, ☐ Ativan, ☐ Loramet®, ☐ Sedoxil, ☐ Dormicum, ☐ Megalodon, ☐ Serax®, ☐ Restoril, ☐ Halcion

Agonist Modulator of GABA Receptors (nonbenzodiazepines)
☐ Ambien CR®, ☐ Sonata®, ☐ Lunesta®, ☐ Imovane

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

Cholinesterase Inhibitors (reversible)
☐ Donepezil, ☐ Galatamine, ☐ Rivastigmine, ☐ Tacrine, ☐ THC, ☐ Edrophonium, ☐ Neostigmine, ☐ Physostigmine, ☐ Pyridostigmine, ☐ Carbamate Insecticides

Dopamine Reuptake Inhibitors
☐ Wellbutrin XL® (Bupropion)

Dopamine Receptor Agonists
☐ Mirapex®, ☐ Sifrol®, ☐ Requip®

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
☐ Flumazenil

Monoamine® Oxidase Inhibitors (MAOI)
☐ Marplan®, ☐ Aurorix®, ☐ Manerix®, ☐ Moclodura, ☐ Nardil, ☐ Adeline®, ☐ Eldepryl®, ☐ Azilect®, ☐ Marsilid®, ☐ Iprozid®, ☐ Ipronid®, ☐ Rivivol, ☐ Popilniazida®, ☐ Zyvox®, ☐ Zyvoxid®

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

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

Selective Serotonin Reuptake Enhancers
☐ Stablon®, ☐ Coaxil, ☐ Tatinol®

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
☐ Effexor®, ☐ Pristiq®, ☐ Meridia, ☐ Serzone®, ☐ Dalcipran®, ☐ Despiramin, ☐ Duloxetine

Tricylic Antidepressants (TCAs)
☐ Elavil®, ☐ Endep®, ☐ Tryptanol, ☐ Trepiline®, ☐ Asendin®, ☐ Asendis®, ☐ Defanyl®, ☐ Demolox®, ☐ Moxadil®, ☐ Anafranil®, ☐ Norpramin®, ☐ Pertofrane®, ☐ Prothiaden®, ☐ Adapin®, ☐ Sinequan®, ☐ Tofranil®, ☐ Janamine®, ☐ Gamanil®, ☐ Aventyl®, ☐ Pamelor®, ☐ Opipramol®, ☐ Vivactil®, ☐ Rhotrimine®, ☐ Surmontil®

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

Other:_____

_____

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:

Health Questionnaire (NTAF)

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

*** Please circle the appropriate number "0 - 3" 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 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

SECTION B

- How high is your stress level? 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? 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 lightheadedness 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

- Do you get fatigued after meals? 0 1 2 3
- Do you crave sugar and sweets after meals? 0 1 2 3
- Do you feel you need stimulants such as coffee after meals? 0 1 2 3
- 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 been increased? 0 1 2 3
- Do you have weight gain when under stress? 0 1 2 3
- Do you have difficulty falling asleep? 0 1 2 3

SECTION 1 - S

- Are you losing your pleasure in 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 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 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 - D

- 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

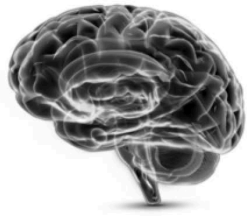
SECTION 3 - G

- 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 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 - ACH

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

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.



Florida Functional Neurology Group

WWW.FFNG.ORG

AUTHORIZATION TO RECEIVE & RELEASE X-RAYS & INFORMATION

TO: _____
(NAME OF HEALTH CARE PROVIDER, CLINIC, HOSPITAL, ETC.)

ADDRESS: _____

I, _____ DOB: _____ SSN: _____
(PATIENT'S NAME)

REQUEST THE FOLLOWING INFORMATION:

☐ X-RAYS ☐ HISTORY ☐ RECORDS ☐ DIAGNOSIS ☐ REPORTS ☐ TREATMENT

CONCERNING MY: ☐ ILLNESS ☐ ACCIDENT ☐ INJURY ☐ OTHER_____

TO BE RELEASED TO: FLORIDA FUNCTIONAL NEUROLOGY GROUP
ALEXANDER C. FRANK, DC, DACNB, FABES

_____

_____

FOR THE PURPOSE OF: Review, Evaluation, Records
(REVIEW, EVALUATION, INSURANCE CLAIM PROCESSING, OR ANY PURPOSE REASONABLY RELATED TO THE ABOVE)

I UNDERSTANT THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON MY REQUEST.

SIGNATURE: _____ DATE: _____
◯ PATIENT ◯ PARENT ◯ GUARDIAN

NOTICE OF PRIVACY PRACTICES

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1966 (HIPPA). I HAVE REVIEWED THE ACT OF HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY AND ACKNOWLEDGE THE FEDERAL RULES TO PROTECT THE RIGHTS OF PERSONAL HEALTH INFORMATION.

PATIENT NAME: _____ DATE: _____

SIGNATURE: _____ _____
◯ PATIENT ◯ PARENT ◯ GUARDIAN