Florida Functional Neurology Group

COMPREHENSIVE PEDIATRIC MEDICAL HISTORY

Unauthorized Use Strictly Prohibited

Patient Name			Date
Street Address		City/State	Zip Code
Guardian Home Phone ( )	Guardian Work Phone ( )	Guardian Cell Phone/Pager ( )	
Email Address	Date of Birth	Current Age: Years Months	
Chief Complaints	Sex Male ◯	Female ◯	Other ◯

Mothers Name:	Father's Name:_____
Legal Guardian:	Other:

Patient's Personal Physician:		Type of Doctor:
Doctors Phone #:	Date of Child's Last Exam:	Diagnosis:
Patient's Personal Physician:		Type of Doctor:
Doctors Phone #:	Date of Child's Last Exam:	Diagnosis:

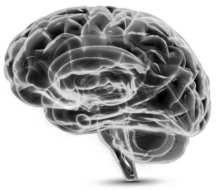
Referred by:

☐ Patient Name:	☒ Physician Name	☐ Other

Parent/Guardian Printed Name_____Date:_____

Guardian Signature_____

4076 E. SR-44 #4 Wildwood, FL. 34785 P: 352.571.5155 F: 352.877.9637 info@FFNG.org



Florida Functional Neurology Group

Terms of Acceptance

Informed Consent:

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.

Women Only:

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 , leave messages on any answering device, i.e. text or voicemails? Yes_____ No_____

Acknowledgement:

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

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

Signature: _____ Date_____

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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, Electrodiagnostic Specialties

Please describe in your own words the condition(s) you are seeking evaluation for. When did it start? What makes it better? What makes it worse? Information such as "pain is worse in the morning", or "the pain reduces when I lay on my left side". What has/has not helped?

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IN CASE OF EMERGENCY

Name of relative or close friend not living in your home:		
Home Phone	Work Phone	Cell Phone

PERSONAL HISTORY Completed by:_____

Height Ft. Inches	Weight Lbs.	Percentile Rank

Current School Grade:_____ ☐ Private School ☐ Public School ☐ N/A ☐ Other

Academic Performance: ☐ Not in School ☐ Remedial/Special Ed ☐ Below Average ☐ Average ☐ Above Average

Number of weeks gestation: ☐ Pre-term # of weeks_____ ☐ Full term (38-40 wks) ☐ Post term - # of weeks_____

Birth by: ☐ NSVD ☐ VD-induced ☐ C-Section ☐ Complications: ☐ No ☐ Yes Explain_____

Birth Weight:_____lbs_____ oz. Apgar Score:_____/_____

Was child breast fed? ☐ Yes # of months_____ ☐ No Formular/Type:_____

At what age was child introduced to solid foods?_____ Any negative reactions? ☐ No ☐ Yes_____

Estimate courses of antibiotics during 1st year of life:_____ Total since birth:_____

How many bowel movements a day on average? ☐ Frequently constipated ☐ 1 ☐ 2 ☐ 3 ☐ Greater than 3

Does child have undigested food in stool? ☐ No ☐ Occasionally ☐ Often ☐ Always

Immunizations: ☐ None ☐ Some _ _____ ☐ All immunization up-to-date for age

Did child have reaction(s) to any immunizations? ☐ No ☐ Yes Explain:_____

At what age did child first sit-up? _____ ☐ Precocious ☐ Average ☐ Delayed ☐ Other _____
point to objects?_____ ☐ Precocious ☐ Average ☐ Delayed
first crawl? _____ ☐ Precocious ☐ Average ☐ Delayed ☐ Other _____
first walk? _____ ☐ Precocious ☐ Average ☐ Delayed ☐ Other _____

Does child seem to avert eye contact? ☐ No ☐ Rarely ☐ Yes
Does child avoid or fear strangers? ☐ No ☐ Rarely ☐ Yes

Motor skills are considered? ☐ Precocious ☐ Average ☐ Delayed ☐ Other _____
Speech is considered? ☐ Precocious ☐ Average ☐ Delayed ☐ Other_____

How many hours/night does child sleep on average? ☐ 4-5 ☐ 6–7 ☐ 7–8 ☐ 9–10 ☐ 10+ Is sleep disturbed? ☐ No ☐ Yes

Rate the quality of sleep? 1-------2-------3-----4-------5-------6-------7-------8-------9-------10
(Poor) (Average) (Excellent)

Does child have night terrors? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often

Does child have dark circles under eyes? ☐ No ☐ Occasionally ☐ Often

Does child have any unexplained rashes or itching, especially in the ears, groin or belly button ? ☐ No ☐ Sometimes ☐ Often

Does child have a chronic whitish or brown coating on tongue that cannot be brushed off? ☐ No ☐ Yes
Does child have dry skin or eczema? ☐ No ☐ Sometimes ☐ Yes

Does child seem to have excessive thirst? ☐ No ☐ Sometimes ☐ Yes

Does child seem "addicted" to sugars, sweets and carbohydrates? ☐ No ☐ Sometimes ☐ Often

Does child get headaches after eating sugar, bread, pasts, fruit, or cereal? ☐ Never ☐ Sometimes ☐ Often

Has child's language skills seem to have regressed? ☐ No ☐ Possibly ☐ Yes

MATERNAL HISTORY

Age of mother at pregnancy?_____ # Pregnancy: ☐ First ☐ Second ☐ Third ☐ Fourth ☐ Other _____

Did mother have any medical problems PRIOR to pregnancy?_____

Did mother smoke during pregnancy? ☐ No ☐ Yes # per day_____

Did mother drink alcohol during pregnancy? ☐ Never ☐ Yes Type: ☐ Wine ☐ Beer ☐ Liquor # drink/wk _____

Maternal complications during pregnancy? ☐ None ☐ High blood pressure ☐ Edema ☐ Diabetes ☐ Pre-eclampsia ☐ Eclampsia

Did mother take any medications or drugs during pregnancy? ☐ No ☐ Yes Type and amount:_____

_____

HAS CHILD (not a family member) EVER BEEN DIAGNOSED WITH

ADD or ADHD	☐ Never	☐ Past	☐ Yes:	_____
Allergies/Hayfever	☐ Never	☐ Past	☐ Yes:	_____
Asperger's syndrome (AS)	☐ Never	☐ Past	☐ Yes:	_____
Asthma	☐ Never	☐ Past	☐ Yes:	_____
Anemia	☐ Never	☐ Past	☐ Yes:	_____
Autism	☐ Never	☐ Past	☐ Yes:	_____
Bladder/Urine Infection (UTI)	☐ Never	☐ Past	☐ Yes:	_____
Blood Pressure Problems	☐ Never	☐ Past	☐ Yes:	_____
Bronchitis/Pneumonia	☐ Never	☐ Past	☐ Yes:	_____
Colitis/Crohn's Disease	☐ Never	☐ Past	☐ Yes:	_____
Croup	☐ Never	☐ Past	☐ Yes:	_____
Cystic Fibrosis	☐ Never	☐ Past	☐ Yes:	_____
Developmental Delay	☐ Never	☐ Past	☐ Yes:	_____
Diabetes Type I (Juvenile Diabetes)	☐ Never	☐ Past	☐ Yes:	_____
Dysentery/Food Poisoning	☐ Never	☐ Past	☐ Yes:	_____
Dyslexia	☐ Never	☐ Past	☐ Yes:	_____
Ear Infection (Otitis Media)	☐ Never	☐ Past	☐ Yes:	_____
Easy Bruising	☐ Never	☐ Past	☐ Yes:	_____
Eating Disorder	☐ Never	☐ Past	☐ Yes:	_____
Eczema/Psoriasis – Skin Problems	☐ Never	☐ Past	☐ Yes:	_____
Enlarged Heart	☐ Never	☐ Past	☐ Yes:	_____
Epilepsy (Seizures)	☐ Never	☐ Past	☐ Yes:	_____
Gastric Reflux or Ulcers	☐ Never	☐ Past	☐ Yes:	_____
Goiter	☐ Never	☐ Past	☐ Yes:	_____
Heart Murmur/Arrhythmia	☐ Never	☐ Past	☐ Yes:	_____
Hemochromatosis (Iron Overload)	☐ Never	☐ Past	☐ Yes:	_____
Hepatitis/Jaundice	☐ Never	☐ Past	☐ Yes	☐ Hep A ☐ Hep B ☐ Hep C

Hives	☐ Never	☐ Past	☐ Yes:	_____
Hperthryroidism	☐ Never	☐ Past	☐ Yes:	_____
Hypothyroidism	☐ Never	☐ Past	☐ Yes:	_____
Irritable Bowel (IBS)	☐ Never	☐ Past	☐ Yes:	_____
Juvenile Rheumatoid Arthritis	☐ Never	☐ Past	☐ Yes:	_____
Kidney Infection	☐ Never	☐ Past	☐ Yes:	_____
Kidney Stones	☐ Never	☐ Past	☐ Yes:	_____
Learning Disorder	☐ Never	☐ Past	☐ Yes:	_____
Lyme Disease	☐ Never	☐ Past	☐ Yes:	_____
Meningitis	☐ Never	☐ Past	☐ Yes:	_____
Mental Retardation	☐ Never	☐ Past	☐ Yes:	_____
Migraine Headaches	☐ Never	☐ Past	☐ Yes:	_____
Mononucleuosis	☐ Never	☐ Past	☐ Yes:	_____
Multiple Sclerosis (MS)	☐ Never	☐ Past	☐ Yes:	_____
Obsessive Compulsive Disorder (OCD)	☐ Never	☐ Past	☐ Yes:	_____
Pervasive developmental disorder	☐ Never	☐ Past	☐ Yes:	_____
Pharyntgitis	☐ Never	☐ Past	☐ Yes:	_____
Sinusitis	☐ Never	☐ Past	☐ Yes:	_____
Speech Delay	☐ Never	☐ Past	☐ Yes:	_____
Strep Throat	☐ Never	☐ Past	☐ Yes:	_____
Syphilis/Chlamydia/STD	☐ Never	☐ Past	☐ Yes:	_____
Tourette's	☐ Never	☐ Past	☐ Yes:	_____
Yeast Infections	☐ Never	☐ Past	☐ Yes:	_____

Other_____

Other_____

ALLERGIES:

Is child SENSITIVE/INTOLERANT/ALLERGIC to any of the following foods?

☐ Milk/Dairy ☐ Wheat/Gluten ☐ Peanuts ☐ Soy ☐ Eggs ☐ Corn ☐ Yeast ☐ Chocolate ☐ Citrus ☐ Fish/Shellfish ☐ Strawberries

Other:_____

Do you live with any pets? ☐No ☐Yes Describe_____

Please list any allergies that your child has been diagnosed with or that you suspect._____

_____

Does anyone in the home smoke? ☐ Never ☐ No ☐ Yes Type: ☐ Cigarettes ☐ Cigars ☐ Pipes Other_____ Number/day:_____

MEDICATIONS: Is child currently taking (or recently discontinued) any PRESCRIBED medications?

Please List _____

OPERATIONS AND HOSPITALIZATIONS: ☐No ☐Yes Yr/Description_____

DEVICES: Please circle any of the following that the child utilizes:

☐ Ear Tubes, ☐ Eyeglasses, ☐ Contact Lenses, ☐ Dental Braces, ☐ Back Brace, ☐ Knee Brace, ☐ Neck Brace, ☐ Implants, ☐ and/or Shunt.

How is child's dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Has child had EYE exam? ☐No ☐Yes Date Last Exam_____

Has child had HEARING exam? ☐No ☐Yes Date Last Exam_____

TESTS: Has child ever had an X-ray, CAT-Scan, MRI, Sonogram, PET-scan, EKG or Bone Scan (circle which test) of:

No ☐ Yes ☐ Yr/Test/Result_____

FAMILY HISTORY: Has any blood relative (NOT CHILD) ever had any of the following?

ADD/AD(H)D	☐No ☐Yes	Relation_____
Arthritis	☐No ☐Yes	Relation_____
Asperger's Symdrome (AS)	☐No ☐Yes	Relation_____
Asthma	☐No ☐Yes	Relation_____
Autism	☐No ☐Yes	Relation_____
Bleeding Disorder	☐No ☐Yes	Relation_____
Bipolar Disorder	☐No ☐Yes	Relation_____
Cancer	☐No ☐Yes	Relation_____
Developmental Delay	☐No ☐Yes	Relation_____
Diabetes Type I / II	☐No ☐Yes	Relation_____
Emphysema	☐No ☐Yes	Relation_____
Hepatitis B or C	☐No ☐Yes	Relation_____
Hypothyroidism	☐No ☐Yes	Relation_____
Learning Disability	☐No ☐Yes	Relation_____
Mental Illness/Suicide	☐No ☐Yes	Relation_____
Migraine Headaches	☐No ☐Yes	Relation_____
Multiple Sclerosis	☐No ☐Yes	Relation_____
Obsessive Compulsive Disorder (OCD)	☐No ☐Yes	Relation_____
PDD	☐No ☐Yes	Relation_____
Siezure Disorder/Epilepsy	☐No ☐Yes	Relation_____
Speech Delay	☐No ☐Yes	Relation_____
Tourette's Syndrome	☐No ☐Yes	Relation_____

DIET AND NUTRITION: Does child consume any of the following?

Milk Dairy ☐No ☐Rarely ☐Often Approx glasses/day_____

Difficulty digesting Milk/Dairy (Lactose Intolerant) ☐No ☐Not Aware ☐Yes

Wheat/Gluten containing grains/cereals ☐No ☐Rarely ☐Often

Soda/Cola ☐No ☐Rarely ☐Often Approx glasses/day_____ Type_____

Juices-Orange/Apple ☐No ☐Rarely ☐Often Approx glasses/day_____

Water directly from Tap ☐Never/Rarely ☐Sometimes ☐Mostly

Soy-Containing Foods ☐No ☐Occasionally ☐Often – (Circle) Soy milk ☐ Tofu ☐ Soy Protein ☐ Times/Week:_____

How many meals plus snacks per day does child eat on average? ☐1 ☐2 ☐3 ☐4 ☐5 ☐Graze

Does child eat fruits and vegetables? ☐Frequently ☐Rarely ☐Almost Never

How many times/week, on average, does child eat Fish/Seafood? ☐More than 3 ☐Rarely 1 – 2X/Wk ☐Almost Never

Which Fats/Oils does child consume?

☐Butter ☐Olive Oil ☐Coconut Oil ☐Flax Oil ☐Safflower Oil ☐Sunflower Oil ☐Peanut Oil ☐Grape Seed Oil ☐Macadmaia Oil
☐Mayonnaise ☐Margarine ☐Crisco ☐Corn Oil ☐Soybean Oil ☐Canola Oil

Is Child in any special diet?

☐Dairy-Free ☐Wheat/Gluten-Free ☐Yeast-Free ☐Feingold ☐Low Carbohydrate ☐High Protein ☐No Special Diet

Other:_____

What diet type does child primarily consume?

☐ High Carbohydrate – Bread, pasta, cereal, rice, potatoes, juices, sweets, etc
☐ High Protein – Meat, fish, fowl, eggs, nuts, etc.
☐ Vegetarian – No meat at all
☐ No Special Diet – Large variety of protein, vegetables, and carbohydrates

Please list the foods in child's "usual" (Please be specific):

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Other _____

Name the five foods consumed MOST frequently (Please be specific)

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

List all vitamins, minerals, herbs, amino acids, and nutritional supplements (with dose) you are taking on a regular basis:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. What was the name of the Jetson's dog?_____

*Directions: Circle impression of the following using grading system "0" not at all to "10" very severe.

Psychological/Emotional

Seems angry at times	0 1 2 3 4 5 6 7 8 9 10
Seems depressed	0 1 2 3 4 5 6 7 8 9 10
Picks on other children	0 1 2 3 4 5 6 7 8 9 10
Disliked by other children	0 1 2 3 4 5 6 7 8 9 10
Has difficulty making friends	0 1 2 3 4 5 6 7 8 9 10
Shows poor self-esteem	0 1 2 3 4 5 6 7 8 9 10
Sleeps excessively	0 1 2 3 4 5 6 7 8 9 10
Violent behavior	0 1 2 3 4 5 6 7 8 9 10
Immature behavior	0 1 2 3 4 5 6 7 8 9 10
Physically hurts self or others	0 1 2 3 4 5 6 7 8 9 10

Score_____

Attention/Hyperactivity

Trouble staying seated for class work	0 1 2 3 4 5 6 7 8 9 10
Fidgets excessively in seat	0 1 2 3 4 5 6 7 8 9 10
Doesn't finish work	0 1 2 3 4 5 6 7 8 9 10
Easily distracted	0 1 2 3 4 5 6 7 8 9 10

Acts before thinking	0 1 2 3 4 5 6 7 8 9 10
Interrupts, often calls out	0 1 2 3 4 5 6 7 8 9 10
Requires assistance to accurately complete assignment	0 1 2 3 4 5 6 7 8 9 10
Excessively stares or appears “spaced out”	0 1 2 3 4 5 6 7 8 9 10

Academic

Disorganized	0 1 2 3 4 5 6 7 8 9 10
Loses things needed for tasks	0 1 2 3 4 5 6 7 8 9 10
Poor math/science skills	0 1 2 3 4 5 6 7 8 9 10
Poor language/vocabulary skills	0 1 2 3 4 5 6 7 8 9 10
Slow to begin/finish schoolwork	0 1 2 3 4 5 6 7 8 9 10
Poor memory	0 1 2 3 4 5 6 7 8 9 10
Forgetful about school assignments and tasks	0 1 2 3 4 5 6 7 8 9 10
Makes careless errors or mistakes	0 1 2 3 4 5 6 7 8 9 10
Poor penmanship	0 1 2 3 4 5 6 7 8 9 10
Has trouble following teacher instructions/group direction	0 1 2 3 4 5 6 7 8 9 10

Score_____

MAIN REASON AND GOALS OF APPOINTMENT:

_____
_____
_____
_____
_____
_____
_____

Please honestly rate your ability, resources, and desire to make the necessary lifestyle, medical, dietary, supplement, and nutrition commitments and modifications for your child in order to significantly impact the typical “natural” course of current disease or disorder.

☐ Likely only minor changes ☐ Likely only moderate changes ☐ Likely I can make major changes ☐ I can do almost everything it may take

asdfadsfdasfadsfasdfdasfasdfsadfasdfasdfasdfasdfasdfadsfadsfasfasdfadsfadsfsdafasdfasdfasdfadsf asdfasdfadsfadsf

To the best of my knowledge all of the above information is true and accurate.

Parent/Guardian Signature:_____
For Patient:_____Date:_____

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Child Neurotransmitter & Nutrition Questionnaire (CNNQ)

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

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

SECTION: GENERAL DIET

- Does your child have any food sensitivities or allergies? (If yes, please list)

  _____

  _____
- List your child's 4 healthiest foods eaten during the average week.

  _____ _____

  _____ _____
- List your child's 4 unhealthiest foods eaten during the average week.

  _____ _____

  _____ _____
- How many times does your child eat candy per week? _____
- How many times does your child drink soda per week? _____
- List the top 4 foods your child craves regularly.

  _____ _____

  _____ _____
- List the medication(s) your child is currently prescribed and any over-the-counter products used. _____

  _____
- Do you find it difficult to have your child on a special diet?

  _____

SECTION A

- Does your child eat pasta, breads, and breaded foods? **0 1 2 3**
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating foods containing wheat/gluten? **0 1 2 3**
- Does your child consume dairy products? **0 1 2 3**
- Does your child have symptoms (fatigue, hyperactivity, etc.) after consuming dairy products? **0 1 2 3**

SECTION B

- Does your child eat fried fish? **0 1 2 3**
- Does your child eat roasted nuts or seeds? **0 1 2 3**
- Is your child missing essential fatty acid-rich foods in his/her diet? (for example: avocados, flax seeds, olives) **0 1 2 3**
  (circle "0" if present, "3" if missing)
- Does your child eat fried foods? **0 1 2 3**

SECTION C

- Is your child's mental speed slow? **0 1 2 3**
- Does your child have difficulty with learning or memory? **0 1 2 3**
- Does your child have difficulty with balance and coordination? **0 1 2 3**

SECTION D

- Does your child have stress? **0 1 2 3**
- Does your child not have enough sleep and rest? **0 1 2 3**
  (circle "0" if enough, "3" if not enough)
- Does your child not have regular exercise? **0 1 2 3**
  (circle "0" if regular exercise, "3" if no exercise)
- Does your child feel overly worried and scared? **0 1 2 3**

SECTION E

- Does your child have temper tantrums? **0 1 2 3**
- Does your child exhibit wild behavior? **0 1 2 3**
- Does your child frequently yell or scream for unnecessary reasons? **0 1 2 3**
- Does your child have an inability to nap or sleep when physically exhausted? (circle "0" if able, "3" if unable) **0 1 2 3**
- Is your child overly talkative? **0 1 2 3**
- Does your child fidget and squirm when seated? **0 1 2 3**
- Does your child run and climb excessively? **0 1 2 3**
- Does your child have difficulty playing quietly or engaging in leisure activities? **0 1 2 3**

SECTION F

- Does your child get excited easily? **0 1 2 3**
- Does your child have anxiety and panic for minor reasons? **0 1 2 3**
- Does your child feel overwhelmed for minor reasons? **0 1 2 3**
- Does your child find it difficult to relax when he/she is awake? **0 1 2 3**
- Does your child have disorganized attention? **0 1 2 3**

SECTION G

- Does your child seem depressed? **0 1 2 3**
- Does your child have mood changes with overcast weather? **0 1 2 3**
- Does your child have symptoms of inner rage? **0 1 2 3**
- Does your child seem uninterested in games or hobbies? **0 1 2 3**
- Does your child have difficulty falling into deep, restful sleep? **0 1 2 3**
- Does your child seem uninterested in friendships? **0 1 2 3**
- Does your child have unprovoked anger? **0 1 2 3**
- Does your child seem uninterested in eating? **0 1 2 3**

SECTION H

- Does your child have difficulty handling stress? **0 1 2 3**
- Does your child have anger and aggression while being challenged? **0 1 2 3**
- Does your child feel tired even after many hours of sleep? **0 1 2 3**
- Does your child tend to isolate himself/herself from others? **0 1 2 3**
- Does your child get distracted easily? **0 1 2 3**
- Does your child have a constant need and desire for candy and sugar? **0 1 2 3**
- Does your child have disorganized attention? **0 1 2 3**

SECTION I

- Does your child have difficulty with visual memory (shapes and images)? **0 1 2 3**
- Does your child have difficulty remembering locations? **0 1 2 3**
- Does your child have fatigue or low endurance for learning activities? **0 1 2 3**
- Does your child have difficulty with attention or a short attention span? **0 1 2 3**
- Does your child have slow or difficult speech? **0 1 2 3**
- Does your child have uncoordinated or slow movements? **0 1 2 3**

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Metabolic Assessment Form

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

PART I

Please list your 5 major health concerns in order of importance:

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

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

Category I

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

Category II

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

Florida Functional Neurology Group

WWW.FFNG.ORG

AUTHORIZATION TO RELEASE & RECEIVE X-RAYS & INFORMATION

TO:_____Fax:_____Phone:_____

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

ADDRESS:_____, _____

I, _____ DOB:_____

(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

4076 E. SR-44 #4, Wildwood, FL. 34785

Fax: 352.877.9637 Phone: 352.571.5155 info@FFNG.org

FOR THE PURPOSE OF:_____

(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: _____

PATIENT SIGNATURE: _____