BRAIN and BODY SOLUTIONS

Intake Questionnaire

Date: _____

Please fill out this application in detail. Add additional pages if needed.

PATIENT INFORMATION

Patient Name	Age	DOB
Address		
City/State/Zip		
Cell Phone	Home Phone (if different)	
Email		

PARENT or GUARDIAN(S) (if patient is a minor)

Name	Age	DOB
Address (if different)		
City/State/Zip		
Cell Phone (if different)	Home Phone (if different)	
Email (if different)		

Please describe the reason(s) you are here, listing the most important first.

Primary Complaint

Complaint	How long have you had it?	Rate its severity today on a scale of 1 to 10, 10 is most severe.

Secondary Complaint (if any)

Complaint	How long have you had it?	Rate its severity today on a scale of 1 to 10, 10 is most severe.

Tertiary Complaint (if any)

Complaint	How long have you had it?	Rate its severity today on a scale of 1 to 10, 10 is most severe.

Quarternary Complaint (if any)

Complaint	How long have you had it?	Rate its severity today on a scale of 1 to 10, 10 is most severe.

Who diagnosed your condition(s) and what is their profession?

Name	Profession	Condition Diagnosed

Please list all medications, who prescribed, and for what condition.

Medication	Doctor that Prescribed	Condition Taken For

Have you ever been diagnosed with any of the following conditions?

	ADD		Seizure Disorder / Epilepsy		Alzheimer's
	ADHD		Depression		Cognitive Impairment
	Traumatic Brain Injury		Bipolar Disorder		Stroke or Transient Ischemia
	Anxiety		Tourette's		High Blood Pressure
	Sleep Disorder		Migraines		Post Traumatic Stress Disorder
	Irritable Bowel		Allergies		Asthma
	Heart Attack		Heart Disease		Chronic Pain
	Fibromyalgia		Reflex Sympathetic Dystrophy		Obsessive Compulsive Disorder

Please indicate any other pertinent diagnosis that is not listed above:

What is your ethnicity (if known)? (This information is used to determine possible genetic factors.)
Be as specific as possible. For example, "Ireland" is more useful than "Europe".

Mother's Ethnicity	Father's Ethnicity	Ethnicity from DNA testing

GOALS: Please list five goals for your health.

SLEEP

Please indicate your current sleep symptoms

	Difficulty going to bed		Walking in Sleep		Sleep too much
	Difficulty going to sleep		Night Terrors		Sleep Apnea
	Wake up frequently		Restless Legs		Bruxism (teeth grinding)
	Early Awakening		Bed Wetting or Soiling		Vivid Dreams
	Restless Sleep		Nightmares		Night Sweats
	Talking in Sleep		Vividly remember dreams		

What time did you try to fall asleep last night?	
Activities the last hour before bedtime (meditation, TV, video games, exercise)?	
After settling down, how long did it take you to fall asleep?	
How many times did you wake up during the night?	
What time(s) did you wake up? How long did you stay awake?	
What time did you wake up today?	
When you woke up did you feel you had gotten enough sleep?	
How would you rate the quality of your sleep last night?(1 very poor,10 best ever)	
What were the last foods you consumed last night? Include type, amount, and time you ate.	
Did you consume any alcoholic beverages yesterday? Include type, number, and time of day.	
Did you take any medications to help you sleep? (prescription, over the counter, or supplements) Include type, amount and time of day.	
Did you take any naps today? Include number and time of day.	
How awake did you feel today? (1-exhausted, 10-wide awake)	

EXERCISE (Circle the activities you like the best.)

What is your typical exercise pattern? (Daily, weekly or monthly exercise)
What exercise have you done in the last week?

MENSES (Females only)

Describe the start of your menses. (age, regularity, frequency, volume)
Describe any changes to your menses. (include age, cause if known, duration)

DIET

Describe your usual diet. What do you typically eat? List any food restrictions (vegetarian, gluten free, allergies, etc.)

Doctor's notes only:

Time	Food or drink

SUPPLEMENTS

Please list all supplements you are currently taking

Supplement	Dose/Frequency	Reason you are taking it

ALLERGIES

Allergy	Severity (1-mild,10-severe)	Treatment Received

Previous TREATMENT for any condition listed (other than medications and supplements)

Treatment/Therapy	When/Duration	Results

MEDIA

Please estimate your use of media (anything with a screen).

Type of Media (TV, video games, computer, phone, iPad, etc)	**Frequency** (Hours per day or week)	**Reason** (Work, pleasure, relaxation, education, etc.)

COGNITIVE SYMPTOMS

Please indicate your current symptoms

	Dyslexia		Poor arithmetic calculation		Poor fine motor skills
	Poor word fluency		Indecisive		Poor spelling
	Poor ability to process		Poor visual spatial skills		Poor sense of direction
	Poor ability to plan		Poor sense of self in space		Poor tracking during reading
	Poor reading comprehension		Inability to write neatly		Poor memory
	Difficulty understanding words				

PAIN SYMPTOMS

Please indicate your current symptoms

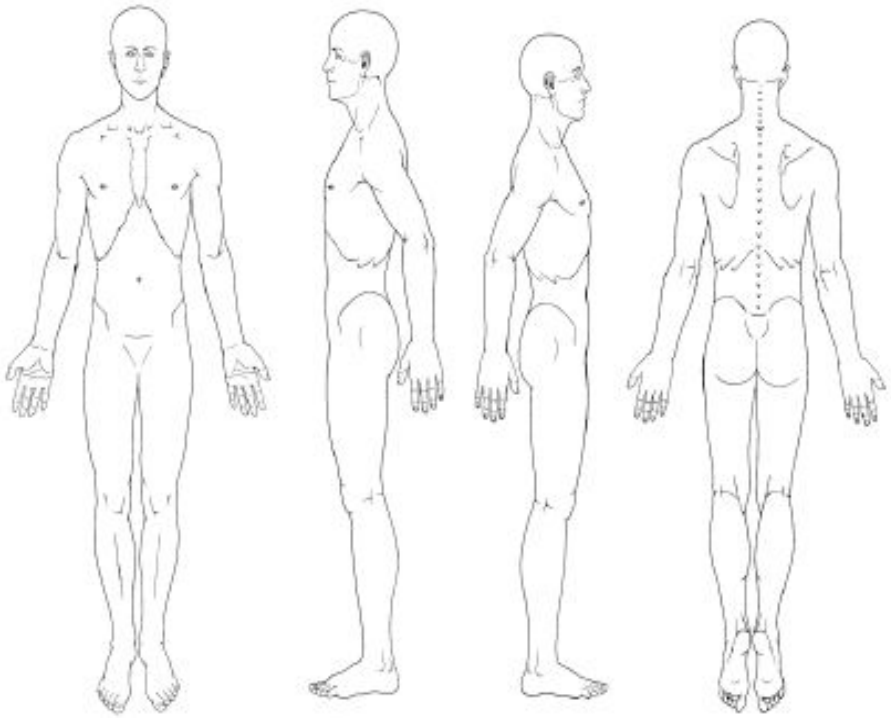
	Chronic pain with depression		Jaw tension		Sciatica pain
	Chronic aching pain		Chronic burning pain		High pain tolerance
	Tension headache		Chronic throbbing pain		Peripheral neuropathy pain
	Low pain tolerance		Chronic stabbing pain		Emotional reactivity to pain
	Fibromyalgia		Chronic shooting pain		Pain in the shoulders and neck
	Migraine				

IF YOU ARE EXPERIENCING PAIN, NUMBNESS, TINGLING, AND/OR BURNING SENSATIONS, THEN

PLEASE COMPLETE THE DIAGRAM BELOW

Please mark off the areas of your complaint on the diagram above with the following indicators:

PPP = pain
NNN = numbness
TTT= tingling
BBB= burning
CCC= cramping



WALSH PROTOCOL CHECKLIST

Check all that apply to you	Symptoms	Check all known to apply to relatives		Check all that apply to you	Symptoms	Check all known to apply to relatives	Clinician Notes:
	white spots on nails				delusions		
	under-achiever				delayed puberty		
	texture sensitive				dark urine		
	tantrums				chronic joint pains		
	strong willed				anxiety		
	stretch marks				"stitch in the side" pain		
	pre-mature gray				"night owl"		
	poor wound healing				ADD/ADHD		
	poor short term memory				ulcers		
	poor muscle tone				kidney disease		
	phobias and fears				diabetes		
	perfectionist				heart disease		
	panic				arthritits		
	pale skin/poor tanning				cancer		
	odor sensitive				dementia		
	obsessions				stroke		
	negative perspective				autism		
	mood swings				schizophrenia		
	menstrual irregularity				bipolar disorder		
	light sensitive				asthma		
	highly creative				sound sensitive		
	heart murmur				social isolation		
	hallucinations				skips breakfast		
	fruity breath odor				sensitive to loud noise		
	frequent nausea				ringing in the ears		
	frequent infections				reading disorder		
	dry mouth				psoriasis		
	depression/sadness				eczema		

Comments/Explanations: _____

_____

_____

Patient Name_____ Date _____

SELF REPORT SCALE

Please answer the questions below, rating yourself in each of the criteria shown using the scale on the right side of the page. As you answer each question, circle the correct number that best describes how you have felt and conducted yourself over the past 6 months.		**0 - Never 1 - Rarely 2 - Sometimes 3 - Often 4 - Very Often**				
1	How often do you make careless mistakes when you have to work on a boring or difficult project?	**0**	**1**	**2**	**3**	**4**
2	How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	**0**	**1**	**2**	**3**	**4**
3	How often do you have difficulty concentrating on what people say to you, even when they are speaking directly to you?	**0**	**1**	**2**	**3**	**4**
4	How often do you have difficulty wrapping up the final details of a project, once the challenging parts have been done?	**0**	**1**	**2**	**3**	**4**
5	How often do you have difficulty getting things in order when you have to do a task that requires organization?	**0**	**1**	**2**	**3**	**4**
6	When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	**0**	**1**	**2**	**3**	**4**
7	How often do you misplace or have difficulty finding things at home or work?	**0**	**1**	**2**	**3**	**4**
8	How often are you distracted by activity or noise around you?	**0**	**1**	**2**	**3**	**4**
9	How often do you have problems remembering appointments or obligations?	**0**	**1**	**2**	**3**	**4**
				PART A SCORE:		
10	How often do you fidget or squirm with your hands or feet when you have to sit for a long time?	**0**	**1**	**2**	**3**	**4**
11	How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	**0**	**1**	**2**	**3**	**4**
12	How often do you feel restless or fidgety?	**0**	**1**	**2**	**3**	**4**
13	How often do you have difficulty unwinding and relaxing when you have time to yourself?	**0**	**1**	**2**	**3**	**4**
14	How often do you feel overly active and compelled to do things, like you are driven by a motor?	**0**	**1**	**2**	**3**	**4**
15	How often do you find yourself talking too much in social situations?	**0**	**1**	**2**	**3**	**4**
16	When you are in a conversation, how often do you finish the sentences of people you are talking to?	**0**	**1**	**2**	**3**	**4**
17	How often do you have difficulty waiting your turn in situations when turn taking is required?	**0**	**1**	**2**	**3**	**4**
18	How often do you interrupt others when they are busy?	**0**	**1**	**2**	**3**	**4**

PART B SCORE:	
TOTAL SCORE:	

HISTORY

TRAUMA

Please list all traumatic events that have occurred in your life, including car accidents, major injuries, head injuries, abuse, loss (like the death of someone close to you), divorce, etc.

Date/Age	What happened?	Treatment / Recovery

ILLNESSES

Please list all illnesses you remember or have record of.

Date/Age	Type of Illness	Treatment / Recovery

SURGERIES and HOSPITALIZATIONS

Please list all surgeries and hospital stays.

Date/Age	Reason	Type of Surgery / Treatment	Recovery

HEAD INJURY QUESTIONAIRE

This questionnaire is designed to determine whether you have ever had a significant injury to your brain. Please read the questions carefully and think carefully about your history. It is common for people to forget

head injuries, car accidents, minor falls, etc. when they are not followed by a loss of consciousness or significant impairment.

Event	Yes	No	List Events and Dates	Low **Severity** High
Have you ever had an injury involving an impact to your head?			1.	1 2 3 4 5 6 7 8 9 10
			2.	1 2 3 4 5 6 7 8 9 10
			3.	1 2 3 4 5 6 7 8 9 10
			4.	1 2 3 4 5 6 7 8 9 10
			5.	1 2 3 4 5 6 7 8 9 10
			6.	1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s _____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____ _____	Length of time unconscious: _____ _____
Were you ever in a motor vehicle, skate board, skiing, bike or other accident?			1.	1 2 3 4 5 6 7 8 9 10
			2.	1 2 3 4 5 6 7 8 9 10
			3.	1 2 3 4 5 6 7 8 9 10
			4.	1 2 3 4 5 6 7 8 9 10
			5.	1 2 3 4 5 6 7 8 9 10
			6.	1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s _____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____ _____	Length of time unconscious: _____ _____
Were you told that you fell as a child (down stairs, off a table or chair, at a park?)			1.	1 2 3 4 5 6 7 8 9 10
			2.	1 2 3 4 5 6 7 8 9 10
			3.	1 2 3 4 5 6 7 8 9 10
			4.	1 2 3 4 5 6 7 8 9 10
			5.	1 2 3 4 5 6 7 8 9 10
			6.	1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above?			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____ _____	Length of time unconscious: _____ _____

Ever been in a fight, been beaten or attacked, passed out from alcohol?			1.	1 2 3 4 5 6 7 8 9 10
			2.	1 2 3 4 5 6 7 8 9 10
			3.	1 2 3 4 5 6 7 8 9 10
			4.	1 2 3 4 5 6 7 8 9 10
			5.	1 2 3 4 5 6 7 8 9 10
			6.	1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s _____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____ _____	Length of time unconscious: _____ _____
Symptoms persisting after event	**Yes**	**No**	**Describe ONLY <u>head injury related symptoms</u> - intensity, durations, affect on life tasks, i.e. work/school**	Low **Severity** High
Headache - tension and/or migraine				1 2 3 4 5 6 7 8 9 10
Tinnitus				1 2 3 4 5 6 7 8 9 10
Light headed				1 2 3 4 5 6 7 8 9 10
Impaired memory				1 2 3 4 5 6 7 8 9 10
Reduced attention span				1 2 3 4 5 6 7 8 9 10
Easily distractible				1 2 3 4 5 6 7 8 9 10
Impaired comprehension				1 2 3 4 5 6 7 8 9 10
Forgetful				1 2 3 4 5 6 7 8 9 10
Frustration				1 2 3 4 5 6 7 8 9 10
Problems with logical thinking				1 2 3 4 5 6 7 8 9 10
Trouble with abstract concepts				1 2 3 4 5 6 7 8 9 10
Anxiety				1 2 3 4 5 6 7 8 9 10
Depression				1 2 3 4 5 6 7 8 9 10
Insomnia				1 2 3 4 5 6 7 8 9 10
Apathy				1 2 3 4 5 6 7 8 9 10

Fatigue				1 2 3 4 5 6 7 8 9 10
Irritability				1 2 3 4 5 6 7 8 9 10
Angry outbursts				1 2 3 4 5 6 7 8 9 10
Mood swings				1 2 3 4 5 6 7 8 9 10
Hyper acute or diminished senses				1 2 3 4 5 6 7 8 9 10
Dizzy				1 2 3 4 5 6 7 8 9 10
Reduced libido				1 2 3 4 5 6 7 8 9 10
Intolerance for alcohol or caffeine				1 2 3 4 5 6 7 8 9 10
Reduced motivation				1 2 3 4 5 6 7 8 9 10

FAMILY HISTORY

Please enter as much information as you know.

	Mother (biological)	Father (biological)	Siblings
Still living?			
Age now or at time of death?			
Health conditions?			
Dominant personality traits?			
Parenting style?			N/A

VACCINATION HISTORY

Did you have full recommended vaccines as a child? Any extra vaccines, for travel perhaps?

CHILDHOOD ILLNESSES / CONDITIONS

Please mark any of the following that you had as a child.

	Ear Infections		Scoliosis		Seizures
	Asthma/Allergies		Digestive Problems		ADHD
	Colic		Bed Wetting		Car Accident
	Chronic Colds		Headaches		Temper Tantrums
	Recurring fevers		Growing Back Pains		

Describe or explain any of the above that have not already been listed.

CHILDHOOD MEDICATIONS

How many courses of antibiotics were taken during your childhood?

What other prescription medications were taken?

PRENATAL HISTORY

Answer as much as you know about your prenatal care and your birth.

Complications during pregnancy?	NO	YES	List:
Ultrasounds during pregnancy?	NO	YES	Number:
Medications during pregnancy/delivery?	NO	YES	List:
Cigarette/Alcohol use during pregnancy?	NO	YES	
Location of Birth (circle)	Hospital Birthing Center Home		
Birth Intervention (circle)	Forceps Vacuum Extraction Planned Ceasarian Emergency Ceasarian		
Complications during delivery?	NO	YES	List:
Genetic disorders or disabilities?	NO	YES	List:
Birth Weight:	Birth Length:		APGAR scores:
Breast fed:	NO	YES	How long?
Formula fed:	NO	YES	How long?
Introduced to solids at _____ months.			Introduced to cows milk at _____ months.
Childhood allergies to food or juice?	NO	YES	List:

DEVELOPMENTAL HISTORY

At what age did you?

Age:		Age:		Age:	
	Respond to sound		Sit up		Stand alone
	Respond to visual stimuli		Cross crawl		Walk alone
	Hold head up				

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, stairs, etc.) Was this the case for you?

Did you play any high-impact or contact type sports (soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? If yes, please list.

CHILDHOOD DISEASES

For each disease listed below please respond with an X if you never had it, or the age at which you had it.

Age:		Age:		Age:	
	Chicken Pox		Rubeola		Whooping Cough
	Rubella		Mumps		Other: _____

Please use the space below to add any additional information that may be relevant to your care.