



Body Wisdom Center for Healing

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Welcome! We are excited you are taking steps to improve your health and well-being by visiting our office. Please take a moment to review the enclosed materials. Here you will find information about the type of care we provide. We have also included a map to our office. Please complete the health history and treatment consent forms and bring them with you on your first visit.

The approach we take in our office is to gently, yet powerfully, assist your body's own innate healing powers. We are very excited about the great results we get with many problem cases that other practitioners have not been able to help. We have put together a system of care that will help you create breakthroughs in your health, energy, and well-being.

- Not only do we address the spine and nervous system in order to increase the vital life force that allows your body to heal itself from within,
- But we also work to detoxify and balance your body's chemistry using natural remedies that safely activate your body's defenses to naturally heal, repair, strengthen, and prevent future illness.
- Plus, we determine if your body is missing any essential nutrients and we will work together to correct any nutritional deficiencies.
- Then, we employ a very powerful technique that releases damaging emotional stress and tension which is harmful not only to the subconscious mind, heart and soul of a person, but to the body as well.

We are attacking your health problems not only on one level, but on 4 levels at the same time, which no other system does. When a person needs this particular system of care, then their condition will likely not get solved any other way. You are not just getting one treatment, but 4 treatments combined and that is why we get such fantastic results. You can rest assured you are stepping into something that will completely and forever change how you view health and wellness.

Our goal at Body Wisdom Center for Healing is to assist you throughout your path of healing. To further support you in receiving the most out of your visits, we offer a few suggestions:

1. Wear loose comfortable, cotton clothing.
2. Please do not wear nylons or clothing made of spandex.
3. Out of respect for those clients who are environmentally sensitive, we ask that you refrain from wearing strong smelling perfume, aftershave or hair products during your visit.

Again, thank you for taking this wonderful step towards your improved health and wellness.

Yours in health,

Ray H. Gin, D.C.  
Director, Body Wisdom Center for Healing



**About You (Confidential)**

Name \_\_\_\_\_ Address \_\_\_\_\_ Today's Date \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home# \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_ Fax# \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Email \_\_\_\_\_  
 Drivers License # \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Birth date \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Single  Married  Divorced  Widowed  Separated   
 or Legal Guardian \_\_\_\_\_ Address \_\_\_\_\_  
 Occupation \_\_\_\_\_ Cell# \_\_\_\_\_ Home# \_\_\_\_\_  
 Spouses Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_  
 # of children \_\_\_\_\_ At home \_\_\_\_\_  
**Whom may we thank for referring you to our office?** \_\_\_\_\_

**Responsible Party (If other than yourself)**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Home # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Method of payment: Cash  Insurance  WorkComp  Personal Injury

**Present Chief Complaint**

What is your primary reason for your visit today? \_\_\_\_\_

**Other health goals** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

When did your problem begin?  Job Injury/Date \_\_\_\_\_  AutoAcc./Date \_\_\_\_\_  Other/Date \_\_\_\_\_

Explain how \_\_\_\_\_

Have you had this problem previously?  Yes  No When? \_\_\_\_\_

Have you been given a named diagnosis for your condition? Yes  No  Name \_\_\_\_\_

Treated by 1. D.C. \_\_\_\_\_ 2. M.D. \_\_\_\_\_ 3. P.T. \_\_\_\_\_  
 4. Acupuncture \_\_\_\_\_ 5. Others \_\_\_\_\_

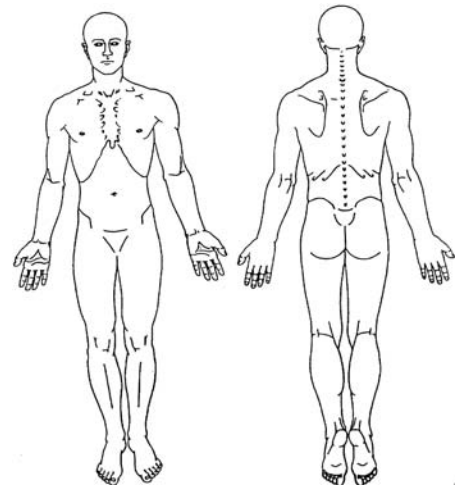
(circle the pain severity level)

**Pain Severity Level** 0 1 2 3 4 5 6 7 8 9 10  
 None Mild Moderate Severe

**Please draw your areas of pain**

Check P- Prior or C - Currently

P	C	Habits/Exercise
		Smoking
		Alcohol
		Coffee
		Chocolate
		Drugs
		Stretching/Yoga
		Weights
		Cardio Exercise
		Prayer/Meditation



**We will review your findings during your second visit,  
therefore we recommend bringing your spouse to the visit.**

**Affects on Lifestyle** (check all that apply)

- |  |  |   |
|--|--|---|
| <b>You</b> <input type="checkbox"/> Interrupted sleep    | <b>Work</b> <input type="checkbox"/> Not as productive | <b>Family</b> <input type="checkbox"/> Losing patience w/Spouse |
| <input type="checkbox"/> Moody                           | <input type="checkbox"/> Hinders decisions             | <input type="checkbox"/> Losing patience w/Kids                 |
| <input type="checkbox"/> Uncomfortable/Nervousness       | <input type="checkbox"/> Poorer attitude               | <input type="checkbox"/> Hinders household activities           |
| <input type="checkbox"/> Hinders recreational activities | <input type="checkbox"/> Can't work long hours         | <input type="checkbox"/> Poorer attitude                        |
| <input type="checkbox"/> Trouble falling asleep          | <input type="checkbox"/> Other _____                   | <input type="checkbox"/> Other _____                            |
| <input type="checkbox"/> Irritable                       | _____  | _____   |
| <input type="checkbox"/> Anxiety                         | _____  | _____   |

What vitamins, minerals or herbs do you take? \_\_\_\_\_

List current medications, prescribed or not, used to treat your injury/pain? \_\_\_\_\_

List all other medications \_\_\_\_\_

**Past Medical Injuries**

List any significant injuries, surgeries, fractures hospitalizations, major dental work, medical condition	When	Length of treatment?	By Whom	Treatment
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Family History**

Check **Y** if you have had. Check **F** if a family member has had.

<input type="checkbox"/> Allergy	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Polio	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Anemia	<input type="checkbox"/> Eczema	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gout	<input type="checkbox"/> Measles	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease/Attack	<input type="checkbox"/> Migraines	<input type="checkbox"/> Small Pox	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Influenza	<input type="checkbox"/> Mumps	<input type="checkbox"/> Spinal Disorders	_____

*Our mission is to make every effort to do whatever is necessary so that everyone we come in contact with has the opportunity to have their nerve system checked, cared for, and to receive preventative nerve system care so they may live the longest, healthiest and most active lifestyle possible. Everyone deserves chiropractic and mind/body medicine.*

**PLEASE READ AND SIGN BELOW**

**OFFICE POLICIES:**

1. **Please be on time for your appointment.** Being late or last minute cancellations will cause severe scheduling disruptions which can interfere with the quality of care you and other patients receive.
2. **Please do not wear strong perfume or colognes.** We see many patients with allergies or respiratory problems. Strong scents can impair their progress.
3. Continued cancellations or missed appointments may result in being released from care. If you need to reschedule, please call at least 24 hours prior to your scheduled appointment.
4. If you need to spend extra time discussing your health concerns with your doctor, please let our staff know, so we may schedule your next appointment accordingly.

**FINANCIAL AGREEMENT:**

- 1) We accept the following forms of payment: Cash, Personal checks, Visa, and Master card.
- 2) Payment is expected at the time of the visit.
- 3) We will bill primary insurance company for the Initial Intensive Care as courtesy to you.
- 4) The patient is always responsible for the payment of their care. An insurance contract is between the patient and the insurance company.
- 5) **Insurance coverage is never guaranteed.** If there are any problems between the insurance company and the patient, the latter may file a grievance directly with their insurance company. The signature below allocates assignment to this office for collection of benefits and also authorizes this office to release daily chart notes when necessary for the processing claims.
- 6) The office manager may approve account balances. Active monthly payments are required. Accounts with balances 30 days past due may be charged a service fee of 12% per year compounded monthly.
- 7) Any account where no payment has been received for sixty days may be sent to a third party collection agency. Any additional collection fees will be the responsibility of the patient. NSF checks or rejected credit card payments will be charged a service fee of \$25 per occurrence.
- 8) **We do offer a time of service discount** when services are paid in full at the time of the visit.
- 9) **There is a \$35.00 charge for missed appointments** (cancellation must be received 24 hours before appointment)
- 10) Please feel free to ask us any financial questions you may have. Our intent is to provide you with the highest level of service as well as care.
- 11) Your insurance company determines benefits when they receive our billings. Any statements made by our staff regarding you coverage in no way or guarantees that your care will be covered by your insurance company and you will be responsible for your account regardless of insurance.
- 12) **Non Assignment of Benefits:** Certain Insurance companies (eg., Anthem Blue Cross and Blue Shield ) will not assign benefits directly to us. Some companies will pay you directly instead of paying our office. You accept the responsibility of reimbursing to us in full what was paid out to you.

**Body Wisdom Center for Healing... Where You Matter!**

By signing below, I acknowledge that I understand the policies as contained herein.

Patient or guardian: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# Metabolic Assessment Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

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

<b>Category I</b>			
Feeling that bowels do not empty completely . . . . .	0	1	2 3
Lower abdominal pain relief 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 of “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
<b>Category II</b>			
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 movements . . . . .	0	1	2 3
Sense of fullness during and after meals . . . . .	0	1	2 3
Difficulty digesting fruits and vegetables; undigested foods found in stools . . . . .	0	1	2 3
<b>Category III</b>			
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 from antacids, food, milk, 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
<b>Category IV</b>			
Roughage and fiber cause constipation . . . . .	0	1	2 3
Indigestion and fullness lasts 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
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
Difficulty losing weight . . . . .	0	1	2 3

<b>Category V</b>			
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
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	
<b>Category VI</b>			
Crave sweets during the day . . . . .	0	1	2 3
Irritable if meals are missed . . . . .	0	1	2 3
Depend on coffee to keep yourself going or started . .	0	1	2 3
Get lightheaded 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
<b>Category VII</b>			
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
<b>Category VIII</b>			
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

<b>Category IX</b>				
Cannot fall asleep . . . . .	0	1	2	3
Perspire easily . . . . .	0	1	2	3
Under high amounts 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
<b>Category X</b>				
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 gain 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 falling hair . . . . .	0	1	2	3
Dryness of skin and/or scalp . . . . .	0	1	2	3
Mental sluggishness . . . . .	0	1	2	3
<b>Category XI</b>				
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
<b>Category XII</b>				
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
<b>Category XIII</b>				
Increased sex drive . . . . .	0	1	2	3
Tolerance to sugars reduced . . . . .	0	1	2	3
“Splitting” type headaches . . . . .	0	1	2	3

<b>Category XIV (Males only)</b>				
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 evacuation . . . . .	0	1	2	3
Leg nervousness at night . . . . .	0	1	2	3
<b>Category XV (Males only)</b>				
Decrease in libido . . . . .	0	1	2	3
Decrease in spontaneous morning erections . . . . .	0	1	2	3
Decrease in fullness of erections . . . . .	0	1	2	3
Difficulty in maintain 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
Decrease in 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
<b>Category XVI (Menstruating Females Only)</b>				
Are you perimenopausal . . . . .	Yes	No		
Alternating menstrual cycle lengths . . . . .	Yes	No		
Extended menstrual cycle, greater than 32 days . . . . .	Yes	No		
Shortened menses, less than every 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 breakouts . . . . .	0	1	2	3
Facial hair growth . . . . .	0	1	2	3
Hair loss/thinning . . . . .	0	1	2	3
<b>Category XVII (Menopausal Females Only)</b>				
How many years have you been menopausal?				
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

How many alcoholic beverages do you consume per week? \_\_\_\_\_

How many times do you eat out per week? \_\_\_\_\_

How many times a week do you eat fish? \_\_\_\_\_

List the three worst foods you eat during the average week: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

List the three healthiest foods you eat during the average week: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If yes, how many times a day: \_\_\_\_\_

Rate your stress levels on a scale of 1-10 during the average week: \_\_\_\_\_

**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
- Are you getting regular exercise? 0 1 2 3
- Do you think people don't care about you? 0 1 2 3
- Do you feel you are not accomplishing your life's purpose? 0 1 2 3
- Do you have no one to share your problems with? 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.

# Medication History

Please circle any of the following medication you have been or are currently taking.

## Acetylcholine Receptor Antagonist – Antimuscarinic Agents

Atropine, Ipratropium, Scopolamine, Tiotropium

## Acetylcholine Receptor Antagonist - Ganglionic Blockers

Mecamylamine, Hexamethonium, Nicotine (high doses), Trimethaphan

## Acetylcholinesterase Reactivators

Pralidoxime

## Acetylcholine Receptor Antagonist - Neuromuscular Blockers

Atracurium, Cisatracurium, Doxacurium, Metocurine, Mivacurium, Pancuronium, Rocuronium, Uccinylcholine, Tubocurarine, Vecuronium, Hemicholine

## Agonist Modulator of GABA Receptor (benzodiazepines)

Xanax, Lexotanil, Lexotan, Librium, Klonopin, Valium, ProSom, Rohypnol, Dalmane, Ativan, Loramet, Sedoxil, Dormicum, Megadon, Serax, Restoril, Halcion

## Agonist Modulator of GABA Receptors (nonbenzodiazepines)

Ambien, Sonata, Lunesta, Imovane

## Cholinesterase Inhibitors (irreversible)

Echotiophate, Isoflurophate, Organophosphate Insecticides, Organophosphate-containing nerve agents

## Cholinesterase Inhibitors (reversible)

Donepezil, Galatamine, Rivastigmine, Tacrine, THC, Erophonium, Neostigmine, Phystigimine, Pyridostigmine, Carbamate Insecticides

## Dopamine Reuptake Inhibitors

Wellbutrin (Bupropion)

## Dopamine Receptor Agonists

Mirapex, Sifrol, Requip

## D2 Dopamine Receptor Blockers (antipsychotics)

Thorazine, Prolixin, Trilafon, Compazine, Mellaril, Stelazine, Vesprin, Nozinan, Depixol, Navane, Iuanxol, Clopixol, Acuphase, Haldol, Orap, Clozaril, Zyprexa, Zydis, Seroquel, Geodon, Solian, Invega, Abilify

## GABA Antagonist Competitive binder

Flumazenil

## Monoamine Oxidase Inhibitor (MAOI)

Marplan, Aurorix, Maneric, Moclodura, Nardil, Adlegiine, Elepryl, Azilect, Marsilid, Iprozid, Ipronid, Rivivol, Popilniazida, Zyvox, Zyvoxid

## Noradrenergic and Specific Serotonergic Antidepressants (NaSSa)

Remeron, Zispin, Avanza, Norset, Remergil, Axit

## Selective Serotonin Reuptake Inhibitor

Paxil, Zoloft, Prozac, Celexa, Lexapro, Luvox, Cipramil, Emocal, Serpam, Seropram, Ciprallex, Esteria, Fontex, Seromex, Seronil, Sarafem, Fluctin, Faverin, Seroxat, Aropax, Deroxat, Rexetin, Xentor, Paroxat, Lustral, Serlain, Dapoxetine

## Selective Serotonin Reuptake Enhancers

Stablon, Coaxil, Tatinol

## Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

Effexor, Pristiq, Meridia, Serzone, Dalcipran, Despramine, Duloxetine

## Tricyclic Antidepressants (TCAs)

Elavil, Endep, Tryptanol, Trepiline, Asendin, Asendis, Defanyl, Demolox, Moxadil, Anafranil, Norpramin, Pertofrane, Prothiadin, Thanden, Adapin, Sinequan, Trofranil, Janamine, Gamanil, Aventyl, Pamelor, Opipramol, Vivactil, Rhotrimine, Surmontil



**Body Wisdom Center for Healing**

**23232 Peralta Drive, Suite 205  
Laguna Hills, CA 92653  
949-458-6728**

From the North:

Take the 5 or 405 Southbound. Get off at Lake Forest Drive. Make a right onto Lake Forest Drive. Take a left at Del Lago. Take a left at La Cadena. Continue until this veers right into Peralta Drive (we're at the corner of Peralta and South Pointe Dr.)

From the South:

Take the 5 Northbound. Get off at Lake Forest Drive. Make a left onto Lake Forest Drive. Take a left at Del Lago. Take a left at La Cadena. Continue until this veers right into Peralta Drive (we're at the corner of Peralta and South Pointe Dr.)

From the West:

Go east on Lake Forest Drive. Take a right at Del Lago. Take a left at La Cadena. Continue until this veers right into Peralta Drive (we're at the corner of Peralta and South Pointe Dr.)

From the East:

Go west on Lake Forest Drive. Take a left at Del Lago. Take a left at La Cadena. Continue until this veers right into Peralta Drive (we're at the corner of Peralta and South Pointe Dr.)

