

Case History/Patient Information

Date: _____ Patient # _____ Doctor: _____
Name: _____ Social Security # _____ Home Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail address: _____ Fax # _____ Cell Phone: _____
Age: _____ Birth Date: _____ Race: _____ Marital: M S W D Cell Phone Carrier: _____
Occupation: _____ Employer: _____
Employer's Address: _____ Office Phone: _____
Spouse: _____ Occupation: _____ Employer: _____
How many children? _____ Names and Ages of Children: _____

Name of Nearest Relative: _____ Address: _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

Please check any and all insurance coverage that may be applicable in this case:

Major Medical Worker's Compensation Medicaid Medicare Auto Accident
 Medical Savings Account & Flex Plans Other

Name of Primary Insurance Company: _____
Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. *I understand, if turned over to Collections I will be charged an 40% collections fee.*

It is understood and agreed the amount paid to Spine & Sports Wellness Clinic for x-ray, is for examination only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

Patient's Signature: _____

Date: _____

Guardian's Signature Authorizing Care: _____

Date: _____

PATIENT NAME _____

DATE _____

Doctor _____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment: _____

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

1 no pain or discomfort	2 slight discomfort	3 Pain that does not affect my daily activity.	4 Pain that affects my daily activities	5 Pain that prevents performing my daily activities	6 Pain that limits my work schedule	7 Pain that prevents working at all	8 pain that prevents working all personal activity.	9 Pain that keeps me bed ridden.	10 Pain that causes thoughts of suicide.
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Date symptoms appeared or accident happened: _____

Is this due to: Auto ___ Work ___ Other _____

Have you ever had the same or a similar condition? Yes No If yes, when and describe: _____

Days lost from work: _____ Date of last physical examination: _____

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? Yes No

If yes, describe: _____

Do you have any allergies of any kind? Yes No

If yes, describe: _____

Do you have any Congenital Condition? ___ Yes ___ No If YES, Describe _____

Women: Are you pregnant? _____

Women: What was the date of last menstrual cycle? _____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

	N = Now	P = Previously	
Headaches _____ Frequency _____	_____		Loss of Balance _____
Neck Pain _____	_____		Fainting _____
Stiff Neck _____	_____		Loss of Smell _____
Sleeping Problems _____	_____		Loss of Taste _____
Back Pain _____	_____		Unusual Bowel Patterns _____
Nervousness _____	_____		Feet Cold _____
Tension _____	_____		Hands Cold _____
Irritability _____	_____		Arthritis _____
Chest Pains/Tightness _____	_____		Muscle Spasms _____
Dizziness _____	_____		Frequent Colds _____
Shoulder/Neck/Arm Pain _____	_____		Fever _____
Numbness in Fingers _____	_____		Sinus Problems _____
Numbness in Toes _____	_____		Diabetes _____
High Blood Pressure _____	_____		Indigestion Problems _____
Difficulty Urinating _____	_____		Joint Pain/Swelling _____
Weakness in Extremities _____	_____		Menstrual Difficulties _____
Breathing Problems _____	_____		Weight Loss/Gain _____
Fatigue _____	_____		Depression _____
Lights Bother Eyes _____	_____		Loss of Memory _____
Ears Ring _____	_____		Buzzing in Ears _____
Broken Bones/Fractures _____	_____		Circulation Problems _____
Rheumatoid Arthritis _____	_____		Seizures/Epilepsy _____
Excessive Bleeding _____	_____		Low Blood Pressure _____
Osteoarthritis _____	_____		Osteoporosis _____
Pacemaker _____	_____		Heart Disease _____
Stroke _____	_____		Cancer _____
Ruptures _____	_____		Coughing Blood _____
Eating Disorder _____	_____		Alcoholism _____
Drug Addiction _____	_____		HIV Positive _____
Gall Bladder Problems _____	_____		Depression _____
Ulcers _____	_____		

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:

OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise	_____ Family Pressures
_____ Moderate Exercise	_____ Financial Pressures
_____ Alcohol Use	_____ Other Mental Stresses
_____ Drug Use	_____ Other (specify)_____
_____ Tobacco Use	_____
_____ Caffeine	_____
_____ High Stress Activity	

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTERS		CHILDREN	
	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []
Arthritis									
Asthma-Hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problem									
Emphysema									
Epilepsy									
Headaches									
Heart Trouble									
HighBlood Pressure									
Insomnia									
Kidney Trouble									
Liver Trouble									
Migraine									
Nervousness									
Neuritis									
Neuralgia									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Stomach Trouble									
Other:									

If any of the above family members are deceased, please list their age at death and cause:

DOCTOR _____

DATE OF VISIT ___/___/20___ Patient _____ Age _____

Check ONE: INITIAL EXAMINATION RE-EVALUATION NEW CONDITION

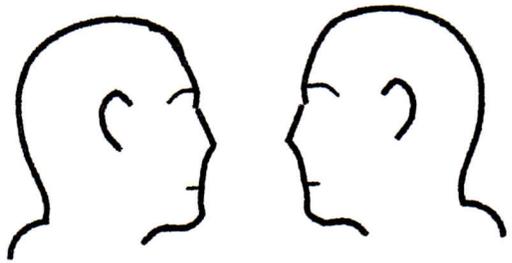
FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms _____

FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? _____

SUBJECTIVE PAIN ASSESSMENT

RATE YOUR PAIN

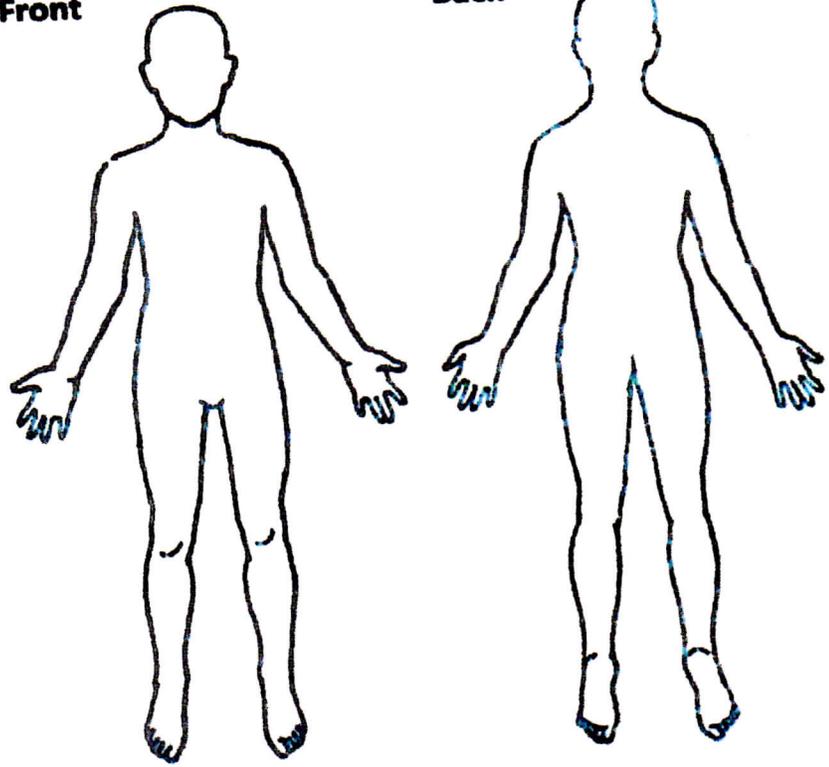
Right Left



Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

Front

Back



- A=Ache
- B=Burning
- ST=Stabbing
- SP=Spasm
- N=Numbness
- P=Pins and Needles
- T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

DATE

(BACK)

Oswestry Disability Index

Section 1 – Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

- I can look after myself normally but it is very painful.
- I can look after myself normally but it is very painful.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

Section 4 – Walking

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than 1 mile.
- Pain prevents me walking more than ¼ of a mile.
- Pain prevents me walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6 – Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than ½ an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 – Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain, I have less than 6 hours sleep.
- Because of pain, I have less than 4 hours sleep.
- Because of pain, I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

Section 9 – Social Life

- My social life is normal and cause me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

Section 10 – Traveling

- I can travel anywhere without pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys of over two hours.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- No
- Yes (if yes, please state the type of treatment you have received)

Date:

Patient Signature

Date:

Doctor Signature

Neck Disability Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- I have no pain at the moment. (0)
- The pain is very mild at the moment. (1)
- The pain is moderate at the moment. (2)
- The pain is fairly severe at the moment. (3)
- The pain is very severe at the moment. (4)
- The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain. (0)
- I can look after myself normally but it causes extra pain. (1)
- It is painful to look after myself and I am slow and careful. (2)
- I need some help but manage most of my personal care. (3)
- I need help every day in most aspects of self care. (4)
- I do not get dressed, I wash with difficulty and stay in bed. (5)

Section 3 – Lifting

- I can lift heavy weights without extra pain. (0)
- I can lift heavy weights but it gives extra pain. (1)
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- I can lift very light weights. (4)
- I cannot lift or carry anything at all. (5)

Section 4 – Reading

- I can read as much as I want to with no pain in my neck. (0)
- I can read as much as I want to with slight pain in my neck. (1)
- I can read as much as I want with moderate pain in my neck. (2)
- I cannot read as much as I want because of moderate pain in my neck. (3)
- I can hardly read at all because of severe pain in my neck. (4)
- I cannot read at all. (5)

Section 5 – Headaches

- I have no headaches at all. (0)
- I have slight headaches that come infrequently. (1)
- I have moderate headaches which come infrequently. (2)
- I have moderate headaches which come frequently. (3)
- I have severe headaches which come frequently. (4)
- I have headaches almost all the time. (5)

Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty. (0)
- I can concentrate fully when I want to with slight difficulty. (1)
- I have a fair degree of difficulty in concentrating when I want to. (2)
- I have a lot of difficulty in concentrating when I want to. (3)
- I have a great deal of difficulty in concentrating when I want to. (4)
- I cannot concentrate at all. (5)

Section 7 – Work

- I can do as much work as I want to. (0)
- I can do my usual work, but no more. (1)
- I can do most of my usual work, but no more. (2)
- I cannot do my usual work. (3)
- I can hardly do any work at all. (4)
- I cannot do any work at all. (5)

Section 8 – Driving

- I can drive my car without any neck pain. (0)
- I can drive my car as long as I want with slight pain in my neck. (1)
- I can drive my car as long as I want with moderate pain in my neck. (2)
- I cannot drive my car as long as I want because of moderate pain in my neck. (3)
- I can hardly drive at all because of severe pain in my neck. (4)
- I cannot drive my car at all. (5)

Section 9 – Sleeping

- I have no trouble sleeping. (0)
- My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- My sleep is mildly disturbed (1-2 hours sleepless). (2)
- My sleep is moderately disturbed (2-3 hours sleepless). (3)
- My sleep is greatly disturbed (3-5 hours sleepless). (4)
- My sleep is completely disturbed (5-7 hours sleepless). (5)

Section 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all. (0)
- I am able to engage in all my recreation activities, with some pain in my neck. (1)
- I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- I can hardly do any recreation activities because of pain in my neck. (4)
- I cannot do any recreation activities at all. (5)

0-4 **No disability**
5-14 **Mild disability**
15-24 **Moderate disability**
25-34 **Severe disability**
> 35 **Complete disability**

_____ Date _____

_____ patient signature _____

_____ Date _____

_____ Doctor signature _____



SPINE & SPORTS

WELLNESS CLINIC

WHERE WELLNESS IS A WAY OF LIFE

3501 Soncy Suite # 1
Amarillo, TX 79119

Dr. Michael Vennell D.C. PA

(806) 356-7291

New Patient Intake Form

Informed Consent for Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, decompression and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician at Spine and Sports Wellness Clinic and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Michael Vennell and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in the best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask question about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

To be completed by the patient's representative, if necessary (e.g. if the patient is a minor or is physically or mentally incapacitated)

Print Patient's Name

Print Name of Representative

Signature of Patient

Signature of Representative

_____/_____/_____
Date

_____/_____/_____
Date

Physician Signature _____ Date _____/_____/_____

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 movements	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 of 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 (Cont.)			
Nausea and/or vomiting	0	1	2 3
Stool undigested, foul smelling, mucus 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



Brain Region Localization Form

INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please answer every question, do not skip any questions. Follow the 0 to 4 key, and select which best fits for all of your answers.

Par Inf Lob (Area 39 and 40)		0	1	2	3	4
32.	Right/left confusion					
33.	Difficulty with math calculations <input type="checkbox"/> L					
34.	Difficulty finding words					
35.	Difficulty with writing <input type="checkbox"/> L					
36.	Difficulty recognizing symbols or shapes					
37.	Difficulty with simple drawings <input type="checkbox"/> R					
38.	Difficulty interpreting maps					
Temp Lobe Aud Cortex (Areas 41, 42)		0	1	2	3	4
39.	Reduced function in overall hearing					
40.	Difficulty interpreting speech with background or scatter noise					
41.	Difficulty comprehending language without perfect pronunciation					
42.	Need to look at someone's mouth when they are speaking to understand what they are saying					
43.	Difficulty in localizing sound					
44.	Dislike of left predictable rhythmic, repeated tempo and beat music <input type="checkbox"/> L					
45.	Dislike of non-predictable rhythmic with multiple instruments					
46.	Noticeable ear preference when using your phone	right, left, no preference				
Temp Lobe Aud Asso Cortex (Area 22)		0	1	2	3	4
47.	Difficulty comprehending meaning of spoken word <input type="checkbox"/> L					
48.	Tend toward monotone speech without fluctuations or emotions					

KEY:

- 0 = I never have symptoms (0% of the time)
- 1 = I rarely have symptoms (Less than 25% of the time)
- 2 = I often have symptoms (Half of the time)
- 3 = I frequently have symptoms (75% of the time)
- 4 = I always have symptoms (100% of the time)

Med Temp lobe and Hipp		0	1	2	3	4
49.	Memory less efficient					
50.	Memory loss that impacts daily activities					
51.	Confusion about dates, the passage of time, or place					
52.	Difficulty remembering events					
53.	Misplacement of things and difficulty retracing steps					
54.	Difficulty with memory of locations (addresses) <input type="checkbox"/> R					
55.	Difficulty with visual memory					
56.	Always forgetting where you put items such as keys, wallet, phone, etc. <input type="checkbox"/> R					
57.	Difficulty remembering faces					
58.	Difficulty remembering names with faces <input type="checkbox"/> L					
59.	Difficulty with remembering words					
60.	Difficulty remembering numbers					
61.	Difficulty remembering to stay or be on time					
Occ Lobe (Area 17, 18, and 19)		0	1	2	3	4
62.	Difficulty in discriminating similar shades of color					
63.	Dullness of colors in visual field					
64.	Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach out for objects					
66.	Floater or halos in visual field					



Brain Region Localization Form

INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please answer every question, do not skip any questions. Follow the 0 to 4 key, and select which best fits for all of your answers.

0 = I never have symptoms (0% of the time)
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 4 = I always have symptoms (100% of the time)

Cerebellum – Spinocerebellum		0	1	2	3	4
67.	Difficulty with balance, or balance that is worse on one side					
68.	A need to hold the handrail or watch each step carefully when going down stairs					
69.	Feeling unsteady and prone to falling in the dark					
70.	Proness to sway to one side when walking or standing					
Cerebellum - Cerebrocerebellum		0	1	2	3	4
71.	Recent clumsiness in hands					
72.	Recent clumsiness in feet or frequent tripping					
73.	A slight hand shake when reaching for something at the end of movement					
Cerebellum - Vestibulocerebellum		0	1	2	3	4
74.	Episodes of dizziness or disorientation					
75.	Back muscles that tire quickly when standing or walking					
76.	Chronic neck or back muscle tightness					
77.	Nausea, car sickness, or sea sickness					
78.	Feeling of disorientation or shifting of the environment					
79.	Crowded places cause anxiety					
Bas Gang Dir Path		0	1	2	3	4
80.	Slowness in movements					
81.	Stiffness in your muscles (not joints) that goes away when you move					

82.	Cramping of hands when writing					
83.	A stooped posture when walking					
84.	Voice has become softer					
85.	Facial expression changed leading people to frequently ask if you are upset or angry					
Bas Gang Ind Path		0	1	2	3	4
86.	Uncontrollable muscle movements					
87.	Intense need to clear your throat regularly or contract a group of muscles					
88.	Obsessive compulsive tendencies					
89.	Constant nervousness and restless mind					
Auto Red Parasymp Act		0	1	2	3	4
90.	Dry mouth or eyes					
91.	Difficulty swallowing supplements or large bites of food					
92.	Slow bowel movements and tendency for constipation					
93.	Chronic digestive complaints					
94.	Bowel or bladder incontinence resulting in staining your underwear					
Auto Inc Symp Act		0	1	2	3	4
95.	Tendency for anxiety					
96.	Easily startled					
97.	Difficulty relaxing					
98.	Sensitive to bright or flashing lights					
99.	Episodes of racing heart					
100.	Difficulty sleeping					



Brain Region Localization Form

INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please select yes or no.

Epileptiform Activity	Yes / No
Have you ever been diagnosed with a seizure disorder?	Yes / No
Have you ever been diagnosed with epilepsy?	Yes / No
Have you ever been told that you seemed frozen, absent, or tuned out at times without any recollection of the event?	Yes / No
Have you ever experienced sudden muscle stiffness and rigidity throughout your body?	Yes / No
Have you ever experienced sudden muscle jerks throughout your body?	Yes / No
Have you ever experienced a total loss of your muscle tone that lead to loss of control of your muscles or a fall?	Yes / No
Have you ever been told that you stare into space while you're lip smacking, chewing, or fidgeting that you are not aware of?	Yes / No
Do you ever experience sudden emotional responses such as anxiety, sadness, cry, or laugh for no real reason?	Yes / No
Do you ever experience sudden racing heart rate, sudden loss of bladder function, intestinal spasm, respiration, sweating, or any other sudden changes of function?	Yes / No
Do you ever experience sudden involuntary muscle contractures or jerks in any individual parts of your limbs or face?	Yes / No
Do you ever experience sudden involuntary head rotation and your eyes move forcefully to one side?	Yes / No
Do you ever experience sudden involuntary shift in your eyes to the side or upwards?	Yes / No
Do you ever experience sudden vocalization of random words or notice a sudden inability to speak?	Yes / No
Do you ever experience any spontaneous sensations of tingling, pins and needles" numbness, coldness, burning or other random sensations in any region of your body?	Yes / No
Do you ever experience a ringing sensation in your ears (tinnitus), sounds, or voices spontaneously?	Yes / No
Do you ever experience spontaneous perception of smells such as burning rubber, foul smells, or other odors without finding the source of the odor?	Yes / No
Do you ever experience flashing lights, stars, or jagged lines in your visual field?	Yes / No

SIGNATURE:

DATE: