
# Imagine Perfect Health.....

*Congratulations on taking your first step toward Reclaiming your health, your youth and your life.*

*I personally want to commend you on moving forward and taking responsibility for your most valuable asset...Your health and well-being. You are preparing to not only make a difference in your life, but many others around you that love you and depend on you.*

*If you qualify for my "Life Restoration" program, you can be rest assured that you will be treated as one of Our most valuable assets; Our Patients!*

*Prepare for a life changing experience that will empower you to take charge of your health and live the abundant life you were destined to live!*

*Warm regards,*

*Dr. Jay Goodbinder, DC DABCI*

# 10 Common Objections to Creating a Healthy, Abundant Life.

- **I don't have the personal knowledge to make the correct lifestyle choices.**
  - You have the power to choose to learn. If you are open to learning, our personal mentoring program will guide you along an easy to follow path. Our programs our structured in a manner that gives each and every patient the information needed to bring independence to their life. You do have the choice to avoid the all too common dependency of a care-giver or assisted living environment.

- **I don't have the time to take appropriate care of myself.**
  - We all live in a world that gives each of us 24 hours /day. What we do with that time is a personal decision based on values (real or perceived). If you do not take time to care for yourself, you will have to take time to try and repair yourself. Pro-activity and maintenance are required for optimized health. It takes no more time to eat correctly than poorly. Proper exercise requires no more than approximately 35 minutes 3-4 times / week. If you're honest with yourself, you recognize it really is based on what you judge as a valuable use of your time. Hum? TV, or a thriving, abundant life.

- **My family won't be on board with the changes I need to make.**
  - I recognize this sounds like a silly thought, but also realize it is a real concern for some. You would certainly think that all family members would be on board, however, in infrequent situations a spouse or family member may be negative toward your new enthusiasm. This usually comes down to a lack of understanding of what your lifestyle program entails, as well as some distrust of whether this approach will really work.
    It may help to steer these family members to our site, www.drgoodbinder.com, and view some of the incredible testimonials from our patients. Without taking the time to learn about our programs and proven success it is only human nature to be cautious. Once familiarizing themselves, you will not only get support, but an accountability partner to help ensure your success.

- **Eating right is too hard and expensive.**
  - If you have not been eating right, you should already understand how expensive eating wrong can be. Health deteriorates and medical bills escalate with each year that these poor choices are made. Like any habits, there are good and bad. Once you develop a habit it can be a challenge to change or alter. Once the good or correct habit is developed it will be hard to break. I would challenge anyone to compare grocery bills of a cart full of healthy food compared to one full of junk. And speaking of expense, this is not just a financial term. Losing

out on the joys and experience in life because you are not feeding your body nutritious foods is a terrible, unnecessary expense.

- **I can't afford a lifestyle program or hire a health coach.**
  - Most people recognize the importance of an education, whether this is a high-school, college or even an online education. It's widely accepted that this is an investment that must be made in order to have the best insurance of meeting our financial needs. The return on this financial investment can materialize into a very secure and abundant life.
    Although there are situations in life where funding higher education can seem impossible, we witness people every day finding solutions to "get it done". These individuals simply think differently. They do not accept anything less than their God given potential. I am suggesting that your health should be viewed as at least as valuable as your financial situation. What value is wealth if you do not have the health and vitality to enjoy it. At The Epigenetics Healing Center, we work with each individual to overcome any financial obstacles. We have solutions to allow those on fixed budgets and retired to easily move forward.

- **I'm afraid that proper lifestyle changes might isolate me from my friends and family.**
  - It is true that not all of your friends will share your newly found optimism toward taking control of your health. Friends who do not place high priority on their health often play down healthy lifestyle choices. Although they may not mean any negative intent, this behavior is sabotaging. The bottom line is those who truly care for you will support your decision to place your health as a priority.

- **My doctor may not approve.**
  - I will always be open and willing to work with any doctor or health professional you currently have. They also, should be open and willing to do the same if the goal is to optimize health and improve lifestyle choices. This includes reducing and/or eliminating unnecessary medications. A doctor's main concern and intent should always be to aid in the optimization of health in his/her patients. This begins with "Do No Harm". I am always cautious of a physician that dismisses any holistic and natural approach to health. In summary, you are ultimately responsible for your health and therefore, the final decision and direction you wish to pursue.
- **I don't have the self discipline to make permanent changes.**
  - Self discipline is not a trait that we are born with, but one that is developed over time through life experience. Discipline coincides with positive experience. In other words, as your actions result in positive changes you will be inclined to continue these actions. One could look at this as positive habits or simply, discipline. Self discipline is also strengthened thru accountability held by loved ones, a friend or a mentor.

- **What happens if I commit to a lifestyle program and then hate the experience and give up?**
  - Life is a series of ups and downs. We do not always enjoy the duties required for the end result we are seeking. It's funny how these duties or actions can initially seem to be difficult or "no fun", but later take on an uplifting emotion. This is because we come to recognize the most meaningful successes we have in life came from such actions. Having a successful marriage; raising children; optimizing our health and becoming financial independent all require discipline and actions that sometimes have us wanting to "give up and quit". Those of us who continue to play the game are allowed the pleasures of earned rewards.

- **I don’t have the personal confidence to take action.**
  - Very few of us have a natural born instinct of confidence. This comes from continually taking action even when we are fearful. The actual definition for this is courage. As we continue to develop skills from taking these bold steps, we become less fearful or confident. My son, Gabriel, has always lacked confidence as he enters new situations. He is often hesitant to even giving it a try. Once he jumps in, regardless of the fear, he begins to develop skills that ultimately lead to enjoyment and yes, confidence! We are here to mentor you and support you. We do not judge or chastise. We offer an environment that anyone at any level can feel comfortable and genuinely cared for. As you become a veteran in the art of wellness, you too will become very confident.


Dear Friend,

When I sat down to set standards and goals for my practice, it occurred to me that I want to give my patients the same kind of care that I would want for myself. As a doctor with years of experience, a teacher and mentor for other doctors, creator of the Life Restoration Program and numerous letters after my name indicating honors and earned designations, I can assure you I have some pretty high standards.

I would want my doctor to know me as an individual, to know me on a personal level, not just as a number or the next patient. I would want my doctor to foster this relationship by knowing what I consider important and respecting my opinions and views.

I would want my doctor to accept me and to understand who I am. And I wouldn't want any finger-wagging or scolding. Moreover, I don't want to be taken for granted just because I have been a patient for many years.

As a patient myself, I prefer not to experience discomfort during my visit. I want my doctor to genuinely have concern for my comfort before, during and after the visit. And I want my doctor to have mastered techniques that help ensure as the best possible outcome. I would want my doctor to use the latest technology to improve the delivery of my treatment and do it as quickly as possible.

Frankly, I don't want to wait long for my appointment when I arrive. I want to be seen on time and have the full attention of my doctor and the team. I know it isn't always possible, but I do want to know that the doctor is respectful of my time.

As you might guess, I am a stickler for quality and I am willing to pay a little more if I am receiving top of the line treatment. Since this is the only body I will ever have, I wouldn't choose my doctor because his or her fees were the lowest. I wouldn't choose based on where the doctor was located. I would choose based on the quality of care I want to receive – the highest level possible – because I know how important my health is to the quality of my life and how long I live.

I would appreciate someone who pays attention to the smallest details, someone who is a perfectionist about the treatment itself.

So what I want for myself, as a patient, is what I hope you would want because the results of this kind of care are my standard: optimal health, a body I can be proud of, a daily feeling of joy and vitality and the confidence that I'm in control of my destination.

If this is what you want, I would be happy to be your doctor.

Best Regards,
Dr. Jay Goodbinder, DC DABCI

# Can You Afford Getting Healthy?

A common question for so many Americans. My question is **"Can You Afford Not To?"**

Let's take a look at some financial *costs* of the typical American living in the paradigm of *"outdated thoughts, habits and tradition".*

- Health care in this country exceeds health care costs in rest of the world...combined!

- This equates to $8,000 per person living in this country.

- Health care costs exceed the total costs of America's education, agriculture and transportation combined.

- Over $800 Billion worth of pharmaceutical drugs are sold throughout the world each year; $400 Billion or 1/2 of these drugs ares sold to Americans.

- Once prescribed medication, the typical scenario is "take them for the rest of your life".

- Leading cause of Bankruptcy in this country over the age of 65 is **$250,000** worth of medical bills, due to lack of prevention.

**Here is what this might look like for you:**

1) Prescription and over-the-counter medications...$150/mth
    a. Over a 5 year period = $9,000
    b. Over a 10 year period = $18,000
    c. Over a 20 year period = $36,000

2) High monthly insurance premiums (raise deductable to save $100/mth)
    a. Over a 5 year period = $6,000
    b. Over a 10 year period = $12,000
    c. Over a 20 year period = $24,000

By **Investing** into your health, you avoid the **Expense** of poor health and associated symptoms. By simply reducing the ongoing costs of "symptom based" medications and reducing your monthly insurance premiums you can easily save over $60,000 over a 20 year period.

As you can see by this simple illustration, there are no Costs in getting healthy and staying healthy.....Only a exceptionally high Return -On- Investment!


## The Epigenetics Healing Center

***Life Restoration Program***

At The Epigenetics Center we practice in a holistic manner, but believe in the science of appropriate testing. This type of practice is actually called "functional medicine".

We use testing, whether it is blood analysis, urine, saliva, stool, MRI and other means to give us objective evidence of your current state of health. We then can use these same tests to re-measure for positive functional changes.

All of our treatment is directed towards the *cause* of dysfunction and not to simply cover up your symptoms with medication. By no means do we claim to treat specific diseases, nor offer any cure. No doctor or medication can actually cure the body. Healing is the responsibility of your own body's intelligence.

We offer solutions to help balance the body using specific and customized nutritional and Nutriceutical protocols, allowing the body to do what it is programmed to do…*Heal Itself*.

Dr. Goodbinder is not able to and does not accept every case. Dr. Goodbinder's schedule is extremely busy, therefore the number of patients are strictly limited to ensure a high quality of care.

If you are currently on prescription medication, we ask you not to make any changes or go off of these medications without first consulting with your doctor.

It is the responsibility of your prescribing doctor to make these changes and work with us toward helping you become as drug free as possible.

I have read this disclaimer and understand its content,

_____Date: _____

Signature

_____

Print Name

Please list below the name of your physician that you are currently under care.

_____Phone:_____


# Acknowledgement of Receipt
# Of
# Notice of Privacy Practices

I, _____ have received a copy of
(Name of Patient)

Dr. Goodbinder's The Epigenetics Healing Center Notice of Privacy Practice

_____
(Signature of Patient or Guardian)

_____
Staff Will Fill Out Section if Patient's Signature Not Obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our Notice of Privacy Practices, but it could not be obtained for the following reason:

_____ Patient refused to sign.

_____ Emergency situation kept us from obtaining the patient's signature.

_____ Language barriers kept us from obtaining the patient's signature.

_____ Other: _____

_____

# Consultation Terms

1. I understand that today's consultation is used to determine whether or not I am a candidate for care.

2. I understand that the consultation process does not establish me as a patient under Dr. Goodbinder's care and there is no doctor-patient relationship or obligation.

3. I am aware that after the consultation, I may not be accepted as a patient.

4. I understand that Dr. Goodbinder is not able to and does not accept every case. Dr. Goodbinder's schedule is extremely busy and he strictly limits the number of new patients he accepts so as to ensure a high quality of care.

5. Please fill out all paperwork completely to the best of your knowledge. Do not leave anything blank. If paperwork is not filled out completely Dr. Goodbinder may refuse to do the consultation.

6. It is imperative that you are under the care of a medical doctor or a doctor licensed to prescribe medication. Please list below the name and contact information of that physician.

_____ _____

Name of Physician Phone number

**I have read, understand, and accept the terms of the consultation.**

Name (please print) _____

Signature _____

Date _____


# Patient Introduction

**Personal History:**

Your Name: _____
First Middle Last

Your Address:

_____
Street City/State Zip

Telephone: Home:_____ Bus: _____

Email Address: _____

Birth Date: Month: _____ Day: _____ Year: _____

Marital Status:_____

Occupation: _____

Employer: _____

Present MD: _____ City: _____

Referred to our Centre or Seminar by:
_____

Thank You!

# Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

**Name:** _____ **Date:** _____ (dd/mm/yr)

**Insurance:** _____

**Date of Birth:** _____ ☐ **male** ☐ **female**

**Address:** _____

_____

_____

**Marital status**

| S | M | W | D | SEP |
|---|---|---|---|---|

**Phone #: home:** _____ **work:** _____

**E-mail address:** _____

**Occupation:** _____ **Employer:** _____

***Check ☑ and indicate the age when you had any of the following:***

**General**
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

**Muscle / Joint**
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

**Skin**
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

**Eye, Ear, Nose & Throat**
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

**Gastrointestinal**
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful deification
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

**Genitourinary**
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

**Cardiovascular**
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

**Respiratory**
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

**Women only**
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow

☐ Reg. ☐ Irreg. ☐ Pain / cramps

Days of flow: ____ Length of cycle: _____

Date - 1st day last period: _____

Are you pregnant? ☐ yes, ☐ no

If yes, how many months? _____

How many children do you have? _____

Birth control method: _____

Date of last PAP test: _____

☐ normal, ☐ abnormal

Date of last mammogram: _____

☐ normal, ☐ abnormal

**Check any of the conditions you have or have had:**
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

**Please list any medication you are currently taking and why:**

_____

_____

_____

_____

## Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

_____

_____

How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

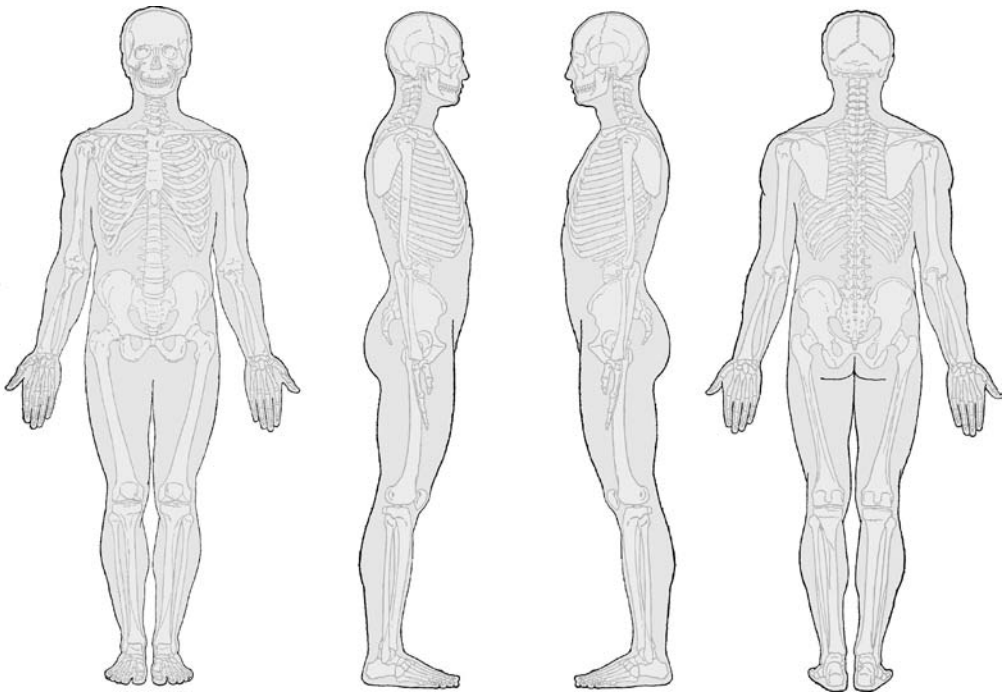
What seemed to be the initial cause: _____

***Please mark you area(s) of pain on the figure below***

***Please place a mark at the level of your pain on the scale below:***

**Worst Possible Pain**

**No Pain**



### Past health history

| Have you... | Yes | No | If yes, explain briefly |
|---|---|---|---|
| ... been hospitalized in the last 5 year? | □ | □ | _____ |
| ... had any mental disorders? | □ | □ | _____ |
| ... had any broken bones? | □ | □ | _____ |
| ... had any strains or sprains? | □ | □ | _____ |
| ... ever used orthotics? | □ | □ | _____ |
| Do you take minerals, herbs or vitamins? | □ | □ | _____ |

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your mattress? _____

When was your last physical exam? _____

| Habits | none | light | mod. | heavy |
|---|---|---|---|---|
| Alcohol | □ | □ | □ | □ |
| Coffee | □ | □ | □ | □ |
| Tobacco | □ | □ | □ | □ |
| Drugs | □ | □ | □ | □ |
| Exercise | □ | □ | □ | □ |
| Sleep | □ | □ | □ | □ |
| Soft drinks | □ | □ | □ | □ |
| Salty foods | □ | □ | □ | □ |
| Water | □ | □ | □ | □ |
| Sugar | □ | □ | □ | □ |

### Family history

***If any blood relative has had any of the following conditions, please check and indicate which relative(s)***

| | | |
|---|---|---|
| □ Alcoholism | □ Cancer | □ High blood pressure |
| □ Anemia | □ Diabetes | □ High cholesterol |
| □ Arteriosclerosis | □ Emphysema | □ Multiple sclerosis |
| □ Arthritis | □ Epilepsy | □ Osteoporosis |
| □ Asthma | □ Glaucoma | □ Stroke |
| □ Bleed easily | □ Heart disease | □ Thyroid disease |

**Do you have any other health issues or concerns that our staff should be made aware of?** _____

_____

# Metabolic Assessment Form™

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

**PART I**

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

**1.** _____ **4.** _____

**2.** _____ **5.** _____

**3.** _____

**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 |

**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 proteins and meats; 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**

| | | | | |
|---|---|---|---|---|
| Difficulty digesting roughage and fiber | 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 |
| Nausea and/or vomiting | 0 | 1 | 2 | 3 |
| Stool undigested, foul smelling, mucus like, greasy, or poorly formed | 0 | 1 | 2 | 3 |
| Frequent loss of appetite | 0 | 1 | 2 | 3 |

**Category VII**

| | | | | |
|---|---|---|---|---|
| Abdominal distention after consumption of fiber, starches, and sugar | 0 | 1 | 2 | 3 |
| Abdominal distention after certain probiotic or natural supplements | 0 | 1 | 2 | 3 |
| Decreased gastrointestinal motility, constipation | 0 | 1 | 2 | 3 |
| Increased gastrointestinal motility, diarrhea | 0 | 1 | 2 | 3 |
| Alternating constipation and diarrhea | 0 | 1 | 2 | 3 |
| Suspicion of nutritional malabsorption | 0 | 1 | 2 | 3 |
| Frequent use of antacid medication | 0 | 1 | 2 | 3 |
| Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome? | Yes | | No | |

**Category VIII**

| | | | | |
|---|---|---|---|---|
| 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 |
| 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 IX**

| | | | | |
|---|---|---|---|---|
| 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 X**

| | | | | |
|---|---|---|---|---|
| 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 between meals | 0 | 1 | 2 | 3 |
| Blurred vision | 0 | 1 | 2 | 3 |

**Category XI**

| | | | | |
|---|---|---|---|---|
| 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 XII**

| | | | | |
|---|---|---|---|---|
| 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 XIII**

| | | | | |
|---|---|---|---|---|
| Cannot fall asleep | 0 | 1 | 2 | 3 |
| Perspire easily | 0 | 1 | 2 | 3 |
| Under a 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 XIV**

| | | | | |
|---|---|---|---|---|
| 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 XV**

| | | | | |
|---|---|---|---|---|
| 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 XVI**

| | | | | |
|---|---|---|---|---|
| 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 |

**Category XVI *(Cont.)***

| | | | | |
|---|---|---|---|---|
| Night sweats | 0 | 1 | 2 | 3 |
| Difficulty gaining weight | 0 | 1 | 2 | 3 |

**Category XVII *(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 XVIII *(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 XIX *(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 XX *(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:**

# Neurotransmitter Assessment Form™ (NTAF)

**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 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 new things? **0 1 2 3**
- How often do you have a hard time remembering your appointments? **0 1 2 3**
- Is your temperament generally getting worse? **0 1 2 3**
- Is your attention span decreasing? **0 1 2 3**
- How often do you find yourself down or sad? **0 1 2 3**
- How often do you become fatigued when driving compared to in the past? **0 1 2 3**
- How often do you become fatigued when reading compared to in 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 you have something that must be done? **0 1 2 3**
- Do you feel you never have time for yourself? **0 1 2 3**
- How often do you feel you are not getting enough sleep or rest? **0 1 2 3**
- Do you find it difficult to get regular exercise? **0 1 2 3**
- Do you feel uncared for by the people in your life? **0 1 2 3**
- Do you feel you are not accomplishing your life's purpose? **0 1 2 3**
- Is sharing your problems with someone difficult for you? **0 1 2 3**

## SECTION C

SECTION C1

- How often do you get irritable, shaky, or have light-headedness 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

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

## SECTION 1

- Are you losing interest in hobbies? **0 1 2 3**
- How often do you feel overwhelmed? **0 1 2 3**
- How often do you have feelings of inner rage? **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 your 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**

*Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.*


SMGENTAF(032116)

# Neurotransmitter Assessment Form™ (NTAF)

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

## SECTION 2

- 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

- How often do you feel anxious or panicked 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

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

## SECTION 5

- A decrease in mental alertness **0 1 2 3**
- A decrease in mental speed **0 1 2 3**
- A decrease in concentration quality **0 1 2 3**
- Slow cognitive processing **0 1 2 3**
- Impaired mental performance **0 1 2 3**
- An increase in the ability to be distracted **0 1 2 3**
- Need coffee or caffeine sources to improve mental function **0 1 2 3**

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# Medication History*

**Please check any of the following medications you have taken in the past or are currently taking.**

## Noradrenergic and Specific Serotonergic Antidepressants (NaSSAs)

- ☐ Remeron®
- ☐ Zispin®
- ☐ Avanza®
- ☐ Norset®
- ☐ Remergil®
- ☐ Axit®

## Tricyclic Antidepressants (TCAs)

- ☐ Elavil®
- ☐ Endep®
- ☐ Tryptanol®
- ☐ Trepiline®
- ☐ Asendin®
- ☐ Asendis®
- ☐ Defanyl®
- ☐ Demolox®
- ☐ Moxadil®
- ☐ Anafranil®
- ☐ Norpramin®
- ☐ Pertofrane®
- ☐ Thaden™
- ☐ Prothiaden®
- ☐ Adapin®
- ☐ Sinequan®
- ☐ Tofranil®
- ☐ Janamine®
- ☐ Gamanil®
- ☐ Aventyl®
- ☐ Pamelor®
- ☐ Opipramol®
- ☐ Vivactil®
- ☐ Rhotrimine®
- ☐ Surmontil®
- ☐ Norpramin®

## Selective Serotonin Reuptake Inhibitors (SSRIs)

- ☐ Paxil®
- ☐ Zoloft®
- ☐ Prozac®
- ☐ Celexa®
- ☐ Lexapro®
- ☐ Esertia®
- ☐ Luvox®
- ☐ Cipramil®
- ☐ Emocal®
- ☐ Seropram®
- ☐ Cipralex®
- ☐ Fontex®
- ☐ Priligy®
- ☐ Seromex®
- ☐ Seronil®
- ☐ Sarafem®
- ☐ Fluctin®
- ☐ Faverin®
- ☐ Seroxat®
- ☐ Aropax®
- ☐ Deroxat®
- ☐ Rexetin®
- ☐ Paroxat®
- ☐ Lustral®
- ☐ Serlain®

## Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

- ☐ Effexor®
- ☐ Pristiq®
- ☐ Meridia®
- ☐ Serzone®
- ☐ Dalcipran®
- ☐ Cymbalta®

## Selective Serotonin Reuptake Enhancers (SSREs)

- ☐ Stablon®
- ☐ Coaxil®
- ☐ Tatinol®

## Monoamine Oxidase Inhibitors (MAOIs)

- ☐ Marplan®
- ☐ Aurorix®
- ☐ Manerix®
- ☐ Moclodura®
- ☐ Nardil®
- ☐ Adeline®
- ☐ Eldepryl®
- ☐ Azilect®
- ☐ Marsilid®
- ☐ Iprozid®
- ☐ Ipronid®
- ☐ Rivivol®
- ☐ Propilniazida®
- ☐ Zyvox®
- ☐ Zyvoxid®

## Dopamine Receptor Agonists

- ☐ Mirapex®
- ☐ Sifrol®
- ☐ Requip®

## Norepinephrine–Dopamine Reuptake Inhibitors (NDRIs)

- ☐ Wellbutrin XL®

## D2 Dopamine Receptor Blockers (antipsychotics)

- ☐ Thorazine®
- ☐ Prolixin®
- ☐ Trilafon®
- ☐ Compazine®
- ☐ Mellaril®
- ☐ Stelazine®
- ☐ Vesprin®
- ☐ Nozinan®
- ☐ Depixol®
- ☐ Navane®
- ☐ Fluanxol®
- ☐ Clopixol®
- ☐ Acuphase®
- ☐ Haldol®
- ☐ Orap®
- ☐ Clozaril®
- ☐ Zyprexa®
- ☐ Zydis®
- ☐ Seroquel XR®
- ☐ Geodon®
- ☐ Solian®
- ☐ Invega®
- ☐ Abilify®

## GABA Antagonist Competitive Binder

- ☐ Romazicon®

## Agonist Modulators of GABA Receptors (benzodiazepines)

- ☐ Xanax®
- ☐ Lexotanil®
- ☐ Lexotan®
- ☐ Librium®
- ☐ Klonopin®
- ☐ Valium®
- ☐ Prosom®
- ☐ Rohypnol®
- ☐ Magadon®
- ☐ Dalmane®
- ☐ Ativan®
- ☐ Loramet®
- ☐ Sedoxil®
- ☐ Dormicum®
- ☐ Serax®
- ☐ Restoril®
- ☐ Halcion®

## Agonist Modulators of GABA Receptors (non-benzodiazepines)

- ☐ Ambien CR®
- ☐ Sonata®
- ☐ Lunesta®
- ☐ Imovane®

## Acetylcholine Receptor Agonists

- ☐ Urecholine®
- ☐ Evoxac®
- ☐ Salagen®
- ☐ Isopto®
- ☐ Nicotone

## Acetylcholine Receptor Antagonists (antimuscarinic agents)

- ☐ AtroPen®
- ☐ Scopace®
- ☐ Atrovent®
- ☐ Spiriva®

## Acetylcholine Receptor Antagonists (ganglionic blockers)

- ☐ Inversine®
- ☐ Nicotine (high doses)
- ☐ Hexamethonium
- ☐ Arfonad®

## Acetylcholine Receptor Antagonists (neuromuscular blockers)

- ☐ Tracrium®
- ☐ Nimbex®
- ☐ Nuromax®
- ☐ Metubine®
- ☐ Mivacron®
- ☐ Pavulon®
- ☐ Zemuron®
- ☐ Anectine®
- ☐ Tubocurarine®
- ☐ Norcuron®
- ☐ Hemicholinium-3®

## Acetylcholinesterase Reactivators

- ☐ Protopam®

## Cholinesterase Inhibitors (reversible)

- ☐ Aricept®
- ☐ Razadyne®
- ☐ Exelon®
- ☐ Cognex®
- ☐ THC
- ☐ Carbamate insecticides
- ☐ Enlon®
- ☐ Prostigmin®
- ☐ Antilirium®
- ☐ Mestinon®

## Cholinesterase Inhibitors (irreversible)

- ☐ Echothiophate
- ☐ Isoflurophate
- ☐ Organophosphate insecticides
- ☐ Organophosphate-containing nerve agents

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

# Brain Function Assessment Form™ (BFAF)

**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 1

- A decrease in attention span **0 1 2 3**
- Mental fatigue **0 1 2 3**
- Difficulty learning new things **0 1 2 3**
- Difficulty staying focused and concentrating for extended periods of time **0 1 2 3**
- Experiencing fatigue when reading sooner than in the past **0 1 2 3**
- Experiencing fatigue when driving sooner than in the past **0 1 2 3**
- Need for caffeine to stay mentally alert **0 1 2 3**
- Overall brain function impairs your daily life **0 1 2 3**

## SECTION 2

- Twitching or tremor in your hands and legs when resting **0 1 2 3**
- Handwriting has gotten smaller and more crowded together **0 1 2 3**
- A loss of smell to foods **0 1 2 3**
- Difficulty sleeping or fitful sleep **0 1 2 3**
- Stiffness in shoulders and hips that goes away when you start to move **0 1 2 3**
- Constipation **0 1 2 3**
- Voice has become softer **0 1 2 3**
- Facial expression that is serious or angry **0 1 2 3**
- Episodes of dizziness or light-headedness upon standing **0 1 2 3**
- A hunched over posture when getting up and walking **0 1 2 3**

## SECTION 3

- Memory loss that impacts daily activities **0 1 2 3**
- Difficulty planning, problem solving, or working with numbers **0 1 2 3**
- Difficulty completing daily tasks **0 1 2 3**
- Confusion about dates, the passage of time, or place **0 1 2 3**
- Difficulty understanding visual images and spatial relationships (addresses and locations) **0 1 2 3**
- Difficulty finding words when speaking **0 1 2 3**
- Misplacement of things and inability to retrace steps **0 1 2 3**
- Poor judgment and bad decisions **0 1 2 3**
- Disinterest in hobbies, social activities, or work **0 1 2 3**
- Personality or mood changes **0 1 2 3**

## SECTION 4

- Reduced function in overall hearing **0 1 2 3**
- Difficulty understanding language with background or scatter noise **0 1 2 3**
- Ringing or buzzing in the ear **0 1 2 3**
- Difficulty comprehending language without perfect pronunciation **0 1 2 3**
- Difficulty recognizing familiar faces **0 1 2 3**
- Changes in comprehending the meaning of sentences, written or spoken **0 1 2 3**
- Difficulty with verbal memory and finding words **0 1 2 3**
- Difficulty remembering events **0 1 2 3**
- Difficulty recalling previously learned facts and names **0 1 2 3**
- Inability to comprehend familiar words when read **0 1 2 3**
- Difficulty spelling familiar words **0 1 2 3**
- Monotone, unemotional speech **0 1 2 3**
- Difficulty understanding the emotions of others when they speak (nonverbal cues) **0 1 2 3**
- Disinterest in music and a lack of appreciation for melodies **0 1 2 3**
- Difficulty with long-term memory **0 1 2 3**
- Memory impairment when doing the basic activities of daily living **0 1 2 3**
- Difficulty with directions and visual memory **0 1 2 3**
- Noticeable differences in energy levels throughout the day **0 1 2 3**

## SECTION 5

- Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach for objects **0 1 2 3**
- Difficulty comprehending written text **0 1 2 3**
- Floaters or halos in your visual field **0 1 2 3**
- Dullness of colors in your visual field during different times of the day **0 1 2 3**
- Difficulty discriminating similar shades of color **0 1 2 3**



*Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.*

# Brain Function Assessment Form™ (BFAF)

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

## SECTION 6

- Difficulty with detailed hand coordination **0 1 2 3**
- Difficulty with making decisions **0 1 2 3**
- Difficulty with suppressing socially inappropriate thoughts **0 1 2 3**
- Socially inappropriate behavior **0 1 2 3**
- Decisions made based on desires, regardless of the consequences **0 1 2 3**
- Difficulty planning and organizing daily events **0 1 2 3**
- Difficulty motivating yourself to start and finish tasks **0 1 2 3**
- A loss of attention and concentration **0 1 2 3**

## SECTION 7

- Hypersensitivities to touch or pain **0 1 2 3**
- Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall **0 1 2 3**
- Frequently bumping into the wall or objects **0 1 2 3**
- Difficulty with right-left discrimination **0 1 2 3**
- Handwriting has become sloppier **0 1 2 3**
- Difficulty with basic math calculations **0 1 2 3**
- Difficulty finding words for written or verbal communication **0 1 2 3**
- Difficulty recognizing symbols, words, or letters **0 1 2 3**

## SECTION 8

- Difficulty swallowing supplements or large bites of food **0 1 2 3**
- Bowel motility and movements slow **0 1 2 3**
- Bloating after meals **0 1 2 3**
- Dry eyes or dry mouth **0 1 2 3**
- A racing heart **0 1 2 3**
- A flutter in the chest or an abnormal heart rhythm **0 1 2 3**
- Bowel or bladder incontinence, resulting in staining your underwear **0 1 2 3**

## SECTION 9

- A decrease in movement speed **0 1 2 3**
- Difficulty initiating movement **0 1 2 3**
- Stiffness in your muscles (not joints) **0 1 2 3**
- A stooped posture when walking **0 1 2 3**
- Cramping of your hand when writing **0 1 2 3**

## SECTION 10

- Abnormal body movements (such as twitching legs) **0 1 2 3**
- Desires to flinch, clear your throat, or perform some type of movement **0 1 2 3**
- Constant nervousness and a restless mind **0 1 2 3**
- Compulsive behaviors **0 1 2 3**
- Increased tightness and tone in specific muscles **0 1 2 3**

## SECTION 11

- Difficulty with balance, or balance that is noticeably worse on one side **0 1 2 3**
- A need to hold the handrail or watch each step carefully when going down stairs **0 1 2 3**
- Episodes of dizziness **0 1 2 3**
- Nausea, car sickness, or seasickness **0 1 2 3**
- A quick impact after consuming alcohol **0 1 2 3**
- A slight hand shake when reaching for something **0 1 2 3**
- Back muscles that tire quickly when standing or walking **0 1 2 3**
- Chronic neck or back muscle tightness **0 1 2 3**



*Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.*

# Brain Health and Nutrition Assessment Form™ (BHNAF)

**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 1

- Low brain endurance for focus and concentration **0 1 2 3**
- Cold hands and feet **0 1 2 3**
- Must exercise or drink coffee to improve brain function **0 1 2 3**
- Poor nail health **0 1 2 3**
- Fungal growth on toenails **0 1 2 3**
- Must wear socks at night **0 1 2 3**
- Nail beds are white instead of pink **0 1 2 3**
- The tip of the nose is cold **0 1 2 3**

## SECTION 2

- Irritable, nervous, shaky, or light-headed between meals **0 1 2 3**
- Feel energized after meals **0 1 2 3**
- Difficulty eating large meals in the morning **0 1 2 3**
- Energy level drops in the afternoon **0 1 2 3**
- Crave sugar and sweets in the afternoon **0 1 2 3**
- Wake up in the middle of the night **0 1 2 3**
- Difficulty concentrating before eating **0 1 2 3**
- Depend on coffee to keep going **0 1 2 3**

## SECTION 3

- Fatigue after meals **0 1 2 3**
- Sugar and sweet cravings after meals **0 1 2 3**
- Need for a stimulant, such as coffee, after meals **0 1 2 3**
- Difficulty losing weight **0 1 2 3**
- Increased frequency of urination **0 1 2 3**
- Difficulty falling asleep **0 1 2 3**
- Increased appetite **0 1 2 3**

## SECTION 4

- Always have projects and things that need to be done **0 1 2 3**
- Never have time for yourself **0 1 2 3**
- Not getting enough sleep or rest **0 1 2 3**
- Difficulty getting regular exercise **0 1 2 3**
- Feel that you are not accomplishing your life's purpose **0 1 2 3**

## SECTION 5

- Dry and unhealthy skin **0 1 2 3**
- Dandruff or a flaky scalp **0 1 2 3**
- Consumption of processed foods that are bagged or boxed **0 1 2 3**
- Consumption of fried foods **0 1 2 3**
- Difficulty consuming raw nuts or seeds **0 1 2 3**
- Difficulty consuming fish (not fried) **0 1 2 3**
- Difficulty consuming olive oil, avocados, flax seed oil, or natural fats **0 1 2 3**

## SECTION 6

- Difficulty digesting foods **0 1 2 3**
- Constipation or inconsistent bowel movements **0 1 2 3**
- Increased bloating or gas **0 1 2 3**
- Abdominal distention after meals **0 1 2 3**
- Difficulty digesting protein-rich foods **0 1 2 3**
- Difficulty digesting starch-rich foods **0 1 2 3**
- Difficulty digesting fatty or greasy foods **0 1 2 3**
- Difficulty swallowing supplements or large bites of food **0 1 2 3**
- Abnormal gag reflex **Yes or No**

## SECTION 7

- Brain fog (unclear thoughts or concentration) **Yes or No**
- Pain and inflammation **Yes or No**
- Noticeable variations in mental speed **Yes or No**
- Brain fatigue after meals **0 1 2 3**
- Brain fatigue after exposure to chemicals, scents, or pollutants **0 1 2 3**
- Brain fatigue when the body is inflamed **0 1 2 3**

## SECTION 8

- Grain consumption leads to tiredness **0 1 2 3**
- Grain consumption makes it difficult to focus and concentrate **0 1 2 3**
- Feel better when bread and grains are avoided **0 1 2 3**
- Grain consumption causes the development of any symptoms **0 1 2 3**
- A 100% gluten-free diet **Yes or No**



*Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.*

# Brain Health and Nutrition Assessment Form™ (BHNAF)

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

## SECTION 9

- A diagnosis of celiac disease, gluten sensitivity, hypothyroidism, or an autoimmune disease — **Yes or No**
- Family members who have been diagnosed with an autoimmune disease — **Yes or No**
- Family members who have been diagnosed with celiac disease or gluten sensitivity — **Yes or No**
- Changes in brain function with stress, poor sleep, or immune activation — **0 1 2 3**

## SECTION 10

- A loss of pleasure in hobbies and interests — **0 1 2 3**
- Feel overwhelmed with ideas to manage — **0 1 2 3**
- Feelings of inner rage or unprovoked anger — **0 1 2 3**
- Feelings of paranoia — **0 1 2 3**
- Feelings of sadness for no reason — **0 1 2 3**
- A loss of enjoyment in life — **0 1 2 3**
- A lack of artistic appreciation — **Yes or No**
- Feelings of sadness in overcast weather — **0 1 2 3**
- A loss of enthusiasm for favorite activities — **0 1 2 3**
- A loss of enjoyment in favorite foods — **0 1 2 3**
- A loss of enjoyment in friendships and relationships — **0 1 2 3**
- Inability to fall into deep, restful sleep — **0 1 2 3**
- Feelings of dependency on others — **0 1 2 3**
- Feelings of susceptibility to pain — **0 1 2 3**

## SECTION 11

- Feelings of worthlessness — **0 1 2 3**
- Feelings of hopelessness — **0 1 2 3**
- Self-destructive thoughts — **0 1 2 3**
- Inability to handle stress — **0 1 2 3**
- Anger and aggression while under stress — **0 1 2 3**
- Feelings of tiredness, even after many hours of sleep — **0 1 2 3**
- A desire to isolate yourself from others — **0 1 2 3**
- An unexplained lack of concern for family and friends — **0 1 2 3**
- An inability to finish tasks — **0 1 2 3**
- Feelings of anger for minor reasons — **0 1 2 3**

## SECTION 12

- A decrease in visual memory (shapes and images) — **Yes or No**
- A decrease in verbal memory — **0 1 2 3**
- Occurrence of memory lapses — **0 1 2 3**
- A decrease in creativity — **0 1 2 3**
- A decrease in comprehension — **0 1 2 3**
- Difficulty calculating numbers — **0 1 2 3**
- Difficulty recognizing objects and faces — **0 1 2 3**
- A change in opinion about yourself — **0 1 2 3**
- Slow mental recall — **0 1 2 3**

## SECTION 13

- A decrease in mental alertness — **0 1 2 3**
- A decrease in mental speed — **0 1 2 3**
- A decrease in concentration quality — **0 1 2 3**
- Slow cognitive processing — **0 1 2 3**
- Impaired mental performance — **0 1 2 3**
- An increase in the ability to be distracted — **0 1 2 3**
- Need coffee or caffeine sources to improve mental function — **0 1 2 3**

## SECTION 14

- Feelings of nervousness or panic for no reason — **0 1 2 3**
- Feelings of dread — **0 1 2 3**
- Feelings of a “knot” in your stomach — **0 1 2 3**
- Feelings of being overwhelmed for no reason — **0 1 2 3**
- Feelings of guilt about everyday decisions — **0 1 2 3**
- A restless mind — **0 1 2 3**
- An inability to turn off the mind when relaxing — **0 1 2 3**
- Disorganized attention — **0 1 2 3**
- Worry over things never thought about before — **0 1 2 3**
- Feelings of inner tension and inner excitability — **0 1 2 3**



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# The Epigenetics Healing Center

## Initial Consultation

Name: _____ Date: _____

Main Complaints:

1)_____ 2)_____

3)_____ 4)_____

How long have you suffered with this problem? _____

Any other complaints: _____

_____

Would you like improvement with any of the following?:

☐ Digestion: Reflux, Gas, Constipation
☐ Sleep: Falling asleep or staying asleep
☐ Sense of Well Being
☐ Energy

What have you tried doing to resolve this problem that Did Not work?

_____

_____

Have you become discouraged or stressed about handling this problem?

_____

_____

When your problem is at its worst, how does it make you feel?

_____

How does this problem interfere with the following areas in your life?

Work: _____
Family: _____
Hobbies: _____
Life: _____

When it's at it's worst, how much older does this make you feel? _____

Do you know how this problem may have started? _____

_____

What effect does this have on your body functions? _____

_____

Are you here visiting us to:

a) Resolve my immediate problem
b) Life style program for optimized living
c) Both
d) Other: _____

How have you taken care of your health in the past?

| | |
|---|---|
| Medications | Holistic |
| Routine medical | Vitamins |
| Exercise | Chiropractic |
| Diet and Nutrition | Other: _____ |

How did the previous methods work for you? _____

_____

What are you afraid this might be or will be affecting without change? Please circle

| | |
|---|---|
| Job | Freedom |
| Kids | Future abilities |
| Marriage | Finances |
| Sleep | Time |

Are there any health conditions you are afraid this might turn into?

| | |
|---|---|
| Diminished Future abilities | Surgery |
| Stress | Arthritis |
| Weight gain | Cancer |
| Heart disease | Diabetes |
| Depression | Other: _____ |

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of? Please be specific _____

_____

_____

What would be different or better without this problem? Please circle:

| | |
|---|---|
| Diminished stress | Sleep |
| More energy | Work |
| Self esteem | Outlook |
| Confidence | Family |

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress?
(Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

What potential barriers do you foresee that would prevent these things from happening?

Do you feel it is possible to eliminate or prevent these potential barriers?

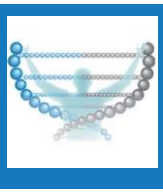
What are your strengths that will enable you to accomplish your goals?

Rate on a scale of 1-10:

_____ How important is it for you to resolve your health concerns?
_____ Do you feel that you are coachable and would enjoy a mentor in helping you?
_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

**Thank You!**

# Chief Complaint Form



**Name:**

**Birthday:**

**Chief Complaint:**

**Date of Onset:**

**Location:**

**Presentation:**

**Scale 1-10:**

**Explain Condition:**

**What makes worse?**

**What makes better?**

Past Medical History:

**Any Prior Care?**

**Barriers to recovery?**

**General Health Issues?**

**Co-Morbidities**

**Past Family History?**

**Past/Current Social Habits? Work environment/smoking/alcohol intake/activities?**


Dr. Jay Goodbinder, DC DABCI

**Holmes Corporate Center II**
(I-435 & Holmes on the corner of 101st Terrace & Holmes)
800 E 101st Terrace
Suite 100
Kansas City, MO 64131
Office 816-673-1230
Fax 816-673-1235

www.drgoodbinder.com

# Steps for your appointment:

1. Please fill out all New Patient forms in their entirety before your set appointment.
2. If you have any recent labs (within 6 months), please bring them to your appointment.
3. Please bring your spouse, significant other, or loved one with you to your appointment. (There will be much information covered concerning your unique condition as well as the fundamentals of the program.)
4. Please arrive on time.
5. We require a 24-hour notice to change or cancel your appointment.

Note: If these steps are not followed it may compromise the full value of your consultation and therefore we may kindly reschedule your appointment.


**Holmes Corporate Center II**
**(I-435 & Holmes on the corner of 101st Terrace)**
**800 E 101st Terrace**
**Suite 100**
**Kansas City, MO 64131**
**816-673-1230 Office**
**816-673-1235 Fax**

## Directions from 435 West:

Heading West, take the exit onto Holmes. Turn right onto Holmes and right on 101st Terrace. It is the office building on the left. Walk in the front door, we are the first office on the left, suite 100.

## Directions from 435 East:

Heading East, take the exit onto Holmes. Turn left onto Holmes and right onto 101st Terrace. It is the office building on the left. Walk in the front door, we are the first office on the left, suite 100.

## Directions when going North:

Turn right at 101st Terrace. It is the office building on the left. Walk in the front door, we are the first office on the left, suite 100.

## Directions when going South:

Turn left at 101st Terrace. It is the office building on the left. Walk in the front door, we are the first office on the left, suite 100.

**Dr. Goodbinder's The Epigenetics Healing Center**
**800 E 101st Terrace**
**Suite 100**
**Kansas City, MO 64131**
**816-673-1230**

**Notice of Privacy Practices**

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

**Treatment**: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

**Payment**: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

**Operations**: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid

disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

**Others Involved in Your Healthcare**: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

**Communication Barriers and Emergencies**: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to: Privacy Officer