



LAKE POINTE WELLNESS CENTER

Embrace. Educate. Empower.

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Kennesaw, GA 30144

Steps for your appointment:

- 1) Please fill out all of your New Patient forms in their entirety.
- 2) If you have any recent labs (within 12 months), please bring them to your appointment.
- 3) If you are married or in a relationship, please bring your spouse or significant other with you to your appointment. *(There will be a lot of information covered concerning your overall health as well as the fundamentals of the Lifelong Wellness Programs we offer.)*
- 4) Please arrive on time.
- 5) We require 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 will kindly reschedule your appointment.*

Lake Pointe Wellness 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

Sense of Well Being

Sleep: Falling asleep or staying asleep

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 its 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) Lifestyle program for optimized living
- c) Both
- d) Other: _____

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

Medications
Routine medical
Exercise
Diet and Nutrition

Holistic
Vitamins
Chiropractic
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
Kids
Marriage
Sleep

Freedom
Future abilities
Finances
Time

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

Diminished Future abilities
Stress
Weight gain
Heart disease
Depression

Arthritis
Cancer
Diabetes
Other: _____

Surgery

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
More energy
Self esteem
Confidence

Sleep
Work
Outlook
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?

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. Deb Schreiberman'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. Deb Schreiberman is not able to and does not accept every case. Dr. Schreiberman's schedule is extremely busy and she strictly limits the number of new patients she 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. Schreiberman 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(s) of Physician(s)

Phone number(s)

Practice Name

Address Line 1

City

State

Zip

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

Name (please print)

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.

<p>Category I</p> <p>Feeling that bowels do not empty completely 0 1 2 3</p> <p>Lower abdominal pain relieved by passing stool or gas 0 1 2 3</p> <p>Alternating constipation and diarrhea 0 1 2 3</p> <p>Diarrhea 0 1 2 3</p> <p>Constipation 0 1 2 3</p> <p>Hard, dry, or small stool 0 1 2 3</p> <p>Coated tongue or “fuzzy” debris on tongue 0 1 2 3</p> <p>Pass large amount of foul-smelling gas 0 1 2 3</p> <p>More than 3 bowel movements daily 0 1 2 3</p> <p>Use laxatives frequently 0 1 2 3</p> <p>Category II</p> <p>Increasing frequency of food reactions 0 1 2 3</p> <p>Unpredictable food reactions 0 1 2 3</p> <p>Aches, pains, and swelling throughout the body 0 1 2 3</p> <p>Unpredictable abdominal swelling 0 1 2 3</p> <p>Frequent bloating and distention after eating 0 1 2 3</p> <p>Abdominal intolerance to sugars and starches 0 1 2 3</p> <p>Category III</p> <p>Intolerance to smells 0 1 2 3</p> <p>Intolerance to jewelry 0 1 2 3</p> <p>Intolerance to shampoo, lotion, detergents, etc 0 1 2 3</p> <p>Multiple smell and chemical sensitivities 0 1 2 3</p> <p>Constant skin outbreaks 0 1 2 3</p> <p>Category IV</p> <p>Excessive belching, burping, or bloating 0 1 2 3</p> <p>Gas immediately following a meal 0 1 2 3</p> <p>Offensive breath 0 1 2 3</p> <p>Difficult bowel movements 0 1 2 3</p> <p>Sense of fullness during and after meals 0 1 2 3</p> <p>Difficulty digesting fruits and vegetables; undigested food found in stools 0 1 2 3</p> <p>Category V</p> <p>Stomach pain, burning, or aching 1-4 hours after eating 0 1 2 3</p> <p>Use of antacids 0 1 2 3</p> <p>Feel hungry an hour or two after eating 0 1 2 3</p> <p>Heartburn when lying down or bending forward 0 1 2 3</p> <p>Temporary relief by using antacids, food, milk, or carbonated beverages 0 1 2 3</p> <p>Digestive problems subside with rest and relaxation 0 1 2 3</p> <p>Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine 0 1 2 3</p> <p>Category VI</p> <p>Roughage and fiber cause constipation 0 1 2 3</p> <p>Indigestion and fullness last 2-4 hours after eating 0 1 2 3</p> <p>Pain, tenderness, soreness on left side under rib cage 0 1 2 3</p> <p>Excessive passage of gas 0 1 2 3</p>	<p>Category VI (Cont.)</p> <p>Nausea and/or vomiting 0 1 2 3</p> <p>Stool undigested, foul smelling, mucous like, greasy, or poorly formed 0 1 2 3</p> <p>Frequent urination 0 1 2 3</p> <p>Increased thirst and appetite 0 1 2 3</p> <p>Category VII</p> <p>Greasy or high-fat foods cause distress 0 1 2 3</p> <p>Lower bowel gas and/or bloating several hours after eating 0 1 2 3</p> <p>Bitter metallic taste in mouth, especially in the morning 0 1 2 3</p> <p>Burpy, fishy taste after consuming fish oils 0 1 2 3</p> <p>Difficulty losing weight 0 1 2 3</p> <p>Unexplained itchy skin 0 1 2 3</p> <p>Yellowish cast to eyes 0 1 2 3</p> <p>Stool color alternates from clay colored to normal brown 0 1 2 3</p> <p>Reddened skin, especially palms 0 1 2 3</p> <p>Dry or flaky skin and/or hair 0 1 2 3</p> <p>History of gallbladder attacks or stones 0 1 2 3</p> <p>Have you had your gallbladder removed? Yes No</p> <p>Category VIII</p> <p>Acne and unhealthy skin 0 1 2 3</p> <p>Excessive hair loss 0 1 2 3</p> <p>Overall sense of bloating 0 1 2 3</p> <p>Bodily swelling for no reason 0 1 2 3</p> <p>Hormone imbalances 0 1 2 3</p> <p>Weight gain 0 1 2 3</p> <p>Poor bowel function 0 1 2 3</p> <p>Excessively foul-smelling sweat 0 1 2 3</p> <p>Category IX</p> <p>Crave sweets during the day 0 1 2 3</p> <p>Irritable if meals are missed 0 1 2 3</p> <p>Depend on coffee to keep going/get started 0 1 2 3</p> <p>Get light-headed if meals are missed 0 1 2 3</p> <p>Eating relieves fatigue 0 1 2 3</p> <p>Feel shaky, jittery, or have tremors 0 1 2 3</p> <p>Agitated, easily upset, nervous 0 1 2 3</p> <p>Poor memory/forgetful 0 1 2 3</p> <p>Blurred vision 0 1 2 3</p> <p>Category X</p> <p>Fatigue after meals 0 1 2 3</p> <p>Crave sweets during the day 0 1 2 3</p> <p>Eating sweets does not relieve cravings for sugar 0 1 2 3</p> <p>Must have sweets after meals 0 1 2 3</p> <p>Waist girth is equal or larger than hip girth 0 1 2 3</p> <p>Frequent urination 0 1 2 3</p> <p>Increased thirst and appetite 0 1 2 3</p> <p>Difficulty losing weight 0 1 2 3</p>
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Category XI			
Cannot stay asleep	0	1	2 3
Crave salt	0	1	2 3
Slow starter in the morning	0	1	2 3
Afternoon fatigue	0	1	2 3
Dizziness when standing up quickly	0	1	2 3
Afternoon headaches	0	1	2 3
Headaches with exertion or stress	0	1	2 3
Weak nails	0	1	2 3
Category XII			
Cannot fall asleep	0	1	2 3
Perspire easily	0	1	2 3
Under 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 XIII			
Edema and swelling in ankles and wrists	0	1	2 3
Muscle cramping	0	1	2 3
Poor muscle endurance	0	1	2 3
Frequent urination	0	1	2 3
Frequent thirst	0	1	2 3
Crave salt	0	1	2 3
Abnormal sweating from minimal activity	0	1	2 3
Alteration in bowel regularity	0	1	2 3
Inability to hold breath for long periods	0	1	2 3
Shallow, rapid breathing	0	1	2 3
Category XIV			
Tired/sluggish	0	1	2 3
Feel cold—hands, feet, all over	0	1	2 3
Require excessive amounts of sleep to function properly	0	1	2 3
Increase in weight even with low-calorie diet	0	1	2 3
Gain weight easily	0	1	2 3
Difficult, infrequent bowel movements	0	1	2 3
Depression/lack of motivation	0	1	2 3
Morning headaches that wear off as the day progresses	0	1	2 3
Outer third of eyebrow thins	0	1	2 3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2 3
Dryness of skin and/or scalp	0	1	2 3
Mental sluggishness	0	1	2 3
Category XV			
Heart palpitations	0	1	2 3
Inward trembling	0	1	2 3
Increased pulse even at rest	0	1	2 3
Nervous and emotional	0	1	2 3
Insomnia	0	1	2 3

Category XV (Cont.)			
Night sweats	0	1	2 3
Difficulty gaining weight	0	1	2 3
Category XVI (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 XVII (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 XVIII (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 XIX (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? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat fish per week? _____

How many times do you eat out per week? _____

How many times do you work out per week? _____

How many times do you eat raw nuts or seeds 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

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

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®
- Pertofranc®
- Thaden™
- Prothiaden®
- Adapin®
- Sinequan®
- Tofranil®
- Janamine®
- Gamamil®
- Aventyl®
- Pamelor®
- Opipramol®
- Vivactyl®
- Rhotrimine®
- Surmontil®

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®
- Norpramin®
- 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®
- Propilniazide®
- Zyvox®
- Zyvoxid®

Dopamine Receptor Agonists

- Mirapex®
- Sifrol®
- Requip®

Norepinephrine and Dopamine Reuptake Inhibitors (NDRI)

- Wellbutrin XL®

D2 Dopamine Receptor Blockers (antipsychotics)

- Thorazine®
- Prolixin®
- Trilafon®
- Compazine®
- Mellaril®
- Stelazine®
- Vesprin®
- Nozinan®
- Depixol®
- Navane®
- Fluaxol®
- 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®
- Dalmanc®
- Ativan®
- Loramet®
- Sedoxil®
- Dormicum®
- Serax®
- Restoril®
- Halcion®

Agonist Modulators of GABA Receptors (non-benzodiazepines)

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

Acetylcholine Receptor Agonists

- Urecholine®
- Evoxac®
- Anectine®
- Salagen®
- Isopto®
- Nicotine

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

- Atracurium
- Cisatracurium
- Doxacurium
- Metocurine
- Mivacurium
- Pancuronium
- Rocuronium
- Anectine®
- Tubocurarine
- Vecuronium
- Hemicholinium

Acetylcholinesterase Reactivators

- Protopam®

Cholinesterase Inhibitors (reversible)

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

Cholinesterase Inhibitors (irreversible)

- Echothiophate
- Flexyx®
- Organophosphate insecticides
- Organophosphate-containing nerve agents

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

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

Family Health History

Patient Name: _____ Date: _____

Please review the conditions listed below and indicate those that are current health problems of a family member by the designation C under his or her column. The designation P should be used to indicate a past problem. Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	Children		
	Age	Age	Age	Age	Age	Age
Allergies						
Anxiety						
Asthma						
ADHD						
Back trouble						
Bed wetting						
Cancer						
Colic						
Constipation						
Depression						
Diabetes						
Disc problems						
Ear infections						
Emotional issues						
Emphysema						
Epilepsy						
Headaches						
Heart trouble						
Heart burn						
High blood pressure						
IBS						
Indigestion						
Infertility						
Insomina						
Kidney trouble						
Neck pain						
Nervousness						
Obesity						
Pinched nerve						
Scoliosis						
Sinus trouble						
Other						

Additional Comments: _____



Lake Pointe Wellness Center

Lifelong Wellness Programs

At Lake Pointe Wellness 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 nutraceutical protocols, allowing the body to do what it is programmed to do...*Heal Itself*.

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 it's content:

_____ Date: _____
Signature

Print Name

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

_____ Phone: _____

_____ Phone: _____