

NCR QUESTIONNAIRE

Name:	Phone: Home	Work
Street	City	State Zip
Birthdate	Social Security#	Occupation
Referred by:	Primary Care Physician:	
Emergency Contact:		
Chief Complaint:		
Current treatment with other physicians? Explain:		

How will payment be made?	Cash	Check	Credit Card	Health Insurance	Automobile Insurance	Workers Comp.
Insurance Company Name:	Tel #			ID#		
Insurance company Address:						
PLEASE PRESENT YOUR INSURANCE CARD FOR COPYING ALONG WITH YOUR DRIVER'S LICENSE						

Please list your complains in order of importance:

1. _____
2. _____
3. _____
4. _____

Is your health complaint getting better, worse, or staying the same? _____ How do you know? _____

Please check any of the below symptoms if you have experienced any of them in the last six (6) months:

- | | |
|---|--|
| <input type="checkbox"/> Headaches
<input type="checkbox"/> Jaw pain or clicking
<input type="checkbox"/> Visual disturbances
<input type="checkbox"/> Ringing in the ears
<input type="checkbox"/> Trouble with balance
<input type="checkbox"/> Dizziness/vertigo
<input type="checkbox"/> Allergies
<input type="checkbox"/> Sinus congestion
<input type="checkbox"/> Difficulty breathing through nose
<input type="checkbox"/> Post-nasal drip | <input type="checkbox"/> Facial paralysis
<input type="checkbox"/> Difficulty focusing/short attention span
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Wake up tired
<input type="checkbox"/> Wake up during night
<input type="checkbox"/> Loss of smell
<input type="checkbox"/> Loss of hearing
<input type="checkbox"/> Pain in face
<input type="checkbox"/> Numbness in face
<input type="checkbox"/> Sinus infections |
|---|--|

Please describe any major dental procedures that have been performed _____

Please describe any surgeries you have had which required general anesthesia _____

List any trauma(s) you may have had to your neck, back and head _____

Are you aware of any complications during your birth? Y N If yes, describe _____

Please mark which describes your sleeping habits:

- | | |
|---|---|
| <input type="checkbox"/> Sleep on stomach | <input type="checkbox"/> Wake up w/ anxiety |
| <input type="checkbox"/> Sleep on side | <input type="checkbox"/> Difficulty falling asleep |
| <input type="checkbox"/> Sleep on back | <input type="checkbox"/> Difficulty staying asleep |
| <input type="checkbox"/> Use orthopedic/supportive pillow | <input type="checkbox"/> Congestion that changes nostrils depending on side and sleep |
| <input type="checkbox"/> Wake up with neck, back and/or head pain | <input type="checkbox"/> Often eat late |
| <input type="checkbox"/> Snore | <input type="checkbox"/> Wake up often to urinate |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Wake up exhausted/tired |
| <input type="checkbox"/> Frequent use of sleeping pills | |
| <input type="checkbox"/> Frequent use of anxiety medication | |

If you are having difficulties breathing, please describe how you may be suffering from lack of oxygen _____

What have you tried to do to improve your problem (i.e, other doctors, treatments, etc.)? _____

What might it cost you if you don't improve your lifestyle and underlying contributors to your compromised health? (For example: vitality, longevity, joy, happiness, peace of mind, future physical independence, current and/or future relationships, career effectiveness, etc.) _____

Patient Signature

Date

Metabolic Assessment Form

Name: _____ Age: _____ Sex: _____

PART I

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

1. _____
2. _____
3. _____
4. _____
5. _____

PART II Please circle the appropriate number "0 - 3" 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 relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard dry or small stool	0	1	2	3
Coated tongue of "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Do you use laxatives frequently	0	1	2	3

Category II				
Excessive belching burping or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3

Category III				
Stomach pain, burning or aching 1- 4 hours after eating	0	1	2	3
Do you frequently use antacids	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0	1	2	3

Category IV				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage bloated	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Excessive passage of gas	0	1	2	3
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category V				
Greasy or high fat foods cause distress	0	1	2	3
Lower bowel gas and or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates for 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 VI				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded and if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category VII				
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 & appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category VIII				
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 IX				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X				
Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervousness and emotional	0	1	2	3
Insomnia	0	1	2	3
Night Sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII				
Diminished sex drive	0	1	2	3
Menstrual disorders of lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII				
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

Category XIV (Male Only)				
Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males Only)				
Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintain morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVI (Menstruating Females Only)				
Are you a menopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 24 days	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne break outs	0	1	2	3
Facial Hair Growth	0	1	2	3
Hair Loss/Thinning	0	1	2	3

Category XVII (Menopausal Females only)				
How many years have you been menopausal?				
Do you ever have uterine bleeding since menopause?	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 breast	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 alcohol beverages they consume per week? _____ How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____ How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____ How many times a week do you schedule for work outs? _____

List the three worst foods you eat during the average week? _____, _____, _____

List the three healthiest foods you eat during the average week? _____, _____, _____

Rate your stress levels on a scale of 1-10 during the average week. _____

Circle any of the following medication that you are currently taking?

- | | | | |
|-----------------|--------------------|-----------------------|----------------------|
| Antacids | Antihistamines | Diuretics | Hydrocortisone Cream |
| Antibiotics | Anti-Inflammatory | High Blood Pressure | Oral Contraceptives |
| Antidepressants | Anxiety Medication | High Cholesterol | Thyroid Hormones |
| Antifungals | Aspirin/Tylenol | Hormones Replacements | Others: |