

Dr. Amy Neuzil, N.D.
CONFIDENTIAL HEALTH INFORMATION

Name: _____ Today's Date: _____

How did you hear about us? Newspaper Yellow Pages Radio/TV Location
 Internet Referred by _____
 Other _____

Age: _____ Date of Birth: _____ Marital Status: _____

Permanent Address: _____

Mailing Address: _____

Email Address: _____

Phone (home): _____ (cell): _____ (work): _____

Name of spouse (or parent for minor child): _____

Whom may we contact in case of emergencies? Name: _____

Relationship to client: _____ Phone: _____

CLINIC POLICY REQUIRES PAYMENT AT THE TIME OF SERVICES.

We accept cash, check, Visa, Mastercard, AMEX, and Discover. We do not bill to insurance.

At the time of payment you can request a bill from our office. This will show the diagnosis, services, and charges for that day. You can submit this form directly to your insurance company for reimbursement. The following insurance information will assist our office in dealing with any possible follow up inquiries from your insurance company regarding your claims.

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. I hereby authorize Dr. Amy Neuzil, N.D. to furnish medical information to my insurance carriers should it be necessary. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable. Furthermore, any charges, fees, or court costs incurred as a result of collection efforts will be added to my account balance.

Client's Signature: _____ Date: _____

Signature of Parent or Guardian (for minors): _____

CONFIDENTIAL CLIENT INFORMATION

Please fill in all portions of this form. If you need help, please ask.

Name : _____ D.O.B. _____ Today's Date: _____

Please list the main reason(s) for your visit: _____

Symptoms: Please check all that apply

GENERAL

- Chills
- Fever
- Sleep Disturbance
- Sweats

EMOTIONAL

- Anxiety
- Depression
- Eating Disorder
- Fear/Panic
- High Strung
- Irritability
- Psychiatric Disorder
- Suicidal

NEUROLOGICAL

- Carpal Tunnel
- Dizziness
- Fainting
- Forgetfulness
- Numbness/Tingling
- Paralysis
- Sciatica
- Seizures

SKIN

- Bruise Easily
- Change in Moles
- Dry Skin
- Itching
- Rash
- Sores that Won't Heal
- Warts

HEENT

- Bleeding Gums
- Blurred Vision
- Cataracts
- Difficult Swallowing
- Double Vision
- Dry Eyes
- Earache
- Ear Discharge
- Hair Loss
- Headache
- Hearing Loss
- Hoarseness
- Glaucoma
- Gum Disease
- Migraine
- Mouth Sores
- Nasal Congestion
- Nosebleeds
- Persistent Cough
- Post Nasal Drip
- Ringing in Ears
- Sinus Problems
- Swollen Lymph Nodes
- Visual Disturbance

MUSCULOSKELETAL

- Joint Pain
- Lack of Coordination
- Stiffness
- Tremors
- Weakness

GI

- Bad Breath
- Bloating
- Bowel Changes
- Change in Appetite
- Constipation
- Diarrhea
- Excessive Thirst
- Gas
- Heartburn
- Hemorrhoids
- Indigestion
- Nausea
- Rectal Bleeding
- Stomach Pain
- Vomiting

HEART/LUNGS

- Chest Pain
- High Blood Pressure
- Irregular Pulse
- Low Blood Pressure
- Murmur
- Pain Breathing
- Palpitations
- Poor Circulation
- Rapid Heart Beat
- Short of Breath
- Suffocating Feeling
- Swelling Ankles
- Varicose Veins
- Wheezing

MALE ONLY

- Breast Lump
- Discharge from Penis
- Erection Difficulties
- Lump in Testicle
- Sore on Penis
- Testicular Pain
- Testicular Swelling
- Other: _____

FEMALE ONLY

- Abnormal Pap Smear
- Bleeding between Periods
- Breast Lump
- Heavy Bleeding
- Hot Flashes
- Nipple Discharge
- Painful Intercourse
- PMS
- Vaginal Discharge
- Vaginal Dryness
- Other

Last Menstrual Period: _____

Last Pap: _____

Have you had a Mammogram? _____

URINARY

- Blood in Urine
- Difficult Urination
- Frequent Infections
- Frequent Urination
- Lack of Bladder Control
- Painful Urination

MEDICATIONS:

Please List all medications and dosages

- _____
- _____
- _____
- _____
- _____
- _____

ALLERGIES:

Please List

- _____
- _____
- _____
- _____
- _____
- _____

HEALTH HABITS:

Please check any you use and indicate how much

- Coffee: _____
- Alcohol: _____
- Tobacco: _____
- Marijuana: _____
- Drugs: _____
- Other: _____

CONDITIONS

Please check (✓) any conditions you have had.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Psoriasis/Eczema |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal Disease |

FAMILY HISTORY

Relation:	<u>Father</u>	<u>Mother</u>	<u>Sibling 1</u>	<u>Sibling 2</u>	<u>Child 1</u>	<u>Child 2</u>
Age if living:						
Age at Death:						
Cause of Death:						

Please check if any of the following conditions applied to the above relatives:

- | | | | | | | |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Auto-Immune Disease: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack/Stroke: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental Illness: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| TB: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

PREGNANCY HISTORY

Number of Pregnancies: _____
 Number of Live Births: _____
 Check if you've had any of the following:
 Abortion Miscarriage Premie

SLEEP HISTORY

How many hours per night? _____
 Please check if you have any of the following:
 Frequent Waking Nightmares Snoring
 Nap during day Sleep walk Grind Teeth

OCCUPATION

Check if you are exposed to: Stress
 Heavy Lifting Hazardous Substances

EXERCISE

How often do you exercise? _____
 What type? _____

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Amy Neuzil, ND or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

CLIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives clients the right to request a restriction on the uses and disclosures of their protected health information (PHI). The individual is also given the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's residence. We would like to respect those rights in every way possible and request that you fill in the following:

I wish to be contacted in the following manner (check all that apply):

- Home Telephone _____
 - O.K. to leave message with detailed information
 - Leave message with name and call-back number only
- Work Telephone _____
 - O.K. to leave message with detailed information
 - Leave message with name and call-back number only
- Written Communication _____
 - O.K. to mail to my home address
 - O.K. to mail to my work address
 - O.K. to fax to this number: _____
- Other: _____

 Client Signature

 Date

 Print Name

 Date of Birth

Date	Disclosed to Whom Address/Fax	(1)	Description of Disclosure Purpose of Disclosure	By Whom Disclosed	(2)	(3)

- (1) Check this box if Disclosure is authorized
- (2) Type Key: T= Treatment Records P= Payment Information O= Healthcare Operations
- (3) Enter how disclosure was made: F=Fax; P= Phone ; E= Email; M= Mail; O= Other

Privacy regulations generally require healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary. These provisions do not apply to uses or disclosures requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided above constitutes an adequate record.

Note: Uses and disclosures for PHI may be permitted without prior consent in an emergency.

Complementary and Alternative Health Client Bill of Rights

As a valued client of Excelon Health, it is important that you are fully aware of the laws surrounding Naturopathic Medicine. If you have any questions or concerns please talk with myself, Dr. Amy Neuzil, N.D. I will be more than happy to discuss them with you.

The state of Texas does not regulate Naturopathic Doctors, or the use of the title "N.D." For this reason it is especially important to verify your Naturopathic Doctor's training and certification. I attended a fully accredited four-year post graduate program at Southwest College of Naturopathic Medicine in Phoenix Arizona. I passed board exams in the State of Arizona and I hold a current and valid Arizona license (AZ# 03-781). Texas does not license Naturopathic Doctors at this time.

Due to lack of State licensing in Texas, I am not legally able to prescribe pharmaceutical drugs, perform minor surgeries, administer injections, diagnose or treat disease. I AM able to use natural methods like supplements, homeopathy, herbs and lifestyle changes to improve your health as a whole person. **The goal is to increase your overall health and vitality as a whole person thereby decreasing the symptoms you suffer and encouraging vibrant health.** If you are interested in learning more about naturopathic medicine and current licensing efforts please see our national association, the AANP at www.naturopathic.org or our state association, TXANP at www.txanp.org.

I stand firmly behind the quality of care you will receive. Please do not hesitate to ask questions or give feedback. I look forward to being your partner in health.

The fee schedule is as follows:

New Clients:

Standard New Client Visits (up to 1.5 hours): \$240.00

New Client Visits for Infants or Children 10 and Under (up to 1 hour): \$160.00

Established Clients (in person or over the phone):

Standard Follow-up Visit (up to 30 min): \$80

Extended Follow-up Visit (up to 45 min): \$120

Compliated Follow-up Visit (up to 1 hour):\$160

Phone or Email Questions or Check-Ins:

General questions (less that 5 minutes): Free within reasonable use. I consider this to be part of our relationship and will only bill if the calls or emails are frequent or extremely complicated.

Complicated calls or emails (up to 15 minutes): \$55

Questions requiring more time: Billed as regular visits.

Because Naturopathic Doctors are not yet licensed in the State of Texas, I require that you maintain a relationship with your primary care physician.

Signature of Client or Guardian

Date

Name of Client or Guardian

General Symptoms

The following questions pertain to you as a whole person.

Which weather conditions make you uncomfortable (please circle any that apply)?

Cloudy	Clear
Wet	Dry
Damp cold	Snow (Dry Cold)
Humid Heat	Dry Heat
Storms	Wind
Fog	Hot Sun

Circle which seasons cause you the most trouble?

Winter	Spring
Fall	Summer

Do you feel better (circle one):

In the Mountains	At the Seashore
Both	Neither

Are you sensitive to and/or troubled by(circle all that apply):

Bright Light	Darkness
Open Air	Stuffy Rooms
Tight Clothing	Noise
Odors	Drafts

Are you generally chilly or warm?

Chilly	Neutral	Warm
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Does it bother you more to be too hot or too cold?

Too Cold	No Preference	Too Hot
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How do you experience sympathy or consolation?

Like sympathy	Neutral	Dislike sympathy
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Do you prefer to be alone or with people?

Alone	With Others
1 2 3 4 5 6 7 8 9 10	

Circle which best expresses your general mood.

Sad
Apathy/Indifferent
Up and Down
Happy
Excitement
Exhilaration

What time(s) of day are you usually worst (mood, energy, symptoms, etc.)?

Worst: _____

What time(s) of day are you generally best (mood, energy, symptoms, etc.)?

Best: _____

Circle all symptoms you experience during sleep.

Tooth Grinding
Restlessness
Talking
Perspiration
Frequent Urination
Excess Heat or Cold
Laughing
Snoring
Sleepwalking
Arms or legs out of the covers

What position do you sleep in most often?

Right Side	On Back
On Knees	Knee to Chest
Left Side	On Abdomen

Is there a position you can not sleep in?

Right Side	On Back
On Knees	Knee to Chest
Left Side	On Abdomen

How much do you perspire?

Never	Sometimes	Most of the Time	All the Time
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Do you have difficulty waking?

Never	Sometimes	Most of the Time	All the Time
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Do you wake unrefreshed?

Never	Sometimes	Most of the Time	All the Time
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Do you wake-up at the same time many nights?

Time: _____

Food Desires and Aversions:

In the following questions you are asked how much you desire or are averse to a particular food or taste. Please answer from the point of view of your natural desires, not your knowledge of nutrition. For example, you may never eat fatty meat because this is known to increase cholesterol, however you do love the taste of fat. Answer the question that you like fat. If you strongly desire or crave a food or taste, mark 10. If you detest or are averse to a food or taste, mark 1.

Tastes:

1 2 3 4 5 6 7 8 9 10	Sweet	1 2 3 4 5 6 7 8 9 10	Ham
1 2 3 4 5 6 7 8 9 10	Sour	1 2 3 4 5 6 7 8 9 10	Ice
1 2 3 4 5 6 7 8 9 10	Salty	1 2 3 4 5 6 7 8 9 10	Ice cream
1 2 3 4 5 6 7 8 9 10	Bitter	1 2 3 4 5 6 7 8 9 10	Indigestible things (chalk, clay, paper)
1 2 3 4 5 6 7 8 9 10	Spicy (hot)	1 2 3 4 5 6 7 8 9 10	Lemonade
1 2 3 4 5 6 7 8 9 10	Smoked	1 2 3 4 5 6 7 8 9 10	Meat
1 2 3 4 5 6 7 8 9 10	Juicy	1 2 3 4 5 6 7 8 9 10	Milk
1 2 3 4 5 6 7 8 9 10	Refreshing	1 2 3 4 5 6 7 8 9 10	Nut butters

Foods:

1 2 3 4 5 6 7 8 9 10	Alcohol	1 2 3 4 5 6 7 8 9 10	Oysters
1 2 3 4 5 6 7 8 9 10	Apples	1 2 3 4 5 6 7 8 9 10	Pickles
1 2 3 4 5 6 7 8 9 10	Bacon	1 2 3 4 5 6 7 8 9 10	Vegetables
1 2 3 4 5 6 7 8 9 10	Bread alone	1 2 3 4 5 6 7 8 9 10	Vinegar

Which do you prefer?

1 2 3 4 5 6 7 8 9 10	Bread with butter	Warm Food	No Preference	Cold Food
1 2 3 4 5 6 7 8 9 10	Butter alone	Warm Drinks	No Preference	Cold Drinks

**Do you notice any specific tastes in your mouth?
Please Circle:**

1 2 3 4 5 6 7 8 9 10	Coffee	Metallic	Bitter	No Taste
1 2 3 4 5 6 7 8 9 10	Pastries	Sweet	Sour	Salty

How thirsty are you generally?

1 2 3 4 5 6 7 8 9 10	Fat (meat, chicken pork, etc.)	Never	Somewhat	Medium	Often	Always
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Do you feel better or worse from physical exertion?

1 2 3 4 5 6 7 8 9 10	Fruit	Much Better	Better	No Change	Worse	Much Worse
1 2 3 4 5 6 7 8 9 10	Fruit (sour)					
1 2 3 4 5 6 7 8 9 10	Grain products (Pasta, bread, cereal)					

Mental and Emotional State:

How strong in general are the following emotional symptoms? (1 = not strong, 10 = overwhelming)

1 2 3 4 5 6 7 8 9 10 Anxiety (worry and fear)

Do you worry about any of the following?
 (1 = not at all, 10 = very much)

1 2 3 4 5 6 7 8 9 10 Emotions

1 2 3 4 5 6 7 8 9 10 Financial Security

1 2 3 4 5 6 7 8 9 10 Health

1 2 3 4 5 6 7 8 9 10 Mental Functioning

1 2 3 4 5 6 7 8 9 10 Morals/Past Indiscretions

1 2 3 4 5 6 7 8 9 10 Others (family and close friends) well being

1 2 3 4 5 6 7 8 9 10 Religion

1 2 3 4 5 6 7 8 9 10 Social Life

1 2 3 4 5 6 7 8 9 10 Social Position

1 2 3 4 5 6 7 8 9 10 Future Work

Answer as honestly as you can about your personality traits.

Frightened Easily	Neutral	Never Afraid
Stingy	Neutral	Overly Generous
Thrifty	Neutral	Extravagant
Hurried/Impatient	Neutral	Slow
Messy	Average	Fastidious
Calm	Average	Restless
Lazy	Average	Always busy
Shy/Timid	Average	Outgoing
Bad Temper	Average	Mild/Yielding
Never to Blame	Sometimes	Always My Fault
Stubborn	Average	Yielding
Reckless	Average	Cowardly

Circle the expression that best describes your feelings about the following issues.

Significant past emotionally traumatic events:

- Resolved Grief
- Dwells on Past
- Inconsolable
- Remorse
- Guilt

Feeling towards people close to you:

- Loving
- Affectionate
- Indifferent
- Resentment
- Hatred

Feeling toward life:

- Love life
- Changeable
- Indifferent
- Bored/Weary of life
- Loathing of life
- Desires death
- Suicidal thoughts or actions

Feeling toward spouse/lover/partner:

- Loving
- Affectionate
- Dissatisfaction
- Disappointed
- Indifferent
- Resentment
- Hatred

How much do you experience the following?
 1 = hardly ever, 10 = all the time.

1 2 3 4 5 6 7 8 9 10	Capriciousness
1 2 3 4 5 6 7 8 9 10	Irresolution
1 2 3 4 5 6 7 8 9 10	Irritability
1 2 3 4 5 6 7 8 9 10	Jealousy
1 2 3 4 5 6 7 8 9 10	Moodiness
1 2 3 4 5 6 7 8 9 10	Selfishness

Please rate yourself on the following scales:

Quiet Average Talkative

Not trusting Average Trusting

How often and easily do you weep?

Never Occasionally Regularly Often

How often do you experience clairvoyance?

Never Occasionally Regularly Often

How is your level of self-confidence?

Very Low Low Average High Very High

How impulsive are you?

Not at all Average Very Impulsive

Are you forgetful of any of the following?

Dates Names Numbers

What someone just said to you Words

What you just said Directions/Location

Do you often make mistakes with the following?

Numbers Words (reading)

Words (speaking) Words (writing)

How sensitive are you to the following?

(1 = not at all, 10 = extremely sensitive)

1 2 3 4 5 6 7 8 9 10 Beauty

1 2 3 4 5 6 7 8 9 10 Criticism

1 2 3 4 5 6 7 8 9 10 Cruel Stories

1 2 3 4 5 6 7 8 9 10 Frightening things

1 2 3 4 5 6 7 8 9 10 Being made fun of

1 2 3 4 5 6 7 8 9 10 Music

1 2 3 4 5 6 7 8 9 10 Reprimand

1 2 3 4 5 6 7 8 9 10 Rudeness

1 2 3 4 5 6 7 8 9 10 The suffering of others

1 2 3 4 5 6 7 8 9 10 The suffering of animals

How afraid are you of the following?

(1 = never afraid. 10 = terrified)

1 2 3 4 5 6 7 8 9 10 Animals

1 2 3 4 5 6 7 8 9 10 Being alone

1 2 3 4 5 6 7 8 9 10 Death

1 2 3 4 5 6 7 8 9 10 Relative's Death

1 2 3 4 5 6 7 8 9 10 Disease

1 2 3 4 5 6 7 8 9 10 Downward Motion

1 2 3 4 5 6 7 8 9 10 Evil

1 2 3 4 5 6 7 8 9 10 Falling

1 2 3 4 5 6 7 8 9 10 Ghosts

1 2 3 4 5 6 7 8 9 10 Heights

1 2 3 4 5 6 7 8 9 10 Insanity

1 2 3 4 5 6 7 8 9 10 Misfortune (bad luck)

1 2 3 4 5 6 7 8 9 10 Of a Crowd

1 2 3 4 5 6 7 8 9 10 People

1 2 3 4 5 6 7 8 9 10 Robbers/Intruders

1 2 3 4 5 6 7 8 9 10 Snakes

1 2 3 4 5 6 7 8 9 10 Spiders

1 2 3 4 5 6 7 8 9 10 Strangers

1 2 3 4 5 6 7 8 9 10 Having a Stroke

1 2 3 4 5 6 7 8 9 10 That something will happen

1 2 3 4 5 6 7 8 9 10 Darkness

1 2 3 4 5 6 7 8 9 10 Thunderstorm

1 2 3 4 5 6 7 8 9 10 Water

1 2 3 4 5 6 7 8 9 10 Wind

How do you usually handle conflict?

Quarrelsome Average Yielding

How are you with regards to authority?

Hate Authority Bossy Average Yielding

How critical are you of others?

Not at All Average Always Critical

1 2 3 4 5 6 7 8 9 10

Striking or injuring others

1 2 3 4 5 6 7 8 9 10

Striking or injuring yourself

How critical are you of yourself?

Not at All Average Always Critical

Do any of the following pertain to your dreams (during sleep)?

How often do you reproach (find fault, scold, or blame) others?

Not at All Rarely Often All the Time

Do not remember dreams

Dreams are prophetic

Dreams continue after brief waking (to use restroom etc...)

Dreams cause waking

Dreams happen while awake

How often do you reproach yourself?

Not at All Rarely Often All the Time

Do you dream (during sleep) of any of the following?

How honest are you?

Always Lie Sometimes Lie Always honest

Accidents

Business

Dead People

Death (your own)

Events of the Day

Falling

Fire

Ghosts

Misfortune

The Future (visionary)

Robbers

Water

Embarrassment

Other: _____

How often do you have the following behaviors?

1 2 3 4 5 6 7 8 9 10 Biting

1 2 3 4 5 6 7 8 9 10 Biting Nails

1 2 3 4 5 6 7 8 9 10 Breaking Things

1 2 3 4 5 6 7 8 9 10 Contradictory

1 2 3 4 5 6 7 8 9 10 Cursing

1 2 3 4 5 6 7 8 9 10 Disobedience

1 2 3 4 5 6 7 8 9 10 Insolence (insulting, boldly rude)

1 2 3 4 5 6 7 8 9 10 Rage

My Sexual Desire is:

Low Below Average Average High Very High

My Sexual Desire has Changed From Normal:

Yes Maybe No

I have Concerns About My Sex Life:

Yes Maybe No

Thank you so much for taking the time to fill out this paperwork accurately. We will use it in the initial visit to help determine the best course of action. I know some of the questions seem unrelated, but often they bring new information to light that most people wouldn't think to talk about in a typical doctors visit. The more information I have, the more accurately I can design a plan for you that will work in your circumstances. I look forward to working with you!

-Dr. Amy Neuzil, ND