

Dr. Amy Neuzil, N.D.
CONFIDENTIAL PATIENT 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 patient: _____ **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.

Excelon Health does not bill to insurance, but we can provide you with a superbll which you can submit for reimbursement. If you would like a superbill after each visit please check here.

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and myself. I hereby authorize Dr. Amy Neuzil 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 and treatment, 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.

Patient's Signature: _____ **Date:** _____

Signature of Parent or Guardian (for minors): _____

Dr. Amy Neuzil, N.D.

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

Patient Name _____ Today's Date _____
Reason(s) for Visit _____

Symptoms: Please check all that apply

GENERAL <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Sleep Disturbance <input type="checkbox"/> Sweats EMOTIONAL <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Fear/Panic <input type="checkbox"/> High Strung <input type="checkbox"/> Irritability <input type="checkbox"/> Psychiatric Disorder <input type="checkbox"/> Suicidal NEUROLOGICAL <input type="checkbox"/> Carpal Tunnel <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Paralysis <input type="checkbox"/> Sciatica <input type="checkbox"/> Seizures SKIN <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Change in Moles <input type="checkbox"/> Dry Skin <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Sores that Won't Heal <input type="checkbox"/> Warts	HEENT <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Cataracts <input type="checkbox"/> Difficult Swallowing <input type="checkbox"/> Double Vision <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Earache <input type="checkbox"/> Ear Discharge <input type="checkbox"/> Hair Loss <input type="checkbox"/> Headache <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hoarseness <input type="checkbox"/> Glaucoma <input type="checkbox"/> Gum Disease <input type="checkbox"/> Migraine <input type="checkbox"/> Mouth Sores <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Post Nasal Drip <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Swollen Lymph Nodes <input type="checkbox"/> Visual Disturbance MUSCULOSKELETAL <input type="checkbox"/> Joint Pain <input type="checkbox"/> Lack of Coordination <input type="checkbox"/> Stiffness <input type="checkbox"/> Tremors <input type="checkbox"/> Weakness	GI <input type="checkbox"/> Bad Breath <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel Changes <input type="checkbox"/> Change in Appetite <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Stomach Pain <input type="checkbox"/> Vomiting HEART/LUNGS <input type="checkbox"/> Chest Pain <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Irregular Pulse <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Murmur <input type="checkbox"/> Pain Breathing <input type="checkbox"/> Palpitations <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Rapid Heart Beat <input type="checkbox"/> Short of Breath <input type="checkbox"/> Suffocating Feeling <input type="checkbox"/> Swelling Ankles <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Wheezing	MALE ONLY <input type="checkbox"/> Breast Lump <input type="checkbox"/> Discharge from Penis <input type="checkbox"/> Erection Difficulties <input type="checkbox"/> Lump in Testicle <input type="checkbox"/> Sore on Penis <input type="checkbox"/> Testicular Pain <input type="checkbox"/> Testicular Swelling <input type="checkbox"/> Other: _____ FEMALE ONLY <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between Periods <input type="checkbox"/> Breast Lump <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> PMS <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Vaginal Dryness <input type="checkbox"/> Other Last Menstrual Period: _____ Last Pap: _____ Have you had a Mammogram? _____ URINARY <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Difficult Urination <input type="checkbox"/> Frequent Infections <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Lack of Bladder Control <input type="checkbox"/> Painful Urination
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MEDICATIONS
Please List all medications and dosages

ALLERGIES
Please List:

HEALTH HABITS
Please check which substances you use and list how much:
 Coffee: _____
 Tobacco: _____
 Alcohol: _____
 Drugs: _____

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"/> Bulemia | <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"/> |
| TR: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

HOSPITALIZATIONS, SURGERIES AND MAJOR ILLNESSES

Year	Condition or Procedure	Outcome
<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 my doctor 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: _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives patients 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):

- | | |
|--|---|
| <input type="checkbox"/> Home Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication
<input type="checkbox"/> O.K. to mail to my home address
<input type="checkbox"/> O.K. to mail to my work address
<input type="checkbox"/> O.K. to fax to this number:
_____ |
| <input type="checkbox"/> Work Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only | <input checked="" type="checkbox"/> Other: _____

_____ |

_____	_____
Patient Signature	Date
_____	_____
Print Name	Birthday

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 to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided above, if completed properly, will constitute an adequate record.

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

Naturopathic Medicine Legal Disclosure

As a valued client of Excelon Health, it is important to us that you, as our patient, are fully aware of the laws surrounding Naturopathic Medicine. If you have any questions or concerns please do not hesitate to speak with Dr. Neuzil, she will be happy to answer any questions you may have.

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 Naturopath’s training and certification. Dr. Amy Neuzil attended a fully accredited four-year post doctorate program at Southwest College of Naturopathic Medicine. She sat for board exams for the state of Arizona and carries a current and valid Arizona license (03-781). In Arizona Naturopaths are licensed as primary care physicians and can diagnose, treat, prescribe pharmaceutical medications and even perform minor surgery.

Naturopathic doctors are not licensed in Texas at this time, largely due to strong opposition from unlicensed alternative health care providers who feel that full licensure for Naturopaths would negatively impact their business. Due to lack of state licensure, Dr. Neuzil is not legally able to prescribe pharmaceutical drugs, perform minor surgeries, administer injections, diagnose, or treat disease. Dr. Neuzil is still able to treat her patients as whole people using natural methods which leads to an increase in overall health and wellness, and a lessening of symptoms. If you are interested in learning more about Naturopathic Medicine and current licensing efforts, please go to www.naturopathic.org.

Excelon Health and Dr. Amy Neuzil firmly stand behind the quality of our care. Please do not hesitate to ask questions or give us feedback. We look forward to being a partner in your healthcare!

Our fee schedule is as follows:

- New Patient visits are \$280 for standard (1.5 hours) and \$330 for extended appointments
- New Patient visits for infants or acute cases are \$225 (1 hour)
- Follow up visits for established patients including phone consults are billed as follows:
 - \$70 for limited visits (up to 20 minutes)
 - \$90 for extended
 - \$120 for complicated
- Cancellations with less than 24 hours notice will be billed.

Because Naturopathic Physicians are not yet licensed as primary care practitioners in the state of Texas, it is recommended that you continue services with your primary care physician.

Signature

Print Name

Date

The following pertain to you as a whole person.

Which weather conditions are you most troubled by?

Cloudy 1 2 3 4 5 6 7 8 9 10	Clear
Wet 1 2 3 4 5 6 7 8 9 10	Dry
Damp cold 1 2 3 4 5 6 7 8 9 10	Snow (Dry Cold)
1 2 3 4 5 6 7 8 9 10	Storms
1 2 3 4 5 6 7 8 9 10	Wind
1 2 3 4 5 6 7 8 9 10	Fog
1 2 3 4 5 6 7 8 9 10	Hot Sun

Circle which seasons cause you the most trouble?

Winter	Spring
Fall	Summer

Do you feel better:

1 2 3 4 5 6 7 8 9 10	In the Mountains
1 2 3 4 5 6 7 8 9 10	At the Seashore

Are you sensitive to and/or troubled by:

1 2 3 4 5 6 7 8 9 10	Bright Light
1 2 3 4 5 6 7 8 9 10	Darkness
1 2 3 4 5 6 7 8 9 10	Open Air
1 2 3 4 5 6 7 8 9 10	Stuffy Rooms
1 2 3 4 5 6 7 8 9 10	Tight Clothing
1 2 3 4 5 6 7 8 9 10	Noise
1 2 3 4 5 6 7 8 9 10	Odors
1 2 3 4 5 6 7 8 9 10	Drafts

Are you generally chilly or warm?

Chilly 1 2 3 4 5 6 7 8 9 10	Warm
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Which are you most sensitive to, warm or cold?

Cold 1 2 3 4 5 6 7 8 9 10	Warm
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What time(s) of day are you generally 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

Circle all that you prefer. Do you sleep:

- Without Covers
- Partly Covered
- Fully Covered (Not including Head)
- Fully Covered (Including Head)
- With Arms or Legs Out of the Covers
- Without Clothing
- With a Fan or Air Blowing on You
- With the Window open

What position do you sleep in most often?

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

How much do you perspire?

Never	All the Time
1 2 3 4 5 6 7 8 9 10	

Do you have difficulty waking?

Never	All the Time
1 2 3 4 5 6 7 8 9 10	

Do you wake unrefreshed?

Never	All the Time
1 2 3 4 5 6 7 8 9 10	

Do you wake-up at the same time many nights?

Time: _____

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 Never Afraid
1 2 3 4 5 6 7 8 9 10

Stingy Overly generous
1 2 3 4 5 6 7 8 9 10

Thrifty Extravagant
1 2 3 4 5 6 7 8 9 10

Hurried, impatient Slow
1 2 3 4 5 6 7 8 9 10

Messy Fastidious
1 2 3 4 5 6 7 8 9 10

Calm Restless
1 2 3 4 5 6 7 8 9 10

Indolence (Lazy) Always busy
1 2 3 4 5 6 7 8 9 10

Shyness/Timidity Outgoing
1 2 3 4 5 6 7 8 9 10

Anger Mildness
1 2 3 4 5 6 7 8 9 10

Lack of moral sense Guilty
1 2 3 4 5 6 7 8 9 10

No Religious feeling Highly Religious feeling
1 2 3 4 5 6 7 8 9 10

Obstinate (stubborn) Yielding
1 2 3 4 5 6 7 8 9 10

Heedless/Reckless Cowardice
1 2 3 4 5 6 7 8 9 10

Do you prefer to be alone or with people?

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

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 disease/condition:

- Optimistic
- Doubtful of recovery
- Discouraged
- Fearful
- Despair of recovery

Feeling toward life:

- Love life
- Changeable
- Indifferent
- Bored
- Weary of life
- Loathing of life
- Desires death
- Suicidal thoughts
- Suicidal disposition

Feeling toward spouse/lover:

- 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

Alternating Moods Even Moods
1 2 3 4 5 6 7 8 9 10

Circle which best expresses your general mood.

- Morose
- Sad
- Apathy/Indifferent
- Up and Down
- Happy
- Excitement
- Exhilaration

How do you experience sympathy or consolation?

Like sympathy Dislike sympathy
1 2 3 4 5 6 7 8 9 10

Better from Worse from
1 2 3 4 5 6 7 8 9 10

Please rate yourself on the following scales:

Quiet Talkative
1 2 3 4 5 6 7 8 9 10

Not trusting Trusting
1 2 3 4 5 6 7 8 9 10

Gullible Suspicious
1 2 3 4 5 6 7 8 9 10

How often and easily do you weep?

Never Often
1 2 3 4 5 6 7 8 9 10

How often do you experience clairvoyance?

Never Often
1 2 3 4 5 6 7 8 9 10

How is your level of self-confidence?

Low Self-Esteem Proud/Haughty
1 2 3 4 5 6 7 8 9 10

How impulsive are you?

Not at all Very
1 2 3 4 5 6 7 8 9 10

Are you forgetful of any of the following?
(1 = not at all, 10 = all the time)

1 2 3 4 5 6 7 8 9 10 Dates

1 2 3 4 5 6 7 8 9 10 Names

1 2 3 4 5 6 7 8 9 10 Numbers

1 2 3 4 5 6 7 8 9 10 What someone just said to you

1 2 3 4 5 6 7 8 9 10 What you just said

1 2 3 4 5 6 7 8 9 10 Words

1 2 3 4 5 6 7 8 9 10 Directions/Location

How often do you make mistakes with the following? (1 = never, 10 = all the time)

1 2 3 4 5 6 7 8 9 10 Numbers

1 2 3 4 5 6 7 8 9 10 Words (reading)

1 2 3 4 5 6 7 8 9 10 Words (speaking)

1 2 3 4 5 6 7 8 9 10 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 Yielding
1 2 3 4 5 6 7 8 9 10

How are you with regards to authority?

Bossy/Dictatorial Yielding/Fawning
1 2 3 4 5 6 7 8 9 10

How critical are you of others?

Not at All All the Time
1 2 3 4 5 6 7 8 9 10

How critical are you of yourself?

Not at All All the Time
1 2 3 4 5 6 7 8 9 10

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

Not at All All the Time
1 2 3 4 5 6 7 8 9 10

How often do you reproach yourself?

Not at All All the Time
1 2 3 4 5 6 7 8 9 10

How honest are you?

Always Lie Always honest
1 2 3 4 5 6 7 8 9 10

How often do you have the following behaviors?

- 1 2 3 4 5 6 7 8 9 10 Abusive
- 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
- 1 2 3 4 5 6 7 8 9 10 Rudeness
- 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
- 1 2 3 4 5 6 7 8 9 10 Violence

Do any of the following pertain to your dreams (during sleep)? (1 = not at all, 10 = often)

- 1 2 3 4 5 6 7 8 9 10 Do not remember dreams
- 1 2 3 4 5 6 7 8 9 10 Dreams are prophetic
- 1 2 3 4 5 6 7 8 9 10 Dreams continue after brief waking (to use restroom etc...)
- 1 2 3 4 5 6 7 8 9 10 Dreams cause waking

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

- 1 2 3 4 5 6 7 8 9 10 Business
- 1 2 3 4 5 6 7 8 9 10 Dead People
- 1 2 3 4 5 6 7 8 9 10 Death (your own)
- 1 2 3 4 5 6 7 8 9 10 Events of the Day
- 1 2 3 4 5 6 7 8 9 10 Falling
- 1 2 3 4 5 6 7 8 9 10 Fire
- 1 2 3 4 5 6 7 8 9 10 Ghosts
- 1 2 3 4 5 6 7 8 9 10 Misfortune
- 1 2 3 4 5 6 7 8 9 10 The Future (visionary)
- 1 2 3 4 5 6 7 8 9 10 Robbers
- 1 2 3 4 5 6 7 8 9 10 Water

Other: _____

Sexual Health

Please circle the best approximation of your sexual desire. This indicates your desire and not your actual frequency.

- Never
- 1x/year
- 1x/3mo
- 1x/mo.
- 2x/mo.
- 1x/wk.
- 2x/wk.
- 4x/wk.
- 1x/day
- 2x/day
- 4x/day

How often do you actually have sex?

- Never
- 1x/year
- 1x/3mo
- 1x/mo.
- 2x/mo.
- 1x/wk.
- 2x/wk.
- 4x/wk.
- 1x/day
- 2x/day
- 4x/day

How often do you masturbate?

- Never
- 1x/year
- 1x/3mo
- 1x/mo.
- 2x/mo.
- 1x/wk.
- 2x/wk.
- 4x/wk.
- 1x/day
- 2x/day
- 4x/day

What worries or concerns do you have about your sexual life?

Not enough desire Too much desire
1 2 3 4 5 6 7 8 9 10

Not enough sex Too much sex
1 2 3 4 5 6 7 8 9 10

- 1 2 3 4 5 6 7 8 9 10 Lack of enjoyment
- 1 2 3 4 5 6 7 8 9 10 Difficulty reaching orgasm
- 1 2 3 4 5 6 7 8 9 10 Impotence
- 1 2 3 4 5 6 7 8 9 10 Troubling fantasies or thoughts
- 1 2 3 4 5 6 7 8 9 10 Sexual confidence
- 1 2 3 4 5 6 7 8 9 10 "Unusual" sexual practices or desire