AMEN CLINICS, INC. A MEDICAL CORPORATION

PATIENT INFORMATION

Please use **BLUE** or **BLACK** ink and write **LEGIBLY.**

Patient's Name: _____SS#_____ - _____ - _____ Sex: ☐ Male ☐ Female

Date of Birth: _____ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race: _____ Religion: _____ Number of Children: _____

Home Address: _____

Home Phone: (_____)_____Cell Phone: (_____)_____ Occupation: _____ ☐ Student

Employer (School, if student): _____ Work/School Phone: (_____) _____

Employer/School Address:_____

E-mail Address:_____ Fax Phone: (_____)_____

SPOUSE'S INFORMATION

Spouse's Name: _____ SS#_____ - _____ - _____ Date of Birth: _____Age: _____

Spouse's Occupation/Employer: _____ Address:_____

RESPONSIBLE PARTY

Responsible Party: _____ SS#_____ - _____ - _____ Date of Birth: _____Age: _____

Home Address: _____

Home Phone: (_____)_____ Occupation:_____

Employer: _____Work Phone: (_____)_____

Employer Address: _____ Driver's License No.:_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

INSURANCE BILLING: Amen Clinics, Inc. (ACI) does not bill insurance. We will provide patients with receipts that may be submitted to insurance carriers for reimbursement. Patients/Responsible Parties are responsible for all charges whether or not they are covered by your insurance. **ACI is not a Medicare, Medicaid or Medi-Cal provider.**

PAYMENT POLICY: ACI requires payment for services at the time they are rendered. The cost of the 5-step evaluation procedure is $3,575 and must be paid in full at the time of your visit. Payment may be made by personal check or credit card (American Express, MasterCard or Visa). Cash is NOT accepted. Since patients are expected to maintain a zero balance, our office does not send patients statements. Accounts need to stay current in order to maintain ongoing treatment. Unpaid accounts over 30 days old are routinely reviewed for submission to our collection agency.

FEES CHARGED: Charged appointments by ACI physician/therapists are scheduled for 20-25 minutes (fee: $175) or 45-50 minutes (fee: $350), depending upon the patient's issues. In addition, patients are charged for time spent with a physician on the telephone, time taken to write triplicate prescriptions outside of scheduled appointments, and time taken to write reports or correspondence on patient's behalf. In the event that your ACI clinician is required to write a legal report, be at a deposition, or testify in court, a different fee structure will apply.

APPOINTMENT CANCELLATION POLICY: ACI is committed to providing quality and timely service to our patients. Therefore, due to the complicated nature of scheduling several appointments and holding appointments to accommodate our patient's needs, the $500.00 start-up fee is non-refundable. Changes or cancellations of full evaluation appointments must be made a minimum of 5 business days before the first scheduled appointment time in order to apply the $500 deposit for rescheduled appointments. If cancellations are made less than 5 business days before the first scheduled appointment, the $500 deposit will be forfeited to the clinic.

For on-going appointments with our physicians/therapists, ACI requires that cancellations for scheduled appointments be received 24 "business" hours in advance during regular office hours (Monday through Friday 8:00am to 5:00pm). **Unkept or late cancelled appointments will be charged** the full fee for the appointment. Insurance companies do not pay for unkept appointment fees and the patient/responsible party is held fully accountable for this charge.

REFUNDS:

- Approved refunds of credit card payments will be credited to the patients account within five (5) business days.
- Approved refunds of check payments will be refunded by check and mailed to the patient within ten (10) business days.

I HAVE READ AND UNDERSTAND THE ABOVE STATED POLICIES OF AMEN CLINICS, INC.

Patient's Name:_____ **Patient's Signature:**_____

Responsible Party's Signature:_____ **Date:**_____

Newport Beach Clinic: 4019 Westerly Place, Ste. 100, Newport Beach, CA 92660 (949) 266-3700 FAX: (949) 266-3750
Brisbane Clinic: 1000 Marina Boulevard Suite 100, Brisbane, CA 94005 (650) 416-7830 FAX: (650) 871-8874
Northwest Clinic: 616 120th Ave NE, Suite C100, Bellevue, WA 98005 (877) 685-5554 FAX: (425) 454-7845
Washington DC Clinic: 1875 Campus Commons Drive, Suite 101, Reston, VA 20191 (703) 880-4000 FAX: (703) 860-5760

Amen Clinics, Inc.

A Medical Corporation

www.amenclinics.com

Adult Intake Questionnaires

In order for us to be able to fully evaluate you, please fill out the following intake form and questionnaires to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information you do not want in your medical chart it is ok to refrain from putting it in this information. Thank you!

REFERRAL SOURCE

How did you first learn about the Amen Clinics? _____

Please complete the following if a professional referred you to our clinic.

Name:_____ Phone #_____ Fax # _____

Specialty/Credentials:_____

Address _____

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

WHY DID YOU SEEK THE EVALUATION AT THIS TIME? What are your goals in being here?

_____

_____

_____

_____

_____

PAST AND PRESENT PSYCHIATRIC MEDICATIONS

We included a detailed list of most psychiatric medication on pages 4-5 to be used as a reference. The information the doctor needs to know in order to do a through evaluation is:

1. The name of the medication
2. The mg, dose
3. The amount of tablets or mg you took in one day
4. The approximate dates taken – preferably in sequential order
5. Whether the medicine worked well, worked partially, or did not work at all.
6. If you took any medications in combination with other medications
7. Any side effects or adverse effects from the medication

If you need more room, please attach another sheet.

Date Taken	**Medication** ***Individual or Combinations*** ***Dosage(s) and time(s) taken per day***	**Effectiveness**	**Side-Effects/Problems**
Ex: 3/2000- 12/2005	**Example** • *Ritalin 5 mg BID* • *Prozac 10mg QAM*	**Example** *Improved concentration in morning, still moody*	**Example** *Very unfocused and hyperactive in evenings; dry mouth*

MEDICATION REFERENCE LIST

ADD Medications

Adderall / Adderall XR *4 amphetamine salts*	Concerta *methylphenidate*	Cylert *pemoline*	Daytrana *methylphenidate transdermal*
Desoxyn *methamphetamine HCL*	Dexedrine *dextroamphetamine*	Dexedrine Spansules *dextroamphetamine*	Dextrostat *dextroamphetamine*
Focalin *dexmethylphenidate*	Focalin XR *dexmethylphenidate hydrochloride*	Intuniv *guanfacine*	Metadate *methylphenidate*
Metadate CR *methylphenidate hydrochloride*	Methylin *methylphenidate*	Provigil *modafinil*	Ritalin *methylphenidate*
Ritalin LA *methylphenidate*	Ritalin SR *methylphenidate*	Strattera *atomoxetine*	Vyvanse *lisdexamfetamine*

Antidepressants

Anafranil *clomipramine hcl*	Asendin *amoxapine*	Celexa *citalopram*	Cymbalta *duloxetine HCl*
Desyrel *trazodone*	Effexor/Effexor XR *venlafaxine*	Elavil *amitriptyline*	Eldepryl *selegiline HCl*
EMSAM *selegiline transdermal system*	Lexapro *escitalopram*	Ludiomil *maprotiline*	Luvox *fluvoxamine*
Marplan *isocarboxazid*	Nardil *phenelzine*	Norpramin *desipramine*	Pamelor *nortriptyline*
Parnate *tranylcypromine*	Paxil/Paxil CR *paroxetine*	Pristiq *desvenlafaxine extended release*	Prozac *fluoxetine*
Remeron *mirtazapine*	Serzone *nefazodone*	Sinequan *doxepin*	Surmontil *trimipramine*
Tofranil *imipramine*	Vivactil *protripfyline*	Wellbutrin/Wellbutrin SR or XL *bupropion*	Zoloft *sertaline*

Anti-Anxiety Medications

Ativan *lorazepam*	BuSpar *buspirone*	Klonopin *clonazepam*	Librium *chlordiazepoxide*
Serax *oxazepam*	Tranxene *clorazepate*	Valium *diazepam*	Visatril *hydroxyzine*
Xanax *alprazolam*			

Mood Stabilizers

Depakene *valproic acid*	Depakote *divalproex*	Dilantin *phenytoin*	Donnatal *phenobarbital*
Gabitril *tigabine*	Keppra *levetiracetam*	Lamictal *lamotrigine*	Lithium/Eskalith *lithium carbonate*
Lyrica *pregablin*	Neurontin *gabapentin*	Tegretol/Carbatrol Tegretol XR *carbamazepeine*	Trileptal *oxcarbazepine*
Topamax *topiramate*	Zonegran *zonisamide*		

Anti-Tic Hypertensive Medications

Catapres *clonidine*	Inderal *propranolol*	Tenex *guanfacine*	

Anti-Psychotic Medications

Abilify *aripiprazole*	Clozaril *clozapine*	Geodon *ziprasidone HCl*	Haldol *haloperidol*
Invega *paliperidone*	Loxitane *loxapine*	Mellaril *molindone*	Moban *molindone*
Navane *thiothixene*	Orap *pimozide*	Prolixin *fluphenazine*	Risperdal *risperidone*
Serentil *mesoridazine*	Seroquel *quetiapine*	Stelazine *trifluoperazine*	Symbyax *olanzapine/fluoxetine HCl*
Thorazine *chlorpromazine*	Trilafon *perphenazine*	Zydis *olanzapine*	Zyprexa *olanzapine*

Movement Disorders

Artane *trihexyphenidyl*	Benadryl *diphenhydramine*	Cogentin *benztropine*	Symmetrel *amantadine*

Memory / Alzheimer's Medications

Aricept *donepezil HCl*	Exelon *revastigmine tartrate*	Namenda *memantine*	Reminyl - now Razadyne ER *galantamine HBR*

Sleep Aid

Ambien/Ambien CR *zolpidem tartrate*	Dalmane *flurazepam*	Desyrel *trazodone*	Doral *quazepam tablets*
Halcion *triazolam*	Lunesta *zopiclone*	ProSom *estazolam*	Restoril *temazepam*
Rohypnol *flunitrazepam*	Rozerem *ramelteon*	Sonata *zaleplon*	

Weight Loss

Fenfluramine *fenfluramine hydrochloride*	Meridia *sibutramine hydrochloride monohydrate*	Phentermine *phenethylamine*	

Sexual Dysfunction

Cialis *tadalafil*	Levitra *Cardenafil HCl*	Viagra *sildenafil citrate*	

Migraine Medications

Amerge *naratriptan*	Axert *almotriptan malate*	Esgic plus *butalbital / acetaminophen*	Fioricet *butalbital / acetaminophen*
Fiorinal *aspirin / butalbital / caffeine*	Frova *frovatriptan succinate*	Imitrex *sumatriptan succinate*	Maxalt *rizatriptan benzoate*
Replax *eletriptan hydrobromide*	Zomig *zolmitriptan*		

Pain Medications

Avinza *morphine sulfate extended release*	Darvocet *propoxyphene*	Darvon *propoxyphene*	Fentanyl *fentanyl citrate*
Kadian *morphine sulfate extended release*	Oxycontin *oxycodone*	Percocet *oxycodone HCl/APAP CII*	Percodan *aspirin / hydrocodone*
Roxanol *morphine sulfate*	Vicodin *hydrocodone*		

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY

Please indicate if you have attempted the following treatment:

- ❑ Psychiatrist
- ❑ Neurologist
- ❑ Cardiologist
- ❑ Alternative/Holistic/Naturopathic (include type) _____
- ❑ Therapy (include type and duration) _____
- ❑ Psychiatric Inpatient Hospitalization (if multiple attempts include overall duration) _____
- ❑ Outpatient Treatment Program (if multiple attempts indicate overall duration) _____
- ❑ Other _____

Please list any prior diagnoses: _____

_____

MEDICAL HISTORY

Current medical problems/medications:_____

_____

Current supplements/vitamins/herbs:_____

_____

Past medical problems/medications:_____

_____

Past supplements/vitamins/herbs:_____

_____

Name of Primary Care Physician: _____

Other doctors/clinics seen currently:_____

Allergies/drug intolerances (describe):_____

Date of last physical exam: _____

Present Height _____ *Present Weight* _____ *Present Waist Size*_____

*Date started last menstrual period:*_____

Please indicate if you have a history of the following:

- ❑ Seizure or seizure like activity
- ❑ Periods of spaciness or confusion
- ❑ Concussion
- ❑ Whiplash
- ❑ Loss of consciousness (describe): _____
- ❑ Head trauma (describe, list date or approximate age): _____
- ❑ Stitches on face or head (describe): _____

Please indicate if you have a history of the following tests or examinations (list date and describe abnormalities):

Test/Examination	Date	Abnormality
❑ Blood work	_____	_____
❑ EKG	_____	_____
❑ EEG	_____	_____
❑ CT scan	_____	_____
❑ PET scan	_____	_____
❑ MRI/fMRI	_____	_____
❑ SPECT	_____	_____
❑ Quantitative EEG	_____	_____
❑ Echocardiogram	_____	_____
❑ Holter Monitor	_____	_____
❑ Carotid Ultrasoud	_____	_____
❑ Other: _____	_____	_____

CURRENT LIFE STRESSES (include anything that is currently stressful for you, examples include relationships, job, school, finances, children):_____
_____
_____

Prenatal and birth events:
Your parents' attitudes toward their pregnancy with you:_____
Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc._____
Any birth problems, trauma, forceps or complications?_____

Diet/Exercise History:
Would you consider your diet mostly healthy or unhealthy?_____
Any food allergies/sensitivities? ☐ Yes ☐ No ___ If yes, please list:_____
Are you currently on a restricted diet (i.e. vegetarian, high protein only, etc)?
☐ Yes ☐ No ___ If yes, please list restrictions: _____
Any experience with a gluten free diet? ☐ Yes ☐ No ___ If yes, please list results:_____
Any experience with a casein free diet? ☐ Yes ☐ No ___ If yes, please list results:_____
Caffeine consumption per day (i.e. coffee, soda, tea, chocolate):_____
How many days a week do you eat fruits?_____ vegetables?_____ breakfast?_____
Describe your current bowel function:_____
Describe your current exercise regimen:_____

If you are seeking treatment for weight related issues, please complete the following:
How many times a day do you eat?_____
What is your typical eating schedule?_____
Do you drink 8 glasses of water per day? ☐ Yes ☐ No
Would you consider yourself to be over or underweight? _____
What is your ideal weight?_____ What is your BMI?_____
How long have you struggled with weight issues?_____
What weight loss measures have you tried?_____

Sleep Behavior:
Any problems falling asleep?_____
Any problems staying asleep?_____
Any problems waking up?_____
On average, how many hours do you sleep per night?_____
Any history of sleepwalking, recurrent dreams, sleep apnea, heavy snoring, or sleep bruxism (grinding your teeth)?_____
_____

School History: Highest Level of Education _____ Last school attended _____
Average grades received _____ Learning strengths _____
Specific learning disabilities _____
Any behavioral problems in school?_____
What have teachers said about you? _____

Employment History: (summarize jobs you've had, list most favorite and least favorite)
_____
_____
Any work-related problems?_____
What would your employers or supervisors say about you?_____

Military History?_____

Ever Any Legal Problems? (including traffic violations)_____
_____

Alcohol and Drug History:
Do you or have you ever experienced withdrawal symptoms from alcohol or drugs?_____
Has anyone told you they thought you had a problem with drugs or alcohol?_____
Have you ever felt guilty about your drug or alcohol use? _____
Have you ever felt annoyed when someone talked to you about your drug or alcohol use? _____
Have you ever used drugs or alcohol first thing in the morning?_____
If you have used or experimented with any of the following, please list the age started and describe how each substance made you feel (i.e. benefits, side effects, or changes to mood).

(C= Current, P= Past)

C	P	
☐	☐	Alcohol (hard liquor, beer, wine) _____
☐	☐	Nicotine (cigarettes, cigars, tobacco chew); indicate use per day (past and present): _____
☐	☐	Marijuana or hash _____
☐	☐	Inhalants (glue, gasoline, cleaning fluids, etc) _____
☐	☐	Cocaine or crack _____
☐	☐	Amphetamines _____
☐	☐	Crank or ice _____
☐	☐	Steroids _____
☐	☐	Opiates (heroin, oxycodone, morphine or other pain killers) _____
☐	☐	Barbiturates _____
☐	☐	Hallucinogens (LSD, mescaline, mushrooms, ecstasy) _____
☐	☐	Prescription tranquilizers or sleeping pills _____
☐	☐	Other: _____

Sexual history: (answer only as much as you feel comfortable)
Age at the time of first sexual experience: _____ Number of sexual partners: _____
Any history of a sexually transmitted disease?_____ History of abortion?_____
History of sexual abuse, molestation or rape?_____
Current sexual problems?_____

Any history of being physically abused? _____
_____

FAMILY HISTORY

Family Structure (who lives in your current household, please list relationship to each):
_____
_____
_____

Current Marital or Relationship Satisfaction_____
_____

History of Past Marriages_____

Significant Developmental Events (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.)_____

_____

Biological Mother's History: ☐ Living; Age ____ ☐ Deceased; Age ____ Cause of death _____
Marriages _____Highest Level of Education: _____Occupation: _____
Learning problems _____ Behavioral/Emotional problems _____
Medical Problems (include heart problems, sudden death, congenital disorders)_____
_____
Has mother ever sought psychiatric treatment? ☐ Yes ☐ No ___ If yes, for what purpose?_____
_____
Patient's mother's alcohol/drug use history_____
_____
Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, or psychiatric hospitalizations?
(specify)_____
_____

Biological Father's History: ☐ Living; Age ____ ☐ Deceased; Age ____ Cause of death _____
Marriages _____Highest Level of Education: _____Occupation: _____
Learning problems _____ Behavior problems _____
Medical Problems (include heart problems, sudden death, congenital disorders)_____
_____
Has father ever sought psychiatric treatment? ☐ Yes ☐ No ___ If yes, for what purpose?_____
_____
Patient's father's alcohol/drug use history_____
_____
Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, or psychiatric hospitalizations?
(specify)_____
_____

Patient's siblings (names, ages, problems, strengths, relationship to patient)_____
_____
_____
_____

Patient's children (names, ages, problems, strengths)_____
_____
_____
_____

Cultural/Ethnic Background _____
_____

Describe yourself _____
_____

Describe your strengths _____
_____

Describe your relationships with friends _____
_____

Amen Adult General Symptom Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. List the other person______________________________

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable

□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□NA□□□

Other Self
____ ___ 1. Feeling depressed or being in a sad mood
____ ___ 2. Having a decreased interest in things that are usually fun, including sex
____ ___ 3. Experiencing a significant change in weight or appetite, increased or decreased
____ ___ 4. Having recurrent thoughts of death or suicide
____ ___ 5. Experiencing sleep changes, such as a lack of sleep or a marked increase in sleep
____ ___ 6. Feeling physically agitated or of being "slowed down"
____ ___ 7. Having feelings of low energy or tiredness
____ ___ 8. Having feelings of worthlessness, helplessness, hopelessness or guilt
____ ___ 9. Experiencing decreased concentration or memory
____ ___ 10. Having periods of an elevated, high or irritable mood
____ ___ 11. Having periods of a very high self-esteem or grandiose thinking
____ ___ 12. Having periods of decreased need for sleep without feeling tired
____ ___ 13. Being more talkative than usual or feeling pressure to keep talking
____ ___ 14. Having racing thoughts or frequently jumping from one subject to another
____ ___ 15. Being easily distracted by irrelevant things
____ ___ 16. Having a marked increase in activity level
____ ___ 17. Excessive involvement in pleasurable activities that have the potential for painful consequences (e.g., spending money, sexual indiscretions, gambling, foolish business ventures)
____ ___ 18. Experiencing panic attacks, which are periods of intense, unexpected fear or emotional discomfort (list number per month ____)
____ ___ 19. Having periods of trouble breathing or feeling smothered
____ ___ 20. Having periods of feeling dizzy, faint or unsteady on your feet
____ ___ 21. Having periods of heart pounding or rapid heart rate
____ ___ 22. Having periods of trembling or shaking
____ ___ 23. Having periods of sweating
____ ___ 24. Having periods of choking
____ ___ 25. Having periods of nausea or abdominal discomfort/trouble
____ ___ 26. Having feelings of a situation "not being real"
____ ___ 27. Experiencing numbness or tingling sensations
____ ___ 28. Experiencing hot or cold flashes
____ ___ 29. Having periods of chest pain or discomfort
____ ___ 30. Fearing death
____ ___ 31. Fearing going crazy or doing something out-of-control
____ ___ 32. Avoiding everyday places for 1) fear of having a panic attack or 2) needing to go with other people in order to feel comfortable
____ ___ 33. Excessive fear of being judged by others, which causes you to avoid or get anxious in situations
____ ___ 34. Experiencing persistent, excessive phobia (heights, closed spaces, specific animals, etc.) please list

_____

_____ ___ 35. Having recurrent bothersome thoughts, ideas, or images that you try to ignore
_____ ___ 36. Having trouble getting "stuck" on certain thoughts, or having the same thought over and over
_____ ___ 37. Experiencing excessive or senseless worrying
_____ ___ 38. Others complaining that you worry too much or get "stuck" on the same thoughts
_____ ___ 39. Having compulsive behaviors that you must do or else you feel very anxious, such as excessive hand washing, checking locks, or counting or spelling
_____ ___ 40. Needing to have things done a certain way or else you become very upset
_____ ___ 41. Others complaining that you do the same thing over and over to an excessive degree (such as cleaning or checking)
_____ ___ 42. Experiencing recurrent and upsetting thoughts of a past traumatic event (molestation, accident, fire, etc.), please list _____
_____ ___ 43. Experiencing recurrent distressing dreams of a past upsetting event
_____ ___ 44. Having a sense of reliving a past upsetting event
_____ ___ 45. Having a sense of panic or fear of events that resemble an upsetting past event
_____ ___ 46. Spending effort avoiding thoughts or feelings associated with a past trauma
_____ ___ 47. Regularly avoiding activities/situations which cause remembrance of an upsetting event
_____ ___ 48. Being unable to recall an important aspect of a past upsetting event
_____ ___ 49. Having a marked decreased interest in important activities
_____ ___ 50. Feeling detached or distant from others
_____ ___ 51. Feeling numb or restricted in your feelings
_____ ___ 52. Feeling that your future is shortened
_____ ___ 53. Being quick to startle
_____ ___ 54. Feeling like you're always watching for bad things to happen
_____ ___ 55. Experiencing a marked physical response to events that remind you of a past upsetting event (e.g., sweating, increased pulse, etc.) when getting in a car if you had been in a car accident
_____ ___ 56. Being markedly more irritable or experiencing anger outbursts
_____ ___ 57. Having unrealistic or excessive worry in at least a couple areas of your life
_____ ___ 58. Trembling, twitching, or feeling shaky
_____ ___ 59. Experiencing muscle tension, aches, or soreness
_____ ___ 60. Having feelings of restlessness
_____ ___ 61. Becoming easily fatigued
_____ ___ 62. Experiencing shortness of breath or feeling smothered
_____ ___ 63. Experiencing a pounding or racing heartbeat
_____ ___ 64. Sweating or having cold, clammy hands
_____ ___ 65. Experiencing dry mouth
_____ ___ 66. Experiencing dizziness or lightheadedness
_____ ___ 67. Having nausea, diarrhea or other abdominal distress
_____ ___ 68. Having hot or cold flashes
_____ ___ 69. Having to urinate frequently
_____ ___ 70. Having trouble swallowing or feeling a "lump in your throat"
_____ ___ 71. Feeling keyed up or on edge
_____ ___ 72. Being quick to startle or feeling jumpy
_____ ___ 73. Finding it difficult to concentrate, or having your "mind go blank"
_____ ___ 74. Having trouble falling or staying asleep
_____ ___ 75. Experiencing irritability
_____ ___ 76. Having trouble sustaining attention or being easily distracted
_____ ___ 77. Experiencing difficulty completing projects
_____ ___ 78. Feeling overwhelmed by the tasks of everyday living
_____ ___ 79. Having trouble maintaining an organized work or living area

____ ___ 80. Being inconsistent in work performance
____ ___ 81. Lacking in attention to detail
____ ___ 82. Making decisions impulsively
____ ___ 83. Having difficulty delaying what you want, having to have your needs met immediately
____ ___ 84. Feeling restless and/or fidgety
____ ___ 85. Making comments to others without considering their impact
____ ___ 86. Being impatient and/or easily frustrated
____ ___ 87. Experiencing frequent traffic violations or near accidents
____ ___ 88. Refusing to maintain body weight above a level that most people consider healthy
____ ___ 89. Intensely fearing gaining weight or becoming fat even though underweight
____ ___ 90. Having feelings of being fat, even though you're underweight
____ ___ 91. Experiencing recurrent episodes of binge eating large amounts of food
____ ___ 92. Feeling of lack of control over eating behavior
____ ___ 93. Engaging in regular activities to purge binges, such as self-induced vomiting, laxatives, diuretics, strict dieting, or strenuous exercise
____ ___ 94. Being overly concerned with body shape and/or weight
____ ___ 95a.Experiencing involuntary physical movements and/or motor tics (such as eye blinking, shoulder shrugging, head jerking or picking). How long have tics been present?_____ How often?_____
Please describe_____
____ ____ 95b.Experiencing involuntary vocal sounds or verbal tics (such as coughing, puffing, blowing, whistling, or swearing).
How long have tics been present?_____ How often?_____
Please describe:_____
____ ___ 96. Having delusional or bizarre thoughts (thoughts you know others would think are false)
____ ___ 97. Seeing objects, shadows or movements that are not real
____ ___ 98. Hearing voices or sounds that are not real
____ ___ 99. Experiencing periods of time where your thoughts or speech were disjointed or didn't make sense to you or others
____ ___ 100. Feeling socially isolated or withdrawn
____ ___ 101. Having a severely impaired ability to function at home or at work
____ ___ 102. Behaving peculiarly
____ ___ 103. Lacking personal hygiene or grooming
____ ___ 104. Being in an inappropriate mood for a given situation (e.g., laughing at sad events)
____ ___ 105. Having a marked lack of initiative
____ ___ 106. Having frequent feelings that someone or something is out to hurt you or discredit you
____ ___ 107. Snoring loudly (or others complaining about your snoring)
____ ___ 108. Others saying that you stop breathing when you sleep
____ ___ 109. Feeling fatigued or tired during the day
____ ___ 110. Often feeling cold when others feel fine or they are warm
____ ___ 111. Often feeling warm when others feel fine or they are cold
____ ___ 112. Having problems with brittle or dry hair
____ ___ 113. Having problems with dry skin
____ ___ 114. Having problems with sweating
____ ___ 115. Having problems with chronic anxiety or tension
____ ___ 116. Having impairment in communication as manifested by at least one of the following (please circle all that apply):
- A delay in or total lack of the development of spoken language (not accompanied by an attempt to compensate);
- In individuals with adequate speech, having a marked impairment in the ability to initiate or sustain

a conversation with others;

- The repetitive use of language, or the use of odd language;
- A lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

____ ___ 117. Having an impairment in social interaction, with at least two of the following (please circle all that apply):

- A marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;
- A failure to develop peer relationships appropriate to developmental level;
- A lack of spontaneously seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest);
- A lack of social or emotional reciprocity.

____ ___ 118. Having repetitive patterns of behavior, interests, and activities, as manifested by at least one of the following (please circle all that apply):

- A preoccupation with an area that is abnormal either in intensity or focus;
- A rigid adherence to specific, nonfunctional routines or rituals;
- Repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements);
- A persistent preoccupation with parts of objects.

Amen Brain System Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. List other ____________________

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable

Other Self

____ ___ 1. Failing to give close attention to details or making careless mistakes
____ ___ 2. Having trouble sustaining attention in routine situations (e.g., homework, chores, paperwork)
____ ___ 3. Having trouble listening
____ ___ 4. Failing to finish things
____ ___ 5. Having poor organization for time or space (such as a backpack, room, desk, paperwork)
____ ___ 6. Avoiding, disliking, or being reluctant to engage in tasks that require sustained mental effort
____ ___ 7. Losing things
____ ___ 8. Being easily distracted
____ ___ 9. Being forgetful
____ ___10. Having poor planning skills
____ ___11. Lacking clear goals or forward thinking
____ ___12. Having difficulty expressing feelings
____ ___13. Having difficulty expressing empathy for others
____ ___14. Experiencing excessive daydreaming
____ ___15. Feeling bored
____ ___16. Feeling apathetic or unmotivated
____ ___17. Feeling tired, sluggish or slow moving
____ ___18. Feeling spacey or “in a fog”
____ ___19. Feeling fidgety, restless or trouble sitting still
____ ___20. Having difficulty remaining seated in situations where remaining seated is expected
____ ___21. Running about or climbing excessively in situations in which it is inappropriate
____ ___22. Having difficulty playing quietly
____ ___23. Being always "on the go" or acting as if "driven by a motor"
____ ___24. Talking excessively
____ ___25. Blurting out answers before questions have been completed
____ ___26. Having difficulty waiting.
____ ___27. Interrupting or intruding on others (e.g., butting into conversations or games)
____ ___28. Behaving impulsively (saying or doing things without thinking first)
____ ___29. Worrying excessively or senselessly
____ ___30. Getting upset when things do not go your way
____ ___31. Getting upset when things are out of place
____ ___32. Tending to be oppositional or argumentative
____ ___33. Tending to have repetitive negative thoughts
____ ___34. Tending toward compulsive behaviors (i.e., things you feel you *must* do)
____ ___35. Intensely disliking change
____ ___36. Tending to hold grudges
____ ___37. Having trouble shifting attention from subject to subject
____ ___38. Having trouble shifting behavior from task to task
____ ___39. Having difficulties seeing options in situations

_____ ___40. Tending to hold on to own opinion and not listen to others
_____ ___41. Tending to get locked into a course of action, whether or not it is good
_____ ___42. Needing to have things done a certain way or else becoming very upset
_____ ___43. Others complaining that you worry too much
_____ ___44. Tending to say no without first thinking about the question
_____ ___45. Tending to predict fear
_____ ___46. Experiencing frequent feelings of sadness
_____ ___47. Having feelings of moodiness
_____ ___48. Having feelings of negativity
_____ ___49. Having low energy
_____ ___50. Being irritable
_____ ___51. Having a decreased interest in other people
_____ ___52. Having a decreased interest in things that are usually fun or pleasurable
_____ ___53. Having feelings of hopelessness about the future
_____ ___54. Having feelings of helplessness or powerlessness
_____ ___55. Feeling dissatisfied or bored
_____ ___56. Feeling excessive guilt
_____ ___57. Having suicidal feelings
_____ ___58. Having crying spells
_____ ___59. Having lowered interest in things that are usually considered fun
_____ ___60. Experiencing sleep changes (too much or too little)
_____ ___61. Experiencing appetite changes (too much or too little)
_____ ___62. Having chronic low self-esteem
_____ ___63. Having a negative sensitivity to smells/odors
_____ ___64. Frequently feeling nervous or anxious
_____ ___65. Experiencing panic attacks
_____ ___66. Symptoms of heightened muscle tension (such as headaches, sore muscles, hand tremors, etc.)
_____ ___67. Experiencing periods of a pounding heart, a rapid heart rate, or chest pain
_____ ___68. Experiencing periods of troubled breathing or feeling smothered
_____ ___69. Experiencing periods of dizziness, faintness, or feeling unsteady on your feet
_____ ___70. Feeling nausea or having an upset stomach
_____ ___71. Experiencing periods of sweating, hot flashes, or cold flashes
_____ ___72. Tending to predict the worst
_____ ___73. Having a fear of dying or doing something crazy
_____ ___74. Avoiding places for fear of having an anxiety attack
_____ ___75. Avoiding conflict
_____ ___76. Excessively fearing being judged or scrutinized by others
_____ ___77. Having persistent phobias
_____ ___78. Having low motivation
_____ ___79. Having excessive motivation
_____ ___80. Experiencing tics (either motor or vocal)
_____ ___81. Having poor handwriting
_____ ___82. Being quick to startle
_____ ___83. Having a tendency to freeze in anxiety-provoking situations
_____ ___84. Lacking confidence in own abilities
_____ ___85. Feeling shy or timid
_____ ___86. Being easily embarrassed
_____ ___87. Being sensitive to criticism
_____ ___88. Biting fingernails or picking at skin
_____ ___89. Having a short fuse or experiencing periods of extreme irritability

____ ___90. Having periods of rage with little provocation
____ ___91. Often misinterpreting comments as negative when they are not
____ ___92. Finding that own irritability tends to build, then explodes, then recedes, often being tired after a rage
____ ___93. Having periods of spaciness and/or confusion
____ ___94. Experiencing periods of panic and/or fear for no specific reason
____ ___95. Experiencing visual and/or auditory changes, such as seeing shadows or hearing muffled sounds
____ ___96. Having frequent periods of *deja vu* (that is, feelings of being somewhere you have never been)
____ ___97. Being sensitive or mildly paranoid
____ ___98. Experiencing headaches or abdominal pain of uncertain origin
____ ___99. Having a history of a head injury or family history of violence or explosiveness
____ ___100. Having dark thoughts, ones that may involve suicidal or homicidal thoughts
____ ___101. Experiencing periods of forgetfulness or memory problems

Amen Learning Disability Screening Questionnaire

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person (such as a spouse, partner or parent) rate you as well. List the other person_____

0 1 2 3 4
□□□NA□□□
Never Rarely Occasionally Frequently Very Frequently Not Applicable

Other Self

Reading

____ ___ 1. I am a poor reader.
____ ___ 2. I do not like reading.
____ ___ 3. I make mistakes when reading, such as skipping words or lines.
____ ___ 4. I read the same line twice.
____ ___ 5. I have problems remembering what I read even though I have read all the words.
____ ___ 6. I reverse letters when I read (such as b/d, p/q).
____ ___ 7. I switch letters in words when reading (such as god and dog).
____ ___ 8. My eyes hurt or water when I read.
____ ___ 9. Words tend to blur when I read.
____ ___ 10. Words tend to move around the page when I read.
____ ___ 11. When reading I have difficulty understanding the main idea or identifying important details.

Writing

____ ___ 12. I have "messy" handwriting.
____ ___ 13. My work tends to be messy.
____ ___ 14. I prefer to print rather than to write in cursive.
____ ___ 15. My letters run into each other or there is no space between words.
____ ___ 16. I have trouble staying within lines.
____ ___ 17. I have problems with grammar or punctuation.
____ ___ 18. I am a poor speller.
____ ___ 19. I have trouble copying off the board or from a page in a book.
____ ___ 20. I have trouble getting thoughts from my brain to the paper.
____ ___ 21. I can tell a story but cannot write it.

Body Awareness/ Spatial Relationships

____ ___ 22. I have trouble with knowing my left from my right.
____ ___ 23. I have trouble keeping things within columns or coloring within lines.
____ ___ 24. I tend to be clumsy, uncoordinated.
____ ___ 25. I have difficulty with eye/hand coordination.
____ ___ 26. I have difficulty with concepts such as up, down, over, or under.
____ ___ 27. I tend to bump into things when walking.

Oral Expressive language

____ ___ 28. I have difficulty expressing myself in words.
____ ___ 29. I have trouble finding the right word to say in conversations.
____ ___ 30. I have trouble talking around a subject or getting to the point in conversations.

Receptive language

____ ___ 31. I have trouble keeping up or understanding what is being said in conversations.
____ ___ 32. I tend to misunderstand people and give the wrong answers in conversations.
____ ___ 33. I have trouble understanding directions people tell me.
____ ___ 34. I have trouble telling the direction sound is coming from.
____ ___ 35. I have trouble filtering out background noises.

Math

____ ___ 36. I am poor at basic math skills for my age (adding, subtracting, multiplying, and dividing)

____ ___ 37. I make “careless mistakes” in math.
____ ___ 38. I tend to switch numbers around.
____ ___ 39. I have difficulty with word problems.

Sequencing
____ ___ 40. I have trouble getting everything in the right order when I speak.
____ ___ 41. I have trouble telling time.
____ ___ 42. I have trouble using the alphabet in order.
____ ___ 43. I have trouble saying the months of the year in order.

Abstraction
____ ___ 44. I have trouble understanding jokes people tell me.
____ ___ 45. I tend to take things too literally.

Organization
____ ___ 46. My notebook/paperwork is messy or disorganized.
____ ___ 47. My room is messy.
____ ___ 48. I tend to shove everything into my backpack, desk or closet.
____ ___ 49. I have multiple piles around my room.
____ ___ 50. I have trouble planning my time.
____ ___ 51. I am frequently late or in a hurry.
____ ___ 52. I often do not write down assignments or tasks and end up forgetting what to do.

Memory
____ ___ 53. I have trouble with my memory.
____ ___ 54. I remember things from long ago but not recent events.
____ ___ 55. It is hard for me to memorize things for school or work.
____ ___ 56. I know something one day but do not remember it the next day.
____ ___ 57. I forget what I am going to say right in the middle of saying it.
____ ___ 58. I have trouble following directions that have more than one or two steps.

Social Skills
____ ___ 59. I have few or no friends.
____ ___ 60. I have trouble reading the body language or facial expressions of others.
____ ___ 61. My feelings are often or easily hurt.
____ ___ 62. I tend to get into trouble with friends, teachers, parents, or bosses.
____ ___ 63. I feel uncomfortable around people whom I do not know well.
____ ___ 64. I am teased by others.
____ ___ 65. Friends do not call and ask me to do things with them.
____ ___ 66. I do not get together with others outside of school or work.

Scotopic Sensitivity
____ ___ 67. I am light sensitive. Bothered by glare, sunlight, headlights or streetlights.
____ ___ 68. I become tired and/or experience headaches, mood changes, feel restless, or have an inability to stay focused with bright or fluorescent lights.
____ ___ 69. I have trouble reading words that are on white, glossy paper.
____ ___ 70. When reading, words or letters shift, shake, blur, move, run together, disappear, or become difficult to perceive.
____ ___ 71. I feel tense, tired, sleepy, or even get headaches with reading.
____ ___ 72. I have problems judging distance and have difficulty with such things as escalators, stairs, ball sports, or driving.

Sensory Integration Issues
____ ___ 73. I seem to be more sensitive to the environment than are other people.
____ ___ 74. I am more sensitive to noise than are other people.
____ ___ 75. I am particularly sensitive to touch or very sensitive to certain clothing or tags on the clothing.
____ ___ 76. I have an unusual sensitivity to certain smells.
____ ___ 77. I have an unusual sensitivity to light.
____ ___ 78. I am sensitive to movement or crave spinning activities.
____ ___ 79. I tend to be clumsy or accident-prone.

Female Hormone Health Questionnaire

Please rate yourself on each of the symptoms listed below using the following scale.

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable

Thyroid Hormone Imbalance #1

____ 1. Have you noticed excessive fatigue or weakness in your body?
____ 2. Do you have dry or coarse skin?
____ 3. Have you experienced hair loss on your head and body?
____ 4. Do you have cold hands and/or feet?
____ 5. Have you experienced weight gain?
____ 6. Do you have insomnia?
____ 7. Do you struggle with constipation?
____ 8. Do you feel depressed?
____ 9. Do you have a poor memory or forgetfulness?
____ 10. Do you feel sluggish?
____ 11. Do you have an intolerance to cold weather?
____ 12. Do you become out of breath easily?
____ 13. Is your voice hoarse?

Thyroid Hormone Imbalance #2

____ 1. Do you notice fatigue?
____ 2. Do you notice weakness?
____ 3. Do you have an intolerance to hot weather?
____ 4. Have you experienced unexplained weight loss?
____ 5. Do you suffer from insomnia?
____ 6. Do you have frequent bowel movements?
____ 7. Do you feel nervous?
____ 8. Do your hands have a shaky tremor?
____ 9. Do you feel heart palpitations (rapid or fluttering heart beat)?
____ 10. Do you experience breathlessness?

Adrenal Hormone Imbalance

____ 1. Do you feel like you have excessive exhaustion?
____ 2. Are you unable to lose gained weight?
____ 3. Do you have a low sex drive?
____ 4. Do you feel lightheaded shortly after standing up?
____ 5. Do you have difficulty getting up in the morning?
____ 6. Do you need coffee or other stimulants to get going in the morning?
____ 7. Do you crave sugar or salty foods?
____ 8. Do you tremble when under pressure?
____ 9. Do you have difficulty remembering things?
____ 10. Do you feel fatigued in the afternoon between 3 and 5 pm?
____ 11. Do you feel suddenly better for a brief period after eating?
____ 12. Is it difficult for you to recover after a physical exercise session?
____ 13. Are you sensitive to bright lights?
____ 14. Do you feel overwhelmed or unable to cope?
____ 15. Do you have low blood pressure?

Low Estrogen

____ 1. Do you experience hot flashes/hot flushes?
____ 2. Do you have night sweats?
____ 3. Have you experienced crying spells over things that wouldn't usually make you cry?
____ 4. Do you have vaginal dryness or pain during intercourse?
____ 5. Do you get frequent bladder infections?
____ 6. Do you struggle with recurrent yeast infections?
____ 7. Do you have leakage from the bladder when you cough or sneeze?
____ 8. Do you wake up often throughout the night?
____ 9. Do you experience anxiousness or a rapid heartbeat?

____ 10. Have you noticed reduced fullness in your breasts?
____ 11. Do you have dry eyes, dry hair, or dry skin?
____ 12. Do you have a decreased sense of well-being?

Low Progesterone

____ 1. Have you tried unsuccessfully to become pregnant?
____ 2. Do you have heavy periods?
____ 3. Have you been diagnosed with fibrocystic breasts?
____ 4. Are your menstrual cycles irregular?
____ 5. Do you experience sudden mood swings?
____ 6. Do you pass blood clots during menstruation?
____ 7. Do you have painful periods?
____ 8. Do you have difficulty concentrating, sometimes called "brain fog?"
____ 9. Do you wake up between 3-5am unable to go back to sleep?
____ 10. Do you crave sweets?
____ 11. Are you tired or have low energy?
____ 12. Do you suffer from PMS?
____ 13. Do you have painful cramping during your menstrual cycle?

Estrogen Dominance

____ 1. Do you have tender breasts?
____ 2. Do you experience mood swings?
____ 3. Do you retain water (your rings feel tight, ankle swelling)?
____ 4. Do you have headaches?
____ 5. Do you have a low sex drive?
____ 6. Are you irritable?
____ 7. Do you suffer from depression?
____ 8. Are you unusually bossy?
____ 9. Have you increased a breast size?
____ 10. Have you been diagnosed with fibrocystic breasts?
____ 11. Have you been diagnosed with uterine fibroids?
____ 12. Is your face puffy?
____ 13. Have you gained weight around the hips and stomach?
____ 14. Do you have difficulty reaching orgasm?
____ 15. Do you suffer from PMS?
____ 16. Do you have heavy periods?

Low Testosterone

____ 1. Have you noticed a decrease in your desire to have sex?
____ 2. Have you noticed a decrease in your enjoyment of life?
____ 3. Do you have a lack of energy?
____ 4. Do you have a decreased amount of strength?
____ 5. Has your endurance for physical exercise decreased?
____ 6. Do you feel depressed?
____ 7. Is it difficult for you to reach orgasm?
____ 8. Do you feel irritable?
____ 9. Do you feel anxious?
____ 10. Do you notice a sense of fatigue in your body?
____ 11. Have you lost significant muscle mass in your body?
____ 12. Have your orgasms become weaker and take longer to achieve?
____ 13. Do you find it more difficult to become sexually aroused?

High Testosterone

____ 1. Do you have acne as an adult?
____ 2. Do you have excessive hair growth on your chin, upper lip, or breast area?
____ 3. Do you have unexplained weight gain around the middle that you are unable to lose?
____ 4. Do you have male-pattern baldness (i.e. receding hairline or bald spot) ?
____ 5. Do you have excessively oily skin or hair?
____ 6. Do you have unexplained depression?
____ 7. Do you have irregular periods?
____ 8. Do you have a loss of sex drive?
____ 9. Do you have an excessive sex drive?

Medical Review

Please place a check mark in the box/boxes that apply (C = Current, P = Past).

General

C P
- ☐ ☐ Being overweight
- ☐ ☐ Recent weight gain or weight loss
- ☐ ☐ Poor appetite
- ☐ ☐ Increased appetite
- ☐ ☐ Abnormal sensitivity to cold
- ☐ ☐ Cold sweats during the day
- ☐ ☐ Tired or worn out
- ☐ ☐ Hot or cold spells
- ☐ ☐ Abnormal sensitivity to heat
- ☐ ☐ Excessive sleeping
- ☐ ☐ Difficulty sleeping
- ☐ ☐ Lowered resistance to infection
- ☐ ☐ Flu-like or vague sick feeling
- ☐ ☐ Sweating excessively at night
- ☐ ☐ Excessive daytime sweating
- ☐ ☐ Excessive thirst
- ☐ ☐ Other: _____

Neurological

C P
- ☐ ☐ Pacing due to muscle restlessness
- ☐ ☐ Forgotten periods of time
- ☐ ☐ Dizziness
- ☐ ☐ Drowsiness
- ☐ ☐ Muscle spasms or tremors
- ☐ ☐ Impaired ability to remember
- ☐ ☐ "Tics"
- ☐ ☐ Numbness
- ☐ ☐ Convulsions/fits
- ☐ ☐ Slurred speech
- ☐ ☐ Speech problem (other)
- ☐ ☐ Weakness in muscles
- ☐ ☐ Other: _____

Respiratory

C P
- ☐ ☐ Asthma, wheezing
- ☐ ☐ Cough
- ☐ ☐ Coughing up blood or sputum
- ☐ ☐ Shortness of breath
- ☐ ☐ Rapid breathing
- ☐ ☐ Repeated nose or chest colds
- ☐ ☐ Other: _____

Chest and Cardiovascular

C P
- ☐ ☐ Ankle swelling
- ☐ ☐ Rapid/irregular pulse
- ☐ ☐ High cholesterol
- ☐ ☐ Breast tenderness
- ☐ ☐ Chest pain
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Stroke
- ☐ ☐ Other: _____

Head, Eye, Ear, Nose, & Throat

C P
- ☐ ☐ Facial pain
- ☐ ☐ Headache
- ☐ ☐ Head injury
- ☐ ☐ Neck pain or stiffness
- ☐ ☐ Frequent sore throat
- ☐ ☐ Blurred vision
- ☐ ☐ Double vision
- ☐ ☐ Overly sensitive to light
- ☐ ☐ See spots or shadows
- ☐ ☐ Hearing loss in both ears
- ☐ ☐ Ear ringing
- ☐ ☐ Chronic ear infections
- ☐ ☐ Disturbances in smell
- ☐ ☐ Runny nose
- ☐ ☐ Dry mouth
- ☐ ☐ Sore tongue
- ☐ ☐ Other: _____

Gastrointestinal and Hepatic

C P
- ☐ ☐ Trouble swallowing
- ☐ ☐ Nausea or vomiting
- ☐ ☐ Abdominal (stomach/belly) pain
- ☐ ☐ Anal itching
- ☐ ☐ Painful bowel movements
- ☐ ☐ Infrequent bowel movements
- ☐ ☐ Liquid bowel movements
- ☐ ☐ Loss of bowel control
- ☐ ☐ Frequent belching or gas
- ☐ ☐ Vomiting blood
- ☐ ☐ Rectal bleeding (red or black blood)
- ☐ ☐ Jaundice (yellowing of skin)
- ☐ ☐ Other: _____

Musculoskeletal

C P
- ☐ ☐ Arthritis
- ☐ ☐ Back pain or stiffness
- ☐ ☐ Bone pain
- ☐ ☐ Joint pain or stiffness
- ☐ ☐ Leg pain
- ☐ ☐ Muscle cramps or pain
- ☐ ☐ Other: _____

Skin and Hair

C P
- ☐ ☐ Dry hair or skin
- ☐ ☐ Itchy skin or scalp
- ☐ ☐ Easy bruising
- ☐ ☐ Hair loss
- ☐ ☐ Increased perspiration
- ☐ ☐ Sun sensitivity
- ☐ ☐ Other: _____

Genitourinary

C P
- ☐ ☐ Itchy privates or genitals
- ☐ ☐ Painful urination
- ☐ ☐ Excessive urination
- ☐ ☐ Difficulty in starting urine
- ☐ ☐ Accidental wetting of self
- ☐ ☐ Pus or blood in urine
- ☐ ☐ Decreased sexual desire
- ☐ ☐ Sexually transmitted disease
- ☐ ☐ Other: _____

Females

C P
- ☐ ☐ No menses
- ☐ ☐ Menstrual irregularity
- ☐ ☐ Painful or heavy periods
- ☐ ☐ Premenstrual moodiness, irritability, anger, tension, bloating, breast tenderness, cramps, and headache
- ☐ ☐ Painful intercourse or sex
- ☐ ☐ Sterility/infertility
- ☐ ☐ Abnormal vaginal discharge
- ☐ ☐ Other: _____

Surgical Procedures

- ☐ Tonsillectomy
- ☐ Adenoidectomy
- ☐ Myringotomy (ear tubes)
- ☐ Appendectomy
- ☐ Hernia repair
- ☐ Other: _____

Illnesses

C P
- ☐ ☐ Pneumonia
- ☐ ☐ Hypothyroidism
- ☐ ☐ Hyperthyroidism
- ☐ ☐ Chronic Fatigue Syndrome
- ☐ ☐ Fibromyalgia
- ☐ ☐ Encephalitis
- ☐ ☐ Meningitis
- ☐ ☐ Lyme Disease
- ☐ ☐ Lupus
- ☐ ☐ Epstein - Barr virus (Mononucleosis)
- ☐ ☐ Fevers over 105°
- ☐ ☐ Autoimmune Disorder
- ☐ ☐ Other: _____

Neuropsychiatric Symptom Checklist

Please review the table of symptoms below and place a check in the appropriate box if you or any of your biological family members have had the problems listed.

Problem Areas	Self	Mother	Father	Brother	Sister	Your Children	Other Relatives
Anxiety							
Panic Attacks							
Phobias							
Depression							
Seasonal Mood Changes (SAD)							
Elevated Mood							
Bipolar Illness							
Mania							
Irritability							
Hot Temper							
Self Mutilation							
Suicide Attempts							
Psychiatric Hospitalization							
Social Isolation							
Hallucinations							
Schizophrenia							
Psychosis							
Paranoia							
Delusions							
Dissociative States							
Grief							
ADHD (attention deficit disorder)							
Concentration Difficulties							
Attention Difficulties							
Hyperactivity							
Intolerance of Boredom							
Learning/School Difficulties							
Juvenile Delinquency							
Defiant Behavior							
Fire Setting							
Bedwetting							
Cruelty to Animals							
Legal Troubles							
Anger or Rage Problems							
Obsessions or Compulsions							
Anorexia Nervosa							

Problem Areas	Self	Mother	Father	Brother	Sister	Your Children	Other Relatives
Bulimia (binging and purging)							
Laxative/Diuretic Abuse							
Alcohol Abuse							
Drug/substance abuse							
Head injury							
Concussion							
Tourette's Syndrome							
Amnesia							
Dementia							
Narcolepsy							
Irresistible sleep attacks							
Sleep apnea							
Heavy snoring during sleep							
Hallucinations going to sleep							
Hallucinations when awakening							
Restless legs during sleep							
Night Terrors							
Sleepwalking							
Sexual Difficulties							
Sexual Abuse Victim							
Sexual Abuse Perpetrator							
Physical Abuse Victim							
Physical Abuse Perpetrator							
Mental Retardation							
Autism							
Asperger's Disorder							
Pervasive Developmental D/O							
Sensitivity to Light							
Sensitivity to Odors							
Sensitivity to Sounds							
Sensitivity to Touch							

Amen Clinic Brain SPECT Informed Consent Form

What is Brain SPECT Imaging? Brain SPECT imaging is a nuclear medicine procedure that uses very small doses of a radioactive substance by intravenous injection that will give you and your doctor information on the cerebral blood flow and activity patterns of your brain.

What is the purpose of the Brain SPECT Imaging Procedure? This clinic and other clinics around the country have correlated certain mental and behavioral states with certain SPECT patterns. The information from the SPECT studies will help you and your doctor understand your specific brain patterns, which may further help in your evaluation and treatment.

Will the SPECT study give me an accurate diagnosis? No. A SPECT study by itself will not give a diagnosis. SPECT imaging helps the clinician understand more about the specific function of your brain. Each person's brain is unique which may lead to unique responses to medicine or therapy. Diagnoses about specific conditions are made through a combination of clinical history, personal interview, information from families, checklists, SPECT studies and other neuropsychological tests. No study by itself is a "doctor in a box" that can give accurate diagnoses on individual patients.

Why are SPECT studies ordered? Some of the common reasons include:

1. Evaluating suspected seizure activity
2. Evaluating suspected cerebral vascular disease
3. Evaluating cognitive decline and suspected dementia or other memory problems
4. Evaluating the effects of mild, moderate and severe head trauma
5. Evaluating the presence of a suspected underlying organic brain condition, such as seizure activity, that contributes to behavioral or emotional disturbance
6. Evaluating aggressive or suicidal behavior
7. Evaluating the extent of brain impairment caused by drug or alcohol abuse or other toxic exposure
8. Subtyping the physiology underlying mood disorders, anxiety disorders, or attention deficit disorders
9. Evaluating atypical, unresponsive or mixed psychiatric condition
10. Following up to evaluate the physiological effects of treatment
11. General brain health check up

Do I need to be off medication before the study? This question must be answered individually between you and your doctor. In general, it is better to be off medications until they are out of your system, but this is not always practical or advisable. If the study is done while on medication make sure to note it on the appropriate forms. In general, we recommend patients try to be off stimulants at least four days before the first scan and remain off of them until after the second scan is done (if you are having two scans). Medications such as Prozac (which lasts in the body 4-6 weeks) are generally not stopped because of practicality. Check with your specific doctor for recommendations.

What should I do the day of the scan? On the day of the scan eliminate your caffeine intake and try to not take cold medication or aspirin (if you do please write it down on the intake form). Eat as you normally would.

Are there any side effects or risks to the study? The study does not involve a dye and people do not have allergic reactions to the study. The possibility exists, although in a very small percentage of patients, of a mild rash, facial redness and edema, fever and a transient increase in blood pressure. The amount of radiation exposure from one brain SPECT study is approximately 2/3rd of a head CT scan. Rarely, patients have reported green urine after the procedure for a day or two.

How is the SPECT procedure done? The evaluation typically consists of two scans that are performed at least 24 hours apart. Usually, the concentration scan is performed first. The imaging agent is injected through a small intravenous (IV) tube in the arm and the patient is given a task which requires prolonged concentration. On the next scheduled day the resting scan is obtained. During this scan, the patient is placed in a quiet room and the imaging agent is once again started through a small intravenous (IV) tube. During this scan, the patient is asked to relax and allow their mind to wander while they remain quiet for approximately 15 minutes. For both scans, following the injection, the patient lies on a table and the SPECT camera rotates around his/her head (the patient does not go into a tube). The time on the table varies from 15-30 minutes. The study is then read within the next few days. Pictures are made available to the patient's treatment professionals. Please ensure you have a follow-up appointment with a physician to go over the results of the study.

Are there alternatives to having a SPECT study? In our opinion, SPECT is the most clinically useful study of brain function for the indications listed above. There are other studies, such as electroencephalograms (EEGs), Positron Emission Tomography (PET) studies and functional MRIs (fMRI). PET studies and fMRI are considerably more costly and they are performed mostly in research settings. EEGs, in our opinion, do not provide enough information about the deep structures of the brain to be as helpful as SPECT studies.

Do I have to have the SPECT study performed at the Amen Clinic? No. SPECT studies may be performed at other clinics. The patient may choose any other facility for this study or any other study or service recommended by our clinic. However, many doctors and patients utilize our services because Dr. Amen has 20 years of experience performing and interpreting over 64,000 SPECT studies for these indications.

Does insurance cover the cost of SPECT studies? Reimbursement by insurance companies varies according to your plan. It is often a good idea to check with the insurance company to see if it is a covered benefit.

Is the use of brain SPECT imaging accepted in the medical community? Brain SPECT studies are widely recognized as an effective tool for evaluating brain function in seizures, strokes, dementia and head trauma. There are literally thousands of research articles on these topics. In our clinic, based on our sixteen years of experience, we have developed this technology further to evaluate neuropsychiatric conditions. Unfortunately, many physicians do not fully understand the application of SPECT imaging and may tell you that the technology is experimental, but over 2,000 physicians and mental health professionals from across the United States have referred patients to us for scans.

Who owns Amen Clinics, Inc? Dr. Amen is the sole owner of the Amen Clinics. The other staff members who work with Dr. Amen are either employees or independent contractors.