

Neurotoxic
Questionnaire



Date _____

Name _____
Address _____
City _____
State/Zip _____

Date of Birth _____
Phone _____
Cell _____
Email _____

How did you hear about us?

What are your reasons for being here?

What is your major complaint?

What are your current medications, vitamins and/or supplements?

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Date: _____

Name: _____ Date of Birth: _____
 Address: _____
 City: _____ Phone: _____
 State/Zip: _____ Cell: _____
 Email: _____

Patient History

Yes/No Answer the following questions to the best of your ability. If you can not answer a question , simply leave it blank.

	Do you have silver (amalgam) fillings?
	Did you wear contact lenses during the 1980's or early 1990's?
	Did you take oral contraceptives during the 1980's or early 1990's?
	Do you receive yearly flu shots, or have you recently received a flu shot, allergy shots or a vaccination?
	If so, have you noticed any adverse reactions to the shots?
	Do you have any tattoos with red ink?
	Do you eat large amounts(more than twice a week) of tuna, shark, swordfish, or Atlantic salmon?

	Do you see mold growing in your home, work or school?
	Have you ever had water damage in your home, work or school?
	Does your home, work, school or car have a damp or mildew smell?
	Does spending time in your basement cause or worsen your symptoms?
	Does spending time in a different location - for at least a few days - cause a noticeable decrease in your symptoms?
	Do your family members, co-workers, or peers at school complain of similar health problems?

	Have you ever been diagnosed with Lyme Disease?
	Have you ever been bitten by a tick or recluse spider?
	Have you ever seen a bulls-eye rash appear on any part of your body?
	If so, did it occur shortly following a tick, spider bite or time spent outdoors?
	Was your mother diagnosed with Lyme Disease?
	Do you frequently go camping, hunting, or are otherwise involved in outdoor activities (especially in wooded or grassy areas)?

	Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?
	Does anyone else in your family experience similar symptoms to yours.

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Date: _____

Name: _____

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank. When your are done with Page 1, continue to Page 2.

Point Scale

- 0 = Never have the symptom
- 1 = Occasionally have it, mild effect
- 2 = Occasionally have it, severe effect
- 3 = Frequently have it, mild effect
- 4 = Frequently have it, severe effect

	Indecisiveness
	Feeling of being overwhelmed or fearful
	Metallic taste in your mouth
	Bad breath
	Bleeding of the gums
	Sensitive teeth
	Canker sores or other sores in the mouth
	Floaters, shadows or swimmers when you read or look up in the sky
	Dyslexia or loss of place while reading, <i>even as a child</i>
	Swelling of the eyelids
	Peeling of the top layer of skin on the hands and feet
	Dry skin
	Heart pain (angina) AND you are under the age of 45
	Depression
	Gout (arthritic pain - especially of the big toes)
	Pain in the shoulders or upper back area
	Twitching of the eyelids
	Anemia (low iron/hemoglobin on a blood test)
	Wrist/ankle drop or weak extensor muscles
	Hair falls out (not normal male pattern baldness)
	<i>Subtotal</i>
	<i>Subtotal</i>
	<i>Subtotal</i>

Total Page 2

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Date: _____

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

Point Scale

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 1 = Occasionally have it, mild effect
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	Sensitivity to light
	Fatigue after exercising - Feel worse after exercise
	Sensitivity to smells (including Multiple Chemical Sensitivity), such as petrochemicals, perfumes, air fresheners
	Shortness of breath - with very little effort
	Joint pain - not necessarily true arthritis - can move from joint to joint
	Bad night vision, or seeing haloes around lights
	Trouble processing new information
	Word reversal or trouble finding words
	Blurred vision at times
	Morning stiffness
	Chronic fatigue or weakness
	Non-restful sleep
	<i>Subtotal</i>

	Seem to get shocked more often and with a more dramatic effect than most people (doorknobs, car, light switch plate covers, water fountains, people, etc.)
	Excessive thirst and/or frequent urination
	Frequent muscle aches, cramps, unusual sharp, sudden pains
	Sensitivity to touch
	Short-term memory loss
	Chronic sinus congestion
	Dry, non-productive cough
	Muscle twitching
	Excessive sweating - especially at night
	Can not lose weight, regardless of diet and exercise
	Persistent fungal or viral infection, including athlete's foot, warts, jock itch, candidiasis
	Frequent illness, prolonged illness or sick days
	Numbness or weakness in arms and legs
	Headaches
	Trouble adding or dividing numbers in your head
	Fluctuating constipation and diarrhea
	Stomach pain for no apparent reason
	Appetite swings
	Red eyes or tearing
	Rashes or rosacea
	Cold extremities (hands and feet)
	<i>Subtotal</i>
	TOTAL Page 3

	TOTAL Page 2
	TOTAL Page 3
	GRAND TOTAL