

# 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. 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:** 616 120<sup>th</sup> Ave NE, Suite C100, Bellevue, WA 98005 (425) 455-7500 FAX: (425) 454-7845

**Washington DC Clinic:** 1875 Campus Commons Drive, Suite 101, Reston, VA 20191 (703) 880-4000 FAX: (703) 860-5760





## MEDICATION REFERENCE LIST

### ADD Medications

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

### Antidepressants

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

### Anti-Anxiety Medications

Ativan <i>lorazepam</i>	BuSpar <i>bupirone</i>	Klonopin <i>clonazepam</i>	Librium <i>chlordiazepoxide</i>
Serax <i>oxazepam</i>	Tranxene <i>clorazepate</i>	Valium <i>diazepam</i>	Visatril <i>hydroxyzine</i>
Xanax <i>alprazolam</i>			

### Mood Stabilizers

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

### Anti-Tic Hypertensive Medications

Catapres <i>clonidine</i>	Inderal <i>propranolol</i>	Tenex <i>guanfacine</i>	
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### Anti-Psychotic Medications

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

### Movement Disorders

Artane <i>trihexyphenidyl</i>	Benadryl <i>diphenhydramine</i>	Cogentin <i>benztropine</i>	Symmetrel <i>amantadine</i>
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### Memory / Alzheimer's Medications

Aricept <i>donepezil HCl</i>	Exelon <i>revastigmine tartrate</i>	Namenda <i>memantine</i>	Reminyl - now Razadyne ER <i>galantamine HBR</i>
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### Sleep Aid

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

### Weight Loss

Fenfluramine <i>fenfluramine hydrochloride</i>	Meridia <i>sibutramine hydrochloride monohydrate</i>	Phentermine <i>phenethylamine</i>	
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### Sexual Dysfunction

Cialis <i>tadalafil</i>	Levitra <i>Cardenafil HCl</i>	Viagra <i>sildenafil citrate</i>	
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### Migraine Medications

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

### Pain Medications

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

**PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY**

Please indicate if you have attempted the following treatment and how many providers you've seen:

- 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: \_\_\_\_\_  
\_\_\_\_\_

Current supplements/vitamins/herbs: \_\_\_\_\_  
\_\_\_\_\_

Past medical problems: \_\_\_\_\_  
\_\_\_\_\_

Past supplements/vitamins/herbs: \_\_\_\_\_  
\_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

Other doctors/clinics seen currently: \_\_\_\_\_

Prior hospitalizations: \_\_\_\_\_

Allergies/drug intolerances (describe): \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Present Height \_\_\_\_\_ Present Weight \_\_\_\_\_ Present Waist Size \_\_\_\_\_

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
<input type="checkbox"/> Blood work	_____	_____
<input type="checkbox"/> EKG	_____	_____
<input type="checkbox"/> EEG	_____	_____
<input type="checkbox"/> CT scan	_____	_____
<input type="checkbox"/> PET scan	_____	_____
<input type="checkbox"/> MRI/fMRI	_____	_____
<input type="checkbox"/> SPECT	_____	_____
<input type="checkbox"/> Quantitative EEG	_____	_____
<input type="checkbox"/> Echocardiogram	_____	_____
<input type="checkbox"/> Holter Monitor	_____	_____
<input type="checkbox"/> Carotid Ultrasoud	_____	_____
<input type="checkbox"/> Other: _____	_____	_____

**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? \_\_\_\_\_

**CURRENT LIFE STRESSORS** (include anything that is currently stressful for you, examples include relationships, job, school, finances, children) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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                        |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol (hard liquor, beer, wine) _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Nicotine (cigarettes, cigars, tobacco chew); indicate use per day (past and present): _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Marijuana or hash _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Inhalants (glue, gasoline, cleaning fluids, etc) _____                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Cocaine or crack _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Amphetamines _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Crank or ice _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Steroids _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Opiates (heroin, oxycodone, morphine or other pain killers) _____                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hallucinogens (LSD, mescaline, mushrooms, ecstasy) _____                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Prescription tranquilizers or sleeping pills _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | 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? \_\_\_\_\_  
Current sexual problems? \_\_\_\_\_

**Any history of being physically, emotionally, or sexually 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 \_\_\_\_\_ Behavior 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

Copyright Daniel G. Amen, MD

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

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

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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

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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.

# Male 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?
- 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 frequently 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 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 often feel nervous?
- 8. Do your hands have a shaky tremor?
- 9. Do you feel heart palpitations (rapid or fluttering heartbeat)?
- 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 ever feel overwhelmed or unable to cope?
- 15. Do you have low blood pressure?

## **Testosterone**

- 1. Has your sex drive noticeably decreased?
- 2. Have you noticed an increase in fat around your abdomen?
- 3. Do you notice your morning erections disappearing?
- 4. Have you noticed a decrease in your enjoyment of life?
- 5. Do you have a lack of energy?
- 6. Do you have a decreased amount of strength or endurance?
- 7. Have you noticed a decrease in the strength/firmness of your erections?
- 8. Do you feel irritable often?
- 9. Do you notice a sense of fatigue in your body?
- 10. Have you lost significant muscle mass in your body?

# Medical Review

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

## General

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

## Neurological

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

## Respiratory

- | C                        | P                        |                              |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma, wheezing             |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing up blood or sputum  |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath          |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid breathing              |
| <input type="checkbox"/> | <input type="checkbox"/> | Repeated nose or chest colds |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____                 |

## Chest and Cardiovascular

- | C                        | P                        |                       |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle swelling        |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid/irregular pulse |
| <input type="checkbox"/> | <input type="checkbox"/> | High cholesterol      |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast tenderness     |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain            |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure   |
| <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure    |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke                |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____          |

## Head, Eye, Ear, Nose, & Throat

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

## Gastrointestinal and Hepatic

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

## Musculoskeletal

- | C                        | P                        |                         |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis               |
| <input type="checkbox"/> | <input type="checkbox"/> | Back pain or stiffness  |
| <input type="checkbox"/> | <input type="checkbox"/> | Bone pain               |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint pain or stiffness |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg pain                |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle cramps or pain   |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____            |

## Skin and Hair

- | C                        | P                        |                        |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Dry hair or skin       |
| <input type="checkbox"/> | <input type="checkbox"/> | Itchy skin or scalp    |
| <input type="checkbox"/> | <input type="checkbox"/> | Easy bruising          |
| <input type="checkbox"/> | <input type="checkbox"/> | Hair loss              |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased perspiration |
| <input type="checkbox"/> | <input type="checkbox"/> | Sun sensitivity        |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____           |

## Genitourinary

- | C                        | P                        |                                  |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Itchy privates or genitals       |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful urination                |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive urination              |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in starting urine     |
| <input type="checkbox"/> | <input type="checkbox"/> | Accidental wetting of self       |
| <input type="checkbox"/> | <input type="checkbox"/> | Pus or blood in urine            |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased sexual desire          |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted disease     |
| <input type="checkbox"/> | <input type="checkbox"/> | Impotence (weak male erection)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Inability to ejaculate or orgasm |
| <input type="checkbox"/> | <input type="checkbox"/> | Scrotal pain                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal penis discharge         |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____                     |

## Surgical Procedures

- |                          |                         |
|--------------------------|-------------------------|
| <input type="checkbox"/> | Tonsillectomy           |
| <input type="checkbox"/> | Adenoidectomy           |
| <input type="checkbox"/> | Myringotomy (ear tubes) |
| <input type="checkbox"/> | Appendectomy            |
| <input type="checkbox"/> | Hernia repair           |
| <input type="checkbox"/> | Other: _____            |

## Illnesses

- | C                        | P                        |                                      |
|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypothyroidism                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperthyroidism                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Fatigue Syndrome             |
| <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Encephalitis                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Meningitis                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Lyme Disease                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Lupus                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Epstein - Barr virus (Mononucleosis) |
| <input type="checkbox"/> | <input type="checkbox"/> | Fevers over 105°                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune Disorder                  |
| <input type="checkbox"/> | <input type="checkbox"/> | 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							

<b>Problem Areas</b>	<b>Self</b>	<b>Mother</b>	<b>Father</b>	<b>Brother</b>	<b>Sister</b>	<b>Your Children</b>	<b>Other Relatives</b>
Anorexia Nervosa							
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 2/3<sup>rd</sup> 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.