Partners in Healing
OF MINNEAPOLIS
A CENTER FOR HOLISTIC HEALTH

This form has been prepared to gather information about your presenting concerns. The information that you provide will help me to be more accurate and effective in how I evaluate your concerns. Thank you in advance for taking the time to complete this form. Please bring it with you to your initial appointment for the evaluation session.

Neuro-behavioral Symptom Checklist

Name:

Date:

Are you currently under a doctor's care?

◯ Yes ◯ No

Your current doctor's name:

For what are you currently being treated?

Directions:
Please check the boxes that best describe your feelings and your ability to function on a day-to-day basis. When answering each question, please consider the degree to which these concerns have affected your daily life.

Over the last year, I have experienced:

- ☐ Memory lapses
- ☐ Less attentiveness
- ☐ Less interest in activities
- ☐ Trouble making decisions
- ☐ Difficulty learning things
- ☐ Word finding problems
- ☐ Difficulty organizing thoughts
- ☐ Problem-solving difficulties
- ☐ Focusing problems
- ☐ Frequent distraction
- ☐ Misplacing things often
- ☐ Trouble concentrating
- ☐ Other

I often experience:

- ☐ Low energy
- ☐ Sleepiness
- ☐ Unexplained sadness
- ☐ Increased appetite
- ☐ Unusual weight gain/loss
- ☐ Loss of sexual interest
- ☐ Other

I frequently:

- [ ] Feel tense or anxious
- [ ] Have trouble relaxing
- [ ] Feel irritable
- [ ] Am short-tempered
- [ ] Get angry without cause
- [ ] Feel worried or scared

I often:

- [ ] Feel overly active
- [ ] Am unable to relax
- [ ] Have trouble falling asleep
- [ ] Can't stay asleep
- [ ] Crave caffeine/stimulants
- [ ] Procrastinate tasks
- [ ] Get bored easily
- [ ] Wake up groggy/not rested
- [ ] Fidget & squirm

The next section deals with physical/sensory symptoms. Please check those that apply.

Visual symptoms:

- [ ] Blurred vision
- [ ] Double vision
- [ ] Loss of vision
- [ ] Blank spots in visual field
- [ ] Flashing lights in visual field
- [ ] Other

Auditory symptoms:

- [ ] Loss of hearing
- [ ] Ringing in ears
- [ ] Hear strange sounds
- [ ] Difficulty tracking conversations
- [ ] Wear hearing aids
- [ ] Can't understand what people say
- [ ] Other

Motor/Sensory Symptoms

- [ ] Muscle weakness
- [ ] Muscle twitching
- [ ] Trouble walking
- [ ] Balance problems
- [ ] Coordination problems
- [ ] Tremors or shakiness
- [ ] Often drop things
- [ ] Experience numbness
- [ ] "Tingling" skin
- [ ] "Pins & needles" on skin
- [ ] Skin "burns"
- [ ] Changes in skin color
- [ ] Can't tell hot from cold
- [ ] Frequent pain
- [ ] Frequent headaches
- [ ] Fainting spells
- [ ] Seizures
- [ ] Frequent blackouts
- [ ] Sense of smell changed
- [ ] Sense of taste changed
- [ ] Bad taste in mouth
- [ ] Smell bad odors often
- [ ] Other

Illness/Injury History

- [ ] Childhool injury or disease
- [ ] Head injury
- [ ] High fevers
- [ ] Serious infections
- [ ] Diabetes
- [ ] Liver problems
- [ ] Kidney problems
- [ ] Blood vessel problems
- [ ] Stroke
- [ ] High blood pressure
- [ ] Heart problems
- [ ] Cholesterol problems
- [ ] History of digestive issues
- [ ] History of cancer
- [ ] History of surgeries
- [ ] List prior surgeries _____

The next section addresses physical, behavioral, cognitive/emotional and chemical concerns. Please check those that apply.

Daily functioning abilities

- [ ] Trouble using tools
- [ ] Trouble telling left from right
- [ ] Writing ability changed
- [ ] Reading ability changed
- [ ] Speaking ability changed
- [ ] Can't do usual routine
- [ ] Other _____

Do you drink alcohol?

- ◯ No
- ◯ Yes
- ◯ How much & how often _____

Do you use tobacco?

- ◯ No
- ◯ Yes
- ◯ How often? _____

Do you use street drugs?

- ◯ No
- ◯ Yes
- ◯ What do you use, and how often _____

Thank you for taking the time to complete this questionnaire.