Erb Family Wellness

The Greatest Place of Hope and Healing!

Neurotoxic Questionnaire

Name: _____ DOB: _____

Email:_____ _____ Cell: _____

How did you Hear About us?: _____ Date:_____

	PATIENT HISTORY
Y or N	Answer the following questions to the best of your ability. If you cannot answer a question, leave it blank.
	Do you have silver (amalgam) fillings? Have you ever had silver fillings?
	Did you wear contact lenses during the 1980's or early 1990's?
	Did you take oral contraceptives during the early 1980's or early 1990's?
	Do you receive yearly flu shots, or have you recently received a flu shot, allergy shot, or a vaccination?
	Do you have tattoos with red ink?
	Do you eat large amounts (more than 2x/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 in your family experience similar symptoms to you?

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.

0= Never **1**= Occasionally, mild effect **2**= Occasionally, severe effect **3**= Frequently, mild effect **4**= Frequently, severe effect

	Anxiety		Depression
	Mood Swings		Gout (arthritic pain – esp. of the big toes)
	Anger for no reason		Pain in the shoulders or upper back area
	Rage behavior		Twitching of the eyelids
	Irritability (not typical to your personality)		Anemia (low iron/hemoglobin on a blood test)
	Insomnia (cannot get to sleep/wake and cannot go back to sleep		Heart pain (angina) AND you are under the age of 45
	Dizziness		Wrist/ankle drop or weak extensor muscles
	Sounds in ears, including ringing or hearing your heartbeat		Sensitivity to smells (including multiple chemical sensitivity), such as petrochemicals, perfumes, etc.
	Psychological symptoms, even thoughts of suicide		Sensitivity to light
	Sensitivity to sound		Fatigue after exercising – feel worse after exercise
	Indecisiveness		Hair falls out (not normal male pattern baldness)
	Feeling of being overwhelmed or fearful		Shortness of breath – with very little effort
	Metallic taste in your mouth		Bad night vision or seeing halos around light
	Bad breath		Trouble processing new information
	Bleeding of gums		Word reversal or trouble finding words
	Sensitive teeth		Blurred vision at times
	Canker sores or other sores in the mouth		Morning stiffness
	Floaters, shadows, or swimmers when you read or look up into the sky		Joint pain – not necessarily true arthritis – can move from joint to joint
	Dyslexia or loss of place while reading, even as a child		Frequent muscle aches, cramps, unusual sharp, sudden pains
	Swelling of the eyelids		Chronic fatigue
	Peeling of the top layer of skin on hands or feet		Non-restful sleep
	Dry skin		Excessive thirst and/or frequent urination
	SUBTOTAL COLUMN #1		**SUBTOTAL COLUMN #2**

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.

0= Never **1**= Occasionally, mild effect **2**= Occasionally, severe effect **3**= Frequently, mild effect **4**= Frequently, severe effect

	Seem to get shocked more often and with more dramatic effect than most people (doorknobs, car, light switch plate covers, water fountain, people, etc.)		Persistent fungal or viral infection, including athletes foot, warts, jock itch, candidiasis
	Sensitivity to touch		Short term memory loss
	Chronic sinus congestion		Dry, non-productive cough
	Muscle twitching		Excessive sweating – especially at night
	Cannot loose weight, regardless of diet & exercise		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)		
	SUBTOTAL COLUMN #3		**SUBTOTAL COLUMN #4**

	SUBTOTAL COLUMN #1
	SUBTOTAL COLUMN #2
	SUBTOTAL COLUMN #3
	SUBTOTAL COLUMN #4
	GRAND TOTAL

What is your major complaint: _____

What are your reasons for being here: _____

Medications: _____

Vitamins/Supplements: _____

_____