

NEUROTOXIC QUESTIONNAIRE

PART A NAME _____ Phone _____ DATE _____

Please check the answer that best applies:

1. Are you tired or fatigued?
Always Often Sometimes Never
2. Are your eyes sensitive to bright light or do they get red?
Always Often Sometimes Never
3. Do you get headaches? If so, describe? _____
Always Often Sometimes Never
4. Do you have muscle aches or cramps or have been diagnosed with fibromyalgia?
Always Often Sometimes Never
5. Do you have a cough or do you get short of breath?
Always Often Sometimes Never
6. Do you have chronic sinus congestion?
Always Often Sometimes Never
7. Do you have trouble concentrating or remembering things shortly after they occur?
Always Often Sometimes Never
8. Do you have recurring joint pains, sometimes just in one joint, sometimes in the small joints of the hands, wrist or feet?
Always Often Sometimes Never
9. Do you feel weak or dizzy when you stand up, as well as being tired?
Always Often Sometimes Never
10. Do you have Multiple Chemical Sensitivity? Yes No
11. Have you had exposure to any chemical that you think has made you sick? Yes No
21. Did your symptoms appear after a high velocity auto accident (greater than 25mph)?
Yes No
13. Do you have impairment of any sense (touch, taste, smell) or experience discomfort from a gentle touch of the skin? Yes No

Please check all the symptoms that apply:

- | | |
|--|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Sinus congestion |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Muscle ache | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Muscle cramp |
| <input type="checkbox"/> Bone pain | <input type="checkbox"/> Metallic taste |
| <input type="checkbox"/> Sensitivity to bright light | <input type="checkbox"/> Tearing |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Skin pain |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Disorientation |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Abdominal pain |

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PART B

1. Have you ever been diagnosed with Lyme disease or thought you had Lyme or some other disease from a tick or spider bite? Yes No
2. If yes, how long ago? _____
3. Have you visited, lived worked or played in estuaries (the areas where rivers meet sounds, bays or oceans)? Yes No
4. If yes, how long ago? _____ Where _____
5. Have you visited, worked, lived or played in the lakes of central Florida? Yes No
6. Have you been to: (check all that apply) Caribbean Islands Central or South America
Hawaii/Pacific Islands Asia Africa Middle East
7. Did you get ill in any of these places? Yes No
If yes, describe. _____
8. Did you eat any fish there? Yes No
9. Did you get sick after eating the fish there? Yes No Does not apply
10. Do you have occupational or residential exposure to (check all that apply):
Pesticides Organic solvents Cleaning solutions Petroleum products Metal fumes
Composting Systems None of the above Other _____
11. Do you live/work in a building that has a reported problem of water leaks, smells of (or has visible) mold, or is a "tight" building that has windows that do not open? Yes No
12. If yes, for how long? _____
13. Have you worked on an airplane? Yes No
14. If so, when? _____
15. Is your workplace thought to be a "sick" building by your coworkers? Yes No Does not apply
16. Do you work, visit, live or play adjacent to agricultural land or rural land that has been abandoned for chemical problems? Yes No
17. Did you have wartime (or military exposure) to:
Agent Orange Yellow rain Chemical defoliants Biological weapons Military vaccinations None of the Above If so, when? _____ Where? _____



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