



A Dr. Hallowell Protocol
SHINE for Doctors

Special Help Integrating Neurological Experience™

ADULT HEALTH HISTORY

Name of Patient	Date
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / / Age
Address	Phone Numbers: Home
Address	Work
	Cell
Occupation	
Emergency Contact	

FAMILY HISTORY

Family history can often be helpful in understanding an individual's problems.

Please check any box that applies:

Mother's highest education level:			
Father's highest education level:			
Please check any box that applies:			
<i>Has anyone in the family had:</i>	<i>Siblings</i>	<i>Parents</i>	<i>Extended Family</i>
Motor problems			
Reading problems			
Speech/language problems			
School/learning problems			
Alcohol/drug problems			
Anxiety, depression, other psychological disorders			
Seizures/epilepsy			
Attention problems/hyperactivity			
Please list all family members (in or out of house) and other people currently in the house:			
NAME	RELATIONSHIP	AGE	CURRENTLY IN HOUSE?
Parents are: Married <input type="checkbox"/> Living together <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/>			

BIRTH HISTORY

Do you have any information with regard to your birth history? _____

DEVELOPMENTAL HISTORY:

Do you have any information with regard to your infant health status?
For example, were you hospitalized, or had any serious health issues?

MEDICAL HISTORY

Are you regularly checked by the following:

- Medical Doctor Chiropractor Osteopath Naturopath Dentist Other

- Do you have/had braces on your teeth? Yes No
 Do you have any amalgam fillings? How many? Yes No
 Do you complain of any ongoing physical pains? (headaches, stomach aches, muscle/joint aches, or growing pains) Yes No
 Do you suffer from dry skin, dandruff, hard skin on elbows, bumps on the outside of the arms, cracked heels, excessive thirst/urination? Yes No

Please list all of your medical and/or psychological diagnoses, past and present:

Please list all current prescription medications: _____

Are you exposed to a toxic environment (including passive smoking or industrial chemicals)? Yes No

Have you had any serious falls, physical traumas, or physical injuries? Yes No

Please list:

Have you ever been involved in a motor vehicle accident? Yes No

Please list:

Has your hearing been tested? Yes No

When was your last hearing test? _____

Has your vision been tested? Yes No

When did you last visit the optometrist? _____

Do you wear glasses/contact lenses? Yes No

Have you been hospitalized? Yes No
If Yes, for what? _____

Have you had any surgeries? Yes No
If Yes, for what reason? _____

Have you had any surgeries recommended to you that have not been performed? Yes No
If Yes, for what? _____

Have you had prior psychotherapy or counseling? Yes No
If Yes, for what issue? _____

BEHAVIOUR/MENTAL HEALTH

On a scale of 1 to 10, describe your stress level (circle one).

<i>Personal</i>	1	2	3	4	5	6	7	8	9	10
<i>Occupational</i>	1	2	3	4	5	6	7	8	9	10

Describe any sports or activities you are involved in. _____

Indicate the number of hours a week of "screen time" you use:

Computer _____ Smart Device (phone, iPad, etc.) _____
Computer games (DS, etc.) _____ Television _____

Describe your family relationships; with parents and siblings.

Do you have many friends? _____

Do you excel at, or struggle to build relationships with your peers? Excel Struggle Neither

If you struggle, why do you think that is?

What problems do you have with peers, if any?

- | | | |
|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Bragging to peers | <input type="checkbox"/> Being Teased |
| <input type="checkbox"/> Being physically attacked | <input type="checkbox"/> Rejected by peers | <input type="checkbox"/> Overly physically affectionate |
| <input type="checkbox"/> Being bullied | <input type="checkbox"/> Jealous of peers | |

Do you have self-esteem issues? Yes No

Do you feel that you exhibit any of the following symptoms more often than is typical? (Please put a check in front of any that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Often touchy/easily annoyed | <input type="checkbox"/> Often bullies/threatens | <input type="checkbox"/> Often irritable |
| <input type="checkbox"/> Often defies rules | <input type="checkbox"/> Initiates physical fights | <input type="checkbox"/> Changes in appetite |
| <input type="checkbox"/> Often angry/resentful | <input type="checkbox"/> Ever been arrested | <input type="checkbox"/> Diminished interest |
| <input type="checkbox"/> Often argues with adults | <input type="checkbox"/> Physically cruel to others | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Often loses temper | <input type="checkbox"/> Physically cruel to animals | <input type="checkbox"/> Restlessness or slowed down |
| <input type="checkbox"/> Blames other for mistakes | <input type="checkbox"/> Motor or vocal tics | <input type="checkbox"/> Fatigues/low energy |
| <input type="checkbox"/> Deliberately annoys | <input type="checkbox"/> Destroys property | <input type="checkbox"/> Feels worthless |
| <input type="checkbox"/> Often spiteful/vindictive | <input type="checkbox"/> Deliberately sets fires | <input type="checkbox"/> Becomes tearful easily |
| <input type="checkbox"/> Refuses to go to work | <input type="checkbox"/> Lies often | <input type="checkbox"/> Often sad |
| <input type="checkbox"/> Repeated nightmares | <input type="checkbox"/> Steals | <input type="checkbox"/> Indecisive/can't think |
| <input type="checkbox"/> Unusual fears | <input type="checkbox"/> Has run away | <input type="checkbox"/> Thinks about death |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Extreme mood swings | <input type="checkbox"/> Talks about suicide |
| <input type="checkbox"/> Self-conscious/clings | <input type="checkbox"/> Does not show emotions | <input type="checkbox"/> Hurts self |
| <input type="checkbox"/> Excessive need for reassurance | <input type="checkbox"/> Overreacts to touch/noise | <input type="checkbox"/> Currently uses drugs |
| <input type="checkbox"/> Self-injurious behaviour | <input type="checkbox"/> Strange or bizarre ideas | <input type="checkbox"/> Currently drinks beer or alcohol |
| <input type="checkbox"/> Worry of future events | <input type="checkbox"/> Used drugs in the past | <input type="checkbox"/> Used beer or alcohol in the past |
| <input type="checkbox"/> Repeats certain actions | <input type="checkbox"/> Poor social interactions | <input type="checkbox"/> Can't stop thinking about things |
| <input type="checkbox"/> Somatic complaints
(headache/stomach) | <input type="checkbox"/> Gets upset by changes in routine | <input type="checkbox"/> Excessive preoccupation with objects or ideas |
| <input type="checkbox"/> Difficulty maintaining friendships | | |

Please place a check mark in the column which best describes you:

	Not at all	Just a little	Pretty much	Very much
Often fails to give close attention to details or makes careless mistakes in work or other activities.				
Often has difficulty sustaining attention in tasks or activities.				
Often does not seem to listen when spoken to directly.				
Often does not follow through on instructions and fails to finish tasks (not due to oppositional behavioral failure to understand directions).				
Often has difficulty organizing tasks and activities.				
Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort				
Often loses things necessary for tasks or activities				
Is often easily distracted by extraneous stimuli				
Is often forgetful in daily activities				
Often fidgets with hands or feet or squirms in seat				
Often leaves seat in situations in which remaining seated is expected				
Often moves about excessively in situations where it is inappropriate (may be limited to subjective feelings of restlessness)				
Often has difficulty playing or engaging in leisure activities quietly				
Is often "on the go" or often acts as if "driven by a motor"				
Often talks excessively				
Often blurts out answers before questions have been completed				
Often has difficulty waiting turn				
Often interrupts or intrudes on others (butts into conversations or activities)				

Childhood conditions had, please check:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> measles | <input type="checkbox"/> mumps | <input type="checkbox"/> chicken pox | <input type="checkbox"/> whooping cough |
| <input type="checkbox"/> scarlet fever | <input type="checkbox"/> diphtheria | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> typhoid fever |
| <input type="checkbox"/> ear infections | <input type="checkbox"/> tubes in ears | <input type="checkbox"/> chronic illness | |

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

O = Occasional F = Frequent C = Constant

- | O | F | C | |
|--------------------------|--------------------------|--------------------------|----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chills |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fevers |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervousness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neuralgia |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Numbness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sweats |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of weight |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | tremors |

Muscle & Joint

- | | | | |
|--------------------------|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bursitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Foot trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Low back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neck pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neck stiffness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain between shoulders |

Respiratory

- | | | | |
|--------------------------|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Spitting blood |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Throat phlegm |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | wheezing |

Eyes, Ears, Nose & Throat

- | | | | |
|--------------------------|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Colds |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Crossed eYes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Deafness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dental decay |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear aches |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear discharges |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear noises |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinus infections |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Enlarged glands |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Enlarged thyroid |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sore throat |

- | O | F | C | |
|--------------------------|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tonsillitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Failing vision |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Far sighted |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gum trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hay fever |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hoarseness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nasal obstruction |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Near sighted |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nosebleeds |

Cardio-Vascular

- | | | | |
|--------------------------|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rapid heart beat |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Slow heart beat |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swelling of ankles |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hardening of arteries |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain over heart |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor circulation |

Gastro Intestinal

- | | | | |
|--------------------------|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive hunger |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Burping or gas |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Liver trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Colon trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficult digestion |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Distension of abdomen |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stomach pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gall bladder trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Intestinal worms |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vomit blood |

Skin

- | | | | |
|--------------------------|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Boils |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bruise easily |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dryness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hives or allergy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | itching |

- | O | F | C | |
|--------------------------|--------------------------|--------------------------|----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin rash |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Varicose veins |

Genito-Urinary

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bed wetting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss control urine |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney infection |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful urination |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prostate trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pus in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Smell of urine |

Pain or Numbness in:

- | | | | |
|--------------------------|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shoulders |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arms |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hands |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hips |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Legs |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Knees |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ankles |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Feet |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful tail bone |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sciatica |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swollen joints |

For Women Only

- | | | | |
|--------------------------|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heavy flow |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Light flow |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irregular cycle |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful cycle |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sore breasts |

Menopausal: Yes No

Last Menstruation Date: _____

Pregnant: Yes No

Due Date: _____

HABITS OF LIFESTYLE

Do you smoke? Yes No

Do you exercise? Yes No

Do you consume alcohol? Yes No

Exercise Indoor Activities: _____

Exercise Outdoor Activities: _____

Rate your sleep hours per night: 4-6 6-8 8-10 12+

Do you wake rested? Yes No

Rate your appetite: Poor Fair Medium Good Excellent

Rate your diet: Poor Fair Medium Good Excellent

Do you eat regularly: Breakfast Lunch Dinner

Do you eat per day: 1 meal 2 meals 3 Meals 4 meals More than 4 Meals

Do you take vitamins and minerals? Yes No

If Yes, please list: _____

Do you take any recreational drugs? Yes No

If so, what? _____

Have you ever been knocked unconscious: Yes No Don't Know

If so, for how long? _____

REASON FOR ASSESSMENT

Please describe in your own words what concerns you have. Also, please add any additional information that you feel is important and may be helpful in our assessment.

What specific question do you have that you hope an evaluation will answer?

SIGNATURE _____

Date: ___ / ___ / ___