Carucci Chiropractic Center & The Connecticut Wellness Institute

My Brain ReClaimed Program

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_

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Phone (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Job/Profession \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hobbies/Recreational activities/Clubs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you drive? Y / N Do you enjoy driving Y / N If no, did you ever enjoy driving? Y / N

Do you read? Y / N IF so, how often? Daily, a few times a week, a few times a month, never

What do you read? Newspaper, magazines, email, online articles, books. What type of

reading? News, mystery , history, biography, science, science fiction, novels, sports,

investing, self-help, other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many days/wk do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of exercise do you perform? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you participate in any brain exercise such as: jigsaw puzzles, word puzzles/games, number

games/puzzles, memory puzzles/games, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use prayer/meditation/visualization? Y / N If yes, how often and for how long? \_\_\_\_\_

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Do you belong to a faith-based group/organization/parish/community? Y / N

Do you participate with this group regularly? Y / N If yes: daily, weekly, monthly, other

Do you pay your own bills? Y / N Do you manage your checking account? Y / N

Do you care for your home? Y / N Do you have help with care of your home Y / N

Do you do your own laundry (wash, fold, iron)? Y / N

Do you shop for your own clothes? Y / N Do you do your own grocery shopping? Y / N

Do you cook your own food? Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_days/wk \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you purchase Organic foods? \_\_\_\_\_\_\_\_\_\_\_\_% Non-GMO Foods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% \_\_\_

Do you snack at night? Y / N If yes, on what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at what time? \_\_\_\_\_\_\_

How many 8 ounce glasses of water do you drink/day? \_\_\_\_\_\_\_\_\_\_tap / filtered / spring\_\_\_\_\_

How many hours of sleep do you get each night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What time do you go to bed? \_\_\_\_\_\_\_\_ What time do you wake up and get out of bed?\_\_\_\_\_\_

Do you sleep through the night? Y / N If not, why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What time do you wake at night (if not sleeping through)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a sleep study? Y / N If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep study results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Treatment implemented \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use a computer or tablet? Y / N If yes, for what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How many hours do you spend on the computer/tablet per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you listen to music? Y / N If yes how often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ how long? \_\_\_\_\_\_

Do you listen to podcasts or books on tape? Y / N If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What type of music? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of book/podcast? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you play video games/cell phone/tablet games? Y / N If yes, how often and how long \_\_\_\_

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Do you use the computer after the sun sets? Y / N If yes, until what time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use Blue light blocking glasses? Y / N If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you use sunscreen? Y / N If yes, year round? Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use a wireless headset? Y / N If yes, how many minutes/day \_\_\_\_\_\_ hours/day \_\_\_\_\_\_

Do you wear your cell phone on your body? Y / N If yes, where? \_\_\_\_\_\_\_\_\_\_\_ hour/day \_\_\_\_\_

Do you sleep with the TV on all night? Y / N

Do you sleep with your phone powered on? Y / N

Do you sleep with your cell phone within 8 feet of your body Y / N

Do you power your modem off at night? Y / N

Do you take Vitamins/Supplements? Y / N If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you get vaccinated? Y / N If yes, for what and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever had a fever, headache, joint pain, indigestion, constipation, diarrhea, muscle pain within 3 days after a vaccine? Y / N If so circle your reaction or list it and how long did the symptoms last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Did you do anything did you do about it?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you on any medications? Y / N If so, what and for what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have dental fillings? Y / N IF so are they mercury, silver, other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you ever have your dental fillings removed? Y / N If so, when and did you have any reactions after the removal? Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever had a Root Canal, Oral Infection, Gingivitis? Y / N If so, which did you have (circle which apply) Did you require antibiotics for either? Y / N Did it clear up with 1 course? Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any head trauma, concussion, whiplash, vertigo? Y / N If yes please explain:

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Do you have allergies or sinus problems? Y /N If yes, to what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What do you do about/for it/them? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any auto-immune conditions Y / N If yes, which: Sjogrens, Hashimotos, Hepatitis,

Diabetes Type I, Crohn’s, MS, RA, Lupus, Psoriasis, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is it managed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you every had Mononucleosis, Epstein Barr or Cytomegalovirus? Y / N

Have you every been diagnoses with Lyme’s Disease? Y / N other tick born illness? Y / N

Have you ever had encephalitis or meningitis? Y / N If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How was it treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been exposed to mold in your: home, car, work, food? Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever undergone mold abatement? Y / N If yes by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If yes, what was the procedure/protocol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever had anesthesia? Y / N If so when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If so, how did you tolerate it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever undergone any genetic testing? Y / N If yes, for what and what were the results and treatment?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are memory issues part of your family history? Y / N If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was their age of diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you hope to gain from this program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How motivated are you to make changes to your lifestyle including testing, sleep, food, cooking,

exercise, vitamin/supplement addition/changes, brain exercise? Very willing, somewhat

willing, somewhat unlikely, very unlikely \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a support network? Y / N If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I consent to Dr. Carucci reviewing my history and making recommendations for My Brain ReClaimed Program. I understand that some of the tests and protocols **WILL NOT** be covered by my healthcare insurance and that she **WILL INFORM** me of those items in advance so that I can decide how I would like to proceed. **If I choose** **to have out of pocket** procedures such as: examination, testing (laboratory, neurocognitive), treatment, materials/supplements, programming, etc. that **payment is due in full at the time of my consent for out of pocket items.**

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Name (printed) Signature Date

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Dr. Gina M. Carucci Date