

Wendy Ormsby D.C., LLC  
Chiropractic Holistic Physician

INFORMED CONSENT

Patient Name \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ City, State Zip Code \_\_\_\_\_, \_\_\_\_\_

**Background:** I desire to be tested to determine possible undesirable reactions to various substances that are natural constituents of my diet, environment or body chemistry. I understand that the testing procedure to be used is not generally employed by the majority of physicians for this purpose. I understand that other methods of testing and treatment are available. These have been described to me.

**Procedures:** I understand that this is a non-invasive procedure where the skin is not pierced. Metal conductors are attached to the skin to measure electrical conductivity on the hands. Additional homeopathic remedies; nutritional supplements and other natural remedies may be used to bring abnormal electrical patterns into equilibrium. I understand the nature of related symptoms are of an unpredictable nature and therefore this facility cannot guarantee any results. **Wendy Ormsby D.C., LLC** cannot guarantee the success nor the longevity of this therapy.

I choose to be tested using the Neurological Stress Reduction Therapy (NSRT) electro dermal system. I understand that NSRT testing has not been scientifically proven to be reliable and that my physician must still rely upon my personal observation as to the effectiveness of the test and any treatment based on the results of this test.

**Risks:** The procedure is very safe because it measures only changes in the electrical properties of the skin. However, since an electrical signal is used there is a slight, risk of electrical burn or shock. Skin irritation or redness may occur at the site of the test. However, any discomfort should be brief.

There are generally no risks associated with the substances recommended to bring your body to equilibrium as long as these substances are taken as recommended. I agree to immediately report any discomfort I may experience from taking these substances to my examiner or physician. I agree I have reported any and all significant health problems (i.e., Diabetes, High Blood Pressure, etc) to my physician.

I understand that sensitivities may increase during therapy. I assume all responsibility for any unpredictable immunity response and understand that this facility does not treat cases of anaphylaxis and I agree to completely disclose all information regarding any life threatening allergies or allergies resulting in anaphylaxis.

**Questions:** I have been provided with the opportunity to ask any pertinent questions I have regarding the NSRT testing procedure, protocol, and/or treatment program.

**Free to Decline:** I understand that I may decline to participate in the NSRT electro dermal testing and can choose instead to have other testing.

**Important:** There is no recognized body of scientific evidence to show that an electrically balanced body is more likely to be healthier and you have chosen to participate in this assessment with that understanding. Your physician may need to use other forms of testing in the course of your treatment.

**Payment of Service:** You are responsible for the payment of the normal and necessary fees associated with the NSRT and any remedies, supplements, or herbals recommended as a result of that testing, if purchased in this clinic. Your physician may need to use other forms of testing in the course of your treatment.

**I have read and understand the above information about NSRT and my rights and responsibilities and hereby consent to the use of the NSRT System.** I consent to the use of clinical reports and results of case for study, the purpose of advancing clinical knowledge, research and scientific purposes, provided that my identity is kept confidential.

I understand **Wendy Ormsby D.C., LLC**, practices Neurological Stress Reduction Therapy independently of HealthSource and HealthSource of Brunswick. I agree to hold HealthSource and HealthSource of Brunswick, their successors and assigns, blameless and not liable or obligated to the therapy provided by Wendy Ormsby D.C., LLC.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Wendy Ormsby D.C., LLC  
Chiropractic Holistic Physician

MIGRAINE QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Home#: \_\_\_\_\_

Gender:  MALE  FEMALE Work#: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

**Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:**

- We do not treat headaches, symptoms or diseases.
- A headache is not a disease, rather a symptom.
- A symptom is an attempt by your body to tell you something.
- We will attempt to find the underlying headache trigger.
- We do not use drugs in this program.
- There is no single "healthy" diet that will work for everyone.
- Just because a food is considered "healthy", does not mean it is "healthy" for you.
- Your diet consists of everything you eat, drink, rub on your skin, or inhale.
- Our procedures are safe and painless.

Briefly describe the reason for your visit and what you hope to accomplish: \_\_\_\_\_

\_\_\_\_\_

**Please check all that apply:**

- Is your head pain getting more severe, unlike past headaches?
- Did your severe headaches start after the age of 40?
- Do you get drowsy with the head pain?
- Did your severe headaches start less than one year ago?
- Have the severe headaches increased in frequency in the last year?
- Do you ever feel confused with the head pain?
- Have you ever felt feverish with the head pain?
- Do you feel that your physical strength is declining rapidly?
- Have the sever headaches increased in severity in the last year?
- Does physical exertion cause a headache?
- Can straining cause a headache?
- Does coughing ever cause a headache?
- Can sexual activity cause a headache?
- Has your blood pressure increased suddenly in the last year?
- Can body position cause a headache?
- Has a doctor ever told you that you have a brain tumor?
- Do you think that you may have a brain tumor?
- Have you been told that you have a jaw problem? (TMJ)

**Please check all that apply (cont):**

- Have you ever had an M.R.I.?
- Have you ever had a CAT scan?
- Have you ever seen a Neurologist for any condition?
- How many doctors have you seen for your head pain?
- Have you been told by a doctor that he can find nothing wrong or there is nothing wrong with you?
- Has a doctor told you that the head pain is stress related?
- Do you feel like the doctors just don't understand your problem?
- Do you feel like the doctors have let you down?
- Are you tired of taking drugs for your headaches?

**What would you like the doctor here to do for you?** \_\_\_\_\_

**Any comments?** \_\_\_\_\_

**Please check all that apply:**

- Pain affects both sides of head
- Starts in the morning, gets worse in the afternoon and evening.
- Feels like a constricting band.
- Pain may last for days.
- Location may vary with each headache.
- Manual pressure can make the headache worse.
- May occur during sleep.
- Associated with stress.
- Pain is usually on one side of the head.
- Often occurs at times of letdown, such as weekends, vacations.
- Throbbing, penetrating pain.
- Often accompanied by a sick or nauseated feeling or vomiting.
- May last a few hours or days.
- May be accompanied by sensitivity to light, sound and odors.
- Nose may run
- May flush and sweat.
- May see flashing lights or halos around objects.
- Starts around menstrual period.
- Pain is located behind the eye.
- Headaches are seasonal and tend to start at the same time of year.
- May have several attacks a day for weeks, then none.
- Pain comes on with little or no warning at all.
- Usually one sided, but may change sides.
- Pain is piercing or burning.
- Attacks last 30 to 45 minutes.
- Eye tears, swells, droops.
- May cause flushing or sweating on one side of face.
- Nostril on affected side becomes congested.
- Pain is above or below the eyes, may spread to forehead and cheeks.
- May be seasonal (hay fever time, when pollen counts are high).
- Starts in morning, gets worse as day goes on.

**Please check all that apply (cont):**

- Pressure like pain.
- Nose feels congested.
- May be accompanied by discharge from nostrils or postnasal drip.
- Area often may be tender to the touch.
- Fever may be present.
- May follow upper respiratory infection.

**Age when headache symptoms were first observed**

- Infant (Age 0 - 2)
- Child (Age 3 - 5)
- Child (Age 6 -12)
- Adolescent (Age 13 - 18)
- Adult (Age 19 - 25)
- Adult (Age 26 - 40)
- Adult (Age 40+)

**Family members with migraine headaches**

- Mother
- Father
- Brother/Sister
- Grandparents
- Son/Daughter
- Spouse
- none

**When are your headaches worse?**

- Outdoors, and better indoors
- At nighttime
- In the bedroom or when in bed
- During windy weather
- During wet or damp weather
- When the weather changes
- During known pollen seasons
- In air conditioning
- In fields or in the country
- In certain rooms or buildings
- When exposed to tobacco smoke
- With yard work, cut grass, leaves, hay or barns
- When sweeping or dusting the house
- In areas with mold or mildew
- Tobacco smoke bothers me more than anything else
- Don't know

**Please select all the answers that apply to you:**

**Where is the headache located?**

- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> Right side of head       | <input type="checkbox"/> Both sides of head | <input type="checkbox"/> Top of head |
| <input type="checkbox"/> Left side of head        | <input type="checkbox"/> Back of neck       |                                      |
| <input type="checkbox"/> Forehead:                |   |                                      |
| <input type="checkbox"/> Left side                | <input type="checkbox"/> Right side         | <input type="checkbox"/> Both sides  |
| <input type="checkbox"/> Behind or above the eye: |   |                                      |
| <input type="checkbox"/> Right eye                | <input type="checkbox"/> Left eye           | <input type="checkbox"/> Both eyes   |
| <input type="checkbox"/> Side of face:            |   |                                      |
| <input type="checkbox"/> Right side               | <input type="checkbox"/> Left side          | <input type="checkbox"/> Both sides  |

**What type of pain do you have with the headache?**

- |                                   |   |   |
|-----------------------------------|---|---|
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Dull Ache                          | <input type="checkbox"/> Feels like a tight band around your head |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Throbbing                          |   |
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Feels like pressure inside of head |   |

**Do you have visual symptoms with your headache?**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Bright light circles around objects | <input type="checkbox"/> Odd light patterns | <input type="checkbox"/> Loss of some vision |
| <input type="checkbox"/> Flashes of light                    | <input type="checkbox"/> Double vision      | <input type="checkbox"/> Loss of all vision  |
|  | <input type="checkbox"/> Spots before eyes  |  |

**How often do you get a headache?**

- |                                     |   |  |
|-------------------------------------|---|--|
| <input type="checkbox"/> Every day  | <input type="checkbox"/> More than one a week | <input type="checkbox"/> One or two a year |
| <input type="checkbox"/> One a week | <input type="checkbox"/> One or two a month   | <input type="checkbox"/> Other: _____      |

**How long do your headaches last?**

- |                                  |                                |                               |                                |
|----------------------------------|--------------------------------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Minutes | <input type="checkbox"/> Hours | <input type="checkbox"/> Days | <input type="checkbox"/> Weeks |
|----------------------------------|--------------------------------|-------------------------------|--------------------------------|

**Is there a time of day that your headaches are more likely to start?**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> No pattern, can start anytime      | <input type="checkbox"/> I often wake up with a headache in the morning. | <input type="checkbox"/> After lunch          |
| <input type="checkbox"/> I wake up at night with a headache | <input type="checkbox"/> During the morning                              | <input type="checkbox"/> If I don't eat lunch |
|   | <input type="checkbox"/> Before lunch                                    | <input type="checkbox"/> Before Dinner        |
|   |  | <input type="checkbox"/> After dinner         |
|   |  | <input type="checkbox"/> Before bedtime       |

**Do you have vomiting with your headaches?**

- |  |   |                             |
|--|---|-----------------------------|
| <input type="checkbox"/> Before the headache | <input type="checkbox"/> After the headache       | <input type="checkbox"/> No |
| <input type="checkbox"/> During the headache | <input type="checkbox"/> After eating or drinking |                             |

**Do you have nausea with your headache?**

- |  |   |                             |
|--|---|-----------------------------|
| <input type="checkbox"/> Before the headache | <input type="checkbox"/> After the headache       | <input type="checkbox"/> No |
| <input type="checkbox"/> During the headache | <input type="checkbox"/> After eating or drinking |                             |

**How long ago did your headaches start?**

\_\_\_\_\_ days ago    \_\_\_\_\_ weeks ago    \_\_\_\_\_ months ago    \_\_\_\_\_ years ago

**How is your energy level?**

- Great in the morning when I wake up
- Terrible when I wake up
- Better in the morning
- Better if I take a nap in the afternoon
- Worse after I take a nap

**Have your headaches changed in the last year?**

- More frequent
- Less frequent
- More severe
- Less severe
- No change

**Has there ever been a time when your headaches just went away, then came back for no apparent reason?**  Yes  No

If Yes, how long ago? \_\_\_\_\_ For what length of time? \_\_\_\_\_

**Additional Information:**

1. Do you feel tired after a full nights sleep?  Yes  No
2. Do you feel more tired in the morning than when you went to bed?  Yes  No
3. Does a short nap make you feel more tired?  Yes  No
4. Do you have more energy when you are physically busy?  Yes  No
5. Do you feel more tired if you sleep late in the morning?  Yes  No
6. Do you get severely fatigued if you stop moving and sit for more than twenty minutes?  Yes  No
7. Do you have days of feeling okay and suddenly become exhausted and you descend into feelings of despair?  Yes  No
8. Do you want to be alone in the evenings?  Yes  No
9. Do you feel as if you have never totally been yourself?  Yes  No
10. Do you have bouts of cloudy thinking or mental fog?  Yes  No
11. Do you have dark shadows under your eyes?  Yes  No
12. Do you have bouts of depression for no apparent reason?  Yes  No
13. Do bright lights make the pain worse?  Yes  No
14. Do you become sensitive to loud sounds when you have a headache?  Yes  No
15. Do you become sensitive to smells when you have a headache?  Yes  No
16. Do movements make the headache pain worse?  Yes  No
17. Do you have any numbness when you have a headache?  Yes  No
18. Do you go into a darkened room and lie motionless until the headache passes?  Yes  No
19. Do environmental factors trigger your headaches? (Rain, heat, cold)?  Yes  No
20. Do you know of anything in your diet that can trigger a headache?  Yes  No

Please list: \_\_\_\_\_

\_\_\_\_\_

21. Do you know of any triggers other than your diet that can cause a headache? \_\_\_\_\_

\_\_\_\_\_

### Additional Information (cont):

22. Are your headaches related to your menstruation?  Yes  No
23. Do your headaches get worse around or after the holidays?  Yes  No
24. How often do you get a severe headache? \_\_\_\_\_
25. How often do you get a regular headache? \_\_\_\_\_
26. At what age did you have your first severe headache? \_\_\_\_\_
27. What was going on in your life at that time? \_\_\_\_\_
28. Did your first severe headache start after some type of **physical** trauma?  Yes  No
29. Did your first severe headache start after some type of **emotional** trauma?  Yes  No
30. Did your first severe headache start after some type of **chemical** exposure?  Yes  No
31. What do you do when you get a severe headache? \_\_\_\_\_
32. What makes your headache go away? \_\_\_\_\_
33. Do you take medications for your headache?  Yes  No
34. What does the medication do for you? \_\_\_\_\_
35. List the medications you have tried that did not help you: \_\_\_\_\_  
\_\_\_\_\_
36. Do you have neck pain?  Yes  No
37. Have you ever had anyone work on or manipulate your spine?  Yes  No
38. Do you think that you may have a brain tumor or some other organic disease?  Yes  No
39. Can body movement or positioning bring on a severe headache?  Yes  No
40. Have you ever had an auto accident?  Yes  No If yes, when? \_\_\_\_\_
41. When is your energy at highest? \_\_\_\_\_
42. When is your energy at its lowest? \_\_\_\_\_
43. Do you get tired after eating a big meal? \_\_\_\_\_
44. Do allergies run in your family?  Yes  No
45. Do you have chronic sinus problems?  Yes  No
46. Do you get recurring joint pains?  Yes  No
47. Do you get recurring muscle pains?  Yes  No
48. Do you have restless legs in the evening?  Yes  No
49. Do you have recurring rashes?  Yes  No
50. Do you have anxiety?  Yes  No
51. Do you have dizziness?  Yes  No
52. Do you have gas?  Yes  No If yes:  Stomach?  Lower bowel?

### Additional Information (cont):

- 53. Do you have depression?     Yes    No
- 54. Do you have ringing in the ears?     Yes    No
- 55. Do you have chronic constipation?     Yes    No
- 56. Do you feel bloated after eating?     Yes    No
- 57. Do you have chronic diarrhea?     Yes    No

### Please select the description below that best describes the pain level of a severe headache:

- Level 1:** Bad head pain, but I can still function as if everything is okay. I usually feel depressed at this point.
- Level 2:** Moderately bad head pain with some mild stomach symptoms, (mild nausea, vomiting, diarrhea). I can still function okay in routine activities such as typing, driving or preparing dinner. Starting to lose my grip and my thinking is getting muddled.
- Level 3:** Awful head pain with pronounced stomach distress. Light sounds and odors make my head hurt worse. I can't think clearly and I don't think I'm going to be good for anything much longer. I feel so bad I could cry.
- Level 4:** Excruciating head pain, vomiting, impaired reasoning, and sensitivity to light, sounds, odors and motion. I'm incapable of functioning at all now. I am in agony. All I want is to be lying down in a dark quiet room.

- 1. Do you feel like the headaches have ruined the quality of your life?     Yes    No
- 2. Have the headaches affected your relationships?     Yes    No
- 3. Have the headaches affected your work?     Yes    No
- 4. Have the headaches affected your family?     Yes    No
- 5. Did your first severe headache start after some type of dental work?     Yes    No
- 6. Did your first severe headache start after childbirth?     Yes    No
- 7. Did your first severe headache start after an injection or vaccination?     Yes    No
- 8. Does putting gasoline in your car seem to affect you?     Yes    No  
If yes, in what way? \_\_\_\_\_

- 9. Do strong odors like perfume seem to trigger some of your severe headaches?     Yes    No
- 10. Do you smoke?     Yes    No
- 11. Does cigarette smoke affect you?     Yes    No  
If yes, in what way? \_\_\_\_\_

- 12. Does drinking alcohol affect your severe headaches?     Yes    No
- 13. Do you wear perfume/aftershave?     Yes    No
- 14. Do you use skin lotions or moisturizers?     Yes    No