Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date:_____

Name:_____ Date of Birth:_____ Email Address:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone: _____

Age:_____ ❑ Male ❑ Female

Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Other _____

Name of Spouse or Nearest Relative:_____ Phone:_____

Your Occupation_____ Your Employer:_____

Referred to this Office by: ❑Friend/Family Member - Name?_____

❑Yellow Pages ❑ Mail ❑Clinic Location ❑Other_____

Payment for Services will be by: ❑Cash ❑Check ❑Credit Card

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	venereal disease

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition_____ Date of Last Physical Exam_____

SURGICAL HISTORY:

1._____ Date:_____

2._____ Date:_____

3._____ Date:_____

Have you ever had a metal implant? ❑Yes ❑No

Ever been gunshot? ❑Yes ❑No

ACCIDENT HISTORY : ❑Job ❑Auto ❑Other 1._____ Date:_____

❑Job ❑Auto ❑Other 2._____ Date:_____

❑Job ❑Auto ❑Other 3._____ Date:_____

(over please)

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS: Please Rate Your symptoms(1-10, with 1 being least serious)

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT

WHEN AND HOW OCCURRED? _____

_____

SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT ❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET DATE OCCURRED: _____

SYMPTOMS HAVE PERSISTED FOR # ___HOUR(S) ___DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)

SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES WHEN? _____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

_____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS ❑NO ❑YES WHAT KIND? _____

ARE YOU TAKING ANY MEDICATIONS ❑NO ❑YES WHAT KIND? _____

ARE YOU PREGNANT ❑NO ❑YES DATE OF LAST MENSTRUAL PERIOD _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD ❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **RELIEVE** YOUR CONDITION:

❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:

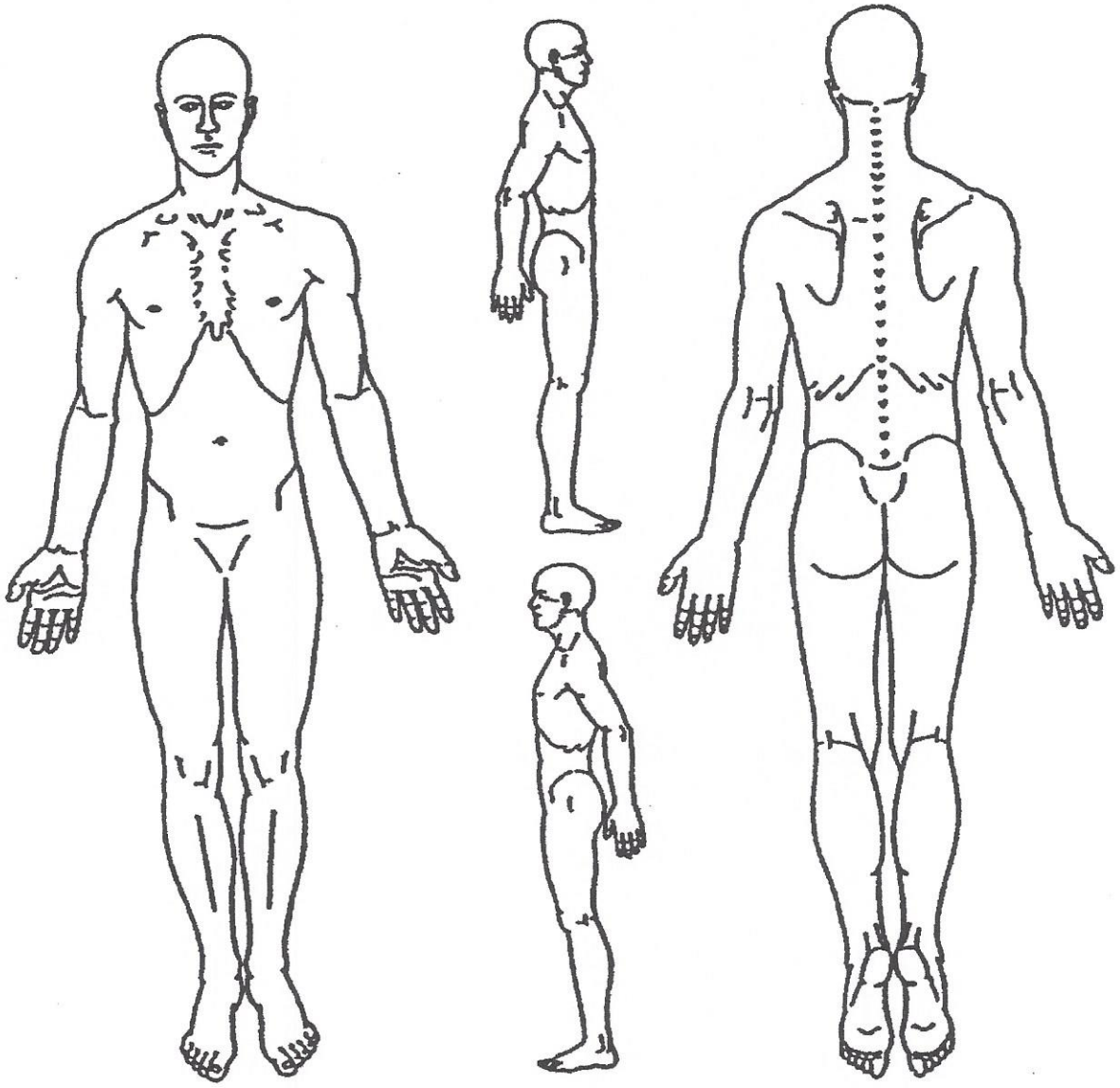
❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss /confusion ❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever ❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

Patient's Signature: _____ Date: _____

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES
O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____ Date _____

What's in a number?

How to rate your symptoms, 1 - 10

10 - Your pain is intense, constant, greatly restricts your activities, and it is impossible to go more than 5 minutes without awareness of the pain.

9 - Same as above, but you can forget about the pain up to 15 minutes at a time.

8 - The pain is significant, moderately intense at times, but not constant. Most activities are affected, you think about it once or twice an hour.

7 - Same as above, except that the pain is never intense.

6 - The pain is moderate yet too frequent to ignore. Some activities are affected. Hours can go by without being aware of the pain.

5 - Same as above, except that almost no activities are affected.

4 - The pain is little more than a nuisance, and you go through the whole day frequently aware, but never affected by it.

3 - Same as above, except that the awareness of the pain may be absent for a whole day at a time.

2 - At it's worst, the pain is best described as "a little uncomfortable". Days can go by without being aware of it.

1 - Same as above, except that the symptom does not recur more frequently than once a week.

SYSTEMS SURVEY FORM

Maestro SYSTEMS SURVEY

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Sex: Male ☐ Female ☐

Pulse: Recumbent _____ Standing _____ Vegetarian ☐ Gluten-free ☐

Blood pressure: Recumbent _____/_____ Standing _____/_____ Ragland's Test is Positive ☐

INSTRUCTIONS: Fill in only the circles which apply to you.
● ○ ○ MILD symptoms (occurs rarely).
○ ● ○ MODERATE symptoms (occurs several times a month).
○ ○ ● SEVERE symptoms (occurs almost constantly)
○ ○ ○ **Leave circles BLANK if they don't apply to you!**

	1 2 3	
		GROUP 1
1	○ ○ ○	Acid foods upset
2	○ ○ ○	Get chilled often
3	○ ○ ○	"Lump" in throat
4	○ ○ ○	Dry mouth-eyes-nose
5	○ ○ ○	Pulse speeds after meal
6	○ ○ ○	Keyed up - fail to calm
7	○ ○ ○	Gag occasionally
8	○ ○ ○	Unable to relax; startles easily
9	○ ○ ○	Extremities cold, clammy
10	○ ○ ○	Strong light irritates
11	○ ○ ○	Occasionally weak urine flow
12	○ ○ ○	Heart pounds after retiring
13	○ ○ ○	"Nervous" stomach
14	○ ○ ○	Appetite reduced occasionally
15	○ ○ ○	Cold sweats often
16	○ ○ ○	Get heated easily
17	○ ○ ○	Nerve discomfort
18	○ ○ ○	Staring, blinks little
19	○ ○ ○	Sour stomach frequent
		GROUP 2
20	○ ○ ○	Joint stiffness on arising
21	○ ○ ○	Muscle-leg-toe cramps at night
22	○ ○ ○	"Butterfly" stomach, cramps
23	○ ○ ○	Eyes or nose watery
24	○ ○ ○	Eyes blink often
25	○ ○ ○	Eyelids swollen, puffy
26	○ ○ ○	Indigestion soon after meals
27	○ ○ ○	Always seems hungry; feels "lightheaded" often
28	○ ○ ○	Digestion rapid
29	○ ○ ○	Vomit occasionally
30	○ ○ ○	Hoarseness frequent
31	○ ○ ○	Uneven breathing
32	○ ○ ○	Pulse slow
33	○ ○ ○	Gagging reflex slow
34	○ ○ ○	Difficulty swallowing
35	○ ○ ○	Temporary constipation or diarrhea
36	○ ○ ○	"Slow starter"
37	○ ○ ○	Get "chilled"
38	○ ○ ○	Perspire easily
39	○ ○ ○	Sensitive to cold
40	○ ○ ○	Upper respiratory challenges
		GROUP 3
41	○ ○ ○	Eat when nervous
42	○ ○ ○	Excessive appetite
43	○ ○ ○	Hungry between meals
44	○ ○ ○	Irritable before meals
45	○ ○ ○	Get "shaky" if hungry
46	○ ○ ○	Fatigue, eating relieves
47	○ ○ ○	"Lightheaded" if meals delayed
48	○ ○ ○	Heart palpitates if meals missed or delayed
49	○ ○ ○	Fatigue in afternoons
50	○ ○ ○	Overeating sweets upsets
	1 2 3	
51	○ ○ ○	Awaken after few hours sleep - hard to get back to sleep
52	○ ○ ○	Crave candy or coffee in afternoons
53	○ ○ ○	Moods of "blues" or melancholy
54	○ ○ ○	Craving for sweets or snacks
		GROUP 4
55	○ ○ ○	Hands and feet go to sleep easily, numbness
56	○ ○ ○	Sigh frequently, "air hunger"
57	○ ○ ○	Aware of "breathing heavily"
58	○ ○ ○	High altitude discomfort
59	○ ○ ○	Opens windows in closed rooms
60	○ ○ ○	Immune system challenges
61	○ ○ ○	Afternoon "yawner"
62	○ ○ ○	Get "drowsy" often
63	○ ○ ○	Swollen ankles, worse at night
64	○ ○ ○	Muscle cramps, worse during exercise; get "charley horses"
65	○ ○ ○	Difficulty catching breath, especially during exercise
66	○ ○ ○	Tightness or pressure in chest, worse on exertion
67	○ ○ ○	Skin discolors easily after impact
68	○ ○ ○	Tendency to anemia
69	○ ○ ○	Noises in head, or "ringing in ears"
70	○ ○ ○	Fatigue upon exertion
		GROUP 5
71	○ ○ ○	Dizziness
72	○ ○ ○	Dry skin
73	○ ○ ○	Burning feet
74	○ ○ ○	Blurred vision
75	○ ○ ○	Itching skin and feet
76	○ ○ ○	Hair loss
77	○ ○ ○	Occasional skin rashes
78	○ ○ ○	Bitter, metallic taste in mouth in mornings
79	○ ○ ○	Occasional constipation
80	○ ○ ○	Worrier, feels insecure
81	○ ○ ○	Nausea occasionally after eating
82	○ ○ ○	Greasy foods upset
83	○ ○ ○	Stools light colored
84	○ ○ ○	Skin peels on foot soles
85	○ ○ ○	Discomfort between shoulder blades
86	○ ○ ○	Occasional laxative use
87	○ ○ ○	Stools alternate from soft to watery
88	○ ○ ○	Sneezing attacks
89	○ ○ ○	Dreaming, nightmare type bad dreams
90	○ ○ ○	Bad breath (halitosis)
91	○ ○ ○	Milk products cause upset
92	○ ○ ○	Sensitive to hot weather
93	○ ○ ○	Burning or itching anus
94	○ ○ ○	Crave sweets
		GROUP 6
95	○ ○ ○	Loss of taste for meat
96	○ ○ ○	Lower bowel gas several hours after eating
97	○ ○ ○	Burning stomach sensations, eating relieves
98	○ ○ ○	Coated tongue
99	○ ○ ○	Pass large amounts of foul-smelling gas
100	○ ○ ○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
101	○ ○ ○	Watery or loose stool
102	○ ○ ○	Gas shortly after eating
103	○ ○ ○	Stomach "bloating"

	1	2	3	GROUP 7A
104	O	O	O	Difficulty sleeping
105	O	O	O	On edge
106	O	O	O	Can't gain weight
107	O	O	O	Intolerance to heat
108	O	O	O	Highly emotional
109	O	O	O	Flush easily
110	O	O	O	Night sweats
111	O	O	O	Thin, moist skin
112	O	O	O	Inward trembling
113	O	O	O	Heart races
114	O	O	O	Increased appetite without weight gain
115	O	O	O	Pulse fast at rest
116	O	O	O	Eyelids and face twitch
117	O	O	O	Irritable and restless
118	O	O	O	Can't work under pressure

GROUP 7B

119	O	O	O	Increase in weight
120	O	O	O	Decrease in appetite
121	O	O	O	Fatigue easily
122	O	O	O	Ringing in ears
123	O	O	O	Sleepy during day
124	O	O	O	Sensitive to cold
125	O	O	O	Dry or scaly skin
126	O	O	O	Temporary constipation
127	O	O	O	Mental sluggishness
128	O	O	O	Hair coarse, falls out
129	O	O	O	Tension in head upon arising wears off during day
130	O	O	O	Slow pulse, below 65
131	O	O	O	Changing urinary function
132	O	O	O	Sounds appear diminished
133	O	O	O	Reduced initiative

GROUP 7C

134	O	O	O	Failing memory with age
135	O	O	O	Increased sex drive
136	O	O	O	Episodes of tension in head
137	O	O	O	Decreased sugar tolerance

GROUP 7D

138	O	O	O	Abnormal thirst
139	O	O	O	Bloating of abdomen
140	O	O	O	Weight gain around hips or waist
141	O	O	O	Sex drive reduced or lacking
142	O	O	O	Tendency for stomach issues
143	O	O	O	Immune system challenges
144	O	O	O	Menstrual disorders

GROUP 7E

145	O	O	O	Dizziness
146	O	O	O	Headaches
147	O	O	O	Hot flashes
148	O	O	O	Hair growth on face or body (female)
149	O	O	O	Sugar in urine (not diabetes)
150	O	O	O	Masculine tendencies (female)

GROUP 7F

151	O	O	O	Weakness, dizziness
152	O	O	O	Tired throughout day
153	O	O	O	Nails weak, ridged
154	O	O	O	Sensitive skin
155	O	O	O	Stiff joints
156	O	O	O	Perspiration increase
157	O	O	O	Bowel discomfort
158	O	O	O	Poor circulation
159	O	O	O	Swollen ankles
160	O	O	O	Crave salt
161	O	O	O	Areas of skin darkening
162	O	O	O	Upper respiratory sensitivity
163	O	O	O	Tiredness
164	O	O	O	Breathing challenges

	1	2	3	GROUP 8
165	O	O	O	Muscle weakness
166	O	O	O	Lack of Stamina
167	O	O	O	Drowsiness after eating
168	O	O	O	Muscular soreness
169	O	O	O	Heart races
170	O	O	O	Hyperirritable
171	O	O	O	Feeling of a band around your head
172	O	O	O	Melancholia (feeling of sadness)
173	O	O	O	Swelling of ankles
174	O	O	O	Change in urinary function
175	O	O	O	Tendency to consume sweets or carbohydrates
176	O	O	O	Muscle spasms
177	O	O	O	Blurred vision
178	O	O	O	Involuntary muscle action
179	O	O	O	Numbness
180	O	O	O	Night sweats
181	O	O	O	Rapid digestion
182	O	O	O	Sensitivity to noise
183	O	O	O	Redness of palms of hands and bottom of feet
184	O	O	O	Visible veins on chest and abdomen
185	O	O	O	Hemorrhoids
186	O	O	O	Apprehension (feeling that something bad will happen)
187	O	O	O	Nervousness causing loss of appetite
188	O	O	O	Nervousness with indigestion
189	O	O	O	Gastritis
190	O	O	O	Forgetfulness
191	O	O	O	Thinning hair

FEMALE ONLY

192	O	O	O	Very easily fatigued
193	O	O	O	Premenstrual tension
194	O	O	O	Menses more painful than usual
195	O	O	O	Depressed feelings before menstruation
196	O	O	O	Painful breasts during menses
197	O	O	O	Menstruate too frequently
198			O	Hysterectomy / ovaries removed
199	O	O	O	Menopausal hot flashes
200	O	O	O	Menses scanty or missed
201	O	O	O	Acne, worse at menses

MALE ONLY

202	O	O	O	Less involved in exercise/social activities
203	O	O	O	Difficult to postpone urination
204	O	O	O	Weak urinary stream
205	O	O	O	Feeling of "blues" or melancholy
206	O	O	O	Feeling of incomplete bowel evacuation
207	O	O	O	Lack of energy
208	O	O	O	Muscles in arms and legs seem softer/smaller
209	O	O	O	Tire too easily
210	O	O	O	Avoids activity
211	O	O	O	Leg nervousness at night
212	O	O	O	Diminished sex drive

List the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Name: Date:

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a detoxification program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0 1 2 3 4
b. Diarrhea	0 1 2 3 4
c. Constipation	0 1 2 3 4
d. Bloated feeling	0 1 2 3 4
e. Belching and/or passing gas	0 1 2 3 4
f. Heartburn	0 1 2 3 4

Total: ____

2. EARS

a. Itchy ears	0 1 2 3 4
b. Earaches or ear infections	0 1 2 3 4
c. Drainage from ear	0 1 2 3 4
d. Ringing in ears or hearing loss	0 1 2 3 4

Total: ____

3. EMOTIONS

a. Mood swings	0 1 2 3 4
b. Anxiety, fear, or nervousness	0 1 2 3 4
c. Anger, irritability	0 1 2 3 4
d. Depression	0 1 2 3 4
e. Sense of despair	0 1 2 3 4
f. Uncaring or disinterested	0 1 2 3 4

Total: ____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0 1 2 3 4
b. Hyperactivity	0 1 2 3 4
c. Restlessness	0 1 2 3 4
d. Insomnia	0 1 2 3 4
e. Startled awake at night	0 1 2 3 4

Total: ____

5. EYES

a. Watery or itchy eyes	0 1 2 3 4
b. Swollen, reddened, or sticky eyelids	0 1 2 3 4
c. Dark circles under eyes	0 1 2 3 4
d. Blurred or tunnel vision	0 1 2 3 4

Total: ____

6. HEAD

a. Headaches	0 1 2 3 4
b. Faintness	0 1 2 3 4
c. Dizziness	0 1 2 3 4
d. Pressure	0 1 2 3 4

Total: ____

7. LUNGS

a. Chest congestion	0 1 2 3 4
b. Asthma or bronchitis	0 1 2 3 4
c. Shortness of breath	0 1 2 3 4
d. Difficulty breathing	0 1 2 3 4

Total: ____

8. MIND

a. Poor memory	0 1 2 3 4
b. Confusion	0 1 2 3 4
c. Poor concentration	0 1 2 3 4
d. Poor coordination	0 1 2 3 4
e. Difficulty making decisions	0 1 2 3 4
f. Stuttering, stammering	0 1 2 3 4
g. Slurred speech	0 1 2 3 4
h. Learning disabilities	0 1 2 3 4

Total: ____

9. MOUTH/THROAT

a. Chronic coughing	0 1 2 3 4
b. Gagging or frequent need to clear throat	0 1 2 3 4
c. Swollen or discolored tongue, gums, lips	0 1 2 3 4
d. Canker sores	0 1 2 3 4

Total: ____

10. NOSE

a. Stuffy nose	0 1 2 3 4
b. Sinus problems	0 1 2 3 4
c. Hay fever	0 1 2 3 4
d. Sneezing attacks	0 1 2 3 4
e. Excessive mucous	0 1 2 3 4

Total: ____

11. SKIN

a. Acne	0 1 2 3 4
b. Hives, rashes, or dry skin	0 1 2 3 4
c. Hair loss	0 1 2 3 4
d. Flushing	0 1 2 3 4
e. Excessive sweating	0 1 2 3 4

Total: ____

12. HEART

a. Skipped heartbeats	0 1 2 3 4
b. Rapid heartbeats	0 1 2 3 4
c. Chest pain	0 1 2 3 4

Total: ____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0 1 2 3 4
b. Stiffness or limited movement	0 1 2 3 4
c. Pain or aches in muscles	0 1 2 3 4
d. Recurrent back aches	0 1 2 3 4
e. Feeling of weakness or tiredness	0 1 2 3 4

Total: ____

14. WEIGHT

a. Binge eating or drinking	0 1 2 3 4
b. Craving certain foods	0 1 2 3 4
c. Excessive weight	0 1 2 3 4
d. Compulsive eating	0 1 2 3 4
e. Water retention	0 1 2 3 4
f. Underweight	0 1 2 3 4

Total: ____

15. OTHER:

a. Frequent illness	0 1 2 3 4
b. Frequent or urgent urination	0 1 2 3 4
c. Leaky bladder	0 1 2 3 4
d. Genital itch, discharge	0 1 2 3 4

Total: ____

Section I Total: ____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16. Circle the corresponding number for questions 16a-16f below.

0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily

a. How often are strong chemicals used in your home?
(disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.) 0 1 2 3 4

b. How often are pesticides used in your home? 0 1 2 3 4

c. How often do you have your home treated for insects? 0 1 2 3 4

d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office? 0 1 2 3 4

e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics? 0 1 2 3 4

f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes? 0 1 2 3 4

g. How often do you consume nonorganic foods? 0 1 2 3 4

Total: _____

17. Circle the corresponding number for questions 17a-17b below.

0	No	1	Mild Change	2	Moderate Change	3	Drastic Change

a. Have you noticed any negative change in your health since you moved into your home or apartment? 0 1 2 3

b. Have you noticed any change in your health since you started your new job? 0 1 2 3

Total: _____

18. Answer yes or no and circle the corresponding number for questions 18a-18d below.

	No	Yes
a. Do you have a water purification system in your home?	2	0
b. Do you have any indoor pets?	0	2
c. Do you have an air purification system in your home?	2	0
d. Are you a dentist, painter, farm worker, or construction worker?	0	2

Total: _____

Section II Total: _____

Grand Total (Section I & Section II) _____

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a detoxification program.