Patient Name: Date:

LENS SENSITIVITY QUESTIONNAIRE

People are very different. Below is a list of statements that other clients have made about themselves. Please pick a number between 0 and 10 to describe how *frequently* you are aware of them or bothered by them: "0" means *NEVER,* and "10" means *ALL THE TIME*. Please give an answer for each of the statements listed below.

SENSITIVITY/DISCERNMENT

Frequency (0-10)

I feel when the weather is about to change. _____
I can tell if a medication is going to work. _____
I can sense unhealthy environments and then take care of myself. _____
I can sense my need for food before I feel hungry. _____
I can sense smells and scents that others seem not to notice. _____
I can feel myself getting a cold or flu prior to having symptoms. _____
I have a wide appreciation for tastes in different foods. _____
I can feel the difference between quietness and stillness. _____
I can feel the difference between relaxation and comfort. _____
I select my friends by how I feel when I'm with them rather than by appearances. _____
I sense mood, energy shifts and attention changes in people. _____
I need to do things at my own pace. _____
I am very creative. _____
I know quickly when something is going to work out, such as a job or relationship. _____
I have some abilities that some people consider psychic. _____

REACTIVITY

I have unpleasant reactions to certain weather changes. _____
I have unpleasant reactions to certain foods. _____
I have unpleasant reactions to certain medications. _____
I have unpleasant reactions to certain smells. _____
I have unpleasant reactions to certain sounds and lights. _____
I have unpleasant reactions to skipping meals. _____
I can be shocked by my reactions. _____
My friends/family find me difficult being around. _____

RESILIENCY/HARDINESS

I have severe problems with the weather. _____
I have little if any physical energy/stamina. _____
I can do little thinking/planning without getting tired. _____
I have great problems with foods. _____
I have great problems with medication(s). _____
I get upset easily. _____
Pain prevents me from working. _____
When life hits me hard, it takes me a very long time to get back on my feet. _____

Patient Name: Date:

LENS CENTRAL NERVOUS SYSTEM (CNS) QUESTIONNAIRE

Are you able to drive a motor vehicle?	YES	PARTIALLY	NO
Are you able to work or study?	YES	PARTIALLY	NO
Are you able to sustain a close relationship with someone?	YES	PARTIALLY	NO

Below is a list of problems. How frequently are you currently bothered by them? Please pick a number from 0 to 10. "0" means *Not at all*, and "10" means *All the time.* If one or more of your parents had this issue, place a *P* in the column titled "***Parents?***" If the problem came on suddenly, put an *S* in the column titled "***Suddenly?***"

	Parents?	Suddenly?
SENSORY		
____ Light, in general, or lights, bother you	____	____
____ Problems with the sense of smell	____	____
____ Problems with vision	____	____
____ Problems with hearing	____	____
____ Problems with the sense of touch	____	____
____ Problems with tinnitus (ringing in the ears)	____	____
EMOTIONS		
____ Problems of sudden, unexplained changes in mood	____	____
____ Problems of sudden, unexplained fearfulness	____	____
____ Problems of unexplained spells of depression	____	____
____ Problems of unexplained spells of elation	____	____
____ Problems with explosiveness	____	____
____ Problems with suicidal thoughts or actions	____	____
CLARITY		
____ Feel "foggy" and have problems with clarity	____	____
____ Problems following conversations (with good hearing)	____	____
____ Problems with confusion	____	____
____ Problems following what you are reading	____	____
____ Realize you have no idea what you have been reading	____	____
____ Problems with concentration	____	____
____ Problems with attention	____	____
____ Problems with sequencing	____	____
____ Problems with prioritizing	____	____
____ Problems not finishing what you start	____	____

____ Problems organizing your room, office, paperwork	____	____
____ Problems with getting lost in daydreaming		
____ You cover up that you don't know what was said or asked of you	____	____
ENERGY		
____ Problems with stamina	____	____
____ Fatigue during the day	____	____
____ Trouble sleeping at night	____	____
____ Problems awakening at night	____	____
____ Problems falling asleep again	____	____
ACTIVATION/ANXIETY		
____ Restlessness	____	____
____ Problems with irritability	____	____
____ Day Dreaming	____	____
____ Worrying	____	____
____ Always moving	____	____
____ Cold hands or feet	____	____
____ Palpitations	____	____
MEMORY		
____ Forget what you have just heard	____	____
____ Forget what you are doing, what you need to do	____	____
____ Problems with procrastination and lack of initiative	____	____
____ Problems not learning from experience	____	____
MOVEMENT		
____ Problems with paralysis of one or more limbs	____	____
____ Problems focusing or converging the eyes	____	____
PAIN		
____ Head pain that is steady	____	____
____ Head pain that is throbbing	____	____
____ Shoulder and neck pain	____	____
____ Wrist pain	____	____
____ Tender areas of muscles	____	____
____ All-over pain	____	____
____ Joint pain	____	____
____ Other pain (please specify)_____	____	____

Patient Name: Date:

LENS INTAKE FORM

MOST PROMINENT PROBLEMS:

_____
_____
_____
_____

HOW LONG:

_____
_____
_____
_____

How were you before these problems occurred (if relevant)?

_____
_____
_____

Previous symptoms throughout your entire life:

_____
_____
_____

Current medications, reasons for taking them, and their effects on you:

_____
_____
_____

Basis for Incomplete Problem Resolution:
(Please answer Yes/No for Past/Present)

	PAST	PRESENT
1. Unpredictable things had a big effect on me.	____	____
2. Situations were embarrassing for me.	____	____
3. Friends and/or family had a hard time being around me.	____	____
4. I was troubled by emotions/feelings.	____	____
5. I have/had problems like seizures, tics, migraines, headaches, stuttering, Tourette's, explosiveness.	____	____

How much time and money have you spent on your primary problem?

_____
_____
_____

How will you know you are done?

_____
_____
_____

