



DR. WILLIAM E. SISSON, JR
Chiropractor

4706 Oleander Drive
Wilmington, NC 28403
(910) 392-3770

License # 1539

CONFIDENTIAL

Patient Name _____

IN CASE OF EMERGENCY PLEASE CALL:

Name: _____ Phone: _____

Relationship to patient: _____

Dear Patient:

In order to best meet your health needs and aid you in meeting your financial responsibilities for services provided by the center it is necessary that we have your signature on the following agreements. If you have any questions, ask a member of our staff and we will be glad to assist you.

- 1) I hereby authorize Dr. William E. Sisson, Jr. to obtain and/or release all necessary information relating to my condition, injury and/or accident.

Signed _____ Date: _____

- 2) I understand that I am completely responsible for all costs incurred at this office. I am also aware that all fees charged are due and payable in full at the time of each visit. It is the patient's responsibility to file primary and secondary insurance claims (except Medicare). We will issue a receipt with a diagnosis code after payment for each visit. This office does file for Medicare carriers. Insurance reimbursements are to be paid directly to the patient. I also understand that this office does not guarantee that the insurance company will pay for claims submitted, nor does this office promise that an insurance company will or should pay the fees as charged.

Signed _____ Date _____

- 3) I am aware that this office does not file Workman's compensation and by signing I am stating that my condition is not work related. If this injury is related to work I am stating it is not an injury for which I will file Workman's Compensation.

Signed _____ Date _____

- 4) I am aware that if I miss any appointment and have not given 24 hours notice to this office to cancel the appointment, I will be charged a regular office visit fee for the cost of the missed appointment. This fee cannot be charged to my insurance company.

Signed _____ Date _____

ALTERNATIVE HEALTH CARE CLINIC



License #1539

PREVIOUS CONDITIONS

Please **CHECK** on appropriate line and **MARK** on drawing **ALL** injuries and surgeries from infancy to present.

Surgeries (including but not limited to):

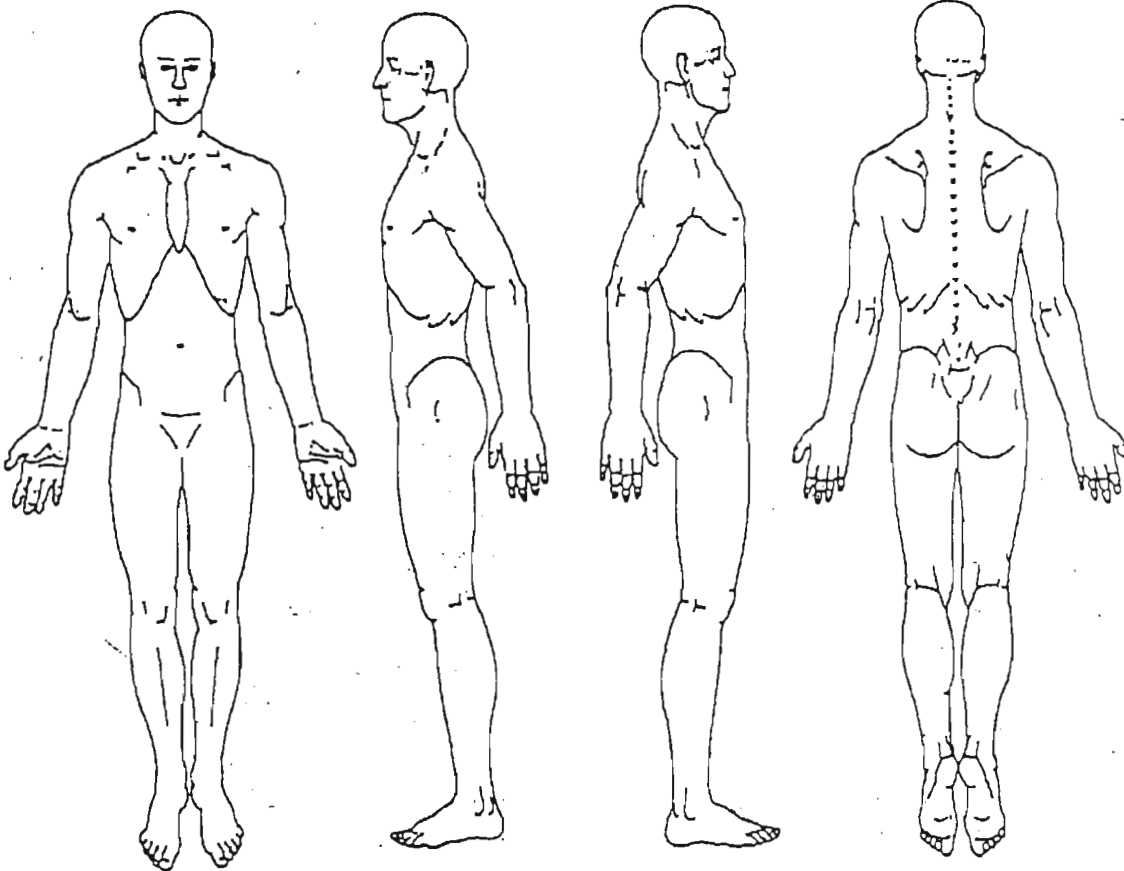
	YES	NO		YES	NO
Tonsils removed	___	___	Gum Disease	___	___
Teeth Pulled <i>(Include wisdom teeth)</i>	___	___	Scars	___	___
Other (please describe) _____					

Accidents:

Auto Accidents	___	___	Falls	___	___
Sports Injuries	___	___			
Other (please describe) _____					

Women:

C-sections	___	___	Episiotomies <i>(stitches after delivery)</i>	___	___
D & C Procedures <i>(scraping lining of uterus)</i>	___	___	Ovarian cysts	___	___
Any procedure on cervix	___	___	Fibroid tumors	___	___



Metabolic Assessment Form

Name: _____ Age: _____ Sex: _____ Date: _____

PART I

Please list your 5 major health concerns in order of importance:

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

PART II

Please circle the appropriate number on all questions below.
0 as the least/never to 3 as the most/always.

Category I					
Feeling that bowels do not empty completely	0	1	2	3	
Lower abdominal pain relieved by passing stool or gas	0	1	2	3	
Alternating constipation and diarrhea	0	1	2	3	
Diarrhea	0	1	2	3	
Constipation	0	1	2	3	
Hard, dry, or small stool	0	1	2	3	
Coated tongue or "fuzzy" debris on tongue	0	1	2	3	
Pass large amount of foul-smelling gas	0	1	2	3	
More than 3 bowel movements daily	0	1	2	3	
Use laxatives frequently	0	1	2	3	
Category II					
Increasing frequency of food reactions	0	1	2	3	
Unpredictable food reactions	0	1	2	3	
Aches, pains, and swelling throughout the body	0	1	2	3	
Unpredictable abdominal swelling	0	1	2	3	
Frequent bloating and distention after eating	0	1	2	3	
Abdominal intolerance to sugars and starches	0	1	2	3	
Category III					
Intolerance to smells	0	1	2	3	
Intolerance to jewelry	0	1	2	3	
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3	
Multiple smell and chemical sensitivities	0	1	2	3	
Constant skin outbreaks	0	1	2	3	
Category IV					
Excessive belching, burping, or bloating	0	1	2	3	
Gas immediately following a meal	0	1	2	3	
Offensive breath	0	1	2	3	
Difficult bowel movement	0	1	2	3	
Sense of fullness during and after meals	0	1	2	3	
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3	
Category V					
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3	
Use antacids	0	1	2	3	
Feel hungry an hour or two after eating	0	1	2	3	
Heartburn when lying down or bending forward	0	1	2	3	
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3	
Digestive problems subside with rest and relaxation	0	1	2	3	
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3	
Category VI					
Roughage and fiber cause constipation	0	1	2	3	
Indigestion and fullness last 2-4 hours after eating	0	1	2	3	
Pain, tenderness, soreness on left side under rib cage	0	1	2	3	
Category VI (continued)					
Excessive passage of gas	0	1	2	3	
Nausea and/or vomiting	0	1	2	3	
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3	
Frequent urination	0	1	2	3	
Increased thirst and appetite	0	1	2	3	
Difficulty losing weight	0	1	2	3	
Category VII					
Greasy or high-fat foods cause distress	0	1	2	3	
Lower bowel gas and/or bloating several hours after eating	0	1	2	3	
Bitter metallic taste in mouth, especially in the morning	0	1	2	3	
Unexplained itchy skin	0	1	2	3	
Yellowish cast to eyes	0	1	2	3	
Stool color alternates from clay colored to normal brown	0	1	2	3	
Reddened skin, especially palms	0	1	2	3	
Dry or flaky skin and/or hair	0	1	2	3	
History of gallbladder attacks or stones	0	1	2	3	
Have you had your gallbladder removed?		Yes	No		
Category VIII					
Acne and unhealthy skin	0	1	2	3	
Excessive hair loss	0	1	2	3	
Overall sense of bloating	0	1	2	3	
Bodily swelling for no reason	0	1	2	3	
Hormone imbalances	0	1	2	3	
Weight gain	0	1	2	3	
Poor bowel function	0	1	2	3	
Excessively foul-smelling sweat	0	1	2	3	
Category IX					
Crave sweets during the day	0	1	2	3	
Irritable if meals are missed	0	1	2	3	
Depend on coffee to keep going/get started	0	1	2	3	
Get light-headed if meals are missed	0	1	2	3	
Eating relieves fatigue	0	1	2	3	
Feel shaky, jittery, or have tremors	0	1	2	3	
Agitated, easily upset, nervous	0	1	2	3	
Poor memory/forgetful	0	1	2	3	
Blurred vision	0	1	2	3	
Category X					
Fatigue after meals	0	1	2	3	
Crave sweets during the day	0	1	2	3	
Eating sweets does not relieve cravings for sugar	0	1	2	3	
Must have sweets after meals	0	1	2	3	
Waist girth is equal or larger than hip girth	0	1	2	3	
Frequent urination	0	1	2	3	
Increased thirst and appetite	0	1	2	3	
Difficulty losing weight	0	1	2	3	

Neurotransmitter Assessment Form (NTAF)

Name: _____ Age: _____ Sex: _____ Date: _____

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

SECTION A

- Is your memory noticeably declining? 0 1 2 3
- Are you having a hard time remembering names and phone numbers? 0 1 2 3
- Is your ability to focus noticeably declining? 0 1 2 3
- Has it become harder for you to learn new things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament generally getting worse? 0 1 2 3
- Is your attention span decreasing? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you become fatigued when driving compared to in the past? 0 1 2 3
- How often do you become fatigued when reading compared to in the past? 0 1 2 3
- How often do you walk into rooms and forget why? 0 1 2 3
- How often do you pick up your cell phone and forget why? 0 1 2 3

SECTION B

- How high is your stress level? 0 1 2 3
- How often do you feel you have something that must be done? 0 1 2 3
- Do you feel you never have time for yourself? 0 1 2 3
- How often do you feel you are not getting enough sleep or rest? 0 1 2 3
- Do you find it difficult to get regular exercise? 0 1 2 3
- Do you feel uncared for by the people in your life? 0 1 2 3
- Do you feel you are not accomplishing your life's purpose? 0 1 2 3
- Is sharing your problems with someone difficult for you? 0 1 2 3

SECTION C

SECTION C1

- How often do you get irritable, shaky, or have light-headedness between meals? 0 1 2 3
- How often do you feel energized after eating? 0 1 2 3
- How often do you have difficulty eating large meals in the morning? 0 1 2 3
- How often does your energy level drop in the afternoon? 0 1 2 3
- How often do you crave sugar and sweets in the afternoon? 0 1 2 3
- How often do you wake up in the middle of the night? 0 1 2 3
- How often do you have difficulty concentrating before eating? 0 1 2 3
- How often do you depend on coffee to keep yourself going? 0 1 2 3
- How often do you feel agitated, easily upset, and nervous between meals? 0 1 2 3

SECTION C2

- How often do you get fatigued after meals? 0 1 2 3
- How often do you crave sugar and sweets after meals? 0 1 2 3
- How often do you feel you need stimulants, such as coffee, after meals? 0 1 2 3
- How often do you have difficulty losing weight? 0 1 2 3
- How much larger is your waist girth compared to your hip girth? 0 1 2 3
- How often do you urinate? 0 1 2 3
- Have your thirst and appetite increased? 0 1 2 3
- How often do you gain weight when under stress? 0 1 2 3
- How often do you have difficulty falling asleep? 0 1 2 3

SECTION 1

- Are you losing interest in hobbies? 0 1 2 3
- How often do you feel overwhelmed? 0 1 2 3
- How often do you have feelings of inner rage? 0 1 2 3
- How often do you have feelings of paranoia? 0 1 2 3
- How often do you feel sad or down for no reason? 0 1 2 3
- How often do you feel like you are not enjoying life? 0 1 2 3

- How often do you feel you lack artistic appreciation? 0 1 2 3
- How often do you feel depressed in overcast weather? 0 1 2 3
- How much are you losing your enthusiasm for your favorite activities? 0 1 2 3
- How much are you losing your enjoyment for your favorite foods? 0 1 2 3
- How much are you losing your enjoyment of friendships and relationships? 0 1 2 3
- How often do you have difficulty falling into deep, restful sleep? 0 1 2 3
- How often do you have feelings of dependency on others? 0 1 2 3
- How often do you feel more susceptible to pain? 0 1 2 3
- How often do you have feelings of unprovoked anger? 0 1 2 3
- How much are you losing interest in life? 0 1 2 3

SECTION 2

- How often do you have feelings of hopelessness? 0 1 2 3
- How often do you have self-destructive thoughts? 0 1 2 3
- How often do you have an inability to handle stress? 0 1 2 3
- How often do you have anger and aggression while under stress? 0 1 2 3
- How often do you feel you are not rested, even after long hours of sleep? 0 1 2 3
- How often do you prefer to isolate yourself from others? 0 1 2 3
- How often do you have unexplained lack of concern for family and friends? 0 1 2 3
- How easily are you distracted from your tasks? 0 1 2 3
- How often do you have an inability to finish tasks? 0 1 2 3
- How often do you feel the need to consume caffeine to stay alert? 0 1 2 3
- How often do you feel your libido has been decreased? 0 1 2 3
- How often do you lose your temper for minor reasons? 0 1 2 3
- How often do you have feelings of worthlessness? 0 1 2 3

SECTION 3

- How often do you feel anxious or panicked for no reason? 0 1 2 3
- How often do you have feelings of dread or impending doom? 0 1 2 3
- How often do you feel knots in your stomach? 0 1 2 3
- How often do you have feelings of being overwhelmed for no reason? 0 1 2 3
- How often do you have feelings of guilt about everyday decisions? 0 1 2 3
- How often does your mind feel restless? 0 1 2 3
- How difficult is it to turn your mind off when you want to relax? 0 1 2 3
- How often do you have disorganized attention? 0 1 2 3
- How often do you worry about things you were not worried about before? 0 1 2 3
- How often do you have feelings of inner tension and inner excitability? 0 1 2 3

SECTION 4

- Do you feel your visual memory (shapes & images) has decreased? 0 1 2 3
- Do you feel your verbal memory has decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity decreased? 0 1 2 3
- Has your comprehension diminished? 0 1 2 3
- Do you have difficulty calculating numbers? 0 1 2 3
- Do you have difficulty recognizing objects & faces? 0 1 2 3
- Do you feel like your opinion about yourself has changed? 0 1 2 3
- Are you experiencing excessive urination? 0 1 2 3
- Are you experiencing a slower mental response? 0 1 2 3

Symptoms groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3
Category XII				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3
Category XIII				
Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3
Category XIV				
Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3
Category XV				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3
Category XVI				
Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XVII				
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" - type headaches	0	1	2	3
Category XVIII (Males Only)				
Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3
Category XIX (Males Only)				
Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3
Category XX (Menstruating Females Only)				
Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3
Category XXI (Menopausal Females Only)				
How many years have you been menopausal?				_____ years
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental foginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____ Rate your stress level on a scale of 1-10 during the average week: _____

How many caffeinated beverages do you consume per day? _____ How many times do you eat fish per week? _____

How many times do you eat out per week? _____ How many times do you work out per week? _____

How many times do you eat raw nuts or seeds per week? _____

List the three worst foods you eat during the average week: _____

List the three healthiest foods you eat during the average week: _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

Medication History*

Please check any of the following medications you have taken in the past or are currently taking.

Noradrenergic and Serotonergic Antidepressants (NASSAs)

- | | |
|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Remeron® | <input type="checkbox"/> Norset® |
| <input type="checkbox"/> Zispin® | <input type="checkbox"/> Remergil® |
| <input type="checkbox"/> Avanza® | <input type="checkbox"/> Axit® |

Triplicic Antidepressants (TRCs)

- | | |
|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Elavil® | <input type="checkbox"/> Prothiaden® |
| <input type="checkbox"/> Endep® | <input type="checkbox"/> Adapin® |
| <input type="checkbox"/> Tryptanol | <input type="checkbox"/> Sinequan® |
| <input type="checkbox"/> Trepiline® | <input type="checkbox"/> Tofranil® |
| <input type="checkbox"/> Asendin® | <input type="checkbox"/> Janamine® |
| <input type="checkbox"/> Asendis® | <input type="checkbox"/> Gamamil® |
| <input type="checkbox"/> Defanyl® | <input type="checkbox"/> Aventyl® |
| <input type="checkbox"/> Demolox® | <input type="checkbox"/> Pamelor® |
| <input type="checkbox"/> Moxadil® | <input type="checkbox"/> Opipramol® |
| <input type="checkbox"/> Anafranil® | <input type="checkbox"/> Vivactil® |
| <input type="checkbox"/> Norpramin® | <input type="checkbox"/> Rhotrimine® |
| <input type="checkbox"/> Pertofrane® | <input type="checkbox"/> Surmontil® |

Selective Serotonin Reuptake Inhibitors (SSRIs)

- | | |
|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Paxil® | <input type="checkbox"/> Seromex® |
| <input type="checkbox"/> Zoloft® | <input type="checkbox"/> Seronil® |
| <input type="checkbox"/> Prozac® | <input type="checkbox"/> Sarafem® |
| <input type="checkbox"/> Celexa® | <input type="checkbox"/> Fluctin® |
| <input type="checkbox"/> Lexapro® | <input type="checkbox"/> Faverin® |
| <input type="checkbox"/> Luvox® | <input type="checkbox"/> Seroxat |
| <input type="checkbox"/> Cipramil® | <input type="checkbox"/> Aropax® |
| <input type="checkbox"/> Emocal® | <input type="checkbox"/> Deroxat® |
| <input type="checkbox"/> Seropram® | <input type="checkbox"/> Rextin® |
| <input type="checkbox"/> Cipralex® | <input type="checkbox"/> Paroxat® |
| <input type="checkbox"/> Fontex® | <input type="checkbox"/> Lustral® |
| <input type="checkbox"/> Dapoxetine | <input type="checkbox"/> Serlain® |

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

- | |
|--------------------------------------|
| <input type="checkbox"/> Effexor® |
| <input type="checkbox"/> Pristiq® |
| <input type="checkbox"/> Meridia® |
| <input type="checkbox"/> Serzone® |
| <input type="checkbox"/> Dalcipran® |
| <input type="checkbox"/> Desipramine |
| <input type="checkbox"/> Duloxetine |

Selective Serotonin Reuptake Enhancers (SSREs)

- | |
|-----------------------------------|
| <input type="checkbox"/> Stablon® |
| <input type="checkbox"/> Coaxil® |
| <input type="checkbox"/> Tatinal® |

Monoamine Oxidase Inhibitors (MAOIs)

- | | |
|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Marplan® | <input type="checkbox"/> Azilect® |
| <input type="checkbox"/> Aurorix® | <input type="checkbox"/> Marsilid® |
| <input type="checkbox"/> Manerix® | <input type="checkbox"/> Iprozid® |
| <input type="checkbox"/> Moclodura® | <input type="checkbox"/> Ipronid® |
| <input type="checkbox"/> Nardil® | <input type="checkbox"/> Rivivol® |
| <input type="checkbox"/> Adeline® | <input type="checkbox"/> Zyvox® |
| <input type="checkbox"/> Eldepryl® | <input type="checkbox"/> Zyvoxid® |

Dopamine Receptor Agonists

- | |
|-----------------------------------|
| <input type="checkbox"/> Mirapex® |
| <input type="checkbox"/> Sifrol® |
| <input type="checkbox"/> Requip® |

Norepinephrine and Dopamine Reuptake Inhibitors (NDRIs)

- | |
|---|
| <input type="checkbox"/> Wellbutrin XL® |
|---|

D2 Dopamine Receptor Blockers (antipsychotics)

- | | |
|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Thorazine® | <input type="checkbox"/> Acuphase® |
| <input type="checkbox"/> Prolixin® | <input type="checkbox"/> Haldol® |
| <input type="checkbox"/> Trilafon® | <input type="checkbox"/> Orap® |
| <input type="checkbox"/> Compazine® | <input type="checkbox"/> Clozaril® |
| <input type="checkbox"/> Mellaril® | <input type="checkbox"/> Zyprexa® |
| <input type="checkbox"/> Stelazine® | <input type="checkbox"/> Zydis® |
| <input type="checkbox"/> Vesprin® | <input type="checkbox"/> Seroquel XR® |
| <input type="checkbox"/> Nozinan® | <input type="checkbox"/> Geodon® |
| <input type="checkbox"/> Depixol® | <input type="checkbox"/> Solian® |
| <input type="checkbox"/> Navane® | <input type="checkbox"/> Invega® |
| <input type="checkbox"/> Fluvoxol® | <input type="checkbox"/> Abilify® |
| <input type="checkbox"/> Clopixol® | |

GABA Antagonist/Competitive Binder

- | |
|-------------------------------------|
| <input type="checkbox"/> Flumazenil |
|-------------------------------------|

Agonist Modulators of GABA Receptors (benzodiazepines)

- | | |
|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Xanax® | <input type="checkbox"/> Dalmane® |
| <input type="checkbox"/> Lexotanil® | <input type="checkbox"/> Ativan® |
| <input type="checkbox"/> Lexotan® | <input type="checkbox"/> Loramet® |
| <input type="checkbox"/> Librium® | <input type="checkbox"/> Sedoxil® |
| <input type="checkbox"/> Klonopin® | <input type="checkbox"/> Dormicum® |
| <input type="checkbox"/> Valium® | <input type="checkbox"/> Serax® |
| <input type="checkbox"/> ProSom® | <input type="checkbox"/> Restoril® |
| <input type="checkbox"/> Rohypnol® | <input type="checkbox"/> Halcion® |

Agonist Modulators of GABA Receptors (nonbenzodiazepines)

- | |
|-------------------------------------|
| <input type="checkbox"/> Ambien CR® |
| <input type="checkbox"/> Sonata® |
| <input type="checkbox"/> Lunesta® |
| <input type="checkbox"/> Imovane® |

Acetylcholine Receptor Antagonists Antimuscarinic Agents

- | |
|--------------------------------------|
| <input type="checkbox"/> Atropine |
| <input type="checkbox"/> Ipratropium |
| <input type="checkbox"/> Scopolamine |
| <input type="checkbox"/> Tiotropium |

Acetylcholine Receptor Antagonists Ganglionic Blockers

- | |
|--|
| <input type="checkbox"/> Mecamylamine |
| <input type="checkbox"/> Hexamethonium |
| <input type="checkbox"/> Nicotine (high doses) |
| <input type="checkbox"/> Trimethaphan |

Acetylcholine Receptor Antagonists Neuromuscular Blockers

- | | |
|--|--|
| <input type="checkbox"/> Atracurium | <input type="checkbox"/> Rocuronium |
| <input type="checkbox"/> Cisatracurium | <input type="checkbox"/> Succinylcholine |
| <input type="checkbox"/> Doxacurium | <input type="checkbox"/> Tubocurarine |
| <input type="checkbox"/> Metocurine | <input type="checkbox"/> Vecuronium |
| <input type="checkbox"/> Mivacurium | <input type="checkbox"/> Hemicholinium |
| <input type="checkbox"/> Pancuronium | |

Acetylcholinesterase Reactivators

- | |
|--------------------------------------|
| <input type="checkbox"/> Pralidoxime |
|--------------------------------------|

Cholinesterase Inhibitors (reversible)

- | | |
|---|---|
| <input type="checkbox"/> Donepezil | <input type="checkbox"/> Edrophonium |
| <input type="checkbox"/> Galantamine | <input type="checkbox"/> Neostigmine |
| <input type="checkbox"/> Rivastigmine | <input type="checkbox"/> Physostigmine |
| <input type="checkbox"/> Tacrine | <input type="checkbox"/> Pyridostigmine |
| <input type="checkbox"/> THC | |
| <input type="checkbox"/> Carbamate Insecticides | |

Cholinesterase Inhibitors (irreversible)

- | |
|--|
| <input type="checkbox"/> Echothiophate |
| <input type="checkbox"/> Isoflurophate |
| <input type="checkbox"/> Organophosphate Insecticides |
| <input type="checkbox"/> Organophosphate-containing nerve agents |

*Please refer to prescribing physician for nutritional interactions with any medications you are taking.