ReCODE Report™
from MPI Cognition

Name:_____

DOB:_____

Patient History and Questionnaire

Onset of Cognitive Decline	_____		Evidence of Leaky Gut?	☐Yes	☐No
Family History of Dementia?	☐Yes	☐No	Tremor at Rest?	☐Yes	☐No
Have you been diagnosed with Diabetes?	☐Yes	☐No	Difficulty Looking Up or Down?	☐Yes	☐No
Simple Carbohydrates in Diet?	☐Yes	☐No	Headaches?	☐Yes	☐No
History of Depression?	☐Yes	☐No	Loss of Sense of Smell?	☐Yes	☐No
Episodes of Aggressive Behavior?	☐Yes	☐No	Alcohol Use More Than 1.5 Drinks Per Day?	☐Yes	☐No
History of Concussions?	☐Yes	☐No	Exposure to Mitochondrial Damaging Agents?	☐Yes	☐No
History of Head Trauma?	☐Yes	☐No	Neuroactive Medications?	☐Yes	☐No
Vomiting After Head Trauma?	☐Yes	☐No	Atrial Fibrillation?	☐Yes	☐No
History of Loss of Consciousness?	☐Yes	☐No	Emphysema or Bronchitis?	☐Yes	☐No
Alcohol Related Withdrawal or Seizures?	☐Yes	☐No	History of Herpes?	☐Yes	☐No
History of Illicit Drug Use?	☐Yes	☐No	Positive Lyme Disease Test?	☐Yes	☐No
Anti-Testosterone Medication?	☐Yes	☐No	Anesthesia After 40 Years Old?	☐Yes	☐No
History of Heart Attack or Angina?	☐Yes	☐No	Anesthesia After 40 Two Or More Times?	☐Yes	☐No
History of Hypertension?	☐Yes	☐No	Mold Exposure?	☐Yes	☐No
History of Peripheral Vascular Disease?	☐Yes	☐No	Poor Oral Hygiene?	☐Yes	☐No
Hysterectomy Before 41?	☐Yes	☐No	Presence of Dental Amalgams?	☐Yes	☐No
Hysterectomy Before 52?	☐Yes	☐No	Presence of Root Canals?	☐Yes	☐No
History of Lyme Disease or Tick Bite?	☐Yes	☐No	More Than 3 Dental Amalgams?	☐Yes	☐No
Meningitis?	☐Yes	☐No	Sleep Less Than 7 Hours/Night?	☐Yes	☐No
Personal History of Cancer?	☐Yes	☐No	New Late Sleeping Patterns?	☐Yes	☐No
Arthritis?	☐Yes	☐No	REM Behavioral Disturbance?	☐Yes	☐No
Chronic Fatigue?	☐Yes	☐No	Sleep Apnea or Hypopnea?	☐Yes	☐No
Chronic Sinnus Problems?	☐Yes	☐No	Problems Calculating?	☐Yes	☐No
Daytime Sleepinedd?	☐Yes	☐No	Problems Reading?	☐Yes	☐No
Failed Visual Contrast Sensitivity Test?	☐Yes	☐No	Problems With Finding Words?	☐Yes	☐No
History of Chemical Sensitivity?	☐Yes	☐No	Problems With Organizing?	☐Yes	☐No
Ice Pick Pains?	☐Yes	☐No	Problems With Recognizing Faces?	☐Yes	☐No
Snoring?	☐Yes	☐No	Saying Inappropriate Things?	☐Yes	☐No
History of Vertigo?	☐Yes	☐No	Delusions?	☐Yes	☐No
Rapid Cognitive Decline (weeks/months)?	☐Yes	☐No	Apathetic Attitude?	☐Yes	☐No
Gluten Sensitivity?	☐Yes	☐No	History of Passing Out?	☐Yes	☐No
Consumption of Seed Oils?	☐Yes	☐No	Loss of Empathy?	☐Yes	☐No
Constipation?	☐Yes	☐No	Stealing Items?	☐Yes	☐No
Evidence of Leaky Blood-Brain Barrier?	☐Yes	☐No	Visual Hallucinations?	☐Yes	☐No