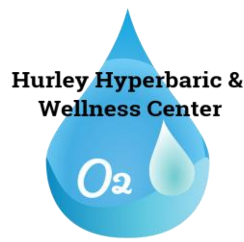


Hurley Wellness & Hyperbaric Center

1807 South Main Street
Kannapolis, NC 28081
(704) 938-1589

WELCOME TO OUR STATE OF THE ART WHOLE BODY DETOXIFICATION & WELLNESS CENTER

Thank you for choosing Hurley Wellness Center for your health care needs. Our wellness clinic is here to provide the highest quality of care.

OFFICE POLICY

Please provide your signature below to indicate your understanding of, and agreement with, the stated policies.

- All paperwork MUST be filled out PRIOR to your scheduled appointment. If paperwork is not filled out, you may be asked to reschedule your appointment.
- Please answer all questions asked on the paperwork given to you. Be as specific as possible to ensure Dr. Hurley has all the necessary information to begin her assessment. If something does not pertain to your case, please write N/A or No.
- All clients will be seen in accordance with their scheduled time. Please arrive 10 minutes early for registration, restroom, etc. If you are late for your appointment, you may be asked to reschedule or pay a late fee.
- Please turn your cell phone on silent before entering the clinic. If you need to make a call, please step outside.
- Please do not bring children to the clinic unless that child has an appointment with Dr. Hurley.
- Please do not wear strong perfumes, colognes, scented lotions, etc., since many patients are chemically sensitive.
- All clients are required to pay a $25 booking fee that will be deducted from the total amount at the time of service.
- No returns or refunds on supplementation or products.
- Appointment Reminder calls and emails are made only as a courtesy. Your scheduled appointments are your responsibility.
- No refunds will be issued on any lab test ordered. A $10 fee will be charged if add on orders are placed at a later date.

With my signature I indicate my understanding of, and agreement with, the above policies.

Client's Signature:	Client's Printed Name:	Date:
____________________	____________________	______________

CONSENT AND RELEASE

I, the undersigned, indicate that I am not a representative of the government or any investigative institution.

I understand and acknowledge that no claims of "curement" are being made. I am aware that during the assessments and some therapies, there may be palpation (physical and biological) involved to establish functional support protocols designed specifically for me. I also understand that I might be asked to take nutritional supplements before, during and after any analysis or therapy administered and will do so at free will.

I understand that I may also volunteer to take nutritional supplements during the research process and will do so of my own free will. I further understand and acknowledge that no claims of any kind are being made by Hurley Wellness Center as to the effectiveness of any of the nutritional supplements suggested. Realize chronic complaints have occurred over time with multitudes of variables, we believe there are 6 steps in obtaining optimal wellness, we believe all 6 steps need to be supported in order to obtain and maintain that optimal wellness. No one is going to live or die for you. We are here to educate and make suggestions for your path to wellness, we will even hold your hand on your journey to wellness but ultimately it is your choice.

Fee and Payment

I understand Dr. Hurley does not participate in private health insurance programs, Medicare, Medicaid, or any other supplemental insurance. I understand that I will be expected to pay in full at the time of service and that Hurley Wellness Center accepts cash, check, Visa, or Mastercard. If I require any copies of medical health records, there will be a charge. If laboratory test are ordered, payment must be paid prior to testing.

I also understand that Dr. Hurley charges for time she spends on my behalf when not in my presence, including telephone consultations, emails, medical record reviews, and preparation of written documents, including review and signing. I understand she charges the same hourly rate as for clinic visits.

Missed Appointments/Cancellation/Rescheduling

- All clients are required to pay a $25 booking fee that will be deducted from the total amount at the time of service. Clients are charged a fee for a missed appointment and for those cancelled or rescheduled with less than 24 hours prior to their scheduled visit. Fees are charges at the regular hourly rate according to the amount of time that has been reserved on Dr. Hurley's schedule.
- Unless cancelled at least 24 hours in advance, your missed appointment will be charged the full amount.

Late Arrivals and Returned Check

Late arrival for an appointment results in shortened length of treatment time. If you are more than 15 minutes late, you may be asked to re-schedule your appointment. I understand that I will be billed for the total time of the original scheduled visit. Therefore, we ask that you arrive at least 10 minutes prior to your scheduled appointment time in order to check in, weigh, drink water, and use the restroom facilities if necessary prior to the start of your visit with Dr. Hurley.

If a check is returned due to insufficient funds, a fee of $30 will be assessed to the patient's account.

With my signature I indicate my understanding of, and agreement with, the above policies.

Client's Signature: Client's Printed Name: Date:

Nutritional Supplements Disclosure

Nutritional supplementation is often a central component of your treatment because vital nutrients help you heal yourself. In our experience, most clients with chronic health problems have functional deficiency states which interfere with their healing. Replacing specific nutrient insufficiencies, often at high doses, is <u>one of our most effective tools</u> to help clients improve their health.

Some people feel benefits from supplements within one month, while others require several months to feel substantially better. Especially in the early phases of your treatment, you might actually feel worse before you begin to feel better.

It is important to us that our treatment plans are built on the highest quality nutritional supplement available. Our suggested supplementation is standardized and pharmaceutical grade. Therefore, the specific supplements we recommend have been chosen after considerable and ongoing investigation into quality and effectiveness. The supplementation suggested are ones that we determine through bio-feedback from blood chemistry, saliva analysis, stool analysis, etc and provide what we believe to be the greatest benefit to our clients. Most of these products are specialized nutritional formulas which are not available at local stores or online and are only available to health care providers.

Like other places where you may purchase supplements, we do have financial interest in the sale of supplements. Income generated from these sales are used to cover the cost of providing this and other clinic services, including continued investigation into new and better products as well as helping to keep our fees for office visits lower. We are aware that many of the stores in the local area sell excellent products, and we encourage you to shop around and compare. *We want you to feel no pressure to buy these products from us.*

With my signature I indicate my understanding of, and agreement with, the above policies.

Client's Signature: Client's Printed Name: Date:

____________________ ____________________ ______________

Therapies Disclosure

Most of the therapies provided by Hurley Wellness Center feature State of the Art equipment. Many, but not all, therapies are FDA approved. The ones that are not approved by the FDA are used strictly for clinical research or are ones that HWC deems supportive to the body. We have daily, weekly, monthly, and annual company maintenance checks on equipment. However, occasionally there may be an equipment malfunction due to no fault of our own. If malfunction prevents you from completing a scheduled therapy session, you will be provided either an equal exchange therapy or a partial refund for any unused time.

Hurley Wellness Center reserves the right to refuse a therapy due to preexisting health issues or any other reason. Be aware that health issues may interfere with therapy results. We suggest that you consult with your physician prior to any therapy.
With my signature below, I indicate that I have read and understood the statement above.

Client's Signature: Client's Printed Name: Date:

____________________ ____________________ ______________

Prepaid Visits, Therapies or Lab Analysis

If I am purchasing a therapy package, individual therapy, or lab analysis, then it is to be used in full within 365 days of the date the contract was signed. After 365 days all prepaid therapies, visits, and lab analysis that are unused are forfeited. I understand that NO refunds or exchanges of **ANY** unused therapy will be given for any reason other than death of the signed client. If such has occurred, the spouse or person listed above may have the package transferred to them. A partial refund may be available for the spouse, but the stipulations will be that the therapies that were not completed will be charged to the package holder at original cost (not the discounted price) and there is a **$300** administrative fee charged to the package holder. These will be totaled and deducted from the package cost to assess the remaining balance that may be refunded to the client's spouse.

Signature____Date____________________
Staff Signature____Date____________________
Witness____ Date_____________________

CONFIDENTIAL CLIENT INFORMATION

PLEASE PRINT

Date ________________________
Full Name ____
Address ____ City _________________ State _______ Zip ______
SSN ________-_______-______

Hurley Wellness Center requires that each and every client provide a social security number. This number is used as your client identification number. Social security numbers are not held in any electronic devices and can only be obtained through a court order. Please be aware; if you do not provide a social security number, Hurley Wellness Center withholds the right to refuse wellness health care.

Marital Status ____________ Sex ______ Age _________ DOB _________________
Phone _______________________ Work Phone _________________ Cell Phone _______________
Email _________________________________ Employer __________________________
Occupation ____________________________ Spouse Name ______________________________
Emergency Contact _______________________ Phone ________________________
How did you hear about our office? ____

Complaint History

Complaint 1:
____
When did your complaint first begin? ____________________
Have you ever experienced this complaint before? ______________
How often do you experience your symptoms?
□Constantly (76-100% of the time) □Occasionally (26-50% of the time)
□Frequently (51-75% of the time) □Intermittently (1-25% of the time)

Complaint 2:
____
When did your complaint first begin? ____________________
Have you ever experienced this complaint before? ______________
How often do you experience your symptoms?
□Constantly (76-100% of the time) □Occasionally (26-50% of the time)
□Frequently (51-75% of the time) □Intermittently (1-25% of the time)

Complaint 3:
____
When did your complaint first begin? ____________________
Have you ever experienced this complaint before? ______________
How often do you experience your symptoms?
□Constantly (76-100% of the time) □Occasionally (26-50% of the time)
□Frequently (51-75% of the time) □Intermittently (1-25% of the time)

Complaint 4:
____
When did your complaint first begin? ____________________
Have you ever experienced this complaint before? ______________
How often do you experience your symptoms?
□Constantly (76-100% of the time) □Occasionally (26-50% of the time)
□Frequently (51-75% of the time) □Intermittently (1-25% of the time)

Continue on back of this paper if additional complaints

List **ALL** medications you take. (Prescriptions and over-the-counter – use additional pages if needed)

Drug name:	Dosage:	How long have you taken this and for what condition?
____________________	______________	____
____________________	______________	____
____________________	______________	____
____________________	______________	____

List **ALL** supplements you take. (Use additional pages if needed)

Name of Supplement:	Dosage:	How long have you taken this and for what condition?
____________________	______________	____
____________________	______________	____
____________________	______________	____
____________________	______________	____

List **ALL** previous hospitalizations, surgeries, accidents, fractures and illnesses (Use additional pages if needed)

(Example: All past Auto, Sports, Work, Home related, etc.)

1. Type ____ When _____________________ Why ___________________________
2. Type ____ When _____________________ Why ___________________________
3. Type ____ When _____________________ Why ___________________________
4. Type ____ When _____________________ Why ___________________________

- Have you had and dental work? (metal fillings nor or in the past, dental surgeries or implants, partial plates, false teeth, root canals, etc.)
  ____
- Do you smoke or have you ever? Yes □ No □ (please check) If yes, how long and how many daily?
  ____
- Do you have any known allergies? Yes □ No □ (please check) If yes, what are the known allergies?
  ____
- Rate your energy level (scale: 1- low energy up to 10-high energy)
  Waking ___ Afternoon___ Evening___
  Is your energy level better, worse or the same after eating? Better □ Worse □ Same □ (please check)
- Blood Type is extremely important when assessing Nutritional and Diet needs.
  Do you know your blood type? Yes □ No □ (please check)
  If yes, please circle your blood type: O/A/B/AB
  If no, would you like it typed today? Yes □ No □ (please check) **(Additional $50)**
- Do you receive chiropractic care? Yes □ No □ (please check)
  If yes, do you receive chiropractic care regularly and when was the last visit? _____________________________________

Liquid Intake

Give an approximate number of 8 oz. servings for the following liquids you drink: (check any boxes that apply)

1. Water_________ (Day/Week)
2. Coffee ________ (Day/ Week) Caffeine□ Decaf□ Sugar□ Artificial Sweetener□ Stevia□ Cream□ Cow Milk □ Nut Milk□ Soy Milk□
3. Soda________ (Day/Week) Caffeine□ Decaf□ Diet□
4. Tea ________ (Day/Week) Green Tea□ Black Tea□ Sugar□ Artificial Sweetener□ Stevia□ Unsweet□
5. Juice _______ (Day/Week)
6. Milk _______ (Day/Week) Cow Milk□ Nut Milk□ Soy Milk□ Goat Milk□ Almond Milk□ Other□
7. Alcohol______ (Day/Week) Wine□ Beer□ Liquor□ Straight□ With Mixer□
8. Energy Drinks_______ (Day/ Week)

Check **ALL** "body signals" (symptoms/pains) you may have had or do have now:

___ ADD/ ADHD	___ Depression	___ Hepatitis	___ Multiple Sclerosis
___ Alcoholism	___ Diabetes	___ High Blood Pressure	___ Neck Pain
___ Allergy	___ Diarrhea	___ High Cholesterol	___ Parkinson's Disease
___ Alzheimer's	___ Skin Issues	___ High Blood Sugar	___ Pneumonia
___ Anemia	___ Emphysema	___ HIV/ AIDS	___ Raynaud's
___ Appendicitis	___ Epilepsy/seizures	___ Irregular menstruation	___ Rheumatoid Arthritis
___ Asthma	___ Fibromyalgia	___ Irritable Bowel	___ Ringing in Ears
___ Arthritis	___ Gall Bladder	___ Kidney problems	___ Sinus infections
___ Back pain	___ Goiter	___ Low Blood Pressure	___ Stroke
___ Cancer	___ Gout	___ Lyme Disease	___ Thyroid Problems
___ Celiac / Gluten Dis.	___ Headaches	___ Lupus	___ Ulcers
___ Chronic Fatigue	___ Heart Attack	___ Migraine	___ Vertigo/dizziness
___ Constipation	___ Heart Disease	___ Miscarriage	___ Anxiety
___ Eye complaints	___ Ear Complaints	___ Aches/Pains	___ Head Injury

Please check all of the following conditions your family has experienced:

Mother: __Alzheimer's __Cancer __ Diabetes __ Heart Disease __Parkinson's __MS __ Stroke
Father: __Alzheimer's __Cancer __ Diabetes __ Heart Disease __Parkinson's __ MS __ Stroke
GrandMother (M): __Alzheimer's __Cancer __ Diabetes __Heart Disease __Parkinson's __ MS __ Stroke
GrandFather (M): __Alzheimer's __Cancer __ Diabetes __ Heart Disease __ Parkinson's __ MS __ Stroke
GrandMother (P): __Alzheimer's __Cancer __ Diabetes __ Heart Disease __ Parkinson's __ MS __ Stroke
GrandFather (P): __Alzheimer's __Cancer __ Diabetes __ Heart Disease __ Parkinson's __ MS __ Stroke
Sisters: __Alzheimer's __Cancer __ Diabetes __ Heart Disease __ Parkinson's __ MS __ Stroke
Brothers: __Alzheimer's __Cancer __ Diabetes __ Heart Disease __ Parkinson's __ MS __ Stroke
Children: __Alzheimer's __Cancer __ Diabetes __ Heart Disease __ Parkinson's __ MS __ Stroke

List any other health conditions that you or your family have had that are not listed:

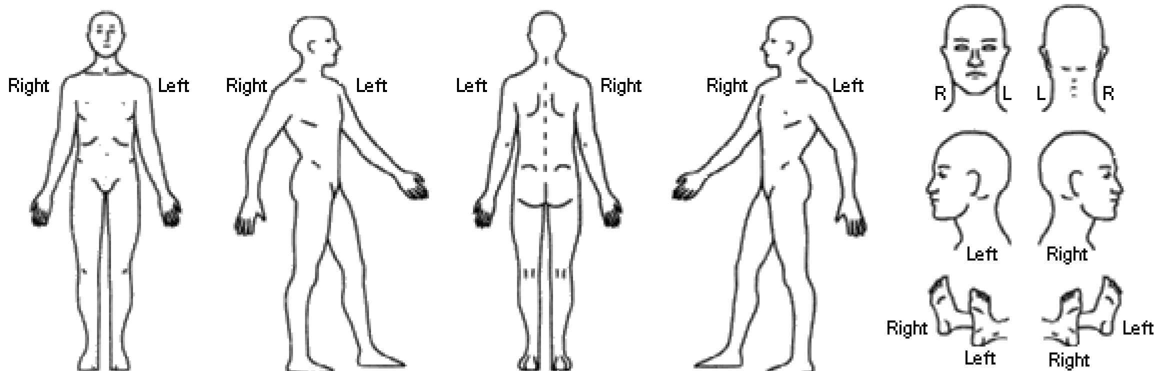
____

- Level of exercise (please circle): None, Moderate (days per week)________, Strenuous (days per week) ________
- Have you experienced any unexplained or rapid weight changes in the last six months? Yes □ No □ (please check)
  If yes, how many pound? _______

Please mark off the area of your complaint on the diagram below.

Use the following symbols:

P= pain, N= numbness, T= tingling, B= burning, C= cramping



Females Only:

- What age did your cycle begin? _______________
- Were your cycles regular□, light□ , or heavy□ (please check)
- Did you or do you have a painful cycle? Yes □ No □ (please check)
- Do you take or have you taken birth control pills? Yes □ No □ (please check)
  If yes, how long? _______________________________
- Do you take or have you taken hormone replacement therapy? Yes □ No □ (please check)
  If yes, how long? _______________________________
- Do you have any children? Yes □ No □ (please check)
  If yes, how many and male or female? _______________________________
- Was the pregnancy full term? Yes □ No □ (please check)
- Did you have any complications before during or after pregnancy? Yes □ No □ (please check)
- If yes, please explain. ____
- Did you nurse? Yes □ No □ (please check)
  If yes, how long? ____
- Check all that apply: Vaginal delivery□ Forceps□ Suction□ Episiotomy□
- Did you suffer from post partum depression? Yes □ No □ (please check)
- When was your last pap smear? _______________________________
  What did the results indicate? _____________________________________
- When was your last mammogram or thermography?_______________________________
  What did the results indicate? _____________________________________
- Are you interested in learning more about thermography offered through Hurley Wellness Center? Yes □ No □ (please check)
- Any sex drive complaints? Yes □ No □ (please check)
- How many times do you wake to urinate at night? ___________

Male Only:

- When did you last have your PSA checked? _________________________
- What was your last PSA score? ____________
- Do you still wake with an erection? _________________
- Any sex drive complaints? Yes □ No □ (please check)
  If yes, please explain. ____
- Any pressure while urinating? Yes □ No □ (please check)
- Do you have a poor slow while urinating? Yes □ No □ (please check)
- How many times do you wake to urinate at night? ___________

All Clients:

- How many children did your mother have? ______________________________
- Which birth number are you? _____________________________
- Was your delivery - Check all that apply: Vaginal delivery□ Forceps□ Suction□ Csection__
- Were you breast fed? Yes □ No □ (please check)
- Can you give us an estimate of how many antibiotics you have taken in your life _______________________
- When did you have your last cold or flu? ________________________________
- Have you ever experienced issues with your ears, nose or throat? __________________________________
- Have you had tubes for your ears? Yes □ No □ (please check) _____________________________________
- Do you have asthma? Yes □ No □ (please check) Are you currently medicated for it?__________________________
- Do you have COPD? Yes □ No □ (please check)
- Have you ever had a collapsed lung? Yes □ No □ (please check)
- Do you have blood sugar complaints? Yes □ No □ (please check)
- Have you ever had MRSA? Yes □ No □ (please check)
- Do you have any open wounds? Yes □ No □ (please check) Please list: ________________________
- Do you have apnea or any other sleep disorder? Yes □ No □ (please check)
- Do you use a CPAP or BiPAP or have you been told you need to? Yes □ No □ (please check)
- Do you have any type of implants in your body? Please list, including dental. Please list any complaints associated with implants ____
- What did you last eat and at what time? _________________________________
- What did you last drink and at what time? _______________________________
- When was your last bowel movement? Was it typical? (ie- constipated, diarrhea) __________________________
- Have you ever been in a automobile accident moving more than 25 mph? Yes □ No □ (please check)
- Have you ever hit your head or been hit in the head? Please discuss details below.

Neurotransmitter Assessment Form (NTAF)

Name: ______________________________ Age: ______ Sex: ________ Date: ____________________

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

SECTION A – GENERAL BRAIN FUNCTION

- 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 things? **0 1 2 3**
- Do you have a hard time remembering your appointments? **0 1 2 3**
- Is your temperament getting worse in general? **0 1 2 3**
- Are you losing your attention span endurance? **0 1 2 3**
- Are you depressed more than usual? **0 1 2 3**
- Do you fatigue sooner when driving than in the past? **0 1 2 3**
- Do you fatigue when reading sooner than in the past? **0 1 2 3**
- Do you walk into rooms and forget why? **0 1 2 3**
- Do you pick up your cell phone and forget why? **0 1 2 3**

SECTION B – GENERAL BRAIN FUNCTION/STRESS

- Is your stress level high? **0 1 2 3**
- Do you always have something that must be done? **0 1 2 3**
- Do you feel you never have time for yourself? **0 1 2 3**
- Do you feel you are not getting enough sleep or rest? **0 1 2 3**
- Do you get regular exercise? **0 1 2 3**
- Do you think people care about you? **0 1 2 3**
- Do you feel you are accomplishing your life purpose? **0 1 2 3**
- Do you have someone to share your problems with? **0 1 2 3**

SECTION C – SUGAR BALANCE

SECTION C1 – BLOOD SUGAR FLUCTUATION

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

SECTION C2 – INSULIN RESISTANCE

- Do you get fatigued after meals? **0 1 2 3**
- Do you crave sugar and sweets after meals? **0 1 2 3**
- Do you feel you need stimulants such as coffee after meals? **0 1 2 3**
- Do you have difficulty losing weight? **0 1 2 3**
- Is your waist girth equal to or larger than your hip girth? **0 1 2 3**
- Do you have frequent urination? **0 1 2 3**
- Has your thirst and appetite been increased? **0 1 2 3**
- Do you still have sugar cravings after eating sweets? **0 1 2 3**
- Do you have weight gain when under stress? **0 1 2 3**
- Do you have difficulty falling asleep? **0 1 2 3**

SECTION 1 – SEROTONIN

- Are you losing your pleasure in hobbies and interests? **0 1 2 3**
- Do you feel overwhelmed with ideas to manage? **0 1 2 3**
- Do you have feelings of inner rage (anger)? **0 1 2 3**
- Do you have feelings of paranoia? **0 1 2 3**
- Do you have feelings of depression? **0 1 2 3**
- In general, do you feel like you are not enjoying life? **0 1 2 3**
- Do you feel you lack artistic appreciation? **0 1 2 3**
- Do you feel depressed in overcast weather? **0 1 2 3**
- Are you losing your enthusiasm for your favorite activities? **0 1 2 3**
- Are you losing enjoyment for your favorite foods? **0 1 2 3**
- Are you losing your enjoyment of friendships and relationships? **0 1 2 3**
- Do you have difficulty falling into deep restful sleep? **0 1 2 3**
- Do you have feeling of dependency on others? **0 1 2 3**
- Do you feel more susceptible to pain? **0 1 2 3**
- Do you have feelings of unprovoked anger? **0 1 2 3**
- Are you losing interest in life? **0 1 2 3**

SECTION 2 – DOPAMINE

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

SECTION 3 – GABA

- Do you feel anxious or panic for no reason? **0 1 2 3**
- Do you have feelings of dread, or pending gloom? **0 1 2 3**
- Do you feel knots in you stomach? **0 1 2 3**
- Do you have feelings of being overwhelmed for no reason? **0 1 2 3**
- Do you have feelings of guilt about everyday decisions? **0 1 2 3**
- Does your mind feel restless? **0 1 2 3**
- Is it difficult to turn your mind off when you want to relax? **0 1 2 3**
- Do you have disorganized attention? **0 1 2 3**
- Do you now worry about things you were not worried about before? **0 1 2 3**
- Do you have feelings of inner tension and inner excitability? **0 1 2 3**

SECTION 4 - ACETYLCHOLINE

- Do you feel your visual memory (shapes & images) is decreased? **0 1 2 3**
- Do you feel your verbal memory is decreased? **0 1 2 3**
- Do you have memory lapses? **0 1 2 3**
- Has your creativity been decreased? **0 1 2 3**
- Has your comprehension been 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 is changed? **0 1 2 3**
- Are you experiencing excessive urination? **0 1 2 3**
- Are you experiencing slower mental response? **0 1 2 3**

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition. For nutritional purposes only.

All Rights Reserved. Copyright © 2008, Datis Kharrazian

Medication History

Please circle any of the following medication you have been or are currently taking.

Agonist Modulator of GABA Receptor (benzodiazpines)
Xanax, Lexotanil, Lexotan, Librium, Klonopin, Valium, ProSon, Rohypnol, Dalmane, Ativan, Loramet, Sedoxil, Dormicum, Megadon, Serax , Restoril, Halcion

Agonist Modulator of GABA Receptors (nonbenzodiazpines)
Ambien, Sonata, Lunesta, Imovane

GABA Antagonist Competitive binder
Flumazenil

D2 Dopamine Receptors Blockers (antipsychotics)
Thorazine, Prolixin, Trilafon, Compazine, Mellaril, Stelazine, Vesprin, Nozinan, Depixol, Navane, luanxol, Clopixol, Acuphase, Haldol, Orap, Clozaril, Zyprexa, Zydis, Seroquel, Geodon, Solian, Invega, Abilify

Dopamine Receptors Agonists
Mirapex, Sifrol, Requip

Acetylcholine Receptor Agonists
Bethenacol, Carbachol, Cervimeline, Pilocarpine, Suberylcholine, Nicotine

Cholinesterase Inhibitors (reversible)
Donepezil, Galatamine, Rivastigmine, Tacrine, THC, Erophonium, Neostigmine, Phystigimine, Pyridostigmine, Carbamate Insecticidses

Cholinesterase Inhibitors (irreversible)
Echotiophate, Isoflurophate, Organophosphate Insecticides, Organophosphate-containing nerve agents

Acetylcholinesterase Reactivators
Pralidoxime

Acetylcholine Receptor Antagonist – Antimuscarinic Agents
Atropine, Ipratopium, Scopolamine, Tiotropium

Acetylcholine Receptor Antagonist - Ganlionic Blockers
Mecamylamine, Hexamethonium, Nicotine (high doses), Trimethaphan

Acetylcholine Receptor Antagonist - Neuromuscular Blockers
Atracurium, Cisatracurium, Doxacurium, Metocurine, Mivacurium, Pancuronium, Rocuronium, uccinylcholine, Tubocurarine, Vecuronium, Hemicholine

Selective Serotonin Reuptake Inhibitor
Paxil, Zoloft, Prozac, Celexa, Lexapro, Luvox, Cipramil , Emocal, Serpam, Seropram, Cipralex, Esteria, Fontex, Seromex, Seronil, Sarafem, Fluctin, Faverin, Seroxat, Aropax, Deroxat, Rexetin, Xentor, Paroxat, Lustral, Serlain, Dapoxetine

Selective Serotonin Reuptake Enhancers
Stablon, Coaxil, Tatinol

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
Effexor, Pristiq, Meridia, Serzone, Dalcipran, Despramine, Duloxetine

Noradrenergic and Specific Sertonergic Antidepressants (NaSSaa)
Remeron, Zispin, Avanza, Norset, Remergil, Axit

Tricylic Antidepresseants (TCAs)
Elavil, Endep, Tryptanol, Trepiline, Asendin, Asendis, Defanyl, Demolox, Moxadil, Anafranil, Norpramin, Pertofrane, Prothiadin, Thanden, Adapin, Sinequan, Trofranil, Janamine, Gamanil, Aventyl, Pamelor, Opipramol, Vivactil, Rhotrimine, Surmontil

Monoamine Oxidase Inhibitor (MAOI)
Marplan, Aurorix, Maneric, Moclodura, Nardil, Adlegiine, Elepryl, Azilect, Marsilid, Iprozid, Ipronid, Rivivol, Popilniazida, Zyvox, Zyvoxid

Dopamine Reuptake Inhibitors
Wellbutrin (Bupropion)

All Rights Reserved. Copyright © 2008, Datis Kharrazian

SMGENAF01(0808).INDD