Health & Lifestyle Assessment

The Boca Raton Center for Healthy Living assures you that information provided by you is kept strictly confidential. When providing your contact information, please be aware that it will be used for medically and financially related correspondence only.

Contact Information

Name: _____

AKA: _____

Date of Birth: _____ Age: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Fax: _____

Email: _____

Business Phone: _____

Business Fax: _____

Primary Care Physician: _____

Office Phone: _____

Office Address: _____

Office Fax: _____

How did you hear about us: _____

Where do you prefer to be contacted? Mark all options that apply.

☐ Home ☐ Cell ☐ Business

Race: _____ Height: _____

Weight: _____ Ideal Weight: _____

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Personal Information

Marital Status: ☐ Single ☐Married ☐ Significant Other
☐Divorced ☐ Widowed

Do you have any children? ☐Yes ☐No If so, how many? _____

Do you have any grandchildren? ☐Yes ☐No If so, how many? _____

Are your parents living? ☐Yes ☐No If no, please explain: _____

_____

Occupation: _____

How would you rate your current health? (Please Circle One)

Excellent Good Average Fair Poor

Health Goals

1. _____
2. _____
3. _____

Health Concerns

1. _____
2. _____
3. _____

How long have you suffered with these problems? _____

_____

Any other complaints? _____

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Would you like improvement with any of the following? (Check all that apply)

☐Digestion	☐Sleep	☐Energy
☐Nutrition	☐Exercise	☐Hormone balance
☐Sexual function	☐Stress	☐Sense of Well Being

What have you tried doing to resolve these problems that **did not** work?

_____

_____

_____

When your problems are at their worst, how do you feel?

_____

_____

How much older do they make you feel?

_____

How does this problem interfere with the following areas in your life?

Work: _____

Family: _____

Hobbies: _____

Life: _____

Do you know how this problem may have started? _____

What effect do these problems have on your body functions? _____

_____

Are you here visiting us to:

a) Resolve your immediate problem
b) Lifestyle program for optimized living
c) Both
d) Other: _____

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How have you taken care of your health in the past? (Check all that apply)

☐Medications ☐Routine Medical
☐Holistic ☐Exercise
☐Diet and Nutrition ☐Vitamins
☐Chiropractic ☐Other: _____

How did the previous methods work for you? _____

_____

What are you afraid this might be or will be affecting without change? (Check all that apply)

☐Job ☐Freedom
☐Kids ☐Future abilities
☐Marriage ☐Finances
☐Sleep ☐Time

Are there any health conditions you are afraid this might turn into? (Check all that apply)

☐Diminished future abilities ☐Surgery
☐Stress ☐Arthritis
☐Weight gain ☐Cancer
☐Heart disease ☐Diabetes
☐Depression ☐Other: _____

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of? Please be specific _____

_____

_____

What would be different or better without these problems? (Check all that apply)

☐Diminished Stress ☐Sleep ☐More Energy ☐Work
☐Self-Esteem ☐Outlook ☐Confidence ☐Family

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If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress?
(Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

_____

_____

_____

_____

_____

_____

What potential barriers do you foresee that would prevent these things from happening?

_____

_____

_____

Do you feel it is possible to eliminate or prevent these potential barriers?

_____

What are your strengths that will enable you to accomplish your goals?

_____

_____

_____

Rate using a numerical scale with 1 being not at all, and 10 being absolutely yes:

_____It is important for you to resolve your health concerns.

_____You feel you are coachable and would enjoy a mentor in helping you.

_____ You are prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals.

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Personal Health History

When was the last time you went to the doctor for a general check up or illness?

Within the past 12 months, how many times did you see a medical doctor about your health?

Which of the following do you do on a regular basis? check all that apply

☐ Annual dental check ups

☐ Annual teeth cleaning

☐Brush your teeth at least twice a day

☐ Use dental floss on a daily basis

☐ None of the above

Comparing your health to other of your age, how would you rate your health? (Please Circle One)

Excellent **Good** **Average** **Fair** **Poor**

During the past year, how many days did you miss from work, or have your regular activities curtailed, due to illness? _____

In the past 12 months, how many days were you in the hospital? _____

Please review the list of conditions and check the column(s) that most applies to you and your family history. Leave blank any condition(s) you wish to discuss privately.

Condition	Not Applicable	Myself	Sibling	Parents Mother Father	Grandparents Mother Father	Children
Heart Disease						
Cancer						
Diabetes						
High Blood Pressure						
Arthritis						

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Condition	Not Applicable	Myself	Sibling	Parents Mother Father	Grandparents Mother Father	Children
Mental Health Issues (depression, anxiety, psychotic disorders)						
Autoimmune Disease (lupus, rheumatoid arthritis)						
Endocrine Gland Disorders (thyroid, adrenal, pituitary)						
Neurological Disorders (stroke, seizures, Parkinson's, Alzheimer's, multiple sclerosis)						
Lung Disease (asthma, emphysema, bronchitis)						
Substance Abuse (alcohol, prescription, recreational drugs, tobacco)						

Please check any of the following that may pertain to your medical history:

☐ Abnormal EKG

☐ Abnormal Pap smear

☐ Abnormal PSA

☐ Kidney Disease (stones, infections, cysts)

☐ Stomach/Esophagus Disorders (reflux, stricture, ulcers)

☐ Bowel Disease (malabsorption, lactose intolerance, diverticulitis, Crohn's, colitis, IBS)

☐ Bladder Disease

☐ Weight Control Problems

☐ Osteoporosis

☐ Migraine Headaches

☐ Anemia

☐ HIV/AIDS

☐ Allergies (Hay Fever)

☐ Memory Problems

☐ Sleep Disturbances (Sleep apnea, snoring, insomnia)

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Are you allergic to any drugs? ☐Yes ☐No

If yes, please list the drug(s) and describe the reaction.

_____

_____

_____

Please list all medication, vitamins, supplements, and herbs including the dosage and frequency (prescription and over the counter) you currently take and condition for which it is taken

Medication	Condition	Dosage	Times per Day

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Please describe any current usage of recreational drugs, tobacco, and/or alcohol

_____

_____

_____

Please list any history of trauma that you have experienced (car accident, head injuries, broken bones)

_____

_____

_____

Please list any surgical procedures you have had, including plastic surgery, along with the approximate date, and reason for the surgery

_____

_____

_____

Have you ever had a blood transfusion? ☐Yes ☐No

If yes, please list the approximate date(s) and reason(s)

_____

_____

_____

Please indicate if you are currently receiving any of the following.

☐Radiation Therapy Condition: _____

☐Chemotherapy Condition: _____

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Please provide the date and length of exposure, if any, to the environmental risks listed below:

Exposure	Date(s)	Length of Exposure
Asbestos		
Coal Dust		
Chemicals		
Sun/Tanning		
Fumes/Gasses		
Radon Testing		
X-ray Treatments		
Other		

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For Men

Symptom	Yes	No
Difficulty maintaining/attaining an erection (or insufficient to maintain		
Ejaculation causes pain		
Sexual drive overactive		
Pain/coldness in genital area		
Varicose veins on scrotum		
Discharge from penis		
Past or present rash on penis		
Swollen genitals		
Swelling in groin		
Genital sores		
Lump or mass in scrotum		
Jock itch		
Past or present sexually transmitted disease (specify):		

Medication	Yes	No
Do you use Viagra, Cialis, Levitra or any other erectile enhancement drugs? If yes, which one(s) and how often?		
Have they helped you?		
Do you use any other medication for sexual function? If yes, please list and describe results:		
Have you ever use testosterone, HCG, DHEA, or hGH? If yes, which one(s) and when?		

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Male BHRT Questionnaire

Name: _____ **Date**: _____

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experiences with 0 being Not At All and 10 being Extremely Severe.

	Mild					Moderate					Severe
Sleep Disruptions	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Breast Development	0	1	2	3	4	5	6	7	8	9	10
Decreased Morning Erections	0	1	2	3	4	5	6	7	8	9	10
Decreased Sex Drive	0	1	2	3	4	5	6	7	8	9	10
Harder to Reach Climax	0	1	2	3	4	5	6	7	8	9	10
Reduced Testicular Size	0	1	2	3	4	5	6	7	8	9	10
Decreased Motivation	0	1	2	3	4	5	6	7	8	9	10
Decreased Self Confidence	0	1	2	3	4	5	6	7	8	9	10
Abdominal Fat	0	1	2	3	4	5	6	7	8	9	10
Muscle Atrophy	0	1	2	3	4	5	6	7	8	9	10
Fatigue	0	1	2	3	4	5	6	7	8	9	10
Loss of Recent Memory	0	1	2	3	4	5	6	7	8	9	10
Dry Skin	0	1	2	3	4	5	6	7	8	9	10
Arthritis	0	1	2	3	4	5	6	7	8	9	10
Hair Loss	0	1	2	3	4	5	6	7	8	9	10
Weight Gain	0	1	2	3	4	5	6	7	8	9	10

For Women

Symptom	Yes	No
Missed Periods		
Pelvic or vaginal soreness or pain		
Menstrual pain		
Heavy menstrual bleeding		
Irregular periods		
Infertility		
Hot flashes/night sweats		
Under active sex drive		
Overactive sex drive		
Pre-menstrual syndrome (PMS)		
Monthly weight gain		
Bloating and swelling		
Tender breasts		
Low backache		
Vaginal itching		
Vaginal discharge or sores		
Past or present sexually transmitted disease (specify):		
Dislike of intercourse		
Pain in ovaries		
Water retention		
Craving for sweets		
Sweating throughout the day		
Vaginal dryness		
History of miscarriages		
History of ovarian cysts		
History of uterine cysts/fibroids		
History of endometriosis		
Have you had a hysterectomy? If yes, please provide the date and reason.		
Have you ever taken estrogen, progesterone, testosterone, DHEA or hGH? If yes, which one(s) and when?		
Date of last menstrual period:		
What form of birth control do you use? If yes, please circle. None Pill IUD Sponge Diaphragm Foam Vasectomy Condoms Tubal Ligation Hysterectomy		
How many pregnancies have you had?		
Are you menopausal?		

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Female BHRT Questionnaire

Name: _____ **Date**: _____

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experiences with 0 being Not At All and 10 being Extremely Severe.

	Mild					Moderate				Severe
Sleep Disruptions	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10
Nervousness	0	1	2	3	4	5	6	7	8	9	10
Mood Swings	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Cramps	0	1	2	3	4	5	6	7	8	9	10
Breakthrough Bleeding	0	1	2	3	4	5	6	7	8	9	10
Hot Flashes	0	1	2	3	4	5	6	7	8	9	10
Night Sweats	0	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness	0	1	2	3	4	5	6	7	8	9	10
Painful Intercourse	0	1	2	3	4	5	6	7	8	9	10
Breast Tenderness	0	1	2	3	4	5	6	7	8	9	10
Fluid Retention	0	1	2	3	4	5	6	7	8	9	10
Headaches	0	1	2	3	4	5	6	7	8	9	10
Decreased Sex Drive	0	1	2	3	4	5	6	7	8	9	10
Harder to Reach Climax	0	1	2	3	4	5	6	7	8	9	10
Decreased Motivation	0	1	2	3	4	5	6	7	8	9	10
Decreased Self-confidence	0	1	2	3	4	5	6	7	8	9	10
Fatigue	0	1	2	3	4	5	6	7	8	9	10
Arthritis	0	1	2	3	4	5	6	7	8	9	10
Loss of Recent Memory	0	1	2	3	4	5	6	7	8	9	10
Dry Skin	0	1	2	3	4	5	6	7	8	9	10
Hair Loss	0	1	2	3	4	5	6	7	8	9	10
Urinary Incontinence	0	1	2	3	4	5	6	7	8	9	10
Weight Gain	0	1	2	3	4	5	6	7	8	9	10

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 movements	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 of 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
Excessive passage of gas	0	1	2	3

Category VI *(Cont.)*				
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
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
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	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

Symptom 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 a 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

Category XV *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI *(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 XVII *(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 XVIII *(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 XIX *(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 fogginess	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? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

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

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

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

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

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**

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

Medication History*

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

Noradrenergic and Specific Sertonergic Antidepressants (NaSSAas)

- ☐ Remeron®
- ☐ Zispin®
- ☐ Avanza®
- ☐ Norset®
- ☐ Remergil®
- ☐ Axit®

Tricylic Antidepressants (TCAs)

- ☐ Elavil®
- ☐ Endep®
- ☐ Tryptanol
- ☐ Trepiline®
- ☐ Asendin®
- ☐ Asendis®
- ☐ Defanyl®
- ☐ Demolox®
- ☐ Moxadil®
- ☐ Anafranil®
- ☐ Norpramin®
- ☐ Pertofrane®
- ☐ Thaden™
- ☐ Prothiaden®
- ☐ Adapin®
- ☐ Sinequan®
- ☐ Tofranil®
- ☐ Janamine®
- ☐ Gamanil®
- ☐ Aventyl®
- ☐ Pamelor®
- ☐ Opipramol®
- ☐ Vivactil®
- ☐ Rhotrimine®
- ☐ Surmontil®

Selective Serotonin Reuptake Inhibitors (SSRIs)

- ☐ Paxil®
- ☐ Zoloft®
- ☐ Prozac®
- ☐ Celexa®
- ☐ Lexapro®
- ☐ Esertia®
- ☐ Luvox®
- ☐ Cipramil®
- ☐ Emocal®
- ☐ Seropram®
- ☐ Cipralex®
- ☐ Fontex®
- ☐ Priligy®
- ☐ Seromex®
- ☐ Seronil®
- ☐ Sarafem®
- ☐ Fluctin®
- ☐ Faverin®
- ☐ Seroxat®
- ☐ Aropax®
- ☐ Deroxat®
- ☐ Rexetin®
- ☐ Paroxat®
- ☐ Lustral®
- ☐ Serlain®

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

- ☐ Effexor®
- ☐ Pristiq®
- ☐ Meridia®
- ☐ Serzone®
- ☐ Dalcipran®
- ☐ Norpramin®
- ☐ Cymbalta®

Selective Serotonin Reuptake Enhancers (SSREs)

- ☐ Stablon®
- ☐ Coaxil®
- ☐ Tatinol®

Monoamine Oxidase Inhibitors (MAOIs)

- ☐ Marplan®
- ☐ Aurorix®
- ☐ Manerix®
- ☐ Moclodura®
- ☐ Nardil®
- ☐ Adeline®
- ☐ Eldepryl®
- ☐ Azilect®
- ☐ Marsilid®
- ☐ Iprozid®
- ☐ Ipronid®
- ☐ Rivivol®
- ☐ Propilniazide®
- ☐ Zyvox®
- ☐ Zyvoxid®

Dopamine Receptor Agonists

- ☐ Mirapex®
- ☐ Sifrol®
- ☐ Requip®

Norepinephrine and Dopamine Reuptake Inhibitors (NDRI)

- ☐ Wellbutrin XL®

D2 Dopamine Receptor Blockers (antipsychotics)

- ☐ Thorazine®
- ☐ Prolixin®
- ☐ Trilafon®
- ☐ Compazine®
- ☐ Mellaril®
- ☐ Stelazine®
- ☐ Vesprin®
- ☐ Nozinan®
- ☐ Depixol®
- ☐ Navane®
- ☐ Fluanxol®
- ☐ Clopixol®
- ☐ Acuphase®
- ☐ Haldol®
- ☐ Orap®
- ☐ Clozaril®
- ☐ Zyprexa®
- ☐ Zydis®
- ☐ Seroquel XR®
- ☐ Geodon®
- ☐ Solian®
- ☐ Invega®
- ☐ Abilify®

GABA Antagonist Competitive Binder

- ☐ Romazicon®

Agonist Modulators of GABA Receptors (benzodiazepines)

- ☐ Xanax®
- ☐ Lexotanil®
- ☐ Lexotan®
- ☐ Librium®
- ☐ Klonopin®
- ☐ Valium®
- ☐ ProSom®
- ☐ Rohypnol®
- ☐ Magadon®
- ☐ Dalmane®
- ☐ Ativan®
- ☐ Loramet®
- ☐ Sedoxil®
- ☐ Dormicum®
- ☐ Serax®
- ☐ Restoril®
- ☐ Halcion®

Agonist Modulators of GABA Receptors (non-benzodiazepines)

- ☐ Ambien CR®
- ☐ Sonata®
- ☐ Lunesta®
- ☐ Imovane®

Acetylcholine Receptor Agonists

- ☐ Urecholine®
- ☐ Evoxac®
- ☐ Anectine®
- ☐ Salagen®
- ☐ Isopto®
- ☐ Nicotine

Acetylcholine Receptor Antagonists Antimuscarinic Agents

- ☐ AtroPen®
- ☐ Scopace®
- ☐ Atrovent®
- ☐ Spiriva®

Acetylcholine Receptor Antagonists Ganglionic Blockers

- ☐ Inversine®
- ☐ Nicotine (high doses)
- ☐ Hexamethonium
- ☐ Arfonad®

Acetylcholine Receptor Antagonists Neuromuscular Blockers

- ☐ Atracurium
- ☐ Cisatracurium
- ☐ Doxacurium
- ☐ Metocurine
- ☐ Mivacurium
- ☐ Pancuronium
- ☐ Rocuronium
- ☐ Anectine®
- ☐ Tubocurarine
- ☐ Vecuronium
- ☐ Hemicholinium

Acetylcholinesterase Reactivators

- ☐ Protopam®

Cholinesterase Inhibitors (reversible)

- ☐ Aricept®
- ☐ Razadyne®
- ☐ Exelon®
- ☐ Cognex®
- ☐ THC
- ☐ Carbamate insecticides
- ☐ Enlon®
- ☐ Prostigmin®
- ☐ Antilirium®
- ☐ Mestinon®

Cholinesterase Inhibitors (irreversible)

- ☐ Echothiophate
- ☐ Flexyx®
- ☐ Organophosphate insecticides
- ☐ Organophosphate-containing nerve agents

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