East/West Integrated Medicine
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****THIS PAGE IS FOR YOU TO KEEP****

Directions to office:

- Map & Directions to Dr. Desai's office
  - From Denver and points east along Route 36 West toward Louisville
    - Exit Route 36 at Highway 287 North or right
    - 287 to So. Boulder Rd.-Turn left or west
    - Building is on the north/west side of the road at Garfield
  - See or print a map on MapQuest®

Recommended books on Ayurveda you may want to read before your appointment:

- *Perfect Health* by Deepak Chopra
- *Ayurvedic Cooking for Self Healing* by Usha Lad & Dr. Vasant Lad
- *EAT•TASTE•HEAL: An Ayurvedic Cookbook for Modern Living* by Thomas Yarema, MD; Daniel Rhoda; and Chef Johnny Brannigan

Instructions from Dr. Desai for new patients:

- Please come 5-10 minutes early to your new appointment.
- Please bring in all supplements, herbs or vitamins you are taking as the doctor needs to see the bottles.
- Please bring in all medication bottles
- Please bring in or mail two weeks before your visit any blood tests you have had in the last five to ten years. Dr. Desai often disagrees with what other doctors may consider normal.
- If you have any other testing (ex. ultrasound reports, etc.) relevant to your condition, bring in those reports. Dr. Desai does not need all your medical records.
- No fingernail polish at first visit.
- Mail your patient information form and history form to us two weeks before your appointment date.

Patient History

RUGNA PATRAKAM

Date_____

Instructions: Please fill out completely and mail to the above address. Information must arrive at least 2 weeks before your appointment.

Name	
Age	
Gender	
Phone (best # to leave a message)	
Birth date	
Birth place	
Marital Status	
Occupation	

Please explain your chief concerns:
(Please give date of onset of each condition, progression, aggravating factors, any treatment you have tried and results of such treatments. List each condition in chronological order or on a separate page if necessary.)

Past Medical History

1.Any illness, hospitalization, injury, accident, or surgery as a child?

Problem	Date(s)	Treatment	Resolved/still an issue

2. Any illness, hospitalization, injury, accident, or surgery as an adult?

Problem	Date(s)	Treatment	Resolved/still an issue

3. Date of last lab testing:_____
Any abnormal findings?_____

Date of last complete physical:_____ Any abnormal findings?_____

Emotional Traumas

Have you had any significant emotional traumas? (ex: death, divorce, history of abuse, difficult childhood)

Have you been treated for any mental/emotional illness?

Medications/ Supplements

What medications are you currently taking?

Name	Dose	For what condition

What supplements are you currently taking?

Name	Brand Name	Dose	Reason for taking

Allergies

Do you have any allergies or intolerances to the following?

Medications	
Foods	
Environmental substances, pollen, or chemicals	
Do you have Hay Fever or seasonal allergies?	

Family History

Please list your family members current age and any medical conditions they have

Mother	
Father	

Siblings	
Are there any conditions that run in your extended family?	

Habits/ Addictions

	Yes	No	If "Yes":
Do you drink coffee?			# cups/day
Do you drink black tea, green tea, or matte?			# cups/day
Do you drink soda?			# cans/day
Do you eat chocolate?			Amount eaten daily
Do you have any other source of caffeine?			
Do you drink alcohol?			What kind? How much? How often?
Have you ever had an alcohol addiction?			
Do you smoke tobacco?			How much?
Have you ever smoked tobacco?			How much? When quit?
Do you frequently use over the counter medication?			Name? For what reason?
Do you use any illegal drugs/ substances?			
Do you consume white flour and/ or white sugar?			
Is there anything that you feel is a habit or addiction in your life?			Please explain:

Cravings

Do you have any food or taste cravings?

Digestion

How is your digestion?

Are you hungry in the morning?

After your first meal of the day is your appetite regular and predictable 2-3x a day or is it irregular and variable each day?

Do you have a problem with frequent gas, bloating heartburn, burping, belching, or any abdominal discomfort or pain?

Do you get lightheaded, irritable, low energy, or cannot function well if you skip a meal?

Do you often skip or forget to eat meals? Please note the number of meals eaten per day.

Do you eat frequent small meals? How many?

Elimination

Do you have a bowel movement daily?
times/day

Do you have a tendency toward constipation or diarrhea?

Any problems with urination?

Menstruation (*for Women only*)

Do you have regular menstrual periods?	
# days of cycle	
# days of bleeding	
Is the bleeding heavy?	
Any PMS symptoms?	
Cramping?	
Before or after bleeding starts?	
Any pregnancies?	
Any difficulties with pregnancy?	
How many children do you have?	
List ages and any health concerns.	
Are you in menopause?	
Any symptoms?	

Heat/ Cold

Are you frequently cold when others seem comfortable?

Are you frequently warm when others seem comfortable?

Do you prefer warm or cold weather?

Sleep

Do you sleep well?

Time you go to bed

Time you wake up

Do you feel awake and ready to go in the morning?

Please describe any sleep disturbances:

Energy

Describe your energy level

Any drops in energy through the day?

Exercise

Do you exercise regularly? # times per week and what type

Emotions

Do you have any emotional issues at this time?

How do you react when under stress?

Are you a frequent worrier or anxious and fearful?

Are you frequently angry or irritable?

Do you tend to get depressed or sad easily?

Daily Routine

What is your daily routine from waking up in the morning to going to bed at night?

Diet

What time do you usually eat **breakfast**?	AM/PM
What do you usually eat?	
What time do you usually eat **lunch**?	AM/PM
What do you usually eat?	
What time do you usually eat **dinner**?	AM/PM
What do you usually eat?	
What time do you usually eat **snacks in the morning**?	
What do you usually eat?	
What time do you usually eat **snacks in the afternoon?**	
What do you usually eat?	
What time do you usually eat **snacks before bed?**	
What do you usually eat?	
What do you usually drink (tea, juice, soda, etc.)?	

How much do you usually drink?	
How much water do you drink on a typical day?	
What other foods do you eat regularly (weekly)?	

Please keep a three day food diary and send it in with this history.

Patient Information Sheet

Instructions: Please fill out completely and mail to the above address. Information must arrive at least 2 weeks before your appointment.

Patient's Full Name	
Age	
Gender	
Address	
City	
State & Zip	
Phone (day & cell)	
Phone (evening)	
Email	
Birth date	
Referred by	
Date of First Visit	
Onset of illness date	

Insurance information for our files:

Insured's Name	
Birth date	
Insured's Address	
Phone	
City	
State & ZIP	
SSN	
Patient's relationship to the insured	
Insurance Company's Name	
Customer Service Telephone Number	

I authorize the release of any medical or other information necessary to process any claim I submit. I also request payment of government or private benefits to myself or to the party who accepts assignment to this claim.

_____ _____
SIGNATURE OF RESPONSIBLE PARTY Date

I agree to pay for all services at the time they are rendered. I agree to pay for any appointment cancelled with less than 48 hours notice.

_____ _____
Signature Date

Credit Card Number: _____

Vcode: _____ Expiration Date: _____

(This information is kept on file in case of payment issues and will not be used unless you are delinquent in payment.)

In case of emergency or need for hospitalization:

Primary Care Physician Name: _____ Phone:_____

health equations

INTAKE FORM

Name _____ Date _____

Occupation _____ Age _____ Sex _____ D.O.B. _____

Blood Pressure _____ Pulse _____ Blood Type _____

Please circle words or check boxes for whatever applies to you; fill in blanks.

◆ **Water, Salt, Energy, Stress:**

My current salt use is- *low, moderate, heavy, by taste*

I have never used much or any salt- *True* or *False*

I previously used salt more than now- *True* or *False*

I have followed a low salt diet for _____ years.

Average energy level on a scale of 1 to 10 _____

Number of glasses of water each day _____

I crave salt and/or salty foods- *True* or *False*

I have unquenchable thirst- *True* or *False*

I sweat ... *a-lot, moderately, very little, not-at-all*

Average stress level on a scale of 1 to 10 _____

◆ **Family History:** ❑ cardiovascular disease ❑ adult onset diabetes ❑ thyroid disease ❑ osteoporosis

◆ **Milk Intolerance:** (circle one) **Y N**

◆ **Number of TOTAL pounds lost throughout your life dieting** _____.

◆ **Number of silver/amalgam fillings, currently** _____, **removed** _____.

◆ **Number of root canals, currently** _____, **removed** _____.

◆ **Exposure to heavy metals, chemicals, dust, infections, radiation, plastics:** _____

_____

◆ ***Women Only***

Number of childbirths _____

Number of years nursing _____

Menstrual-related symptoms _____

_____

Perimenopausal years _____

Menopausal years _____

Menopausal symptoms _____

_____

◆ ***Men Only***

Prostate enlargement? **Y N**

Elevated PSA? **Y N**

Urination difficulties? **Y N**

Nighttime urination? **Y N**

Sexual difficulties? **Y N**

FOOD DIARY

Please indicate the NUMBER OF SERVINGS PER WEEK you have of each of the following foods:

beef_____

poultry
white_____
dark_____

lamb_____

fish_____

pork_____

soy "milk"_____

tofu/soy products_____

milk_____ %fat____

yogurt _____ %fat____

cottage cheese____ %fat____

eggs (# per week)_____

butter_____
(sticks per week)

cheese _____
(ounces per week)

fresh fruit _____

fresh vegetables _____

breads, cereals, grains and pastas:
~refined/processed_____
~whole grain _____

legumes_____ seeds _____

nuts/nutbutters _____

oils, *please specify kind(s)* *weekly servings*

_____ _____

_____ _____

_____ _____

protein powder, *specify kind - weekly*

_____ _____

sweets (cookies, cakes, sodas, candy, ice cream, *etc.*)_____

caffeine: tea_____ coffee_____

dark soda_____ light soda_____

wine_____ beer_____ liquor_____

How much *calcium* do you supplement daily? _____ *mg*
For how long? *(circle one)* weeks, months, years

How much *magnesium* do you supplement daily? _____ *mg*
For how long? *(circle one)* weeks, months, years

EXERCISE

Please describe the type, frequency and duration of exercise.

_____

_____

_____

For Calculation of %BODY FAT

Height _____ Weight _____

Abdomen Measurement at Navel _____ inches

(Women only) Hips Measurement at the Widest Point _____ inches

(Men only) Wrist Measurement _____ inches

DIGESTION INDICATOR CHECKLIST

- ❑ food allergies/intolerances: _____
  _____
- ❑ crave specific foods: _____
  _____
- ❑ avoid specific foods: _____
  _____
- ❑ low fat or no animal fat
- ❑ low or no carbohydrates
- ❑ burning sensation in stomach which eating relieves
- ❑ burping
- ❑ acid indigestion, sour stomach, heartburn
- ❑ tight/full upper abdomen after eating
- ❑ pale stools
- ❑ crave fats
- ❑ gall bladder attacks or stones
- ❑ abdominal bloating / distention
- ❑ flatulence (gas)
- ❑ coated tongue
- ❑ diarrhea
- ❑ constipation / incomplete evacuation
- ❑ alternating diarrhea and constipation
- ❑ loss of taste for meat
- ❑ always hungry
- ❑ low blood sugar ❑ high blood sugar

SLEEP CHECKLIST

Number of hours _____

Sleep quality:
❑ poor ❑ good
❑ fair ❑ excellent

- ❑ awake during night at _____ a.m.
- ❑ awake rested
- ❑ difficulty falling asleep
- ❑ awake too early
- ❑ frequent snoring
- ❑ another person has witnessed you stop breathing during sleep

PLEASE INCLUDE A LIST OF ALL SUPPLEMENTS AND MEDICATIONS YOU ARE CURRENTLY TAKING. BE SURE TO LIST THE DOSE AND FREQUENCY FOR EACH ONE.

health equations

HEALTH SURVEY FORM Name _____ Date_____

INSTRUCTIONS: Number the boxes that apply to you with either a 1, 2, or 3 - -
(**1**) for **MILD** symptoms
(**2**) for **MODERATE** symptoms
(**3**) for **SEVERE** symptoms

Leave the box blank if it does not apply to you!

GROUP 1

1 ☐ Acid foods upset
2 ☐ Get chilled, often
3 ☐ "Lump" in throat
4 ☐ Dry mouth-eyes-nose
5 ☐ Pulse speeds after meals
6 ☐ Keyed up–fail to calm
7 ☐ Cuts heal slowly
8 ☐ Gag easily
9 ☐ Unable to relax; startles easily
10 ☐ Extremities cold, clammy
11 ☐ Strong light irritates
12 ☐ Urine amount reduced
13 ☐ Heart pounds after retiring
14 ☐ "Nervous" stomach
15 ☐ Appetite reduced
16 ☐ Cold sweats often
17 ☐ Fever easily raised
18 ☐ Neuralgia-like pains
19 ☐ Staring, blinks little
20 ☐ Sour stomach frequent

GROUP 2

21 ☐ Joint stiffness after arising
22 ☐ Muscle-leg-toe cramps at night
23 ☐ "Butterfly" stomach
24 ☐ Eyes or nose watery
25 ☐ Eyes blink often
26 ☐ Eyelids swollen, puffy
27 ☐ Indigestion soon after meals
28 ☐ Always seems hungry; feels "lightheaded" often
29 ☐ Digestion rapid
30 ☐ Vomiting frequent
31 ☐ Hoarseness frequent
32 ☐ Breathing irregular
33 ☐ Pulse slow; feels "irregular"
34 ☐ Gagging reflex slow
35 ☐ Difficulty swallowing
36 ☐ Constipation, diarrhea alternating
37 ☐ "Slow starter"
38 ☐ Get "chilled" frequently
39 ☐ Perspire easily
40 ☐ Circulation poor, sensitive to cold
41 ☐ Subject to colds, asthma, bronchitis

GROUP 3

42 ☐ Eat when nervous
43 ☐ Excessive appetite
44 ☐ Hungry between meals
45 ☐ Irritable before meals
46 ☐ Get "shaky" if hungry
47 ☐ Fatigue, eating relieves
48 ☐ "Lightheaded" if meals delayed
49 ☐ Heart palpitates if meals missed or delayed
50 ☐ Afternoon headaches
51 ☐ Overeating sweets upsets
52 ☐ Awaken after few hours sleep--hard to get back to sleep
53 ☐ Crave candy or coffee in afternoons
54 ☐ Moods of depression–"blues" or melancholy
55 ☐ Abnormal craving for sweets or snacks

GROUP 4

56 ☐ Hands and feet go to sleep easily, numbness
57 ☐ Sigh frequently, "air hungry"
58 ☐ Aware of "breathing heavily"
59 ☐ High altitude discomfort
60 ☐ Open windows in closed room
61 ☐ Susceptible to colds & fevers
62 ☐ Afternoon “yawner”
63 ☐ Get drowsy often
64 ☐ Swollen ankles, worse at night
65 ☐ Muscle cramps, worse during exercise; get "charley horses"
66 ☐ Shortness of breath on exertion
67 ☐ Dull pain in chest or radiating into left arm, worse on exertion
68 ☐ Bruise easily, "black/blue" spots
69 ☐ Tendency to anemia
70 ☐ Nose bleeds frequent
71 ☐ Noises in head or "ringing in ears"
72 ☐ Tension under breastbone, or feeling of tightness, worse on exertion

GROUP 5

73 ☐ Dizziness
74 ☐ Dry skin
75 ☐ Burning feet
76 ☐ Blurred vision
77 ☐ Itching skin and feet
78 ☐ Excessive falling hair
79 ☐ Frequent skin rashes
80 ☐ Bitter, metallic taste in mouth in mornings
81 ☐ Bowel movements painful or difficult
82 ☐ Worrier, feels insecure
83 ☐ Feeling queasy; headache over eyes
84 ☐ Greasy foods upset
85 ☐ Stools light-colored
86 ☐ Skin peels on foot soles
87 ☐ Pain between shoulder blades
88 ☐ Use laxatives
89 ☐ Stools alternate from soft to watery
90 ☐ History of gallbladder attacks or gallstones
91 ☐ Sneezing attacks
92 ☐ Dreaming, nightmare type bad dreams
93 ☐ Bad breath (halitosis)
94 ☐ Milk products cause distress
95 ☐ Sensitive to hot weather
96 ☐ Burning or itching anus
97 ☐ Crave sweets

GROUP 6

98 ☐ Loss of taste for meat
99 ☐ Lower bowel gas several hours after eating
100 ☐ Burning stomach sensations, eating relieves
101 ☐ Coated tongue
102 ☐ Pass large amounts of foul smelling gas
103 ☐ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104 ☐ Mucus colitis or "irritable bowel"
105 ☐ Gas shortly after eating
106 ☐ Stomach "bloating" after eating

GROUP 7

(A)

107 ☐ Insomnia
108 ☐ Nervousness
109 ☐ Can't gain weight
110 ☐ Intolerance to heat
111 ☐ Highly emotional
112 ☐ Flush easily
113 ☐ Night sweats
114 ☐ Thin, moist skin
115 ☐ Inward trembling
116 ☐ Heart palpitates
117 ☐ Increased appetite without weight gain
118 ☐ Pulse fast at rest
119 ☐ Eyelids and face twitch
120 ☐ Irritable and restless
121 ☐ Can't work under pressure

(B)

122 ☐ Increase in weight
123 ☐ Decrease in appetite
124 ☐ Fatigue easily
125 ☐ Ringing in ears
126 ☐ Sleepy during day
127 ☐ Sensitive to cold
128 ☐ Dry or scaly skin
129 ☐ Constipation
130 ☐ Mental sluggishness
131 ☐ Hair coarse, falls out
132 ☐ Headache upon arising, wears off during day
133 ☐ Slow pulse, below 65
134 ☐ Frequency of urination
135 ☐ Impaired hearing
136 ☐ Reduced initiative

GROUP 7 (continued)

(C)

137 ☐ Failing memory
138 ☐ Low blood pressure
139 ☐ Increased sex drive
140 ☐ Headaches, "splitting or rending" type
141 ☐ Decreased sugar tolerance

(D)

142 ☐ Abnormal thirst
143 ☐ Bloating of abdomen
144 ☐ Weight gain around hips or waist
145 ☐ Sex drive reduced or lacking
146 ☐ Tendency to ulcers, colitis
147 ☐ Increased sugar tolerance
148 ☐ Women: menstrual disorders
149 ☐ Young girls: lack of menstrual function

(E)

150 ☐ Dizziness
151 ☐ Headaches
152 ☐ Hot flashes
153 ☐ Increased blood pressure
154 ☐ Hair growth on face or body (female)
155 ☐ Sugar in urine (not diabetes)
156 ☐ Masculine tendencies (female)

(F)

157 ☐ Weakness, dizziness
158 ☐ Chronic fatigue
159 ☐ Low blood pressure
160 ☐ Nails weak, ridged
161 ☐ Tendency to hives
162 ☐ Arthritic tendencies
163 ☐ Perspiration increases
164 ☐ Bowel disorders
165 ☐ Poor circulation
166 ☐ Swollen ankles
167 ☐ Crave salt
168 ☐ Brown spots or bronzing of skin
169 ☐ Allergies – tendency to asthma
170 ☐ Weakness after colds, influenza
171 ☐ Exhaustion – muscular and nervous
172 ☐ Respiratory disorders

FEMALE ONLY

173 ☐ Very easily fatigued
174 ☐ Premenstrual tension
175 ☐ Painful menses
176 ☐ Depressed feelings before menstruation
177 ☐ Menstruation excessive and prolonged
178 ☐ Painful breasts
179 ☐ Menstruate too frequently
180 ☐ Vaginal discharge
181 ☐ Hysterectomy/ovaries removed
182 ☐ Menopausal hot flashes
183 ☐ Menses scanty or missed
184 ☐ Acne, worse at menses
185 ☐ Depression of long standing

MALE ONLY

186 ☐ Prostate trouble
187 ☐ Urination difficult or dribbling
188 ☐ Night urination frequent
189 ☐ Depression
190 ☐ Pain on inside of legs or heels
191 ☐ Feeling of incomplete bowel evacuation
192 ☐ Lack of energy
193 ☐ Migrating aches and pains
194 ☐ Tire too easily
195 ☐ Avoids activity
196 ☐ Leg nervousness at night
197 ☐ Diminished sex drive

IMPORTANT

Please list below the five main health complaints you have in order of their importance, most important first:

1._____

2._____

3._____

4._____

5._____

Metabolic Assessment Form

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

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

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

Please circle the appropriate number "0 - 3" 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 relief 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 of "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

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 foods found in stools	0	1	2	3

Category III

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 from antacids, food, milk, 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 IV

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 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
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 V

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 VI

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded 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 VII

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

Category VIII

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

SMGEMAF04(1009)-INHOUSE.INDD

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

Category IX

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts 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 X

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 gain 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 falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI

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 XII

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 XIII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" type headaches	0	1	2	3

Category XIV (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 evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males only)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in 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
Decrease in 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 XVI (Menstruating Females Only)

Are you perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle, greater than 32 days	Yes	No
Shortened menses, less than every 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 breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Females Only)

How many years have you been menopausal? _____

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

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 a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____ How many times a week do you workout? _____

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

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

Do you smoke?_____ If yes, how many times a day: _____

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

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

_____

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

_____

Child Neurotransmitter & Nutrition Questionnaire (CNNQ)

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: GENERAL

- Does your child have any food sensitivities or allergies? (please list)

  _____

  _____
- List your child's 4 healthiest foods eaten regularly.

  _____, _____,

  _____, _____
- List your child's 4 unhealthiest foods eaten regularly.

  asdasdsadsa _____, _____,

  _____, _____
- How many times a week does your child eat candy? _____
- How many times a week does your child drink soda pop? _____
- Please list the top 4 foods your child craves regularly?

  _____, _____,

  _____, _____
- List the medication(s) your child is currently prescribed and over the counter.

  _____

  _____
- Do you find it difficult as a parent to have your child on a special diet?

  _____

SECTION: A (K52)

- Does your child eat pasta, breads, and breaded foods? **0 1 2 3**
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating wheat foods? **0 1 2 3**
- Does your child eat dairy products? **0 1 2 3**
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating dairy products? **0 1 2 3**

SECTION: B (K53)

- Does your child eat fried fish? **0 1 2 3**
- Does your child eat roasted nuts or seeds? **0 1 2 3**
- Is your child **missing** essential fatty acid rich foods in his/her diet? (for example: avocadoes, flax seeds, olives) *(mark "0" if present, "3" if missing)* **0 1 2 3**
- Does your child eat *fried* foods? **0 1 2 3**

SECTION: C (K34)

- Is your child's mental speed slow? **0 1 2 3**
- Does your child have difficulty with learning or memory? **0 1 2 3**
- Does your child have difficulty with balance and coordination? **0 1 2 3**

SECTION: D (K16)

- Does your child have stress? **0 1 2 3**
- Does your child **not** have enough sleep and rest? *(mark "3" if not enough)* **0 1 2 3**
- Does your child **not** have regular exercise? *(mark "3" if no exercise)* **0 1 2 3**
- Does your child feel overly worried and scared? **0 1 2 3**

SECTION: E (K16, K51)

- Does your child have temper tantrums? **0 1 2 3**
- Does your child exhibit wild behavior? **0 1 2 3**
- Does your child frequently yell or scream for unnecessary reasons? **0 1 2 3**
- Does your child have an **inability** to nap or sleep when physically exhausted? *(mark "3" if unable)* **0 1 2 3**
- Is your child overly talkative? **0 1 2 3**
- Does your child fidget and squirm when seated? **0 1 2 3**
- Does your child run and climb excessively when it is inappropriate? **0 1 2 3**
- Does your child have difficulty playing quietly or engaging in leisure activities? **0 1 2 3**

SECTION: F (K51)

- Does your child get excited easily? **0 1 2 3**
- Does your child have anxiousness and panic for minor reasons? **0 1 2 3**
- Does your child feel overwhelmed for minor reasons? **0 1 2 3**
- Does your child find it difficult to relax when she/he is awake? **0 1 2 3**
- Does your child have disorganized attention? **0 1 2 3**

SECTION: G (K50)

- Does your child seem depressed? **0 1 2 3**
- Does your child have mood changes with overcast weather? **0 1 2 3**
- Does your child have symptoms of inner rage? **0 1 2 3**
- Does your child seem uninterested in games or hobbies? **0 1 2 3**
- Does your child have difficulty falling into deep restful sleep? **0 1 2 3**
- Does your child seem uninterested in friendships? **0 1 2 3**
- Does your child have symptoms of unprovoked anger? **0 1 2 3**
- Does your child seem uninterested in eating? **0 1 2 3**

SECTION: H (K49)

- Does your child have difficulty handling stress? **0 1 2 3**
- Does your child have anger and aggression while being challenged? **0 1 2 3**
- Does your child feel tired even after long sleeps? **0 1 2 3**
- Does your child tend to isolate from others? **0 1 2 3**
- Does your child get distracted easily? **0 1 2 3**
- Does your child have constant need and desire for candy and sugar? **0 1 2 3**
- Does your child have disorganized attention? **0 1 2 3**

SECTION: I (K48)

- Does your child have difficulty with visual memory? **0 1 2 3**
- Does your child have difficulty remembering locations? **0 1 2 3**
- Does your child have fatigue or low endurance for learning activities? **0 1 2 3**
- Does your child have difficulty with attention or low attention span or endurance? **0 1 2 3**
- Does your child have slow or difficult speech? **0 1 2 3**
- Does your child have uncoordinated or slow movement? **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

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