

# Food and Chemical Sensitivity Survey



Date: \_\_/\_\_/\_\_

Patient Name \_\_\_\_\_

Gender: M/F

Height: Feet \_\_\_\_ Inches \_\_\_\_

Weight: \_\_\_\_ lbs.

Please list all medications you are currently taking: \_\_\_\_\_

**Please complete the following food and chemical sensitivity questionnaire. Score each symptom based upon your experiences over the last 60 days. This survey should be taken again after the completion of the Alcat Test, prior to reintroduction of "reactive" foods. Typically 3-6 months after initial testing. This comparison will help to assess the success of the eating modification program.**

### Symptom Scoring System:

- = No Symptoms (Zero Points)
- = Experience Mild Symptoms (One Point)
- = Experience Moderate Symptoms (Two Points)
- = Severe Symptoms (Three Points)

### Digestive Symptoms

- Stomach Pains or Cramping
- Constipation
- Diarrhea
- Reflux or Heartburn
- Bloating
- Gas
- Nausea or Vomiting

### Weight

- Inability to Lose Weight
- Food Cravings
- Binge Eating
- Water Retention

### Sinus/Respiratory

- Stuffy or Runny Nose
- Asthma
- Chest Congestion
- Chronic Cough
- Wheezing
- Frequent Sneezing

### Head/Ears

- Migraines
- Headaches
- Earaches
- Ear Infection
- Ringing in Ears

### Eyes/Throat

- Itchy Eyes
- Watery Eyes
- Sore Throat
- Persistent Canker Sores

### Emotional/Mental

- Depression
- Anxiety
- Mood Swings
- Irritability
- Poor Concentration

### Energy

- Fatigue
- Hyperactivity
- Lethargy
- Restlessness
- Insomnia

### Skin Disorders

- Eczema
- Dermatitis
- Excessive Sweating
- Rashes
- Hives

### Other Symptoms:

- Joint Pain
- Arthritis
- Irregular Heartbeat
- Chest Pains
- Muscle Aches

Please list any symptoms not mentioned above:

\_\_\_\_\_

\_\_\_\_\_

**Total Score: \_\_\_\_\_**

# 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.

\_\_\_\_\_, \_\_\_\_\_,

\_\_\_\_\_, \_\_\_\_\_

- 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: avocados, 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

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# Health Questionnaire (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

- 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
- How often 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
- How often do you find yourself down or sad? 0 1 2 3
- How often do you fatigue when driving compared to the past? 0 1 2 3
- How often do you fatigue when reading compared to 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 that 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 have the time to get regular exercise? 0 1 2 3
- How often do you **not** feel cared about by the people in your life? 0 1 2 3
- How often do you **not** feel you are accomplishing your life purpose? 0 1 2 3
- How often do you share your problems with someone? 0 1 2 3

## SECTION C

### SECTION C1

- How often do you get irritable, shaky, or have lightheadedness 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

- 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
- 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 been increased? 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 - S

- Are you losing your pleasure in hobbies and interests? 0 1 2 3
- How often do you feel overwhelmed with ideas to manage? 0 1 2 3
- How often do you have feelings of inner rage (anger)? 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 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 - D

- 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 - G

- How often do you feel anxious or panic 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 - ACH

- 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 has changed? 0 1 2 3
- Are you experiencing excessive urination? 0 1 2 3
- Are you experiencing slower mental response? 0 1 2 3

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# Medication History

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

## Acetylcholine Receptor Antagonist – Antimuscarinic Agents

Atropine, Ipratropium, Scopolamine, Tiotropium

## Acetylcholine Receptor Antagonist - Ganglionic Blockers

Mecamylamine, Hexamethonium, Nicotine (high doses), Trimethaphan

## Acetylcholinesterase Reactivators

Pralidoxime

## Acetylcholine Receptor Antagonist - Neuromuscular Blockers

Atracurium, Cisatracurium, Doxacurium, Metocurine, Mivacurium, Pancuronium, Rocuronium, Uccinylcholine, Tubocurarine, Vecuronium, Hemicholine

## Agonist Modulator of GABA Receptor (benzodiazepines)

Xanax, Lexotanil, Lexotan, Librium, Klonopin, Valium, ProSom, Rohypnol, Dalmane, Ativan, Loramet, Sedoxil, Dormicum, Megadon, Serax, Restoril, Halcion

## Agonist Modulator of GABA Receptors (nonbenzodiazepines)

Ambien, Sonata, Lunesta, Imovane

## Cholinesterase Inhibitors (irreversible)

Echotiophate, Isoflurophate, Organophosphate Insecticides, Organophosphate-containing nerve agents

## Cholinesterase Inhibitors (reversible)

Donepezil, Galatamine, Rivastigmine, Tacrine, THC, Erophonium, Neostigmine, Phystigimine, Pyridostigmine, Carbamate Insecticides

## Dopamine Reuptake Inhibitors

Wellbutrin (Bupropion)

## Dopamine Receptor Agonists

Mirapex, Sifrol, Requip

## D2 Dopamine Receptor Blockers (antipsychotics)

Thorazine, Prolixin, Trilafon, Compazine, Mellaril, Stelazine, Vesprin, Nozinan, Depixol, Navane, Iuanxol, Clopixol, Acuphase, Haldol, Orap, Clozaril, Zyprexa, Zydis, Seroquel, Geodon, Solian, Invega, Abilify

## GABA Antagonist Competitive binder

Flumazenil

## Monoamine Oxidase Inhibitor (MAOI)

Marplan, Aurorix, Maneric, Moclodura, Nardil, Adlegiine, Elepryl, Azilect, Marsilid, Iprozid, Ipronid, Rivivol, Popilniazida, Zyvox, Zyvoxid

## Noradrenergic and Specific Serotonergic Antidepressants (NaSSa)

Remeron, Zispin, Avanza, Norset, Remergil, Axit

## Selective Serotonin Reuptake Inhibitor

Paxil, Zoloft, Prozac, Celexa, Lexapro, Luvox, Cipramil, Emocal, Serpam, Seropram, Ciprallex, 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

## Tricyclic Antidepressants (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

# Metabolic Assessment Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

## PART I

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

## PART II

Please circle the appropriate number "0 - 3" on all questions below.

0 as the least/never to 3 as the most/always.

<p><b>Category I</b></p> <p>Feeling that bowels do not empty completely      0 1 2 3</p> <p>Lower abdominal pain relief by passing stool or gas      0 1 2 3</p> <p>Alternating constipation and diarrhea      0 1 2 3</p> <p>Diarrhea      0 1 2 3</p> <p>Constipation      0 1 2 3</p> <p>Hard, dry, or small stool      0 1 2 3</p> <p>Coated tongue of "fuzzy" debris on tongue      0 1 2 3</p> <p>Pass large amount of foul smelling gas      0 1 2 3</p> <p>More than 3 bowel movements daily      0 1 2 3</p> <p>Use laxatives frequently      0 1 2 3</p> <p><b>Category II</b></p> <p>Excessive belching, burping, or bloating      0 1 2 3</p> <p>Gas immediately following a meal      0 1 2 3</p> <p>Offensive breath      0 1 2 3</p> <p>Difficult bowel movements      0 1 2 3</p> <p>Sense of fullness during and after meals      0 1 2 3</p> <p>Difficulty digesting fruits and vegetables; undigested foods found in stools      0 1 2 3</p> <p><b>Category III</b></p> <p>Stomach pain, burning, or aching 1- 4 hours after eating      0 1 2 3</p> <p>Do you frequently use antacids?      0 1 2 3</p> <p>Feeling hungry an hour or two after eating      0 1 2 3</p> <p>Heartburn when lying down or bending forward      0 1 2 3</p> <p>Temporary relief from antacids, food, milk, carbonated beverages      0 1 2 3</p> <p>Digestive problems subside with rest and relaxation      0 1 2 3</p> <p>Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine      0 1 2 3</p> <p><b>Category IV</b></p> <p>Roughage and fiber cause constipation      0 1 2 3</p> <p>Indigestion and fullness lasts 2-4 hours after eating      0 1 2 3</p> <p>Pain, tenderness, soreness on left side under rib cage      0 1 2 3</p> <p>Excessive passage of gas      0 1 2 3</p> <p>Nausea and/or vomiting      0 1 2 3</p> <p>Stool undigested, foul smelling, mucous-like, greasy, or poorly formed      0 1 2 3</p> <p>Frequent urination      0 1 2 3</p> <p>Increased thirst and appetite      0 1 2 3</p> <p>Difficulty losing weight      0 1 2 3</p>	<p><b>Category V</b></p> <p>Greasy or high fat foods cause distress      0 1 2 3</p> <p>Lower bowel gas and or bloating several hours after eating      0 1 2 3</p> <p>Bitter metallic taste in mouth, especially in the morning      0 1 2 3</p> <p>Unexplained itchy skin      0 1 2 3</p> <p>Yellowish cast to eyes      0 1 2 3</p> <p>Stool color alternates from clay colored to normal brown      0 1 2 3</p> <p>Reddened skin, especially palms      0 1 2 3</p> <p>Dry or flaky skin and/or hair      0 1 2 3</p> <p>History of gallbladder attacks or stones      0 1 2 3</p> <p>Have you had your gallbladder removed      Yes No</p> <p><b>Category VI</b></p> <p>Crave sweets during the day      0 1 2 3</p> <p>Irritable if meals are missed      0 1 2 3</p> <p>Depend on coffee to keep yourself going or started Get lightheaded if meals are missed      0 1 2 3</p> <p>Eating relieves fatigue      0 1 2 3</p> <p>Feel shaky, jittery, tremors      0 1 2 3</p> <p>Agitated, easily upset, nervous      0 1 2 3</p> <p>Poor memory, forgetful      0 1 2 3</p> <p>Blurred vision      0 1 2 3</p> <p><b>Category VII</b></p> <p>Fatigue after meals      0 1 2 3</p> <p>Crave sweets during the day      0 1 2 3</p> <p>Eating sweets does not relieve cravings for sugar      0 1 2 3</p> <p>Must have sweets after meals      0 1 2 3</p> <p>Waist girth is equal or larger than hip girth      0 1 2 3</p> <p>Frequent urination      0 1 2 3</p> <p>Increased thirst &amp; appetite      0 1 2 3</p> <p>Difficulty losing weight      0 1 2 3</p> <p><b>Category VIII</b></p> <p>Cannot stay asleep      0 1 2 3</p> <p>Crave salt      0 1 2 3</p> <p>Slow starter in the morning      0 1 2 3</p> <p>Afternoon fatigue      0 1 2 3</p> <p>Dizziness when standing up quickly      0 1 2 3</p> <p>Afternoon headaches      0 1 2 3</p> <p>Headaches with exertion or stress      0 1 2 3</p> <p>Weak nails      0 1 2 3</p>
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<b>Category IX</b>			
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
<b>Category X</b>			
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
<b>Category XI</b>			
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
<b>Category XII</b>			
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
<b>Category XIII</b>			
Increased sex drive	0	1	2 3
Tolerance to sugars reduced	0	1	2 3
“Splitting” type headaches	0	1	2 3

<b>Category XIV (Males only)</b>			
Urination difficulty or dribbling	0	1	2 3
Urination frequent	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
<b>Category XV (Males only)</b>			
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 maintain 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
<b>Category XVI (Menstruating Females Only)</b>			
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 break outs	0	1	2 3
Facial hair growth	0	1	2 3
Hair loss/thinning	0	1	2 3
<b>Category XVII (Menopausal Females Only)</b>			
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

**PART III**

How many alcohol beverages do you consume per week? \_\_\_\_\_

How many times do you eat out per week? \_\_\_\_\_

How many times a week do you eat fish? \_\_\_\_\_

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:**

\_\_\_\_\_