Steps for Appointment!!

Congratulations! You’ve taken another great step towards transforming your life by making an appointment for a consultation with Dr. Walia!

Please follow the steps below to ensure we are able to spend the MOST time with you during your first consultation.

• Arrive on time
• Bring your spouse or significant other
• Bring any labs you may have done within the last 12 months

***If you need to reschedule, please call Gain Wellness Center at 858-524-3821.

We look forward to meeting you again!

Gain Knowledge to Gain Wellness!

Thank You!
Patient Introduction

Your Name: ____________________________________________________________
First          Middle          Last

Your Address: ____________________________________________________________
Street          City/State          Zip

Telephone: ___________________________ Bus: ___________________________

Email Address: __________________________________________________________________

Birth Date: Month: ___________ Day: ___________ Year: ___________

Marital Status: _______________________

Occupation: _______________________

Employer: ____________________________________________________________

Present MD: ___________________________ City: ___________

Thank You!

Gain Wellness Center
15644 Pomerado Rd. Ste 400
Poway, CA 92064
858-524-3821
Initial Consultation

Name: ___________________________ Date: ______________________

Main Complaints:
1) ____________________________________________ 2) ________________________________
3) ____________________________________________ 4) ________________________________

How long have you suffered with this problem? ________________________________

Any other complaints: _________________________________________________________

Would you like improvement with any of the following:

☐ Digestion: Reflux, Gas, Constipation
☐ Sleep: Falling asleep or staying asleep
☐ Sense of Well Being
☐ Energy

What have you tried doing to resolve this problem that Did Not work?
__________________________________________________________________________

Have you become discouraged or stressed about handling this problem?
__________________________________________________________________________

When your problem is at its worst, how does it make you feel?
__________________________________________________________________________

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

Work: __________________________________________________
Family: ________________________________________________
Hobbies: ______________________________________________
Life: _________________________________________________

When it’s at its worst, how much older does this make you feel? __________________
Do you know how this problem may have started? ______________________________
____________________________________
_________________________________

What effect does this have on your body functions? ______________________________
_______________________________________________________________________

Are you here visiting us to:
   □ Resolve my immediate problem
   □ Life style program for optimized living
   □ Both
   □ Other: ____________________________________________________________

How have you taken care of your health in the past?
   □ Medications
   □ Routine medical
   □ Exercise
   □ Diet and Nutrition
   □ Holistic
   □ Vitamins
   □ Chiropractic
   □ Other: __________________________

How did the previous methods work for you? ______________________________
_____________________________________________________________________
_____________________________________________________________________

What are you afraid this might be or will be affecting without change? Please circle
   □ Job
   □ Kids
   □ Marriage
   □ Sleep
   □ Freedom
   □ Future abilities
   □ Finances
   □ Time

Are there any health conditions you are afraid this might turn into?
   □ Diminished Future abilities
   □ Stress
   □ Weight gain
   □ Heart disease
   □ Depression
   □ Surgery
   □ Arthritis
   □ Cancer
   □ Diabetes
   □ 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 this problem? Please circle:

- Diminished stress
- More energy
- Self esteem
- Confidence
- Sleep
- Work
- Outlook
- Family

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 on a scale of 1-10:

- How important is it for you to resolve your health concerns?
- Do you feel that you are coachable and would enjoy a mentor in helping you?
- Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

Thank You!
**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.

<table>
<thead>
<tr>
<th>Category I</th>
<th>Feeling that bowel does not empty completely</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Category VI (Cont.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower abdominal pain relieved by passing stool or gas</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>Nausea and/or vomiting</td>
</tr>
<tr>
<td></td>
<td>Alternating constipation and diarrhea</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>Stool undigested, foul smelling, mucous like, greasy, or poorly formed</td>
</tr>
<tr>
<td></td>
<td>Diarrhea</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>Frequent urination</td>
</tr>
<tr>
<td></td>
<td>Constipation</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>Increased thirst and appetite</td>
</tr>
<tr>
<td></td>
<td>Hard, dry, or small stool</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coated tongue or “fuzzy” debris on tongue</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pass large amount of foul-smelling gas</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More than 3 bowel movements daily</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Use laxatives frequently</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

| 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 | |

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

• How often do you feel overwhelmed? 0 1 2 3
• How often do you have difficulty falling asleep? 0 1 2 3
• How often do you gain weight when under stress? 0 1 2 3
• Have your thirst and appetite increased? 0 1 2 3
• How much larger is your waist girth compared to in the past? 0 1 2 3
• How often do you have difficulty losing weight? 0 1 2 3
• How often do you get fatigued after meals? 0 1 2 3
• How often do you feel agitated, easily upset, and nervous between meals? 0 1 2 3
• How often do you need coffee to keep yourself going? 0 1 2 3
• How often does your energy level drop in the afternoon? 0 1 2 3
• How often do you find yourself between meals? 0 1 2 3
• How often do you feel energized after eating? 0 1 2 3
• How often do you get light-headedness between meals? 0 1 2 3
• How often do you need caffeine in the morning? 0 1 2 3
• How often 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 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 guilt about everyday decisions? 0 1 2 3
• How often do you have feelings of guilt about family and friends? 0 1 2 3
• How often do you have feelings of guilt about long hours of sleep? 0 1 2 3
• How often do you have feelings of guilt about stress? 0 1 2 3
• How often do you have feelings of guilt about sleep? 0 1 2 3
• How often do you have self-destructive thoughts? 0 1 2 3
• How often do you have thoughts of suicide? 0 1 2 3
• How often do you have an inability to handle stress? 0 1 2 3
• How often do you have self-destructive thoughts? 0 1 2 3
• How often do you have feelings of guilt about long hours of sleep? 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 remembering objects & faces? 0 1 2 3
• Do you feel your memory has decreased? 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.
Family Health History

Patient Name: ___________________ Date:__________

Please review the conditions listed below and indicate those that are current health problems of a family member by the designation C under his or her column. The designation P should be used to indicate a past problem. Leave blank those spaces that do not apply.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Father</th>
<th>Mother</th>
<th>Spouse</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age</td>
<td>Age</td>
<td>Age</td>
<td>Age</td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>ADHD</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Back trouble</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Bed wetting</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
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<tr>
<td>Colic</td>
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<td></td>
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<tr>
<td>Constipation</td>
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<td>Diabetes</td>
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<td>Disc problems</td>
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<tr>
<td>Ear infections</td>
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<tr>
<td>Emotional issues</td>
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<tr>
<td>Emphysema</td>
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<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Heart trouble</td>
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<tr>
<td>Heart burn</td>
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<tr>
<td>High blood pressure</td>
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<tr>
<td>IBS</td>
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<tr>
<td>Indigestion</td>
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<td></td>
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<tr>
<td>Infertility</td>
<td></td>
<td></td>
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<tr>
<td>Insomina</td>
<td></td>
<td></td>
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<tr>
<td>Kidney trouble</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Neck pain</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Nervousness</td>
<td></td>
<td></td>
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<tr>
<td>Obesity</td>
<td></td>
<td></td>
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<tr>
<td>Pinched nerve</td>
<td></td>
<td></td>
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<tr>
<td>Scoliosis</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional Comments: ____________________________________________________________

_________________________________________________________

_________________________________________________________
## Medication History*

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

### Noradrenergic and Specific Serotonin Antidepressants (NaSSAs)
- ☐ Remeron®
- ☐ Zispin®
- ☐ Avanza®
- ☐ Dalcipran
- ☐ Meridia
- ☐ Pristiq
- ☐ Priligy
- ☐ Fontex
- ☐ Luvox
- ☐ Lexapro
- ☐ Prozac
- ☐ Zoloft
- ☐ Paxil
- ☐ Pertofrane
- ☐ Demolox
- ☐ Asendis
- ☐ Asendin
- ☐ Avanza
- ☐ Zispin
- ☐ Remeron
- ☐ Dalcipran
- ☐ Meridia
- ☐ Pristiq
- ☐ Priligy
- ☐ Fontex
- ☐ Luvox
- ☐ Lexapro
- ☐ Prozac
- ☐ Zoloft
- ☐ Paxil
- ☐ Pertofrane
- ☐ Demolox
- ☐ Asendis
- ☐ Asendin
- ☐ Avanza
- ☐ Zispin
- ☐ Remeron

### Tricylic Antidepressants (TCAs)
- ☐ Elavil®
- ☐ Endep®
- ☐ Tryptanol
- ☐ Trepline®
- ☐ Asendin®
- ☐ Asendis®
- ☐ Defan®
- ☐ Demolox®
- ☐ Moxidil®
- ☐ Anafranil®
- ☐ Norpramin®
- ☐ Pertofrane®
- ☐ Thaden™
- ☐ Prothiaden®
- ☐ Adapin®
- ☐ Sinequan®
- ☐ Tofranil®
- ☐ Janamine®
- ☐ Gamani®
- ☐ Aventyl®
- ☐ Pamelor®
- ☐ Opipramol®
- ☐ Vivactil®
- ☐ Surmontil®

### Selective Serotonin Reuptake Inhibitors (SSRIs)
- ☐ Paxil®
- ☐ Zoloft®
- ☐ Prozac®
- ☐ Celexa®
- ☐ Lexapro®
- ☐ Esertia®
- ☐ Luvox®
- ☐ Cipramil®
- ☐ Emocla®
- ☐ Seropram®
- ☐ Cipralex®
- ☐ Fontex®
- ☐ Priligy®
- ☐ Seromex®
- ☐ Saronil®
- ☐ Faverin®
- ☐ Seroxat®
- ☐ Aropax®
- ☐ Deroxat®
- ☐ Rextet®
- ☐ Paroxat®
- ☐ Lustri®
- ☐ Serlaim®

### Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
- ☐ Effexor®
- ☐ Pristiq®
- ☐ Meridia®
- ☐ Serzone®
- ☐ Dalcipran®
- ☐ Norpramin®
- ☐ Cymbalta®

### Selective Serotonin Reuptake Enhancers (SSREs)
- ☐ Stablon®
- ☐ Coaxil®
- ☐ Tatilon®

### Monoamine Oxidase Inhibitors (MAOIs)
- ☐ Marplan®
- ☐ Aurorix®
- ☐ Manerix®
- ☐ Moclodura®
- ☐ Nardil®
- ☐ Adeline®
- ☐ Eldepryl®
- ☐ Azilect®
- ☐ Marsilid®
- ☐ Iprozid®
- ☐ Ipronid®
- ☐ Propliniaze®
- ☐ Zyvox®
- ☐ Zyvoxid®

### Agonist Modulators of GABA Receptors (non-benzodiazepines)
- ☐ Ambien CR®
- ☐ Sonata®
- ☐ Lanesta®
- ☐ Imovane®
- ☐ Urecholine®
- ☐ Salagen®
- ☐ Evoxac®
- ☐ Isoto®
- ☐ Anectine®
- ☐ Nicotine

### Acetylcholine Receptor Agonists
- ☐ Urecholine®
- ☐ Scopace®
- ☐ Spiriva®

### Acetylcholine Receptor Antagonists
- ☐ AtroPen®
- ☐ Atravent®
- ☐ Inversine®
- ☐ Hexamethonium
- ☐ Nicotine (high doses)
- ☐ Arfonad®

### Acetylcholine Receptor Antagonists
- ☐ Atracurium
- ☐ Rocuronium
- ☐ Cisatracurium
- ☐ Anectine®
- ☐ Doxacurium
- ☐ Tubocurarine
- ☐ Metocurine
- ☐ Vecuronium
- ☐ Mivacurium
- ☐ Hemicholinium
- ☐ Pancuronium

### Acetylcholinesterase Reactivators
- ☐ Protopam®

### Cholinesterase Inhibitors (reversible)
- ☐ Aricept®
- ☐ Enlon®
- ☐ Razadyne®
- ☐ Prostigmin®
- ☐ Exelon®
- ☐ Antilirium®
- ☐ Cognex®
- ☐ Mestinon®
- ☐ THC
- ☐ Carbamate insecticides

### Cholinesterase Inhibitors (irreversible)
- ☐ Echotriporate
- ☐ Flexy®
- ☐ Organophosphate insecticides
- ☐ Organophosphate-containing nerve agents

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

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NRGENT2AFA1103131
Please list any medications you currently take and for what conditions:

<table>
<thead>
<tr>
<th>Category XI</th>
<th>0 1 2 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannot stay asleep</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Crave salt</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Slow starter in the morning</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Afternoon fatigue</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Dizziness when standing up quickly</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Afternoon headaches</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Headaches with exertion or stress</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Weak nails</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category XII</th>
<th>0 1 2 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannot fall asleep</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Perspire easily</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Under a high amount of stress</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Weight gain when under stress</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Wake up tired even after 6 or more hours of sleep</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Excessive perspiration or perspiration with little or no activity</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category XIII</th>
<th>0 1 2 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edema and swelling in ankles and wrists</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Muscle cramping</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Poor muscle endurance</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Frequent urination</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Frequent thirst</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Crave salt</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Abnormal sweating from minimal activity</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Alteration in bowel regularity</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Inability to hold breath for long periods</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Shallow, rapid breathing</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category XIV</th>
<th>0 1 2 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tired/sluggish</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Feel cold—hands, feet, all over</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Require excessive amounts of sleep to function properly</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Increase in weight even with low-calorie diet</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Gain weight easily</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Difficult, infrequent bowel movements</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Depression/lack of motivation</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Morning headaches that wear off as the day progresses</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Outer third of eyebrow thins</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Thinning of hair on scalp, face, or genitals, or excessive hair loss</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Dryness of skin and/or scalp</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Mental sluggishness</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category XV</th>
<th>0 1 2 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart palpitations</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Inward trembling</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Increased pulse even at rest</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Nervous and emotional</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Insomnia</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category XV (Cont.)</th>
<th>0 1 2 3</th>
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</thead>
<tbody>
<tr>
<td>Night sweats</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Difficulty gaining weight</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category XVI (Males Only)</th>
<th>0 1 2 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urination difficulty or dribbling</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Frequent urination</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Pain inside of legs or heels</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Feeling of incomplete bowel emptying</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Leg twitching at night</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category XVII (Males Only)</th>
<th>0 1 2 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased libido</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Decreased number of spontaneous morning erections</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Decreased fullness of erections</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Difficulty maintaining morning erections</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Spells of mental fatigue</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Inability to concentrate</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Episodes of depression</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Muscle soreness</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Decreased physical stamina</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Unexplained weight gain</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Increase in fat distribution around chest and hips</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Sweating attacks</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>More emotional than in the past</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category XVIII (Menstruating Females Only)</th>
<th>Yes No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perimenopausal</td>
<td>Yes No</td>
</tr>
<tr>
<td>Alternating menstrual cycle lengths</td>
<td>Yes No</td>
</tr>
<tr>
<td>Extended menstrual cycle (greater than 32 days)</td>
<td>Yes No</td>
</tr>
<tr>
<td>Shortened menstrual cycle (less than 24 days)</td>
<td>Yes No</td>
</tr>
<tr>
<td>Pain and cramping during periods</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Scanty blood flow</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Heavy blood flow</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Breast pain and swelling during menses</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Pelvic pain during menses</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Irritable and depressed during menses</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Acne</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Facial hair growth</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Hair loss/thinning</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category XIX (Menopausal Females Only)</th>
<th>Yes No</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many years have you been menopausal?</td>
<td>________ years</td>
</tr>
<tr>
<td>Since menopause, do you ever have uterine bleeding?</td>
<td>Yes No</td>
</tr>
<tr>
<td>Hot flashes</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Mental fogging</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Disinterest in sex</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Mood swings</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Depression</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Painful intercourse</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Shrinking breasts</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Facial hair growth</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Acne</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Increased vaginal pain, dryness, or itching</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>

**PART III**

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

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? ________

How many times do you eat fish per week? ________

How many times do you work out per week? ________

How many times do you eat fish per week? ________

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

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

**PART IV**

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

Please list any natural supplements you currently take and for what conditions:
Clinic directions: 15644 Pomerado Rd. STE 400, Poway, CA 92064

**Route 52 W and I-15N**
CA-52 W
Use the right 2 lanes to take exit 7 to merge onto I-15 N
Take exit 19 for California 56 Jct W/Ted Williams Pkwy
Follow Ted Williams Pkwy and Pomerado Rd to your destination in Poway
Use the right 2 lanes to turn right onto Ted Williams Pkwy
Use the left 2 lanes to turn left onto Pomerado Rd

**Route 67N**
Turn left to merge onto CA-67 N
Turn left onto Poway Rd
Turn right onto Espola Rd
Use the left 2 lanes to turn left onto Twin Peaks Rd
Turn right onto Pomerado Rd

**Escondido/CA-78**
Turn left onto CA-78 W.
Merge onto I-15 S via EXIT 17 toward San Diego.
Take the Bernardo Center Drive exit, EXIT 23.
Turn left onto Bernardo Center Dr.
Turn right onto Bernardo Heights Pkwy.
Turn right onto Pomerado Rd.
15644 POMERADO RD is on the right.