



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!

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?

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Medications | <input type="checkbox"/> Holistic |
| <input type="checkbox"/> Routine medical | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Chiropractic |
| <input type="checkbox"/> Diet and Nutrition | <input type="checkbox"/> Other: _____ |

How did the previous methods work for you? _____

What are you afraid this might be or will be affecting without change? Please circle

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> Job | <input type="checkbox"/> Freedom |
| <input type="checkbox"/> Kids | <input type="checkbox"/> Future abilities |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Time |

Are there any health conditions you are afraid this might turn into?

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Diminished Future abilities | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Depression | <input type="checkbox"/> 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:

- | | |
|--|----------------------------------|
| <input type="checkbox"/> Diminished stress | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> More energy | <input type="checkbox"/> Work |
| <input type="checkbox"/> Self esteem | <input type="checkbox"/> Outlook |
| <input type="checkbox"/> Confidence | <input type="checkbox"/> 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.

<p>Category I</p> <p>Feeling that bowels do not empty completely 0 1 2 3</p> <p>Lower abdominal pain relieved 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 or "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>Category II</p> <p>Increasing frequency of food reactions 0 1 2 3</p> <p>Unpredictable food reactions 0 1 2 3</p> <p>Aches, pains, and swelling throughout the body 0 1 2 3</p> <p>Unpredictable abdominal swelling 0 1 2 3</p> <p>Frequent bloating and distention after eating 0 1 2 3</p> <p>Abdominal intolerance to sugars and starches 0 1 2 3</p> <p>Category III</p> <p>Intolerance to smells 0 1 2 3</p> <p>Intolerance to jewelry 0 1 2 3</p> <p>Intolerance to shampoo, lotion, detergents, etc 0 1 2 3</p> <p>Multiple smell and chemical sensitivities 0 1 2 3</p> <p>Constant skin outbreaks 0 1 2 3</p> <p>Category IV</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 food found in stools 0 1 2 3</p> <p>Category V</p> <p>Stomach pain, burning, or aching 1-4 hours after eating 0 1 2 3</p> <p>Use of antacids 0 1 2 3</p> <p>Feel 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 by using antacids, food, milk, or 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>Category VI</p> <p>Roughage and fiber cause constipation 0 1 2 3</p> <p>Indigestion and fullness last 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>Category VI (Cont.)</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>Category VII</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>Burpy, fishy taste after consuming fish oils 0 1 2 3</p> <p>Difficulty losing weight 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>Category VIII</p> <p>Acne and unhealthy skin 0 1 2 3</p> <p>Excessive hair loss 0 1 2 3</p> <p>Overall sense of bloating 0 1 2 3</p> <p>Bodily swelling for no reason 0 1 2 3</p> <p>Hormone imbalances 0 1 2 3</p> <p>Weight gain 0 1 2 3</p> <p>Poor bowel function 0 1 2 3</p> <p>Excessively foul-smelling sweat 0 1 2 3</p> <p>Category IX</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 going/get started 0 1 2 3</p> <p>Get light-headed if meals are missed 0 1 2 3</p> <p>Eating relieves fatigue 0 1 2 3</p> <p>Feel shaky, jittery, or have 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>Category X</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 and appetite 0 1 2 3</p> <p>Difficulty losing weight 0 1 2 3</p>
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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

Gain Wellness Center

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.

Condition	Father	Mother	Spouse	Children		
	Age	Age	Age	Age	Age	Age
Allergies						
Anxiety						
Asthma						
ADHD						
Back trouble						
Bed wetting						
Cancer						
Colic						
Constipation						
Depression						
Diabetes						
Disc problems						
Ear infections						
Emotional issues						
Emphysema						
Epilepsy						
Headaches						
Heart trouble						
Heart burn						
High blood pressure						
IBS						
Indigestion						
Infertility						
Insomnia						
Kidney trouble						
Neck pain						
Nervousness						
Obesity						
Pinched nerve						
Scoliosis						
Sinus trouble						
Other						

Additional Comments: _____

Medication History*

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

Noradrenergic and Specific Serotonergic Antidepressants (NaSSAs)

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

Tricyclic Antidepressants (TCAs)

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

Selective Serotonin Reuptake Inhibitors (SSRIs)

- Paxil®
- Zolof®
- 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®
- Dalmanc®
- 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®
- Exelon®
- Cognex®
- THC
- Carbamate insecticides
- Enlon®
- Prostigmin®
- Antilirium®
- Mestinon®

Cholinesterase Inhibitors (irreversible)

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

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? _____

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

How many caffeinated beverages do you consume per day? _____

How many times do you eat fish per week? _____

How many times do you eat out per week? _____

How many times do you work out per week? _____

How many times do you eat raw nuts or seeds 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.

Gain Wellness Center
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