The Hayden Institute

For Health, Nutrition, and Rehabilitation

Welcome to The Hayden Institute!

About Us: We specialize in Holistic Complementary and Alternative Medicine, offering non-invasive, drug-free approaches to individualized patient care. Our licensed and certified practitioners are skilled in various techniques, including structural, neurological, meridian, and nutritional approaches to wellness. Our mission is to guide and mentor patients in achieving their health and wellness goals by addressing the underlying causes of symptomatic dysfunction.

Appointment Times: We understand the value of your time and strive to run on schedule. This ensures that you have a clear start and end time for your appointment, allowing you to plan accordingly and receive your full scheduled time with the doctor. Office visits typically utilize the following format: New Patient Exam - 40 minutes, Report of Findings (2nd visit) - 30-40 minutes, Established Patient visits – 15-20 minutes. Patients that have not been seen in the office for over 12 months, or that have experienced a significant change in health status, may be scheduled for additional time in order to perform a Re-Exam **and** an Established Patient visit.

Insurance: During your first visit, our office staff will collect insurance information to determine any potential out-of-pocket expenses based on your coverage. *As insurance coverage is not a guarantee of office payment, a deposit ($75 for new patients, $80 for existing patients) will be collected at each visit to be applied towards any co-insurance payment until insurance reimbursement is determined.* Payment is due at the time of service, and we accept cash, check, and credit cards.

No Insurance/No Coverage: For individuals without insurance or with high deductible plans, we offer discounted medical services through medical discount programs (CHUSA or ECS). These programs, ranging from $15 to $49 per year, cover the head of the household and all dependents. These medical discount programs allow members to be eligible for flat-rate office visits ($75 for the new patient visit, $80 for existing patient visits), providing better estimation of out-of-pocket expenses. Supplements, laboratory testing, and other additional services to the office visit are not included as part of the medical discount program.

Cancelations: We kindly request a 24-hour notice if you need to reschedule/cancel your appointment. While we understand that unforeseen circumstances may arise, please be aware that repeated cancellations without sufficient notice may result in a fee ($80 for existing patients, $240 for new patients) after three instances. This policy allows us to accommodate other patients on our waitlist and maintain efficient scheduling.

Referrals: We greatly appreciate the referrals we receive, with over 90% of our patients coming from recommendations by family, friends, and co-workers. As you experience improvements, we encourage you to share your success and invite your loved ones to join you on your health journey.

By signing below, you acknowledge that you have read and understood the above information and accept the policies of The Hayden Institute.

Signature: _____ Date: _____

10694 Jones Road #210 Houston, TX 77065 281-826-2685
www.HaydenInstitute.com

The Hayden Institute

For Health, Nutrition, and Rehabilitation

We want you to be well-informed about our goals, philosophies, and what to expect from us in terms of your health and wellness. Our approach is centered on the belief that nutrition and a properly functioning nervous system are crucial for optimal health. We aim to restore health naturally, without relying on drugs or surgery whenever possible. Through a combination of structural, nutritional, meridian, and neurological techniques, we strive to balance your body's systems and support its inherent recuperative abilities. It's important to note that we do not claim to treat or cure specific diseases or conditions. With our certifications and licenses in Texas, we offer a specialized and non-duplicating health services to help you achieve your wellness goals.

Results: During your visits, we focus on promoting natural health by stabilizing your structural, neurological, meridian, and nutritional systems. Healing times vary due to individual factors, and responses can range from quick to gradual changes in symptoms. Different conditions may respond differently, making response time unpredictable. Our approach at The Hayden Institute has shown significant benefits for many medical difficulties. Throughout your health program, we will provide you with comprehensive information to make informed decisions about your care.

Diagnostic Tests: We specialize in analyzing the structural, neurological, meridian, and nutritional aspects of the human body to restore optimal function. To identify imbalances, additional testing such as MRI, x-ray, blood work, stool analysis, or urine tests may be necessary. We will assist you in obtaining these tests at the most affordable cost possible. You will receive copies of the results for your personal records. Please note that imaging and laboratory tests are conducted outside of our office.

Informed Consent – Office Services: By signing this page, you grant The Hayden Institute permission to utilize Complementary and Alternative medical techniques, such as chiropractic, meridian therapy, rehabilitation exercises, low level laser therapy, nutritional supplementation, dietary modification, and/or other services as needed, to help you achieve your desired level of wellness. We rely on your medical history, paperwork, diagnostic testing, and physical examination to support your recovery and prevent further injury, taking into account any previously diagnosed injuries, illnesses, or pathological conditions you have disclosed.

Informed Consent – Documentation: This release grants consent for the use of your audio, video, and written information, while adhering to HIPAA guidelines (without disclosing complete names or addresses), in order to complete your medical health record, for research, presentations, promotional material, and other office applications, if deemed suitable and without compensation. Testimonials may be edited if necessary for print and online distribution.

By signing below, I acknowledge and agree to all of the above statements.

Signature: _____ Date: _____

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For Health, Nutrition, and Rehabilitation

New Patient Information

Personal Information

Name:	D.O.B: (MM/DD/YY)
Street Address:	
City, State Zip:	
Email:	Receive Office Newsletter: Y N
Home Phone:	Cell Phone:
Age: Height: Weight:	Occupation:
Marital Status: M W D S	Pregnant: Y N Preferred Name:
Blood Type: A B AB O	Referred By:
Emergency Contact Information:	

Primary Health Concerns:

List Your Health Concerns in Order of Severity	Rate of Severity 1 = Minimal 10 = Severe	When Did It Begin?	Have You Ever Had This Before?	% of the Day that Symptoms are Present?	Better? Same? Worse?

Diagnostic Tests (Please Bring ALL Results with You or Fax to 281.469.8997)

Type of Test (Blood Work, Urine, X-Ray, MRI, CT, Etc)	Date of Test	Positive Findings

Received a Diagnosis for Any Condition by Another Health Care Provider? Y N
If Yes, What was the Diagnosis? _____
Who Provided the Diagnosis? _____

Daily Activities: Describe the Affects These Symptoms Have on Your Daily Life

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The Hayden Institute
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Accidents, Surgeries, Hospitalizations, Injuries, Major Traumatic Events

Area of Body	Date of Injury

Other Health Care Providers

Name:	Specialty:
Contact Info:	
Reason for Care:	
Did it Help:	Are You Still Seeing Them:
What did They Do:	

Name:	Specialty:
Contact Info:	
Reason for Care:	
Did it Help:	Are You Still Seeing Them:
What did They Do:	

Family Health History: (You, Parents, Siblings, Children – Please Circle)

ADD/ADHD
Arthritis
Asthma
Auto-Immune Disorder
Bi-Polar Disorder
Bleeding Disorder
Blood Pressure Problems
Cancer
Childhood Diseases
Chronic Fatigue
Diabetes
Dizziness
Emotional Distress
Fibromyalgia
Genetic Defects
Hearing Problems (not age related)
Heart Disorder
Hepatitis
Hernia
Liver Disorder
Memory Problems
Nausea/Vomiting
Neurologic Disorder
Numbness
Osteoporosis/Bone Density
Pacemaker
Pneumonia
Restless Leg Syndrome
Seizures
Suicidal Thoughts/Actions
Thyroid Problems
Tremors/Shaking
Tumors/Growths
Vision Problems
Other _____
Other _____

Health Goals: What You Wish to Achieve By Being A Patient in our Office

I have read, and agree to, the provided "Policy" and "Informed Consent" pages. I consent to a physical examination, and subsequent nutrition and rehabilitation office sessions. I understand the office procedures regarding payment at time of service.

Signature: _____ **Date:** _____

(Signature of Parent if Patient is a Minor)

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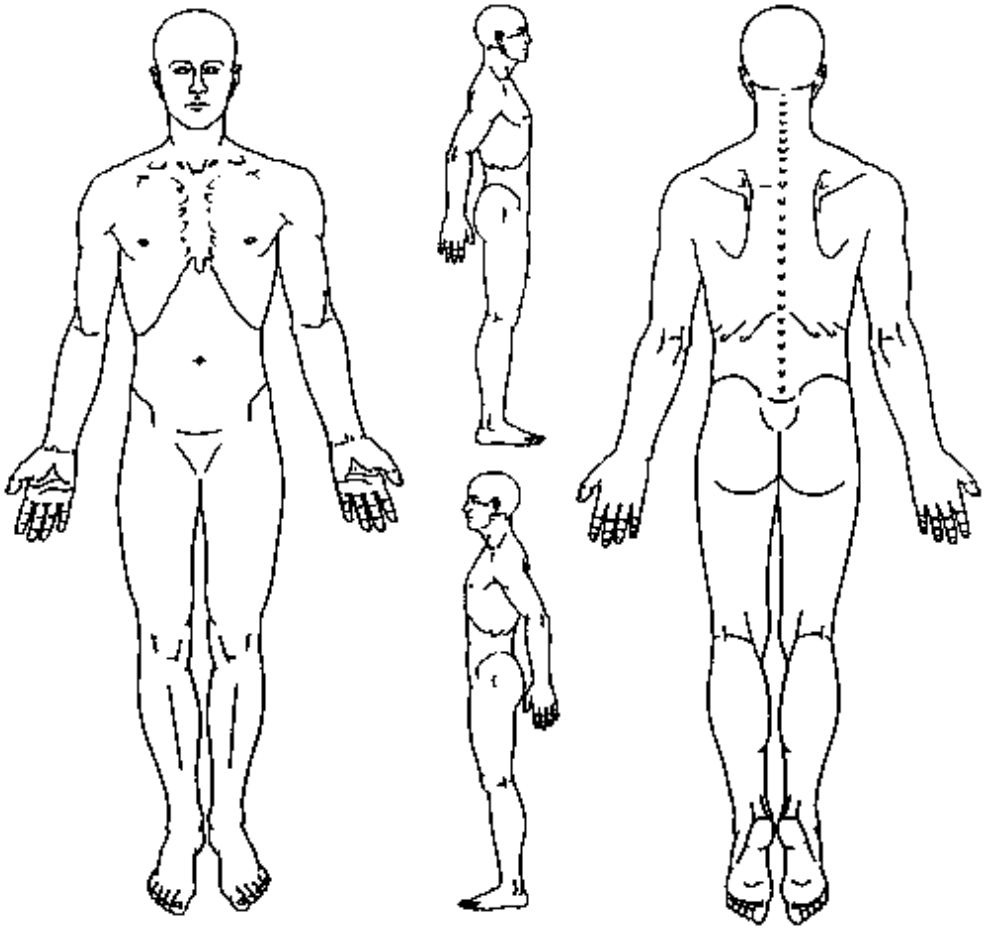
THE HAYDEN INSTITUTE
FOR HEALTH, NUTRITION, AND REHABILITATION

TRAUMA HISTORY

Name: _____ Date: _____



DIRECTIONS

P	**Pain**	Please indicate areas of pain and indicate the severity of it. (0 = no pain, 10 = extreme pain)
↯	**Scars**	Please draw a zig-zag over areas where you have scars, even if they are very old or difficult to see. Don't forget C-sections, episiotomies, vaccination scars, surgeries, body piercings, tattoos, cosmetic surgeries, vasectomies, stretch marks, etc. **Please note the approximate age you were when you got each scar.**
○	**Surgery**	Please circle the location of any surgeries, including exploratory surgeries, laparoscopies, dental extractions, root canals, etc. **Please write the year of the surgery on the drawing.**
□	**Internal Metal**	Please put a square around any internal metal objects, such as surgical pins, metal plates, hip replacements etc.

Medication and Supplement History

Please check every medication that you are taking, or have taken in the last 12 months.

Statin (Cholesterol) Lowering

- ☐ Lipator®
- ☐ Zocor®
- ☐ Crestor®
- ☐ Mevacor®
- ☐ Lescol®
- ☐ _____
- ☐ Pravachol®
- ☐ _____

ACE Inhibitor (Blood Pressure)

- ☐ Lisinopril®
- ☐ Prinivil®
- ☐ Altace®
- ☐ Zestril®
- ☐ Accupril®
- ☐ Vasotec®
- ☐ Capoten®
- ☐ _____

Thiazide Diuretic (B. Pressure)

- ☐ Hydrochlorothiazide®
- ☐ _____

Beta Blockers (Blood Pressure)

- ☐ Atenolol®
- ☐ Toporol®
- ☐ Metoprolol®
- ☐ Corgard®
- ☐ Lopressor®
- ☐ _____
- ☐ Tenormin®
- ☐ _____

Loop Diuretic (Blood Pressure)

- ☐ Furosemide®
- ☐ Bumex®
- ☐ Lasix®
- ☐ Edecrin®
- ☐ Ethacrynic acid®
- ☐ _____

Potassium Sparing Diuretic

- ☐ Amiloride®
- ☐ Dyazide®
- ☐ Spironolactone®
- ☐ Dyrenium®
- ☐ Triamterene®
- ☐ Maxzide®
- ☐ Aldactone
- ☐ _____

Calcium Channel Blocker (HBP)

- ☐ Norvasc®
- ☐ Nimotop®
- ☐ Plendil®
- ☐ Sular®
- ☐ Procardia®
- ☐ Adalat®

Cardiac Glycoside (Heart)

- ☐ Digoxin®
- ☐ Digitek®
- ☐ Lanoxicaps®
- ☐ Lanoxin®

Proton Pump Inhibitor (GERD)

- ☐ Omeprazole®
- ☐ Prevacid®
- ☐ Prilosec®
- ☐ Nexium®
- ☐ Protonix®
- ☐ Aciphex®

Biguanide (Diabetes)

- ☐ Metformin®
- ☐ _____
- ☐ Glucophage®
- ☐ _____

Sulfonylurea (Diabetes)

- ☐ Glyburide®
- ☐ Diabeta®
- ☐ Glipizide®
- ☐ Glucotrol®
- ☐ Glimerpiride®
- ☐ Glynase®
- ☐ Amaryl®
- ☐ Micronase®

Opiate (Narcotic) Pain Relievers

- ☐ Vicodin®
- ☐ Fentora®
- ☐ Lortab®
- ☐ _____
- ☐ Percocet®
- ☐ _____
- ☐ OxyCotin®
- ☐ _____

Bisphosphonate (Osteoperosis)

- ☐ Fosamax®
- ☐ Boniva
- ☐ Actonel®
- ☐ Skelid®
- ☐ Didronel®
- ☐ _____

Beta-2 Adrenergic Receptor Agonist (Asthma/COPD)

- ☐ Albuterol®
- ☐ Tornlate®
- ☐ Aerosol®
- ☐ Ventolin®
- ☐ Brethine®
- ☐ Xopenex®
- ☐ Proventil®
- ☐ Crestor®

Corticosteroid (Asthma/Sinus)

- ☐ Flonase®
- ☐ Beconase®
- ☐ Beclovent®
- ☐ QVar®
- ☐ Vancenase®
- ☐ _____
- ☐ Vancerial®
- ☐ _____

Fluoroquinolone Antibiotic (Bacterial Infection)

- ☐ Levaguin®
- ☐ Noroxin®
- ☐ Avelox®
- ☐ Penetrex®
- ☐ Cipro®
- ☐ Trovan®
- ☐ Floxin®
- ☐ _____

Penicillin Antibiotic (Infection)

- ☐ Amoxicillin®
- ☐ Amoxil®
- ☐ Penicillin®
- ☐ Trimox®

Macrolide Antibiotics

- ☐ Erythromycin®
- ☐ Zithromax®
- ☐ Azithromycin®
- ☐ Biaxin®

Corticosteroids (Inflammation)

- ☐ Prednisone®
- ☐ Deltasone®
- ☐ Cortisone®
- ☐ Celestone®
- ☐ Methylprednisolone®
- ☐ Decadron®
- ☐ Dexamethasone®
- ☐ Medrol®
- ☐ Hydrocortone®
- ☐ _____

Conjugated Estrogens

- ☐ Premarin®
- ☐ HRT
- ☐ Birth control
- ☐ _____

Tricyclic Antidepressants (Depression)

- ☐ Amitriptyline®
- ☐ Asendin®
- ☐ Clomipramine®
- ☐ Anafranil®
- ☐ Doxepin®
- ☐ Vivactil®
- ☐ Tofranil®
- ☐ Elavil®

OTC Pain Relievers

- ☐ Ibuprofen®
- ☐ Tylenol®
- ☐ Asprin®
- ☐ --_____

OTC Antacids

- ☐ Amphojel®
- ☐ Basaljel®
- ☐ Maalox®
- ☐ Gavison®
- ☐ Mylanta®
- ☐ _____

OTC Laxatives with Bisacodyl

- ☐ Carter's Little Pill®
- ☐ Correctol®
- ☐ Feen-a-Mint®
- ☐ Dulcolax®
- ☐ PMS-Bisacodyl®
- ☐ _____

OTC H2 Inhibitors (GERD)

- ☐ Famotidine®
- ☐ Pepcid®
- ☐ Tagamet®
- ☐ Zantac®

Other Medications and/or Supplements

_____

_____

_____

_____

_____

_____

Metabolic Assessment Form

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

PART I

Please list your major health concerns in order of importance (Even if these symptoms are unrelated to today's visit):

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

PART II **Please circle the appropriate number on all questions below.**
0 as the least/never to 3 as the most/always.

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3
Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3
Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movement	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 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

Category VI (continued)				
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 VII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes		No	
Category VIII				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3
Category IX				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category X				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

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

Category XI

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under 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
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI

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 XVII

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

Category XVIII *(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 XIX *(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 XX *(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 XXI *(Menopausal Females Only)*

How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

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

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

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

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

How many times do you eat fish per week? _____

How many times do you work out per week? _____

How many cruciferous (cauliflower, cabbage, etc) foods do you eat? _____

Neurotransmitter Assessment Form (Adult Only)

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

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

SECTION A

- Is your memory noticeably declining? **0 1 2 3**
- Are you having a hard time remembering names and phone numbers? **0 1 2 3**
- Is your ability to focus noticeably declining? **0 1 2 3**
- Has it become harder for you to learn new things? **0 1 2 3**
- How often do you have a hard time remembering your appointments? **0 1 2 3**
- Is your temperament generally getting worse? **0 1 2 3**
- Is your attention span decreasing? **0 1 2 3**
- How often do you find yourself down or sad? **0 1 2 3**
- How often do you become fatigued when driving compared to in the past? **0 1 2 3**
- How often do you become fatigued when reading compared to in the past? **0 1 2 3**
- How often do you walk into rooms and forget why? **0 1 2 3**
- How often do you pick up your cell phone and forget why? **0 1 2 3**

SECTION B

- How high is your stress level? **0 1 2 3**
- How often do you feel you have something that must be done? **0 1 2 3**
- Do you feel you never have time for yourself? **0 1 2 3**
- How often do you feel you are not getting enough sleep or rest? **0 1 2 3**
- Do you find it difficult to get regular exercise? **0 1 2 3**
- Do you feel uncared for by the people in your life? **0 1 2 3**
- Do you feel you are not accomplishing your life's purpose? **0 1 2 3**
- Is sharing your problems with someone difficult for you? **0 1 2 3**

SECTION C

SECTION C1

- How often do you get irritable, shaky, or have light-headedness between meals? **0 1 2 3**
- How often do you feel energized after eating? **0 1 2 3**
- How often do you have difficulty eating large meals in the morning? **0 1 2 3**
- How often does your energy level drop in the afternoon? **0 1 2 3**
- How often do you crave sugar and sweets in the afternoon? **0 1 2 3**
- How often do you wake up in the middle of the night? **0 1 2 3**
- How often do you have difficulty concentrating before eating? **0 1 2 3**
- How often do you depend on coffee to keep yourself going? **0 1 2 3**
- How often do you feel agitated, easily upset, and nervous between meals? **0 1 2 3**

SECTION C2

- How often do you get fatigued after meals? **0 1 2 3**
- How often do you crave sugar and sweets after meals? **0 1 2 3**
- How often do you feel you need stimulants, such as coffee, after meals? **0 1 2 3**
- How often do you have difficulty losing weight? **0 1 2 3**
- How much larger is your waist girth compared to your hip girth? **0 1 2 3**
- How often do you urinate? **0 1 2 3**
- Have your thirst and appetite increased? **0 1 2 3**
- How often do you gain weight when under stress? **0 1 2 3**
- How often do you have difficulty falling asleep? **0 1 2 3**

SECTION 1

- Are you losing interest in hobbies? **0 1 2 3**
- How often do you feel overwhelmed? **0 1 2 3**
- How often do you have feelings of inner rage? **0 1 2 3**
- How often do you have feelings of paranoia? **0 1 2 3**
- How often do you feel sad or down for no reason? **0 1 2 3**
- How often do you feel like you are not enjoying life? **0 1 2 3**
- How often do you feel you lack artistic appreciation? **0 1 2 3**
- How often do you feel depressed in overcast weather? **0 1 2 3**
- How much are you losing your enthusiasm for your favorite activities? **0 1 2 3**
- How much are you losing your enjoyment for your favorite foods? **0 1 2 3**
- How much are you losing your enjoyment of friendships and relationships? **0 1 2 3**
- How often do you have difficulty falling into deep, restful sleep? **0 1 2 3**
- How often do you have feelings of dependency on others? **0 1 2 3**
- How often do you feel more susceptible to pain? **0 1 2 3**
- How often do you have feelings of unprovoked anger? **0 1 2 3**
- How much are you losing interest in life? **0 1 2 3**

SECTION 2

- How often do you have feelings of hopelessness? **0 1 2 3**
- How often do you have self-destructive thoughts? **0 1 2 3**
- How often do you have an inability to handle stress? **0 1 2 3**
- How often do you have anger and aggression while under stress? **0 1 2 3**
- How often do you feel you are not rested, even after long hours of sleep? **0 1 2 3**
- How often do you prefer to isolate yourself from others? **0 1 2 3**
- How often do you have unexplained lack of concern for family and friends? **0 1 2 3**
- How easily are you distracted from your tasks? **0 1 2 3**
- How often do you have an inability to finish tasks? **0 1 2 3**
- How often do you feel the need to consume caffeine to stay alert? **0 1 2 3**
- How often do you feel your libido has been decreased? **0 1 2 3**
- How often do you lose your temper for minor reasons? **0 1 2 3**
- How often do you have feelings of worthlessness? **0 1 2 3**

SECTION 3

- How often do you feel anxious or panicked for no reason? **0 1 2 3**
- How often do you have feelings of dread or impending doom? **0 1 2 3**
- How often do you feel knots in your stomach? **0 1 2 3**
- How often do you have feelings of being overwhelmed for no reason? **0 1 2 3**
- How often do you have feelings of guilt about everyday decisions? **0 1 2 3**
- How often does your mind feel restless? **0 1 2 3**
- How difficult is it to turn your mind off when you want to relax? **0 1 2 3**
- How often do you have disorganized attention? **0 1 2 3**
- How often do you worry about things you were not worried about before? **0 1 2 3**
- How often do you have feelings of inner tension and inner excitability? **0 1 2 3**

SECTION 4

- Do you feel your visual memory (shapes & images) has decreased? **0 1 2 3**
- Do you feel your verbal memory has decreased? **0 1 2 3**
- Do you have memory lapses? **0 1 2 3**
- Has your creativity decreased? **0 1 2 3**
- Has your comprehension diminished? **0 1 2 3**
- Do you have difficulty calculating numbers? **0 1 2 3**
- Do you have difficulty recognizing objects & faces? **0 1 2 3**
- Do you feel like your opinion about yourself has changed? **0 1 2 3**
- Are you experiencing excessive urination? **0 1 2 3**
- Are you experiencing a slower mental response? **0 1 2 3**

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

Neurotransmitter Assessment Form (Child Only)

Name: _____Age: _____ Sex: _____ Date:_____

* Please mark 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: 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**