



Neurotransmitter Assessment MEDICAL HISTORY

Today's Date: _____

Name: _____

Birthdate: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ E-Mail Address: _____

Gender: Male Female

Height: _____ Weight: _____

Doctor Name(s)/Specialty

Phone:

Health Insurance Plan Name

How often and how much?

Do you use tobacco? Yes No

Do you use alcohol? Yes No

Do you use caffeine? Yes No

Allergies: Please check all that apply.

- penicillin morphine dye allergies pet allergies
- codeine aspirin lactose/gluten seasonal (pollen) allergies
- sulfa drug food allergies no known allergies other: _____

Please describe the allergic reaction you experienced and when it occurred?

Over-the-counter (OTC) issues:

Please check all products that you use occasionally or regularly. Check all that apply.

- Pain Reliever
- Aspirin
- Acetaminophen (e.g.: Tylenol®)
- Ibuprofen (e.g.: Motrin IB®)
- Naproxen (e.g.: Aleve®)
- Ketoprofen (e.g.: Orudis KT®)
- Cough suppressant (e.g.: Robitussin DM®)
- Antihistamine product (e.g.: Chlor-Trimeton®)
- Decongestant product (e.g.: Sudafed®)
- Combination product (cough+cold reliever)(e.g.: Triaminic DM®)
- Sleep aids (e.g.: Excedrin PC®, Unisom®, Sominex®, Nytol®)
- Antidiarrheals (e.g.: Imodium®, Pepto Bismol®, Kaopectate®)
- Laxatives/stool softeners (e.g.: Doxidan®, Correctol®, etc.)
- Diet aids/weight loss products (e.g.: Dexatril®)
- Antacids (e.g.: Maalox®, Mylanta®)
- Acid blockers (e.g.: Tagamet HB®, Pepcid C®, Zantac 75®)
- Other (please list) _____

Name: _____

Nutritional/Natural Supplements: Please identify and list the products you are using:

- vitamins (e.g.: multiple or single vitamins such as B complex, E, C, beta carotene)
- minerals (e.g: calcium, magnesium, chromium, colloidal minerals, various single minerals)
- herbs (e.g: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
- enzymes (e.g: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
- nutrition/protein supplements (e.g: shark cartilage, protein powers, amino acids, fish oils, etc.)
- others (glucosamine, etc.)
- None

Current Prescription Medications:

Do you take medications for depression or mood swings? No Yes
If yes, which one(s)? _____

Do you take medications for anxiety? No Yes
If yes, which one(s)? _____

Do you take medications for hypertension? No Yes
If yes, which one(s)? _____

Do you take pain medications or muscle relaxers? No Yes
If yes, which one(s)? _____

Do you take medications to help you sleep? No Yes
If yes, which one(s)? _____

Medication/Supplement Dosing:

How easily can you swallow the following?:

- | | | | |
|----------|-------------------------------------|--|---------------------------------|
| Capsules | <input type="checkbox"/> Not at all | <input type="checkbox"/> With difficulty | <input type="checkbox"/> Easily |
| Tablets | <input type="checkbox"/> Not at all | <input type="checkbox"/> With difficulty | <input type="checkbox"/> Easily |

What would be the preferred means of taking a medication or supplement?

- Capsule Tablet Liquid Powder to add to drink or pudding

Other Medical Conditions/Diseases: Please check all that apply to you.

- | | |
|--|---|
| <input type="checkbox"/> Heart disease (e.g.: Congestive Heart Failure) | <input type="checkbox"/> Blood Clotting Problems |
| <input type="checkbox"/> High cholesterol or lipids (e.g.: Hyperlipidemia) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High blood pressure (e.g.: Hypertension) | <input type="checkbox"/> Arthritis or joint problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ulcers (stomach, esophagus) | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Headaches/migraines |
| <input type="checkbox"/> Hormonal Related Issues | <input type="checkbox"/> Eye Disease (glaucoma, etc.) |
| <input type="checkbox"/> Lung condition (e.g.: asthma, emphysema, COPD) | <input type="checkbox"/> Other: Please list: _____ |

Other Current Medications

Medication Name	Strength	Date Started	How often per day.
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you feel rested when you wake up? No Yes

Do you crave carbohydrates (bread, rice, pasta, potatoes)? No Yes

Do you crave sweets? No Yes

Do you crave chocolate? No Yes

Are you a vegetarian? No Yes

Do you have at least 3 protein servings daily (beans, nuts, seeds, fish, turkey, chicken, beef, tofu)? No Yes

How many glasses of water do you drink daily (no other fluids should be included in this number) _____

What are your goals with starting an Amino Acid Therapy?

Please list any other medical issues you feel need to be addressed. (e.g. hair loss, itchy skin, etc.)

Please write down any questions you have about Brain Chemistry Balance/Amino Acid Therapy.

NEUROTRANSMITTER PATIENT INFORMATION SHEET

	ABSENT	MILD	MODERATE	SEVERE
Anxiety	_____	_____	_____	_____
Attention Deficit/ Problems Concentrating	_____	_____	_____	_____
Attention Deficit with Hyperactivity	_____	_____	_____	_____
Autism	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Insomnia	_____	_____	_____	_____
Low Libido	_____	_____	_____	_____
PMS	_____	_____	_____	_____
Migraines	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Stress	_____	_____	_____	_____
Weight/Appetite Control	_____	_____	_____	_____

Other Notes:
