WOMEN'S NATURAL HEALTH CENTER

Welcome to our Center,

Before you arrive for your thermogram, certain protocols must be followed in order to ensure that your images reflect accurate information. Please read the following instructions and strictly adhere to them.

- No prolonged sun exposure (especially sunburn) to the body areas being imaged 5 days prior to the exam.
- No use of deodorants, lotions, creams, powders, or makeup (no facial makeup for full body or upper body scans) the day of the exam.
- No shaving of the areas to be imaged the day of the exam.
- No treatment (chiropractic, acupuncture, TENS, physical therapy, electrical muscle stimulation, ultrasound, hot or cold pack use) or physical stimulation of the areas to be imaged for 24 hours before the exam.
- No exercise 4 hours prior to the exam.
- If bathing, it must be no closer than 1 hour before the exam.
- If you are using pain medications, please avoid taking them for 4 hours prior to the examination. **You must consult with the prescribing physician for his or her consent prior to any change in medication use such as this**.
- You must wait at least 4 weeks after having a fine needle or core biopsy of the breast before a thermogram can be performed.
- You must wait at least 8 weeks after having a lumpectomy or surgical biopsy of the breast before a thermogram can be performed.
- If you have had any surgical procedure within the last 12 weeks, please notify our office before coming in for your appointment.

If you are scheduled for a breast thermogram, the same protocols above applies along with no physical stimulation of the breasts for 24 hours before the exam, and if you are nursing please try to nurse as far from 1 hour prior to the exam as possible.

Please note: During the examination you will be disrobed (from the waist up for breast exams, and buttocks exposed for lower body exams) during part of the examination for both imaging and to allow for the surface temperature of the body to equilibrate with the room. A female technician is provided for all our female patients.

We have enclosed an intake form(s) for you to fill out before arriving for your examination. A map to our center, along with an appointment card, has been included for your convenience. If you have any further questions, please contact our office.

WOMEN'S NATURAL HEALTH CENTER

Patient's Name:_____ **Date:**_____
Address:_____ **City:**_____ **State:**_____ **Zip:**_____
Phone #:_____ **Date of Birth:** _____ **Age:**_____ **Sex:**_____
Email: _____

Have you ever been diagnosed with breast cancer? ❒ Y ❒ N Date: _____ ❒ R ❒ L Breast
Do you have a family history of breast cancer? If yes, who? _____

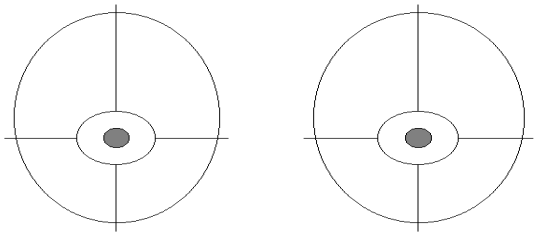
Date of your last mammogram: _____
Was it: ❒ Normal ❒ Abnormal ❒ Suspicious ❒ Watchful – ❒ R ❒ L Breast
Date of your last breast ultrasound: _____ Were both breasts imaged? ❒ Y ❒ N
Was it: ❒ Normal ❒ Abnormal ❒ Suspicious ❒ Watchful – ❒ R ❒ L Breast

Was a follow up biopsy recommended after your LAST mammogram, ultrasound, or MRI? ❒ Y ❒ N
Date of last breast exam by a doctor: _____ ❒ Normal ❒ Lump ❒ Thickening – ❒ R ❒ L

Any tests recommend after this last breast exam? (ex. mammogram) _____
Date of any breast biopsies: _____ ❒ R ❒ L Breast
What was found on the biopsy? ❒ Cancer ❒ Other _____ ❒ R ❒ L Breast
Any breast surgeries? Date and what was done? _____ ❒ R ❒ L Breast
Have you had a mastectomy? ❒ Complete ❒ Partial Date: _____ ❒ R ❒ L Breast
Was the nipple removed? ❒ Y ❒ N Was the surface skin of the original breast entirely removed? ❒ Y ❒ N
Any breast reconstruction? What was done? (ex. trans flap, implant) _____ ❒ R ❒ L Breast
Any breast radiation treatment? Date of last treatment _____ ❒ R ❒ L Breast
Are you currently pregnant? ❒ Y ❒ N Are you currently nursing? ❒ Y ❒ N

Are you CURRENTLY experiencing any of the following with your breasts: ❒ None
❒ Lump ❒ Thickening (date found _____; found by ❒ Self breast exam ❒ Doctor exam)
Pain: ❒ Dull ❒ Sharp ❒ Burning ❒ Stinging ❒ Tenderness ❒ The pain changes with my cycle
❒ Thickening ❒ Skin changes (❒ Color ❒ Texture ❒ Over the lump)
❒ R ❒ L Nipple discharge (❒ Bloody ❒ Milky ❒ Clear ❒ Through 1 duct ❒ Through multiple ducts)
❒ R ❒ L Nipple retraction (❒ For many years ❒ Recently) ❒ R ❒ L Nipple changes (❒ Color ❒ Texture)
❒ Other _____

Place an [O] on the diagram in the area of the lump. [M] for a finding on your mammogram / ultrasound / MRI. [W] for an area being watched. [X] in the area of pain, tenderness, or skin changes. [#] in the area of thickening. [+++] in the area of a scar



RIGHT **LEFT**

❒ Re-Exam
High T:_____ Low T:_____ Tech: _____
Pt T = _____ F Rm T = _____ C ❒ R ❒ L Nipple retraction ❒ R ❒ L Areola traction SLQ SMQ ILQ IMQ
❒ R ❒ L Skin surface bulge or dimple SLQ SMQ ILQ IMQ ❒ R ❒ L Skin changes SLQ SMQ ILQ IMQ
❒ R ❒ L Nipple changes (❒ Color ❒ Texture) ❒ R ❒ L Nipple discharge (❒ Bloody ❒ Milky ❒ Clear – S M)

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.**

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 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
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category VII				
Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Lowered gastrointestinal motility, constipation	0	1	2	3
Raised gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	Yes		No	
Category VIII				
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
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	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 IX				
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 X				
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 XI				
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

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Category XII

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 XIII

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 XIV

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 XV

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 XVI

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 XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(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 XVIII *(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 XIX *(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 XX *(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? __________

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? __________

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:

____

Brain Function Assessment Form™ (BFAF)

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 1

- A decrease in attention span 0 1 2 3
- Mental fatigue 0 1 2 3
- Difficulty learning new things 0 1 2 3
- Difficulty staying focused and concentrating for extended periods of time 0 1 2 3
- Experiencing fatigue when reading sooner than in the past 0 1 2 3
- Experiencing fatigue when driving sooner than in the past 0 1 2 3
- Need for caffeine to stay mentally alert 0 1 2 3
- Overall brain function impairs your daily life 0 1 2 3

SECTION 2

- Twitching or tremor in your hands and legs when resting 0 1 2 3
- Handwriting has gotten smaller and more crowded together 0 1 2 3
- A loss of smell to foods 0 1 2 3
- Difficulty sleeping or fitful sleep 0 1 2 3
- Stiffness in shoulders and hips that goes away when you start to move 0 1 2 3
- Constipation 0 1 2 3
- Voice has become softer 0 1 2 3
- Facial expression that is serious or angry 0 1 2 3
- Episodes of dizziness or light-headedness upon standing 0 1 2 3
- A hunched over posture when getting up and walking 0 1 2 3

SECTION 3

- Memory loss that impacts daily activities 0 1 2 3
- Difficulty planning, problem solving, or working with numbers 0 1 2 3
- Difficulty completing daily tasks 0 1 2 3
- Confusion about dates, the passage of time, or place 0 1 2 3
- Difficulty understanding visual images and spatial relationships (addresses and locations) 0 1 2 3
- Difficulty finding words when speaking 0 1 2 3
- Misplacement of things and inability to retrace steps 0 1 2 3
- Poor judgment and bad decisions 0 1 2 3
- Disinterest in hobbies, social activities, or work 0 1 2 3
- Personality or mood changes 0 1 2 3

SECTION 4

- Reduced function in overall hearing 0 1 2 3
- Difficulty understanding language with background or scatter noise 0 1 2 3
- Ringing or buzzing in the ear 0 1 2 3
- Difficulty comprehending language without perfect pronunciation 0 1 2 3
- Difficulty recognizing familiar faces 0 1 2 3
- Changes in comprehending the meaning of sentences, written or spoken 0 1 2 3
- Difficulty with verbal memory and finding words 0 1 2 3
- Difficulty remembering events 0 1 2 3
- Difficulty recalling previously learned facts and names 0 1 2 3
- Inability to comprehend familiar words when read 0 1 2 3
- Difficulty spelling familiar words 0 1 2 3
- Monotone, unemotional speech 0 1 2 3
- Difficulty understanding the emotions of others when they speak (nonverbal cues) 0 1 2 3
- Disinterest in music and a lack of appreciation for melodies 0 1 2 3
- Difficulty with long-term memory 0 1 2 3
- Memory impairment when doing the basic activities of daily living 0 1 2 3
- Difficulty with directions and visual memory 0 1 2 3
- Noticeable differences in energy levels throughout the day 0 1 2 3

SECTION 5

- Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach for objects 0 1 2 3
- Difficulty comprehending written text 0 1 2 3
- Floaters or halos in your visual field 0 1 2 3
- Dullness of colors in your visual field during different times of the day 0 1 2 3
- Difficulty discriminating similar shades of color 0 1 2 3

SMGEBFAF32(082013)

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Brain Function Assessment Form™ (BFAF)

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

SECTION 6

- Difficulty with detailed hand coordination 0 1 2 3
- Difficulty with making decisions 0 1 2 3
- Difficulty with suppressing socially inappropriate thoughts 0 1 2 3
- Socially inappropriate behavior 0 1 2 3
- Decisions made based on desires, regardless of the consequences 0 1 2 3
- Difficulty planning and organizing daily events 0 1 2 3
- Difficulty motivating yourself to start and finish tasks 0 1 2 3
- A loss of attention and concentration 0 1 2 3

SECTION 7

- Hypersensitivities to touch or pain 0 1 2 3
- Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall 0 1 2 3
- Frequently bumping into the wall or objects 0 1 2 3
- Difficulty with right-left discrimination 0 1 2 3
- Handwriting has become sloppier 0 1 2 3
- Difficulty with basic math calculations 0 1 2 3
- Difficulty finding words for written or verbal communication 0 1 2 3
- Difficulty recognizing symbols, words, or letters 0 1 2 3

SECTION 8

- Difficulty swallowing supplements or large bites of food 0 1 2 3
- Bowel motility and movements slow 0 1 2 3
- Bloating after meals 0 1 2 3
- Dry eyes or dry mouth 0 1 2 3
- A racing heart 0 1 2 3
- A flutter in the chest or an abnormal heart rhythm 0 1 2 3
- Bowel or bladder incontinence, resulting in staining your underwear 0 1 2 3

SECTION 9

- A decrease in movement speed 0 1 2 3
- Difficulty initiating movement 0 1 2 3
- Stiffness in your muscles (not joints) 0 1 2 3
- A stooped posture when walking 0 1 2 3
- Cramping of your hand when writing 0 1 2 3

SECTION 10

- Abnormal body movements (such as twitching legs) 0 1 2 3
- Desires to flinch, clear your throat, or perform some type of movement 0 1 2 3
- Constant nervousness and a restless mind 0 1 2 3
- Compulsive behaviors 0 1 2 3
- Increased tightness and tone in specific muscles 0 1 2 3

SECTION 11

- Difficulty with balance, or balance that is noticeably worse on one side 0 1 2 3
- A need to hold the handrail or watch each step carefully when going down stairs 0 1 2 3
- Episodes of dizziness 0 1 2 3
- Nausea, car sickness, or seasickness 0 1 2 3
- A quick impact after consuming alcohol 0 1 2 3
- A slight hand shake when reaching for something 0 1 2 3
- Back muscles that tire quickly when standing or walking 0 1 2 3
- Chronic neck or back muscle tightness 0 1 2 3

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Brain Health and Nutrition Assessment Form™ (BHNAF)

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 1

- Low brain endurance for focus and concentration 0 1 2 3
- Cold hands and feet 0 1 2 3
- Must exercise or drink coffee to improve brain function 0 1 2 3
- Poor nail health 0 1 2 3
- Fungal growth on toenails 0 1 2 3
- Must wear socks at night 0 1 2 3
- Nail beds are white instead of pink 0 1 2 3
- The tip of the nose is cold 0 1 2 3

SECTION 2

- Irritable, nervous, shaky, or light-headed between meals 0 1 2 3
- Feel energized after meals 0 1 2 3
- Difficulty eating large meals in the morning 0 1 2 3
- Energy level drops in the afternoon 0 1 2 3
- Crave sugar and sweets in the afternoon 0 1 2 3
- Wake up in the middle of the night 0 1 2 3
- Difficulty concentrating before eating 0 1 2 3
- Depend on coffee to keep going 0 1 2 3

SECTION 3

- Fatigue after meals 0 1 2 3
- Sugar and sweet cravings after meals 0 1 2 3
- Need for a stimulant, such as coffee, after meals 0 1 2 3
- Difficulty losing weight 0 1 2 3
- Increased frequency of urination 0 1 2 3
- Difficulty falling asleep 0 1 2 3
- Increased appetite 0 1 2 3

SECTION 4

- Always have projects and things that need to be done 0 1 2 3
- Never have time for yourself 0 1 2 3
- Not getting enough sleep or rest 0 1 2 3
- Difficulty getting regular exercise 0 1 2 3
- Feel that you are not accomplishing your life's purpose 0 1 2 3

SECTION 5

- Dry and unhealthy skin 0 1 2 3
- Dandruff or a flaky scalp 0 1 2 3
- Consumption of processed foods that are bagged or boxed 0 1 2 3
- Consumption of fried foods 0 1 2 3
- Difficulty consuming raw nuts or seeds 0 1 2 3
- Difficulty consuming fish (not fried) 0 1 2 3
- Difficulty consuming olive oil, avocados, flax seed oil, or natural fats 0 1 2 3

SECTION 6

- Difficulty digesting foods 0 1 2 3
- Constipation or inconsistent bowel movements 0 1 2 3
- Increased bloating or gas 0 1 2 3
- Abdominal distention after meals 0 1 2 3
- Difficulty digesting protein-rich foods 0 1 2 3
- Difficulty digesting starch-rich foods 0 1 2 3
- Difficulty digesting fatty or greasy foods 0 1 2 3
- Difficulty swallowing supplements or large bites of food 0 1 2 3
- Abnormal gag reflex Yes or No

SECTION 7

- Brain fog (unclear thoughts or concentration) Yes or No
- Pain and inflammation Yes or No
- Noticeable variations in mental speed Yes or No
- Brain fatigue after meals 0 1 2 3
- Brain fatigue after exposure to chemicals, scents, or pollutants 0 1 2 3
- Brain fatigue when the body is inflamed 0 1 2 3

SECTION 8

- Grain consumption leads to tiredness 0 1 2 3
- Grain consumption makes it difficult to focus and concentrate 0 1 2 3
- Feel better when bread and grains are avoided 0 1 2 3
- Grain consumption causes the development of any symptoms 0 1 2 3
- A 100% gluten-free diet Yes or No

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Brain Health and Nutrition Assessment Form™ (BHNAF)

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

SECTION 9

- A diagnosis of celiac disease, gluten sensitivity, hypothyroidism, or an autoimmune disease — **Yes or No**
- Family members who have been diagnosed with an autoimmune disease — **Yes or No**
- Family members who have been diagnosed with celiac disease or gluten sensitivity — **Yes or No**
- Changes in brain function with stress, poor sleep, or immune activation — **0 1 2 3**

SECTION 10

- A loss of pleasure in hobbies and interests — **0 1 2 3**
- Feel overwhelmed with ideas to manage — **0 1 2 3**
- Feelings of inner rage or unprovoked anger — **0 1 2 3**
- Feelings of paranoia — **0 1 2 3**
- Feelings of sadness for no reason — **0 1 2 3**
- A loss of enjoyment in life — **0 1 2 3**
- A lack of artistic appreciation — **Yes or No**
- Feelings of sadness in overcast weather — **0 1 2 3**
- A loss of enthusiasm for favorite activities — **0 1 2 3**
- A loss of enjoyment in favorite foods — **0 1 2 3**
- A loss of enjoyment in friendships and relationships — **0 1 2 3**
- Inability to fall into deep, restful sleep — **0 1 2 3**
- Feelings of dependency on others — **0 1 2 3**
- Feelings of susceptibility to pain — **0 1 2 3**

SECTION 11

- Feelings of worthlessness — **0 1 2 3**
- Feelings of hopelessness — **0 1 2 3**
- Self-destructive thoughts — **0 1 2 3**
- Inability to handle stress — **0 1 2 3**
- Anger and aggression while under stress — **0 1 2 3**
- Feelings of tiredness, even after many hours of sleep — **0 1 2 3**
- A desire to isolate yourself from others — **0 1 2 3**
- An unexplained lack of concern for family and friends — **0 1 2 3**
- An inability to finish tasks — **0 1 2 3**
- Feelings of anger for minor reasons — **0 1 2 3**

SECTION 12

- A decrease in visual memory (shapes and images) — **Yes or No**
- A decrease in verbal memory — **0 1 2 3**
- Occurrence of memory lapses — **0 1 2 3**
- A decrease in creativity — **0 1 2 3**
- A decrease in comprehension — **0 1 2 3**
- Difficulty calculating numbers — **0 1 2 3**
- Difficulty recognizing objects and faces — **0 1 2 3**
- A change in opinion about yourself — **0 1 2 3**
- Slow mental recall — **0 1 2 3**

SECTION 13

- A decrease in mental alertness — **0 1 2 3**
- A decrease in mental speed — **0 1 2 3**
- A decrease in concentration quality — **0 1 2 3**
- Slow cognitive processing — **0 1 2 3**
- Impaired mental performance — **0 1 2 3**
- An increase in the ability to be distracted — **0 1 2 3**
- Need coffee or caffeine sources to improve mental function — **0 1 2 3**

SECTION 14

- Feelings of nervousness or panic for no reason — **0 1 2 3**
- Feelings of dread — **0 1 2 3**
- Feelings of a "knot" in your stomach — **0 1 2 3**
- Feelings of being overwhelmed for no reason — **0 1 2 3**
- Feelings of guilt about everyday decisions — **0 1 2 3**
- A restless mind — **0 1 2 3**
- An inability to turn off the mind when relaxing — **0 1 2 3**
- Disorganized attention — **0 1 2 3**
- Worry over things never thought about before — **0 1 2 3**
- Feelings of inner tension and inner excitability — **0 1 2 3**

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