PRE-ADMISSION INFORMATION

Name: ____ Date: __________________

Address: ____Phone: (H) ______________

City & State: ____________________________Zip: _______ Phone: (W) ______________

Referred by: ______________________________ DOB:_____________________________

Phone: _______________________Email address: ________________________________

What do you want help with? Sleep ______ Cravings ______ Energy ______ Mood ______

Your General Health:

Your blood type__________ Were you breast ______ or bottle ______ fed as an infant?

Please circle and/or add any health problems you've had: colic, projectile vomiting, sore throats, earaches, stomachaches, constipation, acid reflux, hepatitis, Lyme, herpes, other_______________

____

List any medication(s) and doses you are currently taking _________________________________

____

List the nutritional supplements you are now taking ______________________________________

____

____

What is your exercise pattern?____

Do you have ovarian cysts or PCOS or other symptoms? _ _______________________________

Have you ever had a stroke, a heart attack, hepatitis, or asthma? ____________________

Rate your stress level on a scale of 1-10, with 10 being the worst__________________

Your Body: Your highest weight_______ Your lowest weight________ Your ideal weight____________

Your current weight________ Your Height________

Eating Patterns: Do you have a functional kitchen?____________________________

Do you diet? _____ Binge?______ Fast?______ Eat three meals/day?_________

What number of calories per day do you consider ideal and try to stick to?_________

Do you eat a low-fat diet? ______ Are you vegetarian?______ or have you been in the past?______

Describe a typical day of eating (including beverages and time of meals).____________________

Breakfast: ____

____

Lunch: ____

____

Dinner: ____

____

____

Snacks: ____

____

What foods do you crave or overeat? Circle and/or add to the following): chocolate, other sweets, starchy foods, fatty foods, and salty foods____

How do these foods affect you? Circle and/or add: energizing, calming, numbing, give you a high, a reward, a sleep aid, mood boost:____

Describe any eating disorders you have had: (Circle those that apply) bulimia, anorexia, compulsive eating, bingeing, other:____

Allergies/Substance Sensitivities

Circle, then describe, any past or present food, inhalant or other allergies, sensitivities or negative reactions you have noticed, e.g. to MSG, milk products, gluten, wheat, soy, dander

Others:____

Use of Alcohol, Medication, Other Drugs

Alcohol or Other Drug Use: Please check off all that apply to you, present or past. Put a **P** if you have used this substance in the past, but no longer use it.

Caffeine__________ Alcohol__________ Marijuana____________Tobacco_____________

Cocaine/crystal meth/diet pills/other stimulants (specify type)____________________________

Pain killers/oxycodone, vicodin, heroin (circle or add)_________________________________

Tranquilizers/Zanax, Valium, Ativan (circle or add)___________________________________

Other prescription drugs/medications (used for mental or emotional effects) such as Prozac/Ritalyn/Zyprexa/etc. ____

Over-the-counter drugs (circle and/or add) laxative, diuretic, diet pills_______________________

Other drugs (e.g. LSD, Ecstasy)____

Nutrasweet (aspartame, Equal, Splenda)_______________________________________

Therapy/Support Groups

Are you in, or have you ever been in FA, OA, or any eating disorders treatment program? When and for how long? ____

Your Family Health

Please indicate the number of blood relatives with each problem.

Weight	_________	Overeating	_________	Alcohol	_________
Anorexia	_________	Bulimia	_________	Sleep	_________
Low Energy	_________	Allergies	_________		
Thyroid	_________	Blood Sugar	_________		
Diabetes	_________	Suicidal	_________		
Digestive	_________	Bowel	_________		

Other____

THE MINI AMINO ACID THERAPY CHART

Name_________________________________ **Date**_____________________

(1) In Column A, put a number from zero (no symptoms) to ten next to each symptom you feel, with one being slightly felt or hardly ever felt and ten being strongly felt or felt all the time.

(2) Check the Column B substances that you use to reduce the symptoms in the same section of Column A.

COLUMN A Neurotransmitter Deficiency Symptoms	**COLUMN B** Substances Used	**COLUMN C** Amino Acid Solutions*	**COLUMN D** Neurotransmitter Promotes
TYPE 1-Low Serotonin			
________ negativity, depression	□ sweets	**5-HTP**	**Serotonin:**
_______ winter blues	□ starch	50-200 mg MA	positive outlook
_______ worry, anxiety	□ tobacco	or as needed	flexibility
_______ low self-esteem	□ chocolate		emotional
_______ hyperactivity	□ Ecstasy		self-confidence
_______ obsessive thoughts	□ marijuana	**L-Tryptophan**	sense of humor
or behaviors	□ alcohol	**Either** 500-1000 mg MA	
_______ perfectionist, controlling	□ Prozac	as needed. Use eve by	
_______ irritability, rage (e.g. PMS)	□ Zoloft	10:00 pm only if sleep is a	
_______ panic attacks, phobias	□ Effexor	problem or symptoms	
(fear of heights, snakes,	□ Lexapro	persist into the	
small spaces, etc.)	□ _______	evening	
_______ fibromyalgia, TMJ,	□ _______		
migraines	□ _______		
_______ *afternoon or evening*	□ _______		
cravings for substances			
_______ insomnia, disturbed sleep	□ Trazadone	**Melatonin**	**Melatonin** (made
		3 mg for sleep at ideal	from Serotonin)
_______ night owl, hard to get to sleep		bedtime if the above does	8 hours of deep
		not work alone, or for shift	restful sleep
		workers	
Type 2 -Low Blood Sugar	□ sweets	**L-Glutamine**	**Adequate Fuel source for**
_______ *cravings for sugar,*	□ starches	500-1500 mg	**all brain cells:**
starch, or alcohol	□ alcohol	AM, MM, MA	sense of stability and
_______ irritable, shaky, stressed,			groundedness,
especially if you go			blood sugar balance
too long between meals			
TYPE 3-Low Endorphins		**DL-phenylalanine (DLPA)**	
_______ very sensitive to	□ starch	**or D-phenylalanine (DPA)**	psychological and
emotional/physical pain	□ chocolate	500-1500 mg, AM	physical pain relief
_______ cry or tear up easily	□ marijuana	MM, MA by 3:00 pm	pleasure
_______ history of chronic pain	□ alcohol	reward	
_______ *love/ crave comfort, reward,*	□ Vicoden		loving feelings
pleasure, numbing from	□ heroin		numbness when needed
foods, alcohol, drugs,	□ caffeine		
behaviors (e.g. exercise, porn,	□ tobacco		
self-harm	□ _______		
TYPE 4-Low GABA	□ marijuana	**GABA**	**GABA:**
_______ stiff, tense or painful	□ alcohol	100-500 mg	calmness
muscles	□ Xanax	1-3x per day	relaxation
_______ stressed /burned out	□ Ativan		stress tolerance
_______ unable to relax/	□ tobacco		
loosen up/get to sleep	□ sweets/starch		
_______ often feel overwhelmed	□ _______		
_______ *crave substances*	□ _______		
for stress relief			
	□ caffeine	**L-Tyrosine**	**Catecholamines:**
TYPE 5-Low Catecholamines	□ cocaine	500-2000 mg	alertness
_______ apathetic depression	□ meth	AM, MM, MA by	energy
_______ lack of energy	□ tobacco	3:00 pm	mental focus
_______ lack of drive	□ Wellbutrin		drive
_______ lack of focus,	□ Ritalin	**L-Phenylalanine**	enthusiasm
concentration	□ Adderall	same dosing for a milder	
_______ ADD	□ marijuana	effect	
_______ *crave substances* for	□ chocolate		
energy or focus	□ sweets		

***AM-on arising; B-with breakfast; MM-midmorning; L-with lunch; MA-midafternoon; D-with dinner; BT-at bedtime**

The CRAVING CURE Virtual Clinic

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FINE-TUNING YOUR MOOD ASSESSMENT

NAME: ____________________________ DATE: ________________

A. Are you "moody"? Do your negative moods come and go somewhat unpredictably, and not always in reaction to a particular interaction or event? Yes No

B. Do your mood changes occur only when you skip meals, eat poorly, in winter, or before menstrual period? ______

C. Do you have any of the following: ADD _____ ADHD ___ OCD ____ SAD_____ Postpartum Depression ______

D. *Please answer yes or no or fill in the blanks as indicated below.*

1. Do your moods vary quite a bit? Yes No If yes, please explain: _____________________________________
____
____
2. Do your moods change significantly during a single day? Yes No If yes, how often? ___________________
3. Do they change significantly during a week? Yes No _____ 2-4 times _____ more often _____
4. Do they change significantly during a month? Yes No _____ 1-4 times______ more often _____
5. Do they change significantly during a year? Yes No ______ 1-4 times ______ more often _____
6. How many episodes of depression have you had in your lifetime?_____ More than 10 ______

7. Do you have *episodes* of anxiety? Yes No Of agitation? Yes No Of anger/irritability? Yes No

8. How old were you when you began to have mood swings, episodes of depression, or other mood or sleep problems?______

9. Is your mental energy *very high* most of the time? Yes No *High* physical energy? Yes No
Do others say you talk too fast? Yes No

10. Do you sometimes have periods when you feel (check all symptoms that apply and put a P if you have had these symptoms in the past): "high"? _____ sleepless?_____ very creative? _____ angry? ______
irritable? _____mind races?______ over-energized? ______ manic?______ oversexed?______
Do any of the above symptoms occur frequently?_______

11. Do you have a hard time controlling your mood? Yes No
Do you have a hard time controlling your spending? Yes No

12. Do other people complain about your changing moods? Yes No

13. Have any of your family members had any of the symptoms from questions 1-12? Yes No

14. Have any above symptoms started, changed, or intensified after you started to take an antidepressant drug? Yes No

15. Have you been or has anyone in your family been suicidal? You Yes No Family member? Yes No
Attempts? You? Yes No Or Family Member? Yes No

16. Psychiatric hospitalization? You? Yes No Family? Yes No

17. Have you been/are you currently on mood "stabilizing" medications? Any of the following, or others?
Lamictal, Depakote, Lithium, Geodon, Seroquel, Abilify? Other: ___________________________________

WHAT IS YOUR DIET DOING TO YOU?
YOUR "FOOD-FEEDBACK DIARY"

Please submit a 3-day food journal.

Our goal here is to help you determine what kind of nutritional value your foods have been providing: Enough protein, fat, carbohydrate, vitamins, minerals? Too few or too many calories? How is it distributed throughout the day?

Most important is ***detailed*** food information. An example follows. **Please write legibly.**

Report Food Eaten Like This	**Not Like This**
BREAKFAST: 2 scrambled eggs, 2 slices bacon, two 4"	**BREAKFAST:** Eggs,
pancakes, 1 TBS margarine, 16 oz coffee, ¼ C syrup	bacon, juice, coffee
2 packets Nutrasweet, 4 TBS ½ & ½	
LUNCH: 1 12" flour tortilla, ½ C black beans, ½ C	**LUNCH:** Chicken
white rice, ¼ C jack cheese, 2 oz chicken breast,	Burrito, Diet Coke
¼ C tomato salsa, 1 can Diet Coke (12 oz)	

SAMPLE: YOUR FOOD-FEEDBACK DIARY

Give physical as well as emotional symptoms (e.g., bloated, tired, energetic, craving more food, irritable), note any mood shifts through the day and whether you exercised, if you did.

MEAL/ TIME EATEN	**FOOD**	**HOW DID YOU FEEL? FEEDBACK TIME**
BREAKFAST	2 scrambled eggs, 2 slices bacon, 3-4"	7 AM Energized,
6:45 AM	pancakes, 3 tsp margarine, 16 oz coffee,	bloated
	¼ C syrup, 2 packets Nutrasweet, 4 TBS ½ & ½	
		10 AM exhausted,
		craving sweets, bloated
SNACK	Starbucks blueberry muffin, small caffe mocha	
10:15		
		10:45 Edgy, wired-tired

Name: ___________________________ Date: ____________

MEAL/ TIME EATEN	FOOD	HOW DID YOU FEEL?
BREAKFAST		
SNACK		
LUNCH		
SNACK		
DINNER		

SLEEP: ASLEEP TIME: __________________ AWAKE TIME: __________________

QUALITY: _____________________________ DREAMS: ______________________

COMMENTS: ____

____

Medications and Supplements

Time of Day	Medication/supplement and dose	Reason for Med/Supp

Name: ________________________________ Date:_______________

PYROLURIA QUESTIONNAIRE

Rate each statement that applies to you (now or in the past) on a scale of 1-10, with 1 as rare, very minimal or very slight up to 10 as being severe, constant, or intense. If a statement does not apply, mark it with a zero "0". If an answer applies only to the past, indicate this with a "P."

_____ Anxious, fearful, or inner tension since childhood
_____ Bouts of depression and/or nervous exhaustion
_____ Poor or no dream recall
_____ Nightmares, stressful, anxious or unpleasant repeating dreams
_____ Dislike eating protein/meat or eat it only rarely, and/or feel it does not digest properly
_____ Are a vegetarian or vegan
_____ Prefer not to eat breakfast, may experience light nausea in the morning
_____ Poor appetite, or a poor sense of smell or taste
_____ Prefer the company of one or two close friends rather than a gathering of friends
_____ Tend to become dependent on one person whom you build your life around
_____ Becoming more of a loner and/or avoid outside stress as it upsets your emotional balance
_____ Focus internally (on yourself) rather than on the external world
_____ Changes in your routine (traveling, new situations) are stressful
_____ Feel uncomfortable with strangers
_____ Easily upset (internally) by criticism
_____ Bothered by being seated in a restaurant in the middle of the room
_____ Hard to recall past events and people in your life
_____ Eyes sensitive to bright sunlight and/or noise
_____ White spots/flecks on your fingernails, or have opaquely white or paper-thin nails
_____ Frequent fatigue
_____ Prone to anemia or low ferritin
_____ Joints pop or tension-achy feeling between shoulder blades
_____ Have, or a family member has, thyroid issues
_____ Over-exercise (more than 1 hour a day and/or work out 7 days a week)
_____ Frequent colds or infections
_____ Suffer from irregular, painful, or no menstruation
_____ Prone to acne or eczema
_____ Stretch marks or poor wound healing
_____ Tendency toward morning constipation
_____ Definite breath and body odor (bad or sweet/fruity odor), especially when ill or stressed

Place a checkmark by any statements that apply to you/your family (these are not rated).

_____ Reached puberty later than normal (14 or older)
_____ Crowded teeth and/or need braces
_____ Pale or fair skin, or palest in family, sunburns easily
_____ Upper abdominal, splenic pain (left side under ribs) and/or as a child, got a "stitch" in your side as you ran
_____ Belong to an all-girl family or have look-alike sisters, or for men: your mother is from an all-girl family or has look-alike sisters or the females all tend to look alike
_____ Severe mood problems, mental illness, alcoholism/other addictions in your family

USING AMINO ACIDS: PRECAUTIONS

Before trialing individual amino supplements, complete this form and ask your pharmacist to research any negative interactions between the nine amino acids listed below and any medications or herbs that you take regularly.

COMPLETE CONTRAINDICATIONS

Check off and *avoid any* amino acid (without medical approval):

If you have serious physical illness

If you have severe liver or kidney problems (e.g., lupus)

If you have an ulcer (amino acids are slightly acidic)

If you are pregnant or nursing (no individual amino acids are recommended, but a total amino blend maybe be used with your OB's OK.)

If you have schizophrenia, bipolar spectrum disorder [1], or other mental illness (especially if not stabilized on medication)

If you have overactive thyroid, Melanoma, or PKU (phenylketonuria) do NOT take: L-tyrosine, DL-phenylalanine (DLPA), or L-phenylalanine.

Use the amino acids indicated to the right with caution (or consult your physician first*) if you have had:	L-Tyrosine or L-Phenylalanine[3]	L-Tryptophan and 5-HTP	GABA & Theanine	DLPA[3]	L-Glutamine[1]	Melatonin
High blood pressure *	X			X		
Migraine headaches	X			X		
A tendency to react adversely to supplements	X	X	X	X	X	X
Hashimoto's (in some cases[3])	X			X		
Mania					X [1]	
Severe or suicidal depression *		5-HTP only[2]			X [1]	X
You are taking any medications *that affect serotonin* e.g., SSRIs, some SNRIs, MAOIs, trycyclics, anti-migraine medication like Imitrex, antimicrobials like Linezolid *	(MAOIs only) X	X				
Asthma (rare contraindication)		X				X
A carcinoid tumor (a pathological producer of serotonin) *		X				
Excessively high cortisol output		5-HTP only [2]				
Very low blood pressure			X			
A Lymphatic cancer *					X	

[1] In bipolar spectrum, (significant, chronic mood swings to full blown manic/depression), l-glutamine can trigger mania. *Note*: low dose l-glutamine can sometimes relieve bipolar (or unipolar) depression without triggering mania.
[2] 5-HTP can raise cortisol levels slightly. High cortisol can be a factor in major depression.
[3] These aminos can *sometimes* cause jitteriness or other discomfort in those with Hashimoto's Thyroiditis.

Even if your doctor or pharmacist agrees that you can try amino acids, stop taking them immediately even if you only experience mild discomfort of any kind after taking them.

Signature____ Date____________________

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