

NeuroGraph - Neurotransmitter Analysis

Date _____

Date of Birth _____

Name _____

Phone _____

Address _____

State / Pcode _____

Symptom Severity

- 1 = Mild problem
- 2 = Moderate problem
- 3 = Major problem
- 4 = Severe problem

Frequency

- 1 = Occasionally 1 to 2 times a month
- 2 = Sometimes 3 to 5 times a month
- 3 = Often 6 to 15 times a month
- 4 = Very Often more than 15 times a month or occurs daily

- For the SEVERITY & FREQ. questions - Enter the **NUMBERS** that equal the **Severity** and the **Frequency**
- Note: If No Symptom Exists - write a '0' in the **Severity** square
- For the YES - NO questions - **CIRCLE** the **CORRECT** answer, for example **Yes** - No

Severity Frequency

No appetite, unable to eat _____	1		
Currently taking antidepressants _____	2	Yes - No	
Feel down, depressed or hopeless _____	3		
Have panic attacks or severe anxiety _____	4		
Have headaches - cluster headaches - migraines _____	5		
Feel more down or depressed during winter months _____	6	Yes - No	
Needing more than 8 hours sleep, sleeping too much _____	7	Yes - No	
Suffer from insomnia, trouble falling or staying asleep _____	8		
Have impulsive tendencies, make decisions on spur of the moment _____	9		
Diagnosed with major depression, bipolar disorder / manic depression _____	10	Yes - No	
Feel angry, aggressive - short emotional fuse - aggressive with alcohol _____	11		
Unexpected weight loss or gain more than 5% of body weight in a month _____	12	Yes - No	
Little interest or pleasure in doing things, no motivation, can't get going _____	13		
Mental and/ or physical slowing down - or -Agitation and/ or restlessness _____	14		
Feeling bad about yourself, are a failure, have let yourself or family down _____	15		
Thoughts that you would be better off dead, or hurting yourself some way _____	16		
Feel tired all the time, have little energy _____	17	Yes - No	
Find yourself repeating certain actions constantly e.g. - - Hand washing, checking that the door is locked _____	18		
Have a short attention span, find it difficult to think or concentrate _____	19		
Crave high carbohydrate or sugary foods or binge eat or overeat _____	20		
Feel anxious when in public places or where there's lots of people _____	21		
Do you have a negative reaction to stressful situations ... Worry or dwell over things for an extended period e.g. - - Family problems, financial problems - Stress at work or home, things you haven't done before - Relationship problems with partner, relationship breakup _____	22		
Constantly worry about your body size _____	23		
More sensitive to pain than others (low pain tolerance) _____	24	Yes - No	
Suffer from constipation, including frequent and/or long term _____	25		
Misplace objects frequently _____	26	Yes - No	
Have a low sex drive, problems with arousal, orgasm _____	27	Yes - No	
Use Uppers, eg - Red Bull (caffeine) ... - Coffee, Nicotine, Diet soft drinks, NutriSweet _____	28	Yes - No	
Have trouble remembering details of what happened yesterday _____	29		

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		Severity	Frequency
Prostate enlargement, benign prostatic hypertrophy (BPH) _____	30	Yes - No	
Suffer from chronic pain _____	31		
Have high blood pressure _____	32	Yes - No	
Your muscles constantly feel tight _____	33		
Have dreams that are vague and plain _____	34		
Have difficulty learning something new _____	35		
Feel there is significantly high stress in your life _____	36		
Personal or family history of breast or prostate cancer _____	37	Yes - No	
Your legs jump when you are going to - or - when you are asleep _____	38		
Crave or engage in behaviour such as - - Frequent and / or excess alcohol use, recreational drug use - Gambling, extreme sports _____	39	Yes - No	
Diagnosed with - ALS, Multiple Sclerosis, Dementia, Alzheimer's, - Parkinson's, Huntington's, Myasthenia gravis, Tardive dyskinesia _____	40	Yes - No	
Previously used large amounts of stimulants _____	41	Yes - No	
Suffer from stress induced urinary incontinence _____	42		
Engage in physical activity less than twice per week _____	43	Yes - No	
Put on weight easily and find it difficult to lose weight _____	44		
Find it difficult to remember what happened a long time ago _____	45		
Suffered from chronic stress in the past together with fatigue _____	46	Yes - No	
Have low blood pressure - hypotension _____	47	Yes - No	
Feel mentally fatigued, mentally exhausted _____	48		
Food sensitivities, allergies, seasonal allergies _____	49		
Have low blood sugar problems - hypoglycaemia _____	50	Yes - No	
Currently suffer from chronic stress together with fatigue _____	51		
Suffer from phobias _____	52	Yes - No	
Experience paranoia _____	53	Yes - No	
Diagnosed with Schizophrenia _____	54	Yes - No	
Indigestion, low stomach acidity _____	55		
Have Mercury based dental fillings _____	56	Yes - No	
Low tolerance to medication, drugs _____	57	Yes - No	
Feel anxious - feel tense - worry a lot - have performance anxiety _____	58		
Have a relatively high tolerance to pain _____	59	Yes - No	
Experience manic episodes or feelings of mania _____	60	Yes - No	
Crave alcohol and / or excess alcohol consumption, binge drinking _____	61		
Difficulty with waking in the morning _____	62	Yes - No	
Experience hallucinations or see things that are not there _____	63	Yes - No	

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Hyperactive tendencies _____	64		
Heavy growth of body hair _____	65	Yes - No	
Cuts and sores take a while to heal _____	66	Yes - No	
High tolerance to medication, drugs _____	67	Yes - No	
Dermatitis, eczema, urticaria, asthma _____	68	Yes - No	
Experience phobias, obsessions, compulsions _____	69	Yes - No	
Highly motivated, hard-driving - Type A personality _____	70	Yes - No	
Get mouth ulcers _____	71		
High libido, easily orgasmic _____	72	Yes - No	
Need only 5 - 7 hours sleep per night _____	73	Yes - No	
Have Crohns disease, ulcerative colitis, problems with wheat and gluten _____	74	Yes - No	
Experience bouts of colic, flatulence, and diarrhea _____	75		
Produce tears and saliva easily, never a dry mouth _____	76	Yes - No	
Painful periods, dysmenorrhea, menstrual headaches _____	77		
Have a lean build _____	78	Yes - No	
Have very little body hair _____	79	Yes - No	
Smoke more than one packet of cigarettes per day _____	80	Yes - No	
Attention deficit disorder, attention deficit hyperactive disorder _____	81	Yes - No	
Been diagnosed with epilepsy or suffer seizures _____	82	Yes - No	
Find it difficult to make decisions _____	83		
Have poor coordination or balance _____	84		
Difficulty with rapidly processing new information _____	85		
Developed more digestive symptoms, discomfort, as you have aged _____	86	Yes - No	

When are your Symptoms Worse _____

<input type="checkbox"/> Morning	<input type="checkbox"/> Evening
<input type="checkbox"/> All Day	<input type="checkbox"/> Night
<input type="checkbox"/> Day & Night	
<input type="checkbox"/> Varies	

If you answered YES to any questions or gave them a SCORE ...

How difficult have these problems made it for you to:

- do your work
- take care of things at home
- get along with other people

<input type="checkbox"/> Not difficult at all
<input type="checkbox"/> A bit difficult
<input type="checkbox"/> Very difficult
<input type="checkbox"/> Extremely difficult