Neurogistics eHealth Profile

NEUROGISTICS
THE BRAIN WELLNESS PROGRAM

Patient: _____
Date: _____
Email: _____

This questionnaire is structured to learn more about you so that our neurotransmitter specialists can use the information to compile your personal Brain Wellness Report. The information you provide will be held in strict confidence. Please be as honest and accurate as you can. After all, you want to be sure to obtain the right information.

Please note: Question 32, asks about supplement information, which of our products or other amino acids you take. Please be sure to complete that section below. This information is so vital to compiling your protocol that your report cannot be created with out it.

1. Are you **male** or **female**? Male Female

2. Date of **Birth**: _____

3. What is your **height**? Feet_____ Inches_____

4. What is your **weight**? Pounds_____

5. Have you **lost** or **gained weight recently**?
Yes No

6. Are you **pregnant** or **nursing**?
Yes No

7. Do you **experience mood issues depression**, or **unexplained lethargy**?
Yes No

8. Has your energy level decreased to the point that normal daily activities seem overwhelming?
Yes No

9. Are you at risk of suicide? If yes, please immediately call 911 and your ordering practitioner.
Yes No

10. Do you cry more easily than you used to?
Yes No

11. Does the future look bleak or even hopeless to you?
Yes No

12. Do you experience **anxiety** or **nervousness**?
Yes No

13. Do you feel **restless**, **keyed-up** or **being on edge**?
Yes No

14. Do you experience **trouble falling asleep** due to your **anxiety**?
Yes No

15. Have you been diagnosed with **bipolar disorder**?
Yes No

16. Are you **more forgetful** than you used to be, or do you have **less clarity** in your **thinking**?
Yes No

17. Do you experience **headaches** or **migraines**?
Yes No

18a. Do you have problems **losing weight?**
Yes No

18b. Do you have problems with **carbohydrate cravings?**
Yes No

18c. Do you have problems with **chocolate cravings?**
Yes No

19. Do you have an eating disorder?
Yes No

20. Do you have a diagnosis of Autism or PDD?
Yes No

21. Are you on **medication**?
Yes No

If yes, please list **type** and **how long** you have been on each:

22. Are you having trouble **falling asleep**?
Yes No

23. Are you having trouble **staying asleep**?
Yes No

24. How many **hours of sleep** do you get per night?
_____

25. How high is your **stress level**?
Low Med High

26. Are you having **difficulty focusing**?
Yes No

27. Are you having **short term memory loss**?
Yes No

28. Are you having **long term memory loss?**
Yes No

29. How many **servings of protein** do you have per day? _____Servings

30. Do you **vary your sources of protein** you consume?
Yes No

31. How much **water** do you consume on a daily basis?
_____Ounces

32. If you are currently a Neurogistics client, or if you take supplements, please list **all** of our **amino acid supplements** you take on a regular basis and the number of capsules you take per day. If you are not a current client and take amino acids please list them here along with the daily dosage you take.

Name of Supplement	**Capsules per day (each)**

<u>Please check that you agree or disagree with the following statement:</u>

The information that I have provided in the proceeding eHealth Profile is accurate to the best of my knowledge:

 I agree I disagree

_____
Signature