

Neuro-Metabolic Case History

Name_____

Address_____ City_____ State_____ Zip_____

Date of Birth_____ Home Telephone_____ Cell_____ Work_____

Email_____ Best place to reach you (circle one) Home/Cell/Work

Occupation_____

Emergency Contact: Name_____ Relationship_____ Phone_____

I (signature) _____ consent to allow Dr. DeMasi to speak with me and perform a consultation and examination in order to determine if further testing is necessary, to determine if he is willing to accept my case.

Please answer the following questions.

What are you hoping happens today as a result of your consultation with the Doctor?

Primary Care or Treating Physician

Please list the most troubling symptoms you are suffering—even though you may be taking medication, and even though you have been told your labs are “normal”

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

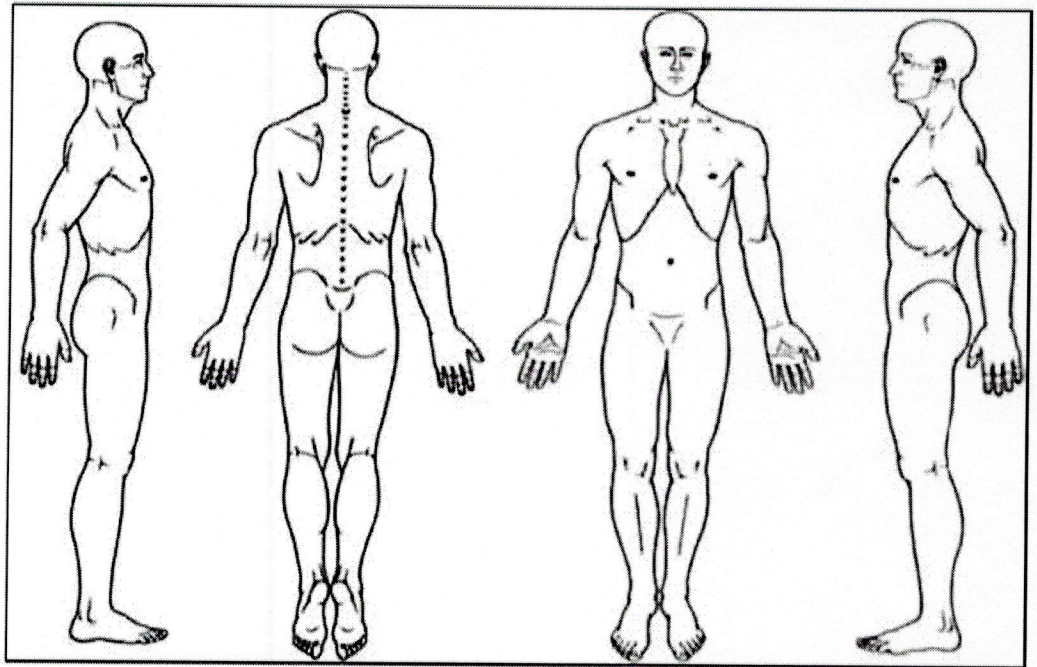
Describe what you hope or think Dr. DeMasi might be able to do for you.

Describe what will be different/better in your life if you can finally be relieved of these problems.

What do you desire most to get from working with us?

Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the diagram to accurately describe what you feel..

PP = PAIN
 WW = WEAKNESS
 NN = NUMBNESS
 HH = HEAT
 TT = TINGLING
 BB= BURNING
 CC = CRAMPING
 FF = STIFFNESS
 RR = Pressure



Circle Y for "YES" or N for "NO" in the box next to each of the questions.

Weakness	Y N	Twitching muscles	Y N
Fatigue	Y N	Decrease in size or tone of your arms or legs	Y N
Pins & Needles feelings, electric shock feelings	Y N	Sensitivity to light	Y N
Racing heart beat	Y N	Difficulty talking?	Y N
Trouble controlling bowels or bladder	Y N	Sweat more on one side (armpit, face etc.)	Y N
Angina—chest pain or shortness of breath	Y N	You feel unsteady or you fall	Y N
Hair loss on the arms or legs	Y N	Dry mouth	Y N
Left arm pain	Y N	Dry eyes	Y N
Balance problems	Y N	Circle: Nausea , vomiting	Y N
Swelling in the lower legs	Y N	Circle: Cold arms, hands, legs, feet	Y N
Fingernails are brittle or have ridges	Y N	Numbness? If so, where? _____	Y N
Symptoms change with arm, leg or neck movement	Y N	Cramping pains in the legs that start after walking	Y N
Blackouts/loss of consciousness	Y N	Uncoordinated	Y N
Fainting	Y N	Poor exercise tolerance	Y N
Light-headedness	Y N	Muscle cramping	Y N
Double Vision	Y N	Men--Erectile Dysfunction Women---can't achieve orgasm	Y N

**Have you had ANY of the following in the last 12 months, or are experiencing currently?
Circle the appropriate choice, either "C" for currently, or "X" for in the last 12 months.**

Unexplained weight loss	C X	Arthritis	C X
Seizures	C X	Alcoholism	C X
Dizziness	C X	Abdominal surgery	C X
Hand Trembling	C X	Bleeding disorder	C X
Weakness	C X	Blood clots	C X
Loss of memory	C X	Breathing difficulty	C X
Loss of coordination	C X	Asthma	C X
Numbness in BOTH hands AND feet	C X	Cancer	C X
High Blood Pressure	C X	Diabetes	C X
Low Blood Pressure	C X	Eczema	C X
Pain over heart	C X	Eating disorder	C X
Poor Circulation	C X	Glaucoma	C X
Rapid Heartbeat	C X	HIV +	Yes No
Slow Heartbeat	C X	Hernia	C X
Other heart condition?	C X	Headaches	C X
Describe _____		Influenza	C X
Stroke	When? _____	Kidney disease	C X
TIA (transient ischemic attack)	When? _____	Liver disease	C X
Varicose veins	C X	Mental illness	C X
Bruise easily	C X	Measles	C X
Aortic aneurysm	C X	Mumps	C X
Appendicitis	C X	Pleurisy	C X
Anemia	C X	Pneumonia	C X
Chest pain	C X	Polio	C X
Chronic cough	C X		
Coughing/spitting blood	C X		

**Please circle the appropriate number for each item below:
0 as the least/never and 3 as the most/always**

Sensitive to odors, perfumes, smoke	0	1	2	3
Sensitive to pollens, molds	0	1	2	3
Extreme sugar cravings	0	1	2	3
Genital rash (vaginal, "jock itch")	0	1	2	3
Ringworm	0	1	2	3
Fungus on toenails or fingernails	0	1	2	3
Repeated use of antibiotics (even in distant past)	0	1	2	3
Repeated use of steroids	0	1	2	3
Mouth thrush (yeast infection)	0	1	2	3
Dark skin under eyes; looks like you might have a mild 'black eye'	0	1	2	3
Bloating	0	1	2	3
Belching	0	1	2	3
Intestinal gas	0	1	2	3
Constipation	0	1	2	3
Diarrhea	0	1	2	3
Indigestion	0	1	2	3
Esophageal reflux	0	1	2	3
Asthma	0	1	2	3
Itching, tingling or burning	0	1	2	3
Hives, psoriasis or dandruff	0	1	2	3
Acne	0	1	2	3
Hair loss	0	1	2	3
Chronic infections (repeated infections)	0	1	2	3
Your symptoms/behaviors worse in the following weather: Damp, hot, misty, moldy, musty	0	1	2	3
Bronchitis	0	1	2	3
Congestion with changing seasons	0	1	2	3
Cough	0	1	2	3
Pneumonia	0	1	2	3
Post nasal drip	0	1	2	3
Sighing	0	1	2	3
Sinus fullness	0	1	2	3
Wheezing	0	1	2	3

Please circle the appropriate number for each item below:
0 as the least/never and 3 as the most/always

Feeling that bowels do not empty completely	0 1 2 3	Excessive passage of gas	0 1 2 3
Lower abdominal pain relieved by passing stool or gas	0 1 2 3	Nausea and/or vomiting	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3	Stool has undigested food, foul smelling, mucous like, greasy, or poorly formed	0 1 2 3
Diarrhea	0 1 2 3	Greasy or high-fat foods cause distress	0 1 2 3
Constipation	0 1 2 3	Lower bowel gas and/or bloating several hours after eating	0 1 2 3
Hard, dry, or small stool	0 1 2 3		
Coated tongue or "fuzzy" debris on tongue	0 1 2 3	Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Pass large amount of foul-smelling gas	0 1 2 3	Unexplained itchy skin	0 1 2 3
Use laxatives frequently	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
Increasing frequency of food reactions	0 1 2 3	Reddened skin, especially palms	0 1 2 3
Unpredictable food reactions	0 1 2 3	Dry or flaky skin and/or hair	0 1 2 3
Unpredictable abdominal swelling	0 1 2 3	History of gallbladder attacks or stones	0 1 2 3
Frequent bloating and distention after eating	0 1 2 3	Have you had your gallbladder removed?	Y N
Eating sugars and starches creates abdominal symptoms	0 1 2 3	Burpy fishy taste after consuming fish oils	0 1 2 3
Intolerance to smells	0 1 2 3	Acne and unhealthy skin	0 1 2 3
Intolerance to jewelry	0 1 2 3	All over sense of bloating (not just abdomen)	0 1 2 3
Intolerance to shampoo, lotion, detergents, etc.	0 1 2 3	Bodily swelling for no reason	0 1 2 3
Multiple smell and chemical sensitivities	0 1 2 3	Hormone imbalances	0 1 2 3
Constant skin outbreaks	0 1 2 3	Symptoms are worse around menstrual period	0 1 2 3
		Excessively foul-smelling sweat	0 1 2 3
Belching, burping or bloating within 45 minutes of eating	0 1 2 3	If you go more 3 or 4 hours without eating you feel light-headed, irritable, headache-y, shaky	0 1 2 3
Intestinal gas immediately following a meal	0 1 2 3	Irritable if meals are missed	0 1 2 3
Food seems to sit heavy in your stomach like a rock	0 1 2 3	Depend on coffee to get started or keep going	0 1 2 3
Sense of fullness during and after meals	0 1 2 3	Get light-headed if meals are missed	0 1 2 3
Difficulty digesting fruits and vegetables; undigested food found in stools	0 1 2 3	Eating relieves fatigue	0 1 2 3
Stomach pain, burning, or aching 1-4 hours after eating	0 1 2 3	15 to 30 minutes after eating you get sleepy, tired or drowsy	0 1 2 3
Use antacids	0 1 2 3	Eating sweets does not relieve cravings for sugar	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3	Must have sweets after meals	0 1 2 3
Temporary relief by using antacids, food, milk, or carbonated beverages	0 1 2 3	Waist girth is equal or larger than hip girth Frequent urination	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3	Increased thirst and appetite	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0 1 2 3	Difficulty losing weight	0 1 2 3
		Numbness or tingling in the toes or feet	0 1 2 3
		Women: difficulty or inability to achieve orgasm	0 1 2 3
Fruits, Vegetables (roughage & 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		

Please circle the appropriate number for each item below:
0 as the least/never and 3 as the most/always

Cannot stay asleep at night	0 1 2 3
Crave salt	0 1 2 3
Afternoon fatigue	0 1 2 3
Afternoon headaches	0 1 2 3
Dizzy or light-headed when standing up quickly	0 1 2 3
Headaches with exertion or stress	0 1 2 3
Cannot fall asleep	0 1 2 3
Perspire very easily	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
Edema and swelling in ankles or 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
Inability to hold breath for long periods	0 1 2 3
Shallow, rapid breathing	0 1 2 3
Tired/sluggish	0 1 2 3
Feel cold in hands, feet, or 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 or exercise	0 1 2 3
Gain weight easily	0 1 2 3
Difficulty or infrequent bowel movements	0 1 2 3
Depression/lack of motivation	0 1 2 3
Outer third of eyebrow thins	0 1 2 3
Thinning of hair on: scalp, face, 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
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
Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3
Diminished sex drive	0 1 2 3
Menstrual disorders or lack of menstruation	0 1 2 3

Increased sex drive	0 1 2 3
"Splitting" - type headaches	0 1 2 3
Males Only	
Urination or dribbling	0 1 2 3
Frequent urination	0 1 2 3
Pain inside of legs or heels	0 1 2 3
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
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
Menstruating Females Only	
Perimenopausal	0 1 2 3
Alternating menstrual cycle lengths	0 1 2 3
Extended menstrual cycle (greater than 32 days)	0 1 2 3
Shortened menstrual cycle (less than 24 days)	0 1 2 3
Pain and cramping during periods	0 1 2 3
Scanty period	0 1 2 3
Heavy period	0 1 2 3
Breast pain and swelling during period	0 1 2 3
Pelvic pain during period	0 1 2 3
Irritable and depressed during period	0 1 2 3
Acne	0 1 2 3
Facial hair growth	0 1 2 3
Menopausal Females Only	
How many years have you been menopausal?	
Since menopause, do you ever have uterine bleeding?	Y N
Hot flashes	0 1 2 3
Mental foginess	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

Please circle the appropriate number for each item below:
0 as the least/never and 3 as the most/always

• Is your memory noticeably declining?	0 1 2 3
• How often do you have a hard time remembering names and phone numbers?	0 1 2 3
• Is your ability to focus noticeably declining?	0 1 2 3
• Has it become harder for you to learn things?	0 1 2 3
• How often do you have a hard time remembering your appointments?	0 1 2 3
• Is your temperament getting worse in general?	0 1 2 3
• Are you losing your attention span endurance?	0 1 2 3
• How often do you find yourself down or sad?	0 1 2 3
• How often do you fatigue when driving compared to the past?	0 1 2 3
• How often do you fatigue when reading compared to the past?	0 1 2 3
• How often do you walk into rooms and forget why?	0 1 2 3
• How often do you pick up your cell phone and forget why?	0 1 2 3
• How high is your stress level? ("3" is highest)	0 1 2 3
• How often do you feel that you have something that must be done?	0 1 2 3
• Do you feel you never have time for yourself?	Y N
• How often do you feel you are not getting enough sleep or rest?	0 1 2 3
• Do you find it difficult to get regular exercise?	Y N
• How often do you find little to no pleasure in your hobbies and interests?	0 1 2 3
• How often do you feel overwhelmed with ideas to manage?	0 1 2 3
• How often do you have feelings of inner rage (anger)?	0 1 2 3
• How often do you have feelings of that things or people are out to get you?	0 1 2 3
• How often do you feel sad or down for no reason?	0 1 2 3
• How often do you feel like you are not enjoying life?	0 1 2 3
• How often do you feel depressed in overcast weather?	0 1 2 3
• How often do you have feelings of sudden, unprovoked anger?	0 1 2 3

• How often do you have feelings of hopelessness?	0 1 2 3
• How often do you have feelings of worthlessness?	0 1 2 3
• How often do you have self-destructive thoughts?	0 1 2 3
• How often do you have an inability to handle stress?	0 1 2 3
• How often do you have anger and aggression while under stress?	0 1 2 3
• How often do you prefer to isolate yourself from others?	0 1 2 3
• How often are you easily distracted from your tasks?	0 1 2 3
• How often do you have an inability to finish tasks?	0 1 2 3
• How often do you lose your temper for minor reasons?	0 1 2 3
• How often do you feel anxious or panic for no reason?	0 1 2 3
• How often do you have feelings of dread or impending doom?	0 1 2 3
• How often do you feel knots in your stomach?	0 1 2 3
• How often do you have feelings of being overwhelmed for no reason?	0 1 2 3
• How often do you have feelings of guilt about everyday decisions?	0 1 2 3
• How often does your mind feel restless?	0 1 2 3
• How often is it difficult to turn your mind off when you want to relax?	0 1 2 3
• How often do you have feelings of inner tension, buzzing, vibration or excitability?	0 1 2 3
• How often do you have memory lapses?	0 1 2 3
• How often do you have difficulty finding the "right" word?	0 1 2 3
• Has your creativity been decreased?	Y N
• Has your ability to understand things been diminished?	Y N
• How often do you have difficulty calculating numbers?	0 1 2 3
• How often do you have difficulty recognizing remembering names and faces?	0 1 2 3
• How often do you feel you are thinking/reacting SLOWER than you used to?	0 1 2 3

Medication History

Please circle any of the following medication you have been or are currently taking.

Acetylcholine Receptor Antagonist – Antimuscarinic Agents

Atropine, Ipratropium, Scopolamine, Tiotropium

Acetylcholine Receptor Antagonist - Ganglionic Blockers

Mecamylamine, Hexamethonium, Nicotine (high doses), Trimethaphan

Acetylcholinesterase Reactivators

Pralidoxime

Acetylcholine Receptor Antagonist - Neuromuscular Blockers

Atracurium, Cisatracurium, Doxacurium, Metocurine, Mivacurium, Pancuronium, Rocuronium, Uccinylcholine, Tubocurarine, Vecuronium, Hemicholine

Agonist Modulator of GABA Receptor (benzodiazepines)

Xanax, Lexotanil, Lexotan, Librium, Klonopin, Valium, ProSom, Rohypnol, Dalmane, Ativan, Loramet, Sedoxil, Dormicum, Megadon, Serax, Restoril, Halcion

Agonist Modulator of GABA Receptors (nonbenzodiazepines)

Ambien, Sonata, Lunesta, Imovane

Cholinesterase Inhibitors (irreversible)

Echthiophate, Isoflurophate, Organophosphate Insecticides, Organophosphate-containing nerve agents

Cholinesterase Inhibitors (reversible)

Donepezil, Galatamine, Rivastigmine, Tacrine, THC, Erophonium, Neostigmine, Phystigimine, Pyridostigmine, Carbamate Insecticides

Dopamine Reuptake Inhibitors

Wellbutrin (Bupropion)

Dopamine Receptor Agonists

Mirapex, Sifrol, Requip

D2 Dopamine Receptor Blockers (antipsychotics)

Thorazine, Prolixin, Trilafon, Compazine, Mellaril, Stelazine, Vesprin, Nozinan, Depixol, Navane, Iuanxol, Clopixol, Acuphase, Haldol, Orap, Clozaril, Zyprexa, Zydis, Seroquel, Geodon, Solian, Invega, Abilify

GABA Antagonist Competitive binder

Flumazenil

Monoamine Oxidase Inhibitor (MAOI)

Marplan, Aurorix, Maneric, Moclodura, Nardil, Adlegiine, Elepryl, Azilect, Marsilid, Iprozid, Ipronid, Rivivol, Popilniazida, Zyvox, Zyvoxid

Noradrenergic and Specific Serotonergic Antidepressants (NaSSa)

Remeron, Zispin, Avanza, Norset, Remergil, Axit

Selective Serotonin Reuptake Inhibitor

Paxil, Zoloft, Prozac, Celexa, Lexapro, Luvox, Cipramil, Emocal, Serpam, Seropram, Cipralex, Esteria, Fontex, Seromex, Seronil, Sarafem, Fluctin, Faverin, Seroxat, Aropax, Deroxat, Rexetin, Xentor, Paroxat, Lustral, Serlain, Dapoxetine

Selective Serotonin Reuptake Enhancers

Stablon, Coaxil, Tatinol

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

Effexor, Pristiq, Meridia, Serzone, Dalcipran, Despramine, Duloxetine

Tricyclic Antidepressants (TCAs)

Elavil, Endep, Tryptanol, Trepiline, Asendin, Asendis, Defanyl, Demolox, Moxadil, Anafranil, Norpramin, Pertofrane, Prothiadin, Thanden, Adapin, Sinequan, Trofranil, Janamine, Gamanil, Aventyl, Pamelor, Opipramol, Vivactil, Rhotrimine, Surmontil

Please circle the appropriate number for each item below:
0 as the least/never and 3 as the most/always

Trouble sustaining attention in routine situations, easily distracted	0	1	2	3
Difficulty remembering where things are Bad memory for directions	0	1	2	3
Bad memory for directions	0	1	2	3
Difficulty understanding body language	0	1	2	3
Don't understand the 'big picture' of words / phrases	0	1	2	3
Often don't get humor and metaphors	0	1	2	3
Not Able to "read between the lines"	0	1	2	3
Act compulsively	0	1	2	3
Difficulty with word problems	0	1	2	3
Not Able to focus	0	1	2	3
Difficulty following through or finishing things	0	1	2	3
Not Able to 'tune out' irrelevant stimuli	0	1	2	3
Trouble imagining or visualizing an activity or physical action	0	1	2	3
Not Able to speak without sounding monotone	0	1	2	3
Blurting out of answers before the question is completed	0	1	2	3
Hyperactive-move excessively	0	1	2	3
Not able to control what you say	0	1	2	3
Not able to cry or be spontaneous	0	1	2	3
Not able to predict what others will do	0	1	2	3
Irregular heart rate--If yes, describe _____	0	1	2	3
Not able to remember facts and figures	0	1	2	3
Not able to identify objects by name	0	1	2	3
Trouble with fine motor skills (small objects, handwriting, buttons)	0	1	2	3
Difficulty with calculations/math	0	1	2	3
Trouble reading (dyslexic)-even if past only	0	1	2	3
Trouble following multiple step directions	0	1	2	3
Truly upset if routine or plan changes	0	1	2	3
Irregular heart RHYTHM --If yes, describe _____	0	1	2	3
Have repetitive thoughts	0	1	2	3
Tend to write very small	0	1	2	3
Start things, but don't finish	0	1	2	3

Please circle the appropriate number for each item below:
 0 as the least/never and 3 as the most/always, or Circle "Yes" or "No"

Grind teeth	0	1	2	3
There is some action you feel you MUST do, and doing it gives you a sense of relief	Yes No			
Muscle cramps Where? _____	0	1	2	3
You have certain muscles that are always tight. Where? _____	0	1	2	3
Restless legs	0	1	2	3
You have small jerks or "twitches" in your muscles. Where? _____	0	1	2	3
Tremors Where? _____	0	1	2	3
Pain in shoulder joint (or past shoulder joint problems) Which shoulder? _____	0	1	2	3
You bite or chew your fingernails	0	1	2	3
You have Obsessive thoughts	0	1	2	3
Song gets stuck in your head	0	1	2	3
Panic attacks	0	1	2	3
Handwriting gets smaller the more you write	0	1	2	3
Move slowly compared to how quickly you used to move	Yes No			
Your walking speed is slow (especially compared to how fast you used to walk)	Yes No			
You are Excessively motivated	0	1	2	3
You startle very very easily	0	1	2	3
You are Easily embarrassed	0	1	2	3
Feelings of nervousness or anxiety	0	1	2	3
Heart pounding, rapid heart rate	0	1	2	3
Feel like you can't take a deep breath	0	1	2	3
Avoidance of public places from fear or anxiety	0	1	2	3
Unexplained Periods of nausea and stomach upset	0	1	2	3
Tendency to predict the worst	0	1	2	3
Fear of being judged or scrutinized	0	1	2	3
Excessive worrying about what others think	0	1	2	3
Tendency to "freeze up" in stressful situations	0	1	2	3

Please circle the appropriate number for each item below:
0 as the least/never and 3 as the most/always

Feelings of sadness	0	1	2	3
Moodiness	0	1	2	3
Negativity	0	1	2	3
Low energy	0	1	2	3
Irritability	0	1	2	3
Suicidal thoughts	0	1	2	3
Low self-esteem	0	1	2	3
Forgetfulness	0	1	2	3
Repetitive movements of your face and lips	0	1	2	3
Feelings of helplessness or powerlessness	0	1	2	3
Feeling dissatisfied or bored	0	1	2	3
Excessive guilt	0	1	2	3
Crying easily	0	1	2	3
Low appetite	0	1	2	3
Very sensitive to smells or odors	0	1	2	3
Poor sense of smell	0	1	2	3
Auditory (sound) or visual hallucinations	0	1	2	3
Sudden fear	0	1	2	3
Sudden anger	0	1	2	3
Sudden sexual arousal	0	1	2	3
History of family violence or explosiveness	0	1	2	3
Extreme irritability	0	1	2	3
Dark thoughts or thoughts of homicide	0	1	2	3
Preoccupation with moral or religious ideas	0	1	2	3
Reading comprehension problems	0	1	2	3
Irritability that tends to build, then explode	0	1	2	3
Ringing (tinnitus) -- If yes, describe it _____	0	1	2	3

Please circle the appropriate number for each item below:
 0 as the least/never and 3 as the most/always, or Circle "Yes" or "No"

You see letters backwards (even if only as a child).	Yes	No
You have real difficulty with math.	Yes	No
You have difficulty with "word" problems in math.	Yes	No
Difficulty with "spatial" skills	0	1 2 3
Hand or foot or leg or arm feels like it doesn't belong to you. Which one? _____	0	1 2 3
Feel odd sensations (bugs crawling, tingling, burning etc) Where? _____	0	1 2 3
Get claustrophobic, tunnel vision, or feeling that the world is closing in	0	1 2 3
You have difficulty understanding how others feel .	0	1 2 3
Getting dressed is difficult	0	1 2 3
Difficulty understanding people's facial expressions	0	1 2 3
Difficulty understanding the emotions in a verbal conversation	0	1 2 3
You get your right and left confused.	0	1 2 3
Speech is slurred	0	1 2 3
You trip	0	1 2 3
When driving, you bump into curbs or objects. Which side of car? _____	0	1 2 3
You knock over or bump into objects when reaching for them. Which arm? _____	0	1 2 3
You drop things. When using which hand? _____	0	1 2 3

Write down **EVERYTHING** you eat drink for 48 hours.
 What you're eating and when you're eating could make your symptoms **WORSE**.

Day 1		
Breakfast Time: Details:	Lunch Time: Details:	Dinner Time: Details:
Snack Time: Details:	Snack Time: Details:	Snack Time: Details:
Day 2		
Breakfast Time: Details:	Lunch Time: Details:	Dinner Time: Details:
Snack Time: Details:	Snack Time: Details:	Snack Time: Details: