Karisma For Life
Symptom Assessment Form

Name _____ **Age** _____ **Sex** _____ **Date** _____

Please click on the appropriate number "0 - 3" on ALL questions below. NO BLANK RESPONSES.
0 = Never / the least 1 = Sometimes 2 = Often 3 = Always / the most

Category I
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Feel better if you don't eat (eating makes you feel worse)	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 II
Excessive belching, burping and/or bloating	0	1	2	3
Heartburn or acid reflux	0	1	2	3
Gas immediately following a meal	0	1	2	3
Difficulty digesting proteins (meats)	0	1	2	3
Offensive breath (halitosis)	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Anemia unresponsive to iron supplementation	0	1	2	3
Difficult bowel movements	0	1	2	3
Difficulty digesting fruits and vegetables	0	1	2	3
Undigested foods found in stools	0	1	2	3

Category III
Stomach burning or aching 1-4 hours after eating	0	1	2	3
Use antacids or reflux medications?	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, eating food, drinking 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/or caffeine	0	1	2	3
Black or tarry colored stools	0	1	2	3

Category IV
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, mucous-like, greasy or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category V
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

How many ounces of WATER do you drink per day? _____Ounces

Category VI
Eating greasy or high-fat foods causes discomfort	0	1	2	3
Difficulty taking fish oil, flax oil or other oils	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
Pain between shoulder blades	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?	No		Yes	

Category VII
Are you easily intoxicated when drinking wine/alcohol	0	1	2	3
Chemical exposure (diesel, paint, solvents, etc.)	0	1	2	3
Pain under right side of rib cage	0	1	2	3
Hemorrhoids or varicose veins	0	1	2	3
Sensitivity to Nutrasweet (aspartame)	0	1	2	3
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
Do you have a history of hepatitis	No		Yes	
Long term use of prescription drugs (including antibiotics)	No		Yes	
History of drug or alcohol abuse	No		Yes	
Are you a recovering alcoholic / drug user	No		Yes	

Category VIII
Intolerance to smells (perfumes, chemicals, etc.)	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotions, detergents, etc.	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IX
How often do you crave sweets during the day	0	1	2	3
How often are you irritable if you miss a meal	0	1	2	3
Depend on coffee to keep yourself going or to get started	0	1	2	3
Function better or feel energized after eating?	0	1	2	3
How often do you feel like skipping breakfast	0	1	2	3
How often do you have difficulty eating large meals or protein based meals (meats) in the morning?	0	1	2	3
Get light-headed and/or shaky if meals are missed	0	1	2	3
How often do you feel shaky, jittery or have tremors	0	1	2	3
How often are you agitated, easily upset or nervous	0	1	2	3
How often do you have poor memory or are forgetful	0	1	2	3
How often do you have blurred vision	0	1	2	3
How often does your energy level drop in the afternoon	0	1	2	3
How often do you wake up in the middle of the night?	0	1	2	3
How often do you have difficulty concentrating before eating	0	1	2	3
Eat large amounts of fruit / Prefer eating fruits	0	1	2	3

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Category X

Fatigue / sleepy after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Binge or uncontrolled eating / excessive appetite	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
Do you have diabetes?	No		Yes	
Do you have any family members with diabetes?	No		Yes	

Category XI

Cannot stay asleep	0	1	2	3
Crave salt / salty foods	0	1	2	3
Salt your food before tasting it	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 XII

Difficulty falling asleep	0	1	2	3
Tend to be a night person	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
High blood pressure	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 XIII

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 XIV

Tired / sluggish	0	1	2	3
Sensitive to iodine	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 gain 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/genitals or hair falling out	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

Heart palpitations	0	1	2	3
Intolerance for high temperatures	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

Category XVI (MALES ONLY)

Prostate problems	0	1	2	3
Urination difficulty or dribbling	0	1	2	3
Difficult to start and stop urine stream	0	1	2	3
Interruption of stream during urination	0	1	2	3
Pain or burning with urination	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVII (MALES ONLY)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining 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 XVIII (MENSTRUATING FEMALES ONLY)

Are you perimenopausal?	No		Yes	
Do you have alternating menstrual cycle lengths?	No		Yes	
Extended menstrual cycle (greater than 32 days)	No		Yes	
Shortened menses (less than every 24 days)	No		Yes	
Pain and cramping during periods	0	1	2	3
Scanty (light, spotting) blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XIX (MENOPAUSAL FEMALES ONLY)

How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?	No		Yes	
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 and/or itching	0	1	2	3

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SECTION XX

How high is your stress level?	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?	0	1	2	3
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?	0	1	2	3
Do you feel uncared for by the people in your life?	0	1	2	3
Do you feel you are **not** accomplishing your life's purpose?	0	1	2	3
Is sharing your problems with someone difficult for you?	0	1	2	3

SECTION XXI

Are you losing your pleasure in 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 feeling of inner rage (anger)?	0	1	2	3
How often do you have feelings of paranoia?	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 you lack artistic appreciation?	0	1	2	3
How often do you feel depressed in overcast weather?	0	1	2	3
Are you losing your enthusiasm for your favorite activities?	0	1	2	3
How much are you losing enjoyment for you favorite foods?	0	1	2	3
Are you losing your enjoyment for friendships & relationships?	0	1	2	3
How often do you have difficulty falling into deep restful sleep?	0	1	2	3
How often do you have feelings of dependency on others?	0	1	2	3
How often do you feel more susceptible to pain?	0	1	2	3
How often do you have feelings of unprovoked anger?	0	1	2	3
How much are you losing interest in life?	0	1	2	3

SECTION XXII

How often do you have feelings of hopelessness?	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 do you feel you are not rested even after long hours of sleep?	0	1	2	3
How often do you have unexplained lack of concern for family and friends?	0	1	2	3
How easily are you 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 feel the need to consume caffeine to stay alert?	0	1	2	3
How often do you feel your libido has been decreased?	0	1	2	3
How often do you lose you temper for minor reasons?	0	1	2	3
How often do you have feelings of worthlessness?	0	1	2	3

SECTION XXIII

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
Do you have feelings of being overwhelmed for no reason?	0	1	2	3
How often do feel guilty about everyday decisions?	0	1	2	3
How often does your mind feel restless?	0	1	2	3
How difficult is it to turn your mind off when you want to relax?	0	1	2	3
How often do you have disorganized attention?	0	1	2	3
How often do you worry about things you were not worried about before?	0	1	2	3
How often do you have feelings of inner tension and inner excitability?	0	1	2	3

SECTION XXIV

Do you feel your visual memory (shapes & images) is decreased?	0	1	2	3
Do you feel your verbal memory is decreased?	0	1	2	3
Do you have memory lapses?	0	1	2	3
Has your creativity been decreased?	0	1	2	3
Has your comprehension been diminished?	0	1	2	3
Do you have difficulty calculating numbers?	0	1	2	3
Do you have difficulty recognizing objects & faces?	0	1	2	3
Do you feel like your opinion about yourself has changed?	0	1	2	3
Are you experiencing slower mental recall?	0	1	2	3

SECTION XXV

Do you feel your mental alertness has decreased?	0	1	2	3
Do you feel your mental speed has decreased?	0	1	2	3
Do you feel your concentration quality has decreased?	0	1	2	3
Do you feel your cognitive processing has decreased?	0	1	2	3
Do you feel your mental performance is impaired?	0	1	2	3
Do you feel you ability to be distracted has increased?	0	1	2	3
Do you have a need for coffee or caffeine to improve mental function?	0	1	2	3

SECTION XXVI

Do you have low brain endurance for focus and concentration?	0	1	2	3
Do you have cold hands and feet?	0	1	2	3
Do you have to exercise or drink coffee to improve brain function?	0	1	2	3
Do you have poor nail health?	0	1	2	3
Do you have fungal growth on toenails?	0	1	2	3
Do you have to wear socks at night?	0	1	2	3
Are your nail beds white instead of pink?	0	1	2	3
How often is the tip of your nose cold?	0	1	2	3

SECTION XXVII

Do you have dry and unhealthy skin?	0	1	2	3
Do you have dandruff or a flaky scalp?	0	1	2	3
Do you consume processed foods that are bagged or boxed?	0	1	2	3
Do you consume fried foods?	0	1	2	3
Do you consume raw nuts or seeds?	0	1	2	3
Do you consume fresh fish (not fried)?	0	1	2	3
Do you consume olive oil, avocados, flax seed oil or natural fats?	0	1	2	3

SECTION XXVIII

Do you have difficulty digesting foods?	0	1	2	3
Do you have constipation or inconsistent bowel movements?	0	1	2	3
Do you have increased bloating or gas?	0	1	2	3
Do you have abdominal distention after meals?	0	1	2	3
Do you have difficulty digesting protein-rich foods?	0	1	2	3
Do you have difficulty digesting starch-rich foods?	0	1	2	3
Do you have difficulty digesting fatty or greasy foods?	0	1	2	3
Have difficulty swallowing supplements or large bites of food?	0	1	2	3
Do you have an abnormal gag reflex?	No		Yes	

SECTION XXIX

Have you been diagnosed with celiac disease, gluten sensitivity, hypothyroidism, or an autoimmune disease?	No		Yes	
Has a family member ever been diagnosed with an autoimmune disease?	No		Yes	
Has a family member ever been diagnosed with celiac disease or a gluten sensitivity	No		Yes	
Do you have changes in brain function with stress, poor sleep, or immune activation	0	1	2	3

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SECTION XXX

Does grain consumption lead to tiredness?	0	1	2	3
Does grain consumption make it difficult to focus and concentrate?	0	1	2	3
Does grain consumption cause development of any symptoms?	0	1	2	3
Do you feel better when bread and grains are avoided?	0	1	2	3
Are you on a **100%** gluten free diet?	No		Yes	

SECTION XXXI

Have brain fog, unclear thoughts, or concentration problems?	No		Yes	
Do you have pain and inflammation?	No		Yes	
Do you have noticeable variations in mental speed?	No		Yes	
Do you have brain fatigue after meals?	0	1	2	3
Do you have brain fatigue after exposure to chemicals, scents, or pollutants?	0	1	2	3
Do you have brain fatigue when the body is inflamed?	0	1	2	3

SECTION XXXII

Do you have a decrease in attention span?	0	1	2	3
Do you have mental fatigue?	0	1	2	3
Do you have difficulty learning new things?	0	1	2	3
Do you have difficulty staying focused and concentrating for extended periods of time?	0	1	2	3
Do you experience fatigue when reading sooner than the past?	0	1	2	3
Do you experience fatigue when driving sooner than the past?	0	1	2	3
Do you need caffeine to stay mentally alert?	0	1	2	3
Does overall brain function impair your daily life?	0	1	2	3

SECTION XXXIII

Have twitching or tremors in your hands and legs when resting?	0	1	2	3
Has your handwriting gotten smaller and more crowded together?	0	1	2	3
Have you lost/decreased smell to foods?	0	1	2	3
Do you have a difficulty sleeping or have fitful sleep?	0	1	2	3
Do you have stiffness in shoulders and hips that goes away when you start to move?	0	1	2	3
Do you have constipation?	0	1	2	3
Has your voice become softer?	0	1	2	3
Do you have a facial expression that is serious or angry?	0	1	2	3
Do you have episodes of dizziness or light-headedness upon standing?	0	1	2	3
Do you have a hunched over posture when getting up or walking?	0	1	2	3

SECTION XXXIV

Do you have memory loss that impacts your daily activities?	0	1	2	3
Do you have difficulty planning, problem solving, or working with numbers?	0	1	2	3
Do you have difficulty completing daily tasks?	0	1	2	3
Do you have confusion about dates, the passage of time, or places?	0	1	2	3
Do you have difficulty understanding visual images and spatial relationships, addresses, and locations?	0	1	2	3
Do you have difficulty finding words when speaking?	0	1	2	3
Do you misplace things or have an inability to retrace steps?	0	1	2	3
Do you have poor judgment or tend to make bad decisions?	0	1	2	3
Do you have a disinterest in hobbies, social activities, or work?	0	1	2	3
Do you have personality or mood changes?	0	1	2	3

SECTION XXXV

Do you have reduced function in overall hearing?	0	1	2	3
Do you have difficulty understanding language with background or scatter noise?	0	1	2	3
Do you have ringing or buzzing in the ear?	0	1	2	3
Do you have difficulty comprehending language without perfect pronunciation?	0	1	2	3
Do you have difficulty recognizing familiar faces?	0	1	2	3
Do you have changes in comprehending the meaning of sentences, written or spoken?	0	1	2	3
Do you have difficulty with verbal memory and finding words?	0	1	2	3
Do you have difficulty remembering events?	0	1	2	3
Do you have difficulty recalling previously learned facts and names?	0	1	2	3
Do you have inability to comprehend familiar words when read?	0	1	2	3
Do you have difficulty spelling familiar words?	0	1	2	3
Do you have monotone, unemotional speech?	0	1	2	3
Do you have difficulty understanding the emotions of others when they speak (nonverbal cues)?	0	1	2	3
Do you have disinterest in music and lack of appreciation for melodies?	0	1	2	3
Do you have difficulty with long-term memory?	0	1	2	3
Do you have memory impairment when doing the basic activities of daily living?	0	1	2	3
Do you have difficulty with directions and visual memory?	0	1	2	3
Do you have noticeable differences in energy levels throughout the day?	0	1	2	3

SECTION XXXVI

Do you have difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach for objects?	0	1	2	3
Do you have difficulty comprehending written text?	0	1	2	3
Do you have floaters or halos in your visual field?	0	1	2	3
Do you have dullness of colors in your visual field during different times of the day?	0	1	2	3
Do you have difficulty discriminating similar shades of a color?	0	1	2	3

SECTION XXXVII

Do you have difficulty with detailed hand coordination?	0	1	2	3
Do you have difficulty with making decisions?	0	1	2	3
Do you have difficulty with suppressing socially inappropriate behavior?	0	1	2	3
Do you have difficulty with suppressing socially inappropriate thoughts?	0	1	2	3
Do you makes decisions based on desires, regardless of the consequences?	0	1	2	3
Do you have difficulty planning and organizing daily events?	0	1	2	3
Do you have difficulty motivating yourself to start and finish tasks?	0	1	2	3
Do you have a loss of attention and concentration?	0	1	2	3

SECTION XXXVIII

Do you have hypersensitivities to touch or pain?	0	1	2	3
Do you have difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall?	0	1	2	3
Do you frequently bump into walls or objects?	0	1	2	3
Do you have difficulty with right-left discrimination?	0	1	2	3
Has your handwriting become sloppier?	0	1	2	3
Do you have difficulty with basic math calculations?	0	1	2	3
Do you have difficulty finding words for written or verbal communication?	0	1	2	3
Do you have difficulty recognizing symbols, words, or letters?	0	1	2	3

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SECTION XXXIX

Do you have difficulty with balance, or balance that is noticeably worse on one side?	0	1	2	3
Do you need to hold the handrail or watch each step carefully when going down stairs?	0	1	2	3
Do you have episodes of dizziness?	0	1	2	3
Do you have nausea, car sickness, or seasickness?	0	1	2	3
Do you have a quick impact after consuming alcohol?	0	1	2	3
Do you have a slight hand shake when reaching for something?	0	1	2	3
Do you have back muscles that tire quickly when standing or walking?	0	1	2	3
Do you have chronic neck or back muscle tightness?	0	1	2	3

SECTION XXXX

Do you have difficulty swallowing supplements or large bites of food?	0	1	2	3
Is your bowel motility and movements slow?	0	1	2	3
Do you have bloating after meals?	0	1	2	3
Do you have dry eyes or dry mouth?	0	1	2	3
Do you have a racing heart?	0	1	2	3
Do you have a flutter in the chest or an abnormal heart rhythm?	0	1	2	3
Do you have bowel or bladder incontinence, resulting in staining your underwear?	0	1	2	3

SECTION XXXXI

Do you have a decrease in movement speed?	0	1	2	3
Do you have difficulty initiating movement?	0	1	2	3
Do you have stiffness in your muscles (not joints)?	0	1	2	3
Do you have a stooped posture when walking?	0	1	2	3
Do you have cramping of your hand when writing?	0	1	2	3

SECTION XXXXII

Do you have abnormal body movements (such as twitching legs)?	0	1	2	3
Do you have desires to flinch, clear your throat, or perform some type of movement?	0	1	2	3
Do you have a constant nervousness and restless mind?	0	1	2	3
Do you have compulsive behaviors?	0	1	2	3
Do you have increased tightness and tone in specific muscles?	0	1	2	3

SECTION XXXXIII

Do you have food allergies / sensitivities?	0	1	2	3
How often does your pulse speed after eating?	0	1	2	3
How often do you have airborne allergies?	0	1	2	3
How often do you experience hives?	0	1	2	3
How often do you have sinus congestion upon waking?	0	1	2	3
How often do you crave bread and/or pasta?	0	1	2	3
Do you have a wheat (gluten) or other grain sensitivity?	0	1	2	3
Do you have a dairy sensitivity?	0	1	2	3
How often do you have bizarre vivid dreams / nightmares?	0	1	2	3
How often do you have sinus infections / stuffy nose?	0	1	2	3
How often do you have dark circles under you eyes?	0	1	2	3
How often do specific foods make you tired or bloated?	0	1	2	3
How often do you have alternating constipation & diarrhea?	0	1	2	3
How often does eating certain foods make you feel better?	0	1	2	3
Are there foods you feel you cannot give up?	0	1	2	3
How often do certain foods make you feel worse?	0	1	2	3
How often after eating do you feel better?	0	1	2	3
How often after eating do you feel worse?	0	1	2	3
How often do you feel spacey or unreal?	0	1	2	3

Please use the section below to add any additional details about symptoms you are experiencing.

Karisma For Life
Symptom Assessment Form

Please check any of the following phycotrophic medications you have taken in the past or are currently taking. (Please note that these are only phycotrophic medications)

☐ I am currently not taking nor have I taken any of the following medications

Noradrenergic and Specific Serotonergic Antidepressants (NaSSAas)
- ☐ Avanza
- ☐ Axit
- ☐ Norset
- ☐ Remergil
- ☐ Remeron
- ☐ Zispin

Tricylic Antidepressants
- ☐ Adapin
- ☐ Anafranil
- ☐ Asendin
- ☐ Asendis
- ☐ Aventyl
- ☐ Defanyl
- ☐ Demolox
- ☐ Elavil
- ☐ Endep
- ☐ Gamanil
- ☐ Janamine
- ☐ Moxadil
- ☐ Norprami
- ☐ Opipramol
- ☐ Pamelor
- ☐ Pertofrane
- ☐ Prothiaden
- ☐ Rhotrimine
- ☐ Sinequan
- ☐ Surmontil
- ☐ Thaden
- ☐ Tofranil
- ☐ Trepiline
- ☐ Tryptanol
- ☐ Vivactil

Selective Serotonin Reuptake Inhibitors (SSRIs)
- ☐ Aropax
- ☐ Celexa
- ☐ Cipralex
- ☐ Cipramil
- ☐ Deroxat
- ☐ Emocal
- ☐ Esteria
- ☐ Faverin
- ☐ Fluctin
- ☐ Fontex
- ☐ Lexapro
- ☐ Lustral
- ☐ Luvox
- ☐ Paroxat
- ☐ Paxil
- ☐ Priligy
- ☐ Prozac
- ☐ Rexetin
- ☐ Sarafem
- ☐ Serlain
- ☐ Seromex
- ☐ Seronil
- ☐ Seropram
- ☐ Seroxat
- ☐ Zoloft

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
- ☐ Cymbalta
- ☐ Dalcipran
- ☐ Effexor
- ☐ Meridia
- ☐ Norpramin
- ☐ Pristiq
- ☐ Serzone

Selective Serotonin Reuptake Enhancers (SSREs)
- ☐ Coaxil
- ☐ Stablon
- ☐ Tatinol

Monoamine Oxidase Inhibitors (MAOIs)
- ☐ Adeline
- ☐ Aurorix
- ☐ Azilect
- ☐ Eldepryl
- ☐ Ipronid
- ☐ Iprozid
- ☐ Manerix
- ☐ Marplan
- ☐ Marsilid
- ☐ Moclodura
- ☐ Nardil
- ☐ Propilniazide
- ☐ Rivivol
- ☐ Zyvox
- ☐ Zyvoxid

Dopamine Receptor Agonists
- ☐ Mirapex
- ☐ Requip
- ☐ Sifrol

Norepinephrine and Dopamine Reuptake Inhibitors (NDRI)
- ☐ Wellbutrin (bupropion)

D2 Dopamine Receptor Blockers (antipsychotics)
- ☐ Abilify
- ☐ Acuphase
- ☐ Clopixol
- ☐ Clozaril
- ☐ Compazine
- ☐ Depixol
- ☐ Fluanxol
- ☐ Geodon
- ☐ Haldol
- ☐ Invega
- ☐ Mellaril
- ☐ Navane
- ☐ Nozinan
- ☐ Orap
- ☐ Prolixin
- ☐ Seroquel
- ☐ Solian
- ☐ Stelazine
- ☐ Thorazine
- ☐ Trilafon
- ☐ Vesprin
- ☐ Zydis
- ☐ Zyprexa

GABA Antagonist Competitive Binder
- ☐ Romazicon

Agonist Modulators of GABA Receptors (Benzodiazepines)
- ☐ Xanax
- ☐ Lexotanil
- ☐ Lexotan
- ☐ Librium
- ☐ Klonopin
- ☐ Valium
- ☐ ProSom
- ☐ Rohypnol
- ☐ Megadon
- ☐ Dalmane
- ☐ Ativan
- ☐ Loramet
- ☐ Sedoxil
- ☐ Dormicum
- ☐ Serax
- ☐ Restoril
- ☐ Halcion

Agonist Modulators of GABA Receptors (non-benzodiazepines)
- ☐ Ambien
- ☐ Imovane
- ☐ Lunesta
- ☐ Sonata

Acetylcholine Receptor Agonists
- ☐ Anectine
- ☐ Evoxac
- ☐ Isopto
- ☐ Nicotine
- ☐ Salagen
- ☐ Urecholine

Acetylcholine Receptor Agonists Antimuscarinic Agents
- ☐ AtropPen
- ☐ Atrovent
- ☐ Scopace
- ☐ Spiriva

Acetylcholine Receptor Agonists Ganglionic Blockers
- ☐ Arfonad
- ☐ Hexamethonium
- ☐ Inversine
- ☐ Nicotine (high dose)

Acetylcholine Receptor Agonists Neuromuscular Blockers
- ☐ Atracurium
- ☐ Anectine
- ☐ Cisatracurium
- ☐ Doxacurium
- ☐ Metocurine
- ☐ Mivacurium
- ☐ Pancuronium
- ☐ Rocuronium
- ☐ Tubocurarine
- ☐ Vecuronium
- ☐ Hemicholinium

Acetylcholine Reactivators
- ☐ Protopam

Acetylcholine Receptor Agonists Neuromuscular Blockers
- ☐ Antilirium
- ☐ Aricept
- ☐ Carbamate Insecticides
- ☐ Cognex
- ☐ Enlon
- ☐ Exelon
- ☐ Mestinon
- ☐ Prostigmin
- ☐ Razadyne
- ☐ THC

Cholinesterase Inhibitors (Irreversible)
- ☐ Echotiophate
- ☐ Organophosphate Insecticides
- ☐ Organophosphate nerve agents
- ☐ Enlon