



THE NATUROPATHIC MEDICAL RESEARCH CLINIC
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Brain Nutrition Quiz © 2010 Raymond J Pataracchia ND

Prospective clients are often curious to find out what biochemical-nutrient profiles (orthomolecular syndromes) they may have. We understand this need to know and offer a free service that uses your symptoms as depicted on the Brain Nutrition Quiz to help you identify distinct biochemical-nutrient tendencies. These tendencies are specific to over-all well-being and mental health. The clustering of symptoms into distinct categories is an ongoing process. For a more reliable assessment of health status we recommend our targeted lab testing. We are pleased to assess and convey quiz results by telephone as a courtesy to our prospective client base. If you are interested, please print the form, fill it out legibly and fax or email it back to our clinic. All information is kept in strict confidence.

Patient Name: _____ Age: ____ Gender: M F Date: _____

Name of Party Requesting Information: _____

Province/State/Country: _____ Phone # (with area code): _____

Best time of day to reach you Monday-Thursday, 8:30am-5:00pm: _____

I provide permission for NMRC staff to process and discuss results by phone. I am a prospective client and I have reviewed the fee schedule at www.nmrc.ca/pages/CLINIC_SERVICES.php :

Patient Signature

Guardian Signature (Required if patient is under 14 years old)

Instructions: Please answer all questions as True or False. (60 questions, ~ 5 minutes)

- | | | |
|---|----------------------------|----------------------------|
| 1. I often have cold hands and/or feet. | T <input type="checkbox"/> | F <input type="checkbox"/> |
| 2. I am poor at adapting to temperature changes. | T <input type="checkbox"/> | F <input type="checkbox"/> |
| 3. I have less than two bowel movements per day or less than one foot of stool per day. | T <input type="checkbox"/> | F <input type="checkbox"/> |
| 4. I have a weight gain problem. | T <input type="checkbox"/> | F <input type="checkbox"/> |
| 5. I have hair loss. | T <input type="checkbox"/> | F <input type="checkbox"/> |
| 6. I have foggy thinking or poor memory. | T <input type="checkbox"/> | F <input type="checkbox"/> |
| 7. I am so sluggish that it interferes with my ability to do daily activities. | T <input type="checkbox"/> | F <input type="checkbox"/> |
| 8. I have a pale or fair complexion. | T <input type="checkbox"/> | F <input type="checkbox"/> |
| 9. I am a fairly heavy coffee drinker. | T <input type="checkbox"/> | F <input type="checkbox"/> |
| 10. I have a slow metabolism. | T <input type="checkbox"/> | F <input type="checkbox"/> |
| 11. I have a problem falling or staying asleep. | T <input type="checkbox"/> | F <input type="checkbox"/> |
| 12. I have allergic or environmental sensitivities. | T <input type="checkbox"/> | F <input type="checkbox"/> |
| 13. I have a mood, behaviour or psychotic condition. | T <input type="checkbox"/> | F <input type="checkbox"/> |
| 14. I have a nervous irritability. | T <input type="checkbox"/> | F <input type="checkbox"/> |
| 15. I have digestive pains, bloating or nausea. | T <input type="checkbox"/> | F <input type="checkbox"/> |
| 16. I have or have had metal dental fillings. | T <input type="checkbox"/> | F <input type="checkbox"/> |
| 17. My gums bleed frequently. | T <input type="checkbox"/> | F <input type="checkbox"/> |
| 18. I am a visual learner. | T <input type="checkbox"/> | F <input type="checkbox"/> |

19. My diet is mainly vegetarian.	T	F
20. I use anti-psychotics, antibiotics, antacids, cortisone, Tagamet, Zantac or diuretics.	T	F
21. I have bouts of depression or irritability.	T	F
22. I have problems swallowing.	T	F
23. I feel worse taking birth control pills or after inserting my copper IUD (women only).	T	F
24. I have a family history of heart disease or strokes.	T	F
25. I have elevated cholesterol.	T	F
26. I have osteoporosis (or osteopenia).	T	F
27. My bowel movements sometimes resemble pellets of varying size.	T	F
28. My bowel movements are unformed, irregular or contain undigested matter.	T	F
29. I often feel anxiety in my stomach.	T	F
30. I did not reach my developmental height or weight landmarks during childhood.	T	F
31. I am hungry all the time.	T	F
32. I have trouble putting on weight.	T	F
33. I have feelings of unreality that have lasted greater than 6 months.	T	F
34. I do not have a mental health problem.	T	F
35. Time seems too slow or too fast or the world seems unreal.	T	F
36. I have been a longstanding user of anti-psychotic medication.	T	F
37. I have poor dream recall (2 or less times per week).	T	F
38. Food tastes bland.	T	F
39. I have weak knees.	T	F
40. I have little or no appetite.	T	F
41. I have white spots on my nails.	T	F
42. I have frequent infections during cold season.	T	F
43. I am irritable before meals or when I skip meals.	T	F
44. I am tired after meals.	T	F
45. I feel better when arguing or fighting.	T	F
46. I have sugar cravings.	T	F
47. I have an addiction to alcohol or illicit substances.	T	F
48. I have abundant ears wax.	T	F
49. I have dry skin (scalp, heels, hands, feet, etc.).	T	F
50. I have small cherry red round bulges on the skin.	T	F
51. I have a prominent history of bacterial infections.	T	F
52. I have a history of anemia.	T	F
53. I have depression or anxiety.	T	F
54. I have a family history of schizophrenia.	T	F
55. I have post-traumatic stress.	T	F
56. Bowel movements pass often with pain or straining.	T	F
57. I sometimes have muscle twitches or cramps in my calves, thighs, arms or face.	T	F
58. I have a problem staying asleep or I sleep lightly.	T	F
59. I have a problem falling asleep; my brain won't shut off.	T	F
60. I have a fast metabolism.	T	F