TOOLS for WELLNESS
Live Smarter®

RESTORE - Anxiety & Depression Relief Formula

Self Assessment of Symptoms Form. Please note this assessment form is for personal use to aid in tracking progress monitoring. Any concerns should be addressed with your health practitioner.

This form is designed to establish a baseline of current health conditions and then monitor changes and improvements. Changes can be subtle so recording changes can help greatly to see improvements.

Prior to starting this formula, please first complete this form to have baseline information
Then, after the: 1st 2 weeks changes are usually noticed within days of starting
1st month
2nd month
Each 2 months after please complete a questionnaire as long as changes are noted

Date each form when completed. It is very important for all items to be checked.

RESTORE *Anxiety & Depression Relief Formula* is a non-molecular, non-prescription formulation based on recombinant DNA isopathically-formulated human cell signaling factors such as hGH, BDNF and Leptin. It is not derived is it from pharmaceutical drugs, or botanical extracts.

Name: _____ Date: _____

Current therapy, if any: Please describe: _____

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Anxiety & Depression cover a wide spectrum of symptoms, some symptoms apply to certain people and not to others.

Check √ or write"**0**" under No if you do **not** currently have/see/experience the symptom listed.

Check "**1 to 7**" if you currently have/notice the symptom listed.
If "**yes**", please assign a number from 1 to 10 to indicate the degree of the symptom currently felt:
1 = very mild, or very decreased or reduced 7 = very severe, or very increased

_____ On a scale of 1 to 7, what is your overall stress level? 1 = none, 7 totally stressed
_____ On a scale of 1 to 7, what is your feeling of health? 1 = excellent, 7 terrible
_____ On a scale of 1 to 7, rate your overall quality of life. 1 = great, 7 horrible

Please remember to circle each entry even with a 0 if not applicable.

Physical Constitution

0 = if not applicable If Yes, score 1 = very mild or hardly noticeable, 7 = very severe

General Fatigue	0	1	2	3	4	5	6	7
Weight Loss	0	1	2	3	4	5	6	7
Weight Gain	0	1	2	3	4	5	6	7
Chest Tightness or Pressure	0	1	2	3	4	5	6	7
Elevated Blood Pressure	0	1	2	3	4	5	6	7

Oral

0 = if not applicable If Yes, score 1 = very mild or hardly noticeable, 7 = very severe

Canker Sores (Mouth Ulcers) (can often result from stress or anxiety weakening the immune system)	0	1	2	3	4	5	6	7
Teeth Grinding (daytime or while sleeping)	0	1	2	3	4	5	6	7

Musculoskeletal

0 = if not applicable If Yes, score 1 = very mild or hardly noticeable, 7 = very severe

Joint Pain in arms or legs	0	1	2	3	4	5	6	7
Muscle Tension or Tightness	0	1	2	3	4	5	6	7
Muscle Weakness	0	1	2	3	4	5	6	7

Gastrointestinal/Abdominal

0 = if not applicable If Yes, score 1 = very mild or hardly noticeable, 7 = very severe

Bloated feeling after eating	0	1	2	3	4	5	6	7
Diarrhea that is undiagnosed	0	1	2	3	4	5	6	7
Constipation	0	1	2	3	4	5	6	7
Sugar Cravings	0	1	2	3	4	5	6	7
Comfort eating when stressed	0	1	2	3	4	5	6	7
Comfort drinking of alcohol beverage when stressed or anxious	0	1	2	3	4	5	6	7

Respiratory

0 = if not applicable If Yes, score 1 = very mild or hardly noticeable, 7 = very severe

Shortness of Breath	0	1	2	3	4	5	6	7
Anxiety/Panic Attacks in Public	0	1	2	3	4	5	6	7
Anxiety/Panic Attacks at Home	0	1	2	3	4	5	6	7
Frequent Use of Asthma Meds	0	1	2	3	4	5	6	7

Skin

0 = if not applicable If Yes, score 1 = very mild or hardly noticeable, 7 = very severe

Rashes	0	1	2	3	4	5	6	7
Itches / Irritation	0	1	2	3	4	5	6	7

Neurological

0 = if not applicable If Yes, score 1 = very mild or hardly noticeable, 7 = very severe

Headaches	0	1	2	3	4	5	6	7
Confusion	0	1	2	3	4	5	6	7
Dizziness	0	1	2	3	4	5	6	7
Poor Short Term Memory	0	1	2	3	4	5	6	7
Tinnitus (Ringing in the Ears)	0	1	2	3	4	5	6	7
Unanticipated Crying	0	1	2	3	4	5	6	7

Sleep

0 = if not applicable If Yes, score 1 = very mild or hardly noticeable, 7 = very severe

Fitful Sleeping	0	1	2	3	4	5	6	7
Late Night TV Watching	0	1	2	3	4	5	6	7

Unable to go to Sleep/Insomnia	0	1	2	3	4	5	6	7
Irregular Sleep Patterns	0	1	2	3	4	5	6	7

Social Interactions

0 = if not applicable	If Yes, score 1 = very mild or hardly noticeable, 7 = very severe							
Insensitive to Feelings of Others	0	1	2	3	4	5	6	7
Not feeling Compassionate	0	1	2	3	4	5	6	7
Obsessive Repetitive Behaviors	0	1	2	3	4	5	6	7
Avoid Social Interactions	0	1	2	3	4	5	6	7
Avoid Sharing Emotions	0	1	2	3	4	5	6	7
Dislike Crowds, If yes, why? _____								
	0	1	2	3	4	5	6	7
Feeling Rejected	0	1	2	3	4	5	6	7
Feeling of Shame	0	1	2	3	4	5	6	7
Drink Alcohol to Numb Feelings	0	1	2	3	4	5	6	7
Use Mind/Pain-Numbing Drugs	0	1	2	3	4	5	6	7
Smoking to Relax	0	1	2	3	4	5	6	7
Spouse or Partner Difficulties	0	1	2	3	4	5	6	7
Low Self Esteem	0	1	2	3	4	5	6	7
Do not like to be Touched or Held, Feeling 'Get out of My Space'								
	0	1	2	3	4	5	6	7

Psychological

0 = if not applicable	If Yes, score 1 = very mild or hardly noticeable, 7 = very severe							
Feeling Emotionally Numb	0	1	2	3	4	5	6	7
Extreme Mood Swings	0	1	2	3	4	5	6	7
Periodically Sad	0	1	2	3	4	5	6	7
Feeling Depressed	0	1	2	3	4	5	6	7
Thoughts of Suicide	0	1	2	3	4	5	6	7
Pent-up or Suppressed Anger	0	1	2	3	4	5	6	7
Lack of Sense of Identity	0	1	2	3	4	5	6	7
Unwanted Frustration or Intolerance	0	1	2	3	4	5	6	7
Mental Isolation	0	1	2	3	4	5	6	7
Poor Short-term Memory	0	1	2	3	4	5	6	7
Inability to Concentrate	0	1	2	3	4	5	6	7
Inappropriately Anxious	0	1	2	3	4	5	6	7
Inappropriately Scared	0	1	2	3	4	5	6	7
Feelings of Being Betrayed	0	1	2	3	4	5	6	7
Feelings of Being Exploited	0	1	2	3	4	5	6	7
Sense of helplessness - 'Why Even Bother?'								
	0	1	2	3	4	5	6	7
Feeling your future has 'shrunk'	0	1	2	3	4	5	6	7
Optimistic about Future Plans	1 = Exceedingly Optimistic					7 = No Hope at All		
	0	1	2	3	4	5	6	7
Sense of Peace or Calm	1 = Excellent					7 = Never, Not at All		
	0	1	2	3	4	5	6	7

Other Symptoms – please add additional observances, thoughts, or feelings.

No	Yes	Score (1-7)	
___	___	_____	_____
___	___	_____	_____

___ ___ _____

Prescription Drug use? If so, what? _____

_____

Please hold onto your assessment each time completed for reference or to provide to your health care provider.