	End your Addiction Now C Gant MD	Column1	Column 2	Column3	Column4
#	Question	Mark Boxes that Apply to you	Mark Boxes that Apply to you	Mark Boxes that Apply to you	Mark Boxes that Apply to you
1	Is alcohol your drug of choice? (If yes.)				
2	If you have used marijuana, does it have a relaxing effect on you (If yes.)				
3	Have you ever obtained relief from depression by taking SSRI antidepressants such as Prozac, Paxil or Zoloft (If yes.)				
4	Have you ever gotten relief from your symptoms by taking 5HTP or the amino acid tryptophan? (If yes.)				
5	Does eating high-sugar foods or processed carbohydrates relax you/relieve irritability & anger? (If yes.)				
6	Do you often have a sense that you are "out of synch" or not attuned to what's going on around you and that a few drinks gets you reconnected? (if yes.)				
7	Do you have a history of angry & irritable depression? (if yes.)				
8	Do you have a regular pattern of unexplained rages or a history of explosive or assaultive behavior? (if yes.)				

9	Do you have a history of sleep problems, especially of waking up early and not being able to get back to sleep? (if yes.)		
10	Is there a history of depression in your family? (If yes.)		
11	Do you often experience episodes of gastrointestinal distress such as gas, bloating, loose stools, constipation and/or abdominal discomfort? (If yes.)		
12	Are sedatives, sleeping pills or downers your "drug of choice"? (If yes.)		
13	Does alcohol relax you or help you sleep? (If yes.)		
14	Have you ever obtained relief for symptoms of anxiety by taking the prescription drugs such as Ativan (lorazepam), Klonopin (clonazepam), Valium (diazepam) or Xanax (alprazolam) or by taking sedatives? (If yes.)		
15	Do you often have symptoms of headache, irritability and/or dizziness if you go for 4 hours or more without food? (If yes.)		
16	Do you have a history of panic attacks or severe anxiety? (If yes.)		
17	Do you have a tendency to be thin or underweight? (If yes)		
18	Do you have problems sleeping/especially falling asleep? (If yes.)		
19	Do you crave sugar? (If yes.)		

20	Do you have a history of anxiety or panic attacks in your family? (If yes.)				
21	Are heroin, Darvon Codeine, methadone, Oxycontin, oxycodone, hydrocodone or other opiates/pain killers your drugs of choice? (If yes.)				
22	Have you ever had difficulty stopping the use of pain killing drugs/opiates? (If yes.)				
23	Do you use drugs or alcohol to carve out a respite or "time out" from a very busy, active life? (If yes.)				
24	Have you ever been diagnosted with post-traumatic stress disorder (PTSD)? (If yes.)				
25	Are you troubled by chronic pain, such as back pain, headaches, etc? (If yes.)				
26	Do you have difficulty enjoying pleasurable experiences much of the time (and not just when you're feeling down)? (If yes.)				
27	Do you have a low pain tolerance? (If yes)				
28	Are either cocaine or amphetamines your drug of choice? (If yes.)				
29	Do you smoke cigarettes, or use nicotine in another form such as smokeless tobacco? (If 1 pack per day or less 1 point, if 2 packs per day 2 points, if 3 or more packs per day 3 points)				
30	If you have used marijuana, does it excite you or have a "speedy" effect on you? (If yes.)				

31	Is there a history of mania in your family? (If yes.)				
32	Do you often experience tiredness, loss of energy, boredom, or an inability to feel pleasure? (If yes.)				
33	Are you a thrill-seeker or risk taker? (If yes.)				
34	Do you respond positively to tricyclic antidepressant drugs such as Tofranil, Elavil, Endep or Pamelor? (If yes.)				
35	Do you respond positively to prescription drugs, such as Ritalin, Cylert, Adderall, Methamphetamine ("uppers")? (If yes.)				
36	Do antihistamine drugs like Benadryl cause you to feel "speedy"? (If yes.)				
	12-15 points = "Probably Deficient"; >15=Deficient				
	Score	A	B	C	D