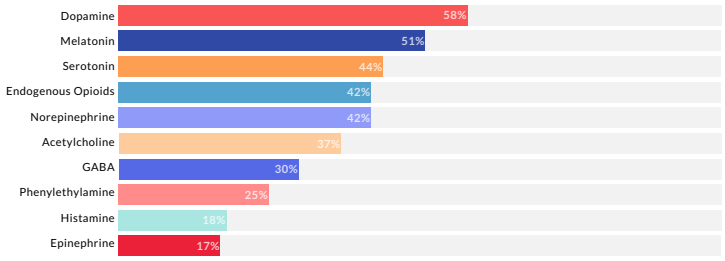
MDA Results

Patient: Joel Barnes (/patients/110522)
Date completed: 09 Oct 2025

Message sent to patient

Hi Joel, Please fill in based on your CURRENT symptoms. Warm regards Nicole

Analysis



Neurotransmitter	Deficiency (%)	Nutritional and herbal supp
Dopamine	58%	Phenylalanine Tyrosine L-Theanine
Melatonin	51%	(S)-S-Adenosylmethionine Glycine Magnesium Tryptophan Ornithine monohydrochlo Lavender oil L-Theanine 5-HTP

Serotonin	44%	Pyridoxal 5-phosphate Tryptophan L-Theanine 5-HTP Hypericum perforatum he Wort)
Endogenous Opioids	42%	Glutamine Phenylalanine Magnesium Zinc
Norepinephrine	42%	Phenylalanine Tyrosine
Acetylcholine	37%	Choline bitartrate Eicosapentaenoic acid (EP Acetyl levocarnitine hydro Docosahexaenoic acid (DH
GABA	30%	Glutamine Magnesium Pyridoxal 5-phosphate Zinc L-Theanine Gamma aminobutyric acid
Phenylethylamine	25%	Glutamine Phenylalanine Magnesium Zinc
Histamine	18%	Histidine Pyridoxal 5-phosphate Ascorbic acid
Epinephrine	17%	(S)-S-Adenosylmethionine Phenylalanine Tyrosine

Results

Do you find it difficult to make decisions?
Very Often (Greater than 15 times a month)

Do you experience digestive symptoms or digestive discomfort and find these symptoms have increased as you have aged?
Never

Do you suffer from long-term constipation?
Never

Are you a light sleeper and wake frequently during the night?
Very Often (Greater than 15 times a month)

Do you experience poor coordination or balance?
Never

Have you been diagnosed with dementia or Alzheimer's disease?
Never

Do you find it difficult to rapidly process new information?
Sometimes (3-5 times a month)

Do your muscles ever feel tight?
Very Often (Greater than 15 times a month)

Do you experience vague or plain dreams?
Often (6-15 times a month)

Do you ever feel unmotivated and struggle to get into what each day has to offer?
Sometimes (3-5 times a month)

Do you find it challenging to learn new things?
Sometimes (3-5 times a month)

Do you feel there is significantly high stress in your life?
Very Often (Greater than 15 times a month)

If applicable, do you feel you have a low sex drive?
Sometimes

Do you ever have difficulty remembering the details of what happened yesterday?
Occasionally (twice or less a month)

Do you ever misplace objects?
Often (6-15 times a month)

Do you ever experience insomnia?
Very Often (Greater than 15 times a month)

Do you experience panic attacks?
Never

Do you experience manic episodes or feelings of mania?
Occasionally (twice or less a month)

Do you experience seizures?
Never

Do you ever crave alcohol?
Never

Do you experience nervousness or worry about doing something you haven't done before?
Occasionally (twice or less a month)

Excluding the use of anticoagulant (blood thinning) medications, do you find that cuts or injuries take a while to heal?
Occasionally (on occasion, cuts or injuries take a week or more to fully heal)

Do you experience hallucinations (or see things that are not actually there)?
Never

Do you have hyperactive tendencies?
Very Often (Greater than 15 times a month)

Do you find it challenging to concentrate?
Sometimes (3-5 times a month)

Do you feel constantly fatigued?
Occasionally (twice or less a month)

Do you have difficulty waking in the morning?
Never

Do you seem to need more sleep than others?
Never

Do you experience feelings of anxiety?
Often (6-15 times a month)

Do you often have a relatively high tolerance to pain?
Never

Do you often feel fatigued for no particular reason?
Occasionally (twice or less a month)

Do you experience hypotension (low blood pressure)?
Never

Do you experience hypoglycaemia (low blood sugar)?
Never

Do you find it difficult to fall asleep at night?
Often (6-15 times a month)

Do you experience headaches or migraines?
Sometimes (3-5 times a month)

Do you experience frequent or long standing insomnia?
Often (6-15 times a month)

Do you experience hypertension (high blood pressure)? Answer very often if you are taking prescribed blood pressure medication/s, even if your blood pressure is no
Occasionally (twice or less a month)

Do you find it difficult to remember what happened a long time ago (poor long term memory)?
Sometimes (3-5 times a month)

Do you experience chronic pain? E.g. Pain that has lasted longer than 6 weeks
Never

Do you suffer from stress urinary incontinence?
Never

Do you put on weight easily and find it difficult to lose weight?
Sometimes

Do you use, or have you previously used, large amounts of stimulants? E.g. Caffeine, Amphetamines, Nicotine, Cocaine
Very Often (Greater than 15 times a month)

Have you experienced chronic stress coupled with fatigue currently or in the past?
Sometimes (3-5 times a month)

Do you have a short attention span and find it difficult to concentrate?
Sometimes (3-5 times a month)

Do your legs jump when you are asleep?
Occasionally (twice or less a month)

Do you avoid regular exercise?
Never (I exercise 3 or more days per week)

Do you have overtly negative reactions to stress or dwell over stressful situations?
Sometimes (3-5 times a month)

Do you feel tense, anxious and worried?
Sometimes (3-5 times a month)

Do you smoke more than one packet of cigarettes a day? Answer never if you do not smoke at all.
Never

Do you crave or actively seek behaviour such as gambling, extreme sports, recreational drug use, frequent excess alcohol use?
Often (6-15 times a month)

Do you experience constipation?
Never

Do you constantly worry about your body size?
Occasionally (twice or less a month)

Do you feel aggressive when drinking alcohol?
Never

Are you more sensitive to pain than others (low pain tolerance)?
Occasionally (twice or less a month)

Do you ever find yourself repeating certain actions constantly such as hand washing, counting things or checking that the door is locked?
Occasionally (twice or less a month)

Do you crave sugary foods or foods high in carbohydrates?
Often (6-15 times a month)

Do you dwell for an extended period of time over a major personal life event e.g. relationship breakup, financial worries?
Often (6-15 times a month)

Do you have problems with self esteem?
Occasionally (twice or less a month)

Do you suffer from headaches?
Sometimes (3-5 times a month)

Do you avoid situations where there will be a large amount of people?
Sometimes (3-5 times a month)

Do you feel nervous when you have to go to public places?
Never

Do you feel angry or aggressive?
Often (6-15 times a month)

Do you feel more depressed or down during the winter months?
Often (6-15 days a month)

Do you have panic attacks or anxiety?
Occasionally (twice or less a month)

Do you suffer from feelings of being down or depressed?
Sometimes (3-5 times a month)

Do you have impulsive tendencies?
Often (6-15 times a month)