# HEALTH APPRAISAL QUESTIONNAIRE

**Name** _____ **Date** _____

**DIRECTIONS**

This questionnaire asks you to assess how you have been feeling **during the last four months**. This information will help you keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

**For each question, circle the number that best describes your symptoms:**

**0 = No or Rarely**—You have never experienced the symptom or the symptom is familiar to you but you perceive it as insignificant (monthly or less)

**1 = Occasionally**—Symptom comes and goes and is linked in your mind to stress, diet, fatigue or some identifiable trigger

**4 = Often**—Symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it

**8 = Frequently**—Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis

**Some questions require a YES or NO response: 0 = NO 8 = YES**

## PART I

| | No/Rarely | Occasionally | Often | Frequently |
|---|---|---|---|---|
| **SECTION A** | | | | |
| 1. Indigestion, food repeats on you after you eat | 0 | 1 | 4 | 8 |
| 2. Excessive burping, belching and/or bloating following meals | 0 | 1 | 4 | 8 |
| 3. Stomach spasms and cramping during or after eating | 0 | 1 | 4 | 8 |
| 4. A sensation that food just sits in your stomach creating uncomfortable fullness, pressure and bloating during or after a meal | 0 | 1 | 4 | 8 |
| 5. Bad taste in your mouth | 0 | 1 | 4 | 8 |
| 6. Small amounts of food fill you up immediately | 0 | 1 | 4 | 8 |
| 7. Skip meals or eat erratically because you have no appetite | 0 | 1 | 4 | 8 |
| **Total points** | | | | |
| **SECTION B** | | | | |
| 1. Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt | 0 | 1 | 4 | 8 |
| 2. Feel hungry an hour or two after eating a good-sized meal | 0 | 1 | 4 | 8 |
| 3. Stomach pain, burning and/or aching over a period of 1-4 hours after eating | 0 | 1 | 4 | 8 |
| 4. Stomach pain, burning and/or aching relieved by eating food; drinking carbonated beverages, cream or milk; or taking antacids | 0 | 1 | 4 | 8 |
| 5. Burning sensation in the lower part of your chest, especially when lying down or bending forward | 0 | 1 | 4 | 8 |
| 6. Digestive problems that subside with rest and relaxation | (0)No | | | (8)Yes |
| 7. Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache | 0 | 1 | 4 | 8 |
| 8. Feel a sense of nausea when you eat | 0 | 1 | 4 | 8 |
| 9. Difficulty or pain when swallowing food or beverage | 0 | 1 | 4 | 8 |
| **Total points** | | | | |
| **SECTION C** | | | | |
| 1. When massaging under your rib cage *on your left side*, there is pain, tenderness or soreness | 0 | 1 | 4 | 8 |
| 2. Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal | 0 | 1 | 4 | 8 |
| 3. Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement | 0 | 1 | 4 | 8 |
| 4. Specific foods/beverages aggravate indigestion | 0 | 1 | 4 | 8 |
| 5. The consistency or form of your stool changes (e.g., from narrow to loose) within the course of a day | 0 | 1 | 4 | 8 |

| | No/Rarely | Occasionally | Often | Frequently |
|---|---|---|---|---|
| **SECTION C** *(cont.)* | | | | |
| 6. Stool odor is embarrassing | 0 | 1 | 4 | 8 |
| 7. Undigested food in your stool | 0 | 1 | 4 | 8 |
| 8. Three or more large bowel movements daily | 0 | 1 | 4 | 8 |
| 9. Diarrhea (frequent loose, watery stool) | 0 | 1 | 4 | 8 |
| 10. Bowel movement shortly after eating (within 1 hour) | 0 | 1 | 4 | 8 |
| **Total points** | | | | |
| **SECTION D** | | | | |
| 1. Discomfort, pain or cramps in your colon (lower abdominal area) | 0 | 1 | 4 | 8 |
| 2. Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas | 0 | 1 | 4 | 8 |
| 3. Generally constipated (or straining during bowel movements) | 0 | 1 | 4 | 8 |
| 4. Stool is small, hard and dry | 0 | 1 | 4 | 8 |
| 5. Pass mucus in your stool | 0 | 1 | 4 | 8 |
| 6. Alternate between constipation and diarrhea | 0 | 1 | 4 | 8 |
| 7. Rectal pain, itching or cramping | 0 | 1 | 4 | 8 |
| 8. No urge to have a bowel movement | (0)No | | | (8)Yes |
| 9. An almost continual need to have a bowel movement | (0)No | | | (8)Yes |
| **Total points** | | | | |

## PART II

| | | | | |
|---|---|---|---|---|
| 1. When massaging under your rib cage *on your right side*, there is pain, tenderness or soreness | 0 | 1 | 4 | 8 |
| 2. Abdominal pain worsens with deep breathing | 0 | 1 | 4 | 8 |
| 3. Pain at night that may move to your back or right shoulder | 0 | 1 | 4 | 8 |
| 4. Bitter fluid repeats after eating | 0 | 1 | 4 | 8 |
| 5. Feel abdominal discomfort or nausea when eating rich, fatty or fried foods | 0 | 1 | 4 | 8 |
| 6. Throbbing temples and/or dull pain in forehead associated with overeating | 0 | 1 | 4 | 8 |
| 7. Unexplained itchy skin that's worse at night | 0 | 1 | 4 | 8 |
| 8. Stool color alternates from clay colored to normal brown | 0 | 1 | 4 | 8 |
| 9. General feeling of poor health | 0 | 1 | 4 | 8 |

## PART II

| | No/Rarely | Occasionally | Often | Frequently |
|---|---|---|---|---|
| 10. Aching muscles not due to exercise | 0 | 1 | 4 | 8 |
| 11. Retain fluid and feel swollen around the abdominal area | 0 | 1 | 4 | 8 |
| 12. Reddened skin, especially palms | 0 | 1 | 4 | 8 |
| 13. Very strong body odor | 0 | 1 | 4 | 8 |
| 14. Are you embarrassed by your breath? | 0 | 1 | 4 | 8 |
| 15. Bruise easily | (0)No | | (8)Yes | |
| 16. Yellowish cast to eyes | (0)No | | (8)Yes | |

**Total points** ____

## PART III

### SECTION A

| | | | | |
|---|---|---|---|---|
| 1. Feel cold or chilled—hands, feet or all over—for no apparent reason | 0 | 1 | 4 | 8 |
| 2. Your upper eyelids look swollen | 0 | 1 | 4 | 8 |
| 3. Muscles are weak, cramp and/or tremble | 0 | 1 | 4 | 8 |
| 4. Are you forgetful? | 0 | 1 | 4 | 8 |
| 5. Do you feel like your heart beats slowly? | 0 | 1 | 4 | 8 |
| 6. Reaction time seems slowed down | 0 | 1 | 4 | 8 |
| 7. In general, are you disinterested in sex because your desire is low? | 0 | 1 | 4 | 8 |
| 8. Feel slow-moving, sluggish | 0 | 1 | 4 | 8 |
| 9. Constipation | 0 | 1 | 4 | 8 |
| 10. Dryness, discoloration of skin and/or hair | (0)No | | (8)Yes | |
| 11. Have you noticed recently that your voice is deepening? | (0)No | | (8)Yes | |
| 12. Thick, brittle nails | (0)No | | (8)Yes | |
| 13. Weight gain for no apparent reason | (0)No | | (8)Yes | |
| 14. Outer third of your eyebrow is thinning or disappearing | (0)No | | (8)Yes | |
| 15. Swelling of the neck | (0)No | | (8)Yes | |

**Total points** ____

### SECTION B

| | | | | |
|---|---|---|---|---|
| 1. Lingering mild fatigue after exertion or stress | 0 | 1 | 4 | 8 |
| 2. Do you find that you get tired and exhaust easily? | 0 | 1 | 4 | 8 |
| 3. Craving for salty foods | 0 | 1 | 4 | 8 |
| 4. Sensitive to minor changes in weather and surroundings | 0 | 1 | 4 | 8 |
| 5. Dizzy when rising or standing up from a kneeling position | 0 | 1 | 4 | 8 |
| 6. Dark bluish or black circles under your eyes | 0 | 1 | 4 | 8 |
| 7. Have bouts of nausea with or without vomiting | 0 | 1 | 4 | 8 |
| 8. Catch colds or infections easily | (0)No | | (8)Yes | |
| 9. Wounds heal slowly | (0)No | | (8)Yes | |
| 10. Your body or parts of your body feel tender, sore, sensitive to the touch, hot and/or painful | 0 | 1 | 4 | 8 |
| 11. Feel puffy and swollen all over your body | 0 | 1 | 4 | 8 |
| 12. Skin is gradually tanning without exposure to sun or the ingestion of high levels of carotene-rich foods (e.g., daily carrot juice intake) or supplements | (0)No | | (8)Yes | |

**Total points** ____

## PART IV

| | No/Rarely | Occasionally | Often | Frequently |
|---|---|---|---|---|

### SECTION A

**When you miss meals or go without food for extended periods of time, do you experience any of the following symptoms?**

| | | | | |
|---|---|---|---|---|
| 1. A sense of weakness | 0 | 1 | 4 | 8 |
| 2. A sudden sense of anxiety when you get hungry | 0 | 1 | 4 | 8 |
| 3. Tingling sensation in your hands | 0 | 1 | 4 | 8 |
| 4. A sensation of your heart beating too quickly or forcefully | 0 | 1 | 4 | 8 |
| 5. Shaky, jittery, hands trembling | 0 | 1 | 4 | 8 |
| 6. Sudden profuse sweating and/or your skin feels clammy | 0 | 1 | 4 | 8 |
| 7. Nightmares possibly associated with going to bed on an empty stomach | 0 | 1 | 4 | 8 |
| 8. Wake up at night feeling restless | 0 | 1 | 4 | 8 |
| 9. Agitation, easily upset, nervous | 0 | 1 | 4 | 8 |
| 10. Poor memory, forgetful | 0 | 1 | 4 | 8 |
| 11. Confused or disoriented | 0 | 1 | 4 | 8 |
| 12. Dizzy, faint | 0 | 1 | 4 | 8 |
| 13. Cold or numb | 0 | 1 | 4 | 8 |
| 14. Mild headaches or head pounding | 0 | 1 | 4 | 8 |
| 15. Blurred vision or double vision | 0 | 1 | 4 | 8 |
| 16. Feel clumsy and uncoordinated | 0 | 1 | 4 | 8 |

**Total points** ____

### SECTION B

| | | | | |
|---|---|---|---|---|
| 1. Frequent urination during the day and night | 0 | 1 | 4 | 8 |
| 2. Unusual thirst—feeling like you can't drink enough water | 0 | 1 | 4 | 8 |
| 3. Unusual hunger—eating all the time | 0 | 1 | 4 | 8 |
| 4. Vision blurs | 0 | 1 | 4 | 8 |
| 5. Feel itchy all over | 0 | 1 | 4 | 8 |
| 6. Tingling or numbness in your feet | 0 | 1 | 4 | 8 |
| 7. Sense of drowsiness, lethargy during the day not associated with missing meals or not sleeping | 0 | 1 | 4 | 8 |
| 8. Eating starchy foods, even if they are healthy and unprocessed (like rice, corn, beans, whole wheat or oats), causes you to gain weight or prevents you from losing weight | (0)No | | (8)Yes | |
| 9. Sores heal slowly | (0)No | | (8)Yes | |
| 10. Loss of hair on your legs | (0)No | | (8)Yes | |

**Total points** ____

## PART V

### SECTION A

| | | | | |
|---|---|---|---|---|
| 1. Feel jittery | 0 | 1 | 4 | 8 |
| 2. First effort of the day causes pain, pressure, tightness or heaviness around the chest | 0 | 1 | 4 | 8 |
| 3. Exhaustion with minor exertion | 0 | 1 | 4 | 8 |
| 4. Heavy sweating (no exertion, no hot flashes) | 0 | 1 | 4 | 8 |
| 5. Difficulty catching breath, especially during exercise | 0 | 1 | 4 | 8 |
| 6. Heart pounding, sensation of heart beating too quickly, too slowly or irregularly | 0 | 1 | 4 | 8 |
| 7. Swelling in feet, ankles and/or legs comes and goes for no apparent reason | 0 | 1 | 4 | 8 |

**Total points** ____

## PART V (cont.)

| | No/Rarely | Occasionally | Often | Frequently |
|---|---|---|---|---|
| **SECTION B** | | | | |
| 1. Muscle pain at rest | 0 | 1 | 4 | 8 |
| 2. Cramp-like pains in your ankles, calves or legs | 0 | 1 | 4 | 8 |
| 3. Numbness, tingling and prickling sensation in hands and feet | 0 | 1 | 4 | 8 |
| 4. Cold feet and/or toes appear blue | 0 | 1 | 4 | 8 |
| 5. Brief moments of hearing loss | 0 | 1 | 4 | 8 |
| 6. Nausea comes and goes quickly (unrelated to eating) | 0 | 1 | 4 | 8 |
| 7. Feel worse standing: legs get heavy and fatigued | 0 | 1 | 4 | 8 |
| 8. Leg discomfort or fatigue relieved by elevating legs | 0 | 1 | 4 | 8 |
| 9. Fingers and toes get numb in cold weather even when protected | 0 | 1 | 4 | 8 |
| 10. Notice changes in your ability to feel pain or differentiate between sensations of hot or cold | (0)No | | | (8)Yes |
| 11. Body hair (on arms, hands, fingers, legs and toes) is thinning or has disappeared | (0)No | | | (8)Yes |
| 12. Do you notice a decline in your ability to make decisions, concentrate, focus attention or follow directions? | (0)No | | | (8)Yes |
| **Total points** | | | | |

## PART VI

| | No/Rarely | Occasionally | Often | Frequently |
|---|---|---|---|---|
| **SECTION A** | | | | |
| 1. Family, friends, work, hobbies or activities you hold dear are no longer of interest | 0 | 1 | 4 | 8 |
| 2. Do you cry? | 0 | 1 | 4 | 8 |
| 3. Does life look entirely hopeless? | 0 | 1 | 4 | 8 |
| 4. Would you describe yourself as feeling miserable and sad, unhappy or blue? | 0 | 1 | 4 | 8 |
| 5. Do you find it hard to make the best of difficult situations? | 0 | 1 | 4 | 8 |
| 6. Sleep problems—too much or too little sleep | 0 | 1 | 4 | 8 |
| 7. Changes in your appetite and weight | (0)No | | | (8)Yes |
| 8. Lately you've noticed an inability to think clearly or concentrate | (0)No | | | (8)Yes |
| 9. Difficulty making decisions and/or clarifying and achieving your goals | (0)No | | | (8)Yes |
| **Total points** | | | | |
| **SECTION B** | | | | |
| 1. Does worrying get you down? | 0 | 1 | 4 | 8 |
| 2. Does every little thing get on your nerves and wear you out? | 0 | 1 | 4 | 8 |
| 3. Would you consider yourself a nervous person? | 0 | 1 | 4 | 8 |
| 4. Do you feel easily agitated? | 0 | 1 | 4 | 8 |
| 5. Do you shake and tremble? | 0 | 1 | 4 | 8 |
| 6. Are you keyed up and jittery? | 0 | 1 | 4 | 8 |
| 7. Do you tremble or feel weak when someone shouts at you? | 0 | 1 | 4 | 8 |
| 8. Do you become scared at sudden movements or noises at night? | 0 | 1 | 4 | 8 |
| 9. Do you find yourself sighing a lot? | 0 | 1 | 4 | 8 |
| 10. Are you awakened out of your sleep by frightening dreams? | 0 | 1 | 4 | 8 |
| 11. Do frightening thoughts keep coming back in your mind? | 0 | 1 | 4 | 8 |

| | No/Rarely | Occasionally | Often | Frequently |
|---|---|---|---|---|
| **SECTION B *(cont.)*** | | | | |
| 12. Do you become suddenly scared for no reason? | 0 | 1 | 4 | 8 |
| 13. Do you break out in a cold sweat? | 0 | 1 | 4 | 8 |
| 14. "Butterflies in your stomach," nausea and/or diarrhea | 0 | 1 | 4 | 8 |
| **Total points** | | | | |
| **SECTION C** | | | | |
| 1. Do you feel pent up and ready to explode? | 0 | 1 | 4 | 8 |
| 2. Are you prone to noisy and emotional outbursts? | 0 | 1 | 4 | 8 |
| 3. Do you do things on impulse? | 0 | 1 | 4 | 8 |
| 4. Are you easily upset or irritated? | 0 | 1 | 4 | 8 |
| 5. Do you go to pieces if you don't control yourself? | 0 | 1 | 4 | 8 |
| 6. Do little annoyances get on your nerves and make you angry? | 0 | 1 | 4 | 8 |
| 7. Does it make you angry to have anyone tell you what to do? | 0 | 1 | 4 | 8 |
| 8. Do you flare up in anger if you can't have what you want right away? | 0 | 1 | 4 | 8 |
| **Total points** | | | | |

## PART VII

| | | | | |
|---|---|---|---|---|
| 1. Eyes water or tear | 0 | 1 | 4 | 8 |
| 2. Mucus discharge from the eyes | 0 | 1 | 4 | 8 |
| 3. Ears ache, itch, feel congested or sore | 0 | 1 | 4 | 8 |
| 4. Discharge from ears | 0 | 1 | 4 | 8 |
| 5. Is your nose continually congested? | 0 | 1 | 4 | 8 |
| 6. Are you prone to loud snoring? | (0)No | | | (8)Yes |
| 7. Does your nose run? | 0 | 1 | 4 | 8 |
| 8. Nosebleeds | (0)No | | | (8)Yes |
| 9. Hoarse voice | 0 | 1 | 4 | 8 |
| 10. Do you have to clear your throat? | 0 | 1 | 4 | 8 |
| 11. Do you feel a choking lump in your throat? | 0 | 1 | 4 | 8 |
| 12. Do you suffer from severe colds? | (0)No | | | (8)Yes |
| 13. Do frequent colds keep you miserable all winter? | (0)No | | | (8)Yes |
| 14. Flu symptoms last longer than 5 days | (0)No | | | (8)Yes |
| 15. Do infections settle in your lungs? | (0)No | | | (8)Yes |
| 16. Chest discomfort or pain | 0 | 1 | 4 | 8 |
| 17. Do you experience sudden breathing difficulties? | 0 | 1 | 4 | 8 |
| 18. Do you struggle with shortness of breath? | 0 | 1 | 4 | 8 |
| 19. Difficulty exhaling (breathing out) | 0 | 1 | 4 | 8 |
| 20. Breathlessness followed by coughing during exertion, no matter how slight | 0 | 1 | 4 | 8 |
| 21. Inability to breathe comfortably while lying down | 0 | 1 | 4 | 8 |
| 22. Do you cough up lots of phlegm? | 0 | 1 | 4 | 8 |
| 23. Can you hear noisy rattling sounds when breathing in and out? | 0 | 1 | 4 | 8 |
| 24. Are you troubled with coughing? | 0 | 1 | 4 | 8 |
| 25. Do you wheeze? | 0 | 1 | 4 | 8 |
| 26. Do you have severe soaking sweats at night? | 0 | 1 | 4 | 8 |
| 27. Do your lips and/or nails have a bluish hue? | 0 | 1 | 4 | 8 |
| 28. Are you sleepy during the day? | 0 | 1 | 4 | 8 |

## PART VII (cont.)

| | No/Rarely | Occasionally | Often | Frequently |
|---|---|---|---|---|
| 29. Do you have difficulty concentrating? | 0 | 1 | 4 | 8 |
| 30. Eyes, ears, nose, throat and lung symptoms seem associated with specific foods like dairy or wheat products | (0)No | | | (8)Yes |
| 31. Eyes, ears, nose, throat and lung symptoms are associated with seasonal changes | (0)No | | | (8)Yes |

**Total points** ____

## PART VIII

| | | | | |
|---|---|---|---|---|
| 1. Involuntary loss of urine when you cough, lift something or strain during an activity | 0 | 1 | 4 | 8 |
| 2. Mild lower back ache or pain | 0 | 1 | 4 | 8 |
| 3. Abdominal achiness or pain | 0 | 1 | 4 | 8 |
| 4. Pain or burning when urinating | 0 | 1 | 4 | 8 |
| 5. Rarely feel the urge to urinate | 0 | 1 | 4 | 8 |
| 6. Feel the need to urinate less than every two hours during the day or night | 0 | 1 | 4 | 8 |
| 7. Strong smelling urine | 0 | 1 | 4 | 8 |
| 8. Back or leg pains are associated with dripping after urination | 0 | 1 | 4 | 8 |
| 9. Sore or painful genitals | 0 | 1 | 4 | 8 |
| 10. Urine is a rose color | 0 | 1 | 4 | 8 |
| 11. Sudden urge to void causes involuntary loss of urine | 0 | 1 | 4 | 8 |
| 12. Generalized sense of water retention throughout your body | 0 | 1 | 4 | 8 |

**Total points** ____

## PART IX

### SECTION A

| | | | | |
|---|---|---|---|---|
| 1. Bones throughout your entire body ache, feel tender or sore | 0 | 1 | 4 | 8 |
| 2. Localized bone pain | 0 | 1 | 4 | 8 |
| 3. Hands, feet or throat get tight, spasm or feel numb | 0 | 1 | 4 | 8 |
| 4. Difficulty sitting straight | 0 | 1 | 4 | 8 |
| 5. Upper back pain | 0 | 1 | 4 | 8 |
| 6. Lower back pain | 0 | 1 | 4 | 8 |
| 7. Pain when sitting down or walking | 0 | 1 | 4 | 8 |
| 8. Find yourself limping or favoring one leg | 0 | 1 | 4 | 8 |
| 9. Shins hurt during or after exercise | 0 | 1 | 4 | 8 |

**Total points** ____

### SECTION B

| | | | | |
|---|---|---|---|---|
| 1. Are you stiff in the morning when you wake up? | 0 | 1 | 4 | 8 |
| 2. Difficulty bending down and picking up clothing or anything from the floor | 0 | 1 | 4 | 8 |
| 3. Joint swelling, pain or stiffness involving one or more areas (fingers, hands, wrists, elbows, shoulders, toes, arches, feet, ankles, knees or ankles) | 0 | 1 | 4 | 8 |
| 4. Joints hurt when moving or when carrying weight | 0 | 1 | 4 | 8 |
| 5. A routine exercise program, like daily walking, causes your knees to swell or hurt | 0 | 1 | 4 | 8 |
| 6. Difficulty opening jars that were previously easy to open | 0 | 1 | 4 | 8 |
| 7. Discomfort, numbness, prickling or tingling sensation, or pain in neck, shoulder or arm | 0 | 1 | 4 | 8 |

| | No/Rarely | Occasionally | Often | Frequently |
|---|---|---|---|---|
| **SECTION B** *(cont.)* | | | | |
| 8. Intermittent pain or ache on one side of head spreading to cheek, temple, lower jaw, ear, neck and shoulder | 0 | 1 | 4 | 8 |
| 9. Difficulty chewing food or opening mouth | 0 | 1 | 4 | 8 |
| 10. Difficulty standing up from a sitting position | 0 | 1 | 4 | 8 |
| 11. Shooting, aching, tingling pain down the back of leg | 0 | 1 | 4 | 8 |
| 12. Is it difficult to reach up and get a 5-pound object like a bag of flour from just above your head? | (0)No | | | (8)Yes |
| 13. Injure, strain or sprain easily | (0)No | | | (8)Yes |

**Total points** ____

### SECTION C

| | | | | |
|---|---|---|---|---|
| 1. Muscles stiff, sore, tense and/or achy | 0 | 1 | 4 | 8 |
| 2. Burning, throbbing, shooting or stabbing muscle pain | 0 | 1 | 4 | 8 |
| 3. Muscle cramps or spasms (involuntary or after exertion/exercise) | 0 | 1 | 4 | 8 |
| 4. Is muscle pain or stiffness greater in the morning than other times of the day? | 0 | 1 | 4 | 8 |
| 5. Specific points on body feel sore when pressed | 0 | 1 | 4 | 8 |
| 6. Feel unrefreshed upon awakening | 0 | 1 | 4 | 8 |
| 7. Headaches | 0 | 1 | 4 | 8 |
| 8. Pain at the sides of your head or in your face especially when awakening | 0 | 1 | 4 | 8 |
| 9. Your jaw clicks or pops | 0 | 1 | 4 | 8 |
| 10. Muscle twitch or tremor—eyelids, thumb, calf muscle | 0 | 1 | 4 | 8 |
| 11. Irresistible urge to move legs | 0 | 1 | 4 | 8 |
| 12. Legs move during sleep | 0 | 1 | 4 | 8 |
| 13. Unpleasant crawling sensation inside calves when lying down | 0 | 1 | 4 | 8 |
| 14. Hand and wrist numbness or pain (e.g., interferes with writing or with buttoning or unbuttoning your clothes) | 0 | 1 | 4 | 8 |
| 15. Feeling of "pins and needles" in your thumb and first three fingers | 0 | 1 | 4 | 8 |
| 16. Pain in forearm and sometimes in shoulder | 0 | 1 | 4 | 8 |

**Total points** ____

## PART X

### SECTION A

| | | | | |
|---|---|---|---|---|
| 1. Head feels heavy | 0 | 1 | 4 | 8 |
| 2. Dizziness | 0 | 1 | 4 | 8 |
| 3. Difficulty bending over, standing up from sitting, rolling over in bed and/or turning your head from side to side | 0 | 1 | 4 | 8 |
| 4. Your hands tremble, ever so slightly, for no apparent reason | 0 | 1 | 4 | 8 |
| 5. You feel like you're wearing heavy weights on your feet when walking | 0 | 1 | 4 | 8 |
| 6. Bump into things, trip, stumble and feel clumsy | 0 | 1 | 4 | 8 |
| 7. Difficulty breathing | 0 | 1 | 4 | 8 |
| 8. Difficulty swallowing | 0 | 1 | 4 | 8 |
| 9. People tell you to speak up because they have trouble hearing you | 0 | 1 | 4 | 8 |
| 10. Speaking and forming words does not feel automatic | 0 | 1 | 4 | 8 |
| 11. Need 10-12 hours of sleep to feel rested | 0 | 1 | 4 | 8 |

## PART X (cont.)

| | No/Rarely | Occasionally | Often | Frequently |
|---|---|---|---|---|
| **SECTION A *(cont.)*** | | | | |
| 12. Lack strength (your grip is weak, holding your head or picking your arms up takes effort) | 0 | 1 | 4 | 8 |
| 13. Hands get tired when you write and your handwriting is less legible and smaller than it used to be | (0)No | | | (8)Yes |
| 14. Muscles in arms and legs seem softer and smaller | (0)No | | | (8)Yes |
| 15. Is your eyesight, sense of smell and taste or ability to hear not as sharp as it used to be? | (0)No | | | (8)Yes |
| 16. Do you find yourself moving slower than you used to? | (0)No | | | (8)Yes |
| **Total points** | | | | |
| **SECTION B** | | | | |
| 1. Difficulty absorbing new information | 0 | 1 | 4 | 8 |
| 2. Tend to forget things | 0 | 1 | 4 | 8 |
| 3. Trouble thinking or concentrating | 0 | 1 | 4 | 8 |
| 4. Easily distracted | 0 | 1 | 4 | 8 |
| 5. Do you have a tendency to become frustrated quickly? | 0 | 1 | 4 | 8 |
| 6. Inability to sit still for any length of time, even at mealtime | 0 | 1 | 4 | 8 |
| 7. Finishing tasks is easier said than done | 0 | 1 | 4 | 8 |
| 8. Do you have more trouble solving problems or managing your time than usual? | 0 | 1 | 4 | 8 |
| 9. Low tolerance for stress and otherwise ordinary problems | 0 | 1 | 4 | 8 |
| **Total points** | | | | |

## PART XI

### *Men Only*

| | | | | |
|---|---|---|---|---|
| 1. Sensation of not emptying your bladder completely | 0 | 1 | 4 | 8 |
| 2. Need to urinate less than 2 hours after you have finished urinating | 0 | 1 | 4 | 8 |
| 3. Find yourself needing to stop and start again several times while urinating | 0 | 1 | 4 | 8 |
| 4. Find it difficult to postpone urination | 0 | 1 | 4 | 8 |
| 5. Have a weak urinary stream | 0 | 1 | 4 | 8 |
| 6. Need to push or strain to begin urinating | 0 | 1 | 4 | 8 |
| 7. Dripping after urination | 0 | 1 | 4 | 8 |
| 8. Urge to urinate several times a night | 0 | 1 | 4 | 8 |
| **Total points** | | | | |

## PART XII

### *Women Only*

**(Menopausal women should skip to Sections E and F)**

**SECTION A**

**Do you persistently experience any of these symptoms within three days to two weeks *prior to menstruation?***

| | | | | |
|---|---|---|---|---|
| **[A]** | | | | |
| 1. Anxious, irritable or restless | (0)No | | | (8)Yes |
| 2. Numbness, tingling in hands and feet | (0)No | | | (8)Yes |
| 3. Easy to anger, resentful | (0)No | | | (8)Yes |
| 4. Aggressive or hostile toward family/friends | (0)No | | | (8)Yes |

| | No/Rarely | Occasionally | Often | Frequently |
|---|---|---|---|---|
| **SECTION A *(cont.)*** | | | | |
| **[B]** | | | | |
| 5. Abdominal bloating, feeling swollen (e.g., feet) | (0)No | | | (8)Yes |
| 6. Temporary weight gain | (0)No | | | (8)Yes |
| 7. Breast tenderness, swelling | (0)No | | | (8)Yes |
| 8. Appearance of breast lumps | (0)No | | | (8)Yes |
| 9. Discharge from nipples | (0)No | | | (8)Yes |
| 10. Nausea and/or vomiting | (0)No | | | (8)Yes |
| 11. Diarrhea or constipation | (0)No | | | (8)Yes |
| 12. Aches and pains (back, joints, etc.) | (0)No | | | (8)Yes |
| **[C ]** | | | | |
| 13. Craving for sweets | (0)No | | | (8)Yes |
| 14. Increased appetite or binge eating | (0)No | | | (8)Yes |
| 15. Headaches | (0)No | | | (8)Yes |
| 16. Being easily overwhelmed, shaky or clumsy | (0)No | | | (8)Yes |
| 17. Heart pounding | (0)No | | | (8)Yes |
| 18. Dizziness or fainting | (0)No | | | (8)Yes |
| **[D]** | | | | |
| 19. Confused and forgetful to the point that work suffers | (0)No | | | (8)Yes |
| 20. Overwhelmed with feelings of sadness and worthlessness | (0)No | | | (8)Yes |
| 21. Difficulty sleeping or falling asleep | (0)No | | | (8)Yes |
| 22. Engaging in self-destructive behavior | (0)No | | | (8)Yes |
| **Total points** | | | | |
| **SECTION B** | | | | |
| **Do you experience any of these symptoms *during your period?*** | | | | |
| 1. Cramping in lower abdomen or pelvic area | (0)No | | | (8)Yes |
| 2. Lower abdominal pain is sharp and/or dull or intermittent | (0)No | | | (8)Yes |
| 3. Bloating and sense of abdominal fullness | (0)No | | | (8)Yes |
| 4. Diarrhea or constipation | (0)No | | | (8)Yes |
| 5. Nausea and/or vomiting | (0)No | | | (8)Yes |
| 6. Low back and/or legs ache | (0)No | | | (8)Yes |
| 7. Headaches | (0)No | | | (8)Yes |
| 8. Unusual fatigue (take naps) resulting in missed work | (0)No | | | (8)Yes |
| 9. Painful and/or swollen breasts | (0)No | | | (8)Yes |
| 10. Scanty blood flow | (0)No | | | (8)Yes |
| **Total points** | | | | |
| **SECTION C** | | | | |
| 1. Painful or difficult sexual intercourse | 0 | 1 | 4 | 8 |
| 2. Low abdominal, back and vaginal pain throughout the month | 0 | 1 | 4 | 8 |
| 3. Pelvic pressure or pain while sitting down or standing up, relieved by lying down | 0 | 1 | 4 | 8 |
| 4. Vaginal bleeding other than during your period | 0 | 1 | 4 | 8 |
| 5. Painful bowel movements | 0 | 1 | 4 | 8 |
| 6. Difficult (straining) urination | 0 | 1 | 4 | 8 |
| 7. Abnormal vaginal discharge | 0 | 1 | 4 | 8 |
| 8. Offensive vaginal discharge | 0 | 1 | 4 | 8 |
| 9. Vaginal itching or burning with or without intercourse | 0 | 1 | 4 | 8 |
| 10. Pain during periods is getting progressively worse | (0)No | | | (8)Yes |
| 11. Profuse or prolonged menstrual bleeding | (0)No | | | (8)Yes |
| 12. Unable to get pregnant | (0)No | | | (8)Yes |
| **Total points** | | | | |

## PART XII (cont.)

### SECTION D

| | No/Rarely | Occasionally | Often | Frequently |
|---|---|---|---|---|
| 1. Absence of periods for six months or longer | (0)No | | | (8)Yes |
| 2. Periods occur irregularly (e.g., 3 to 6 times a year) | (0)No | | | (8)Yes |
| 3. Profuse heavy bleeding during periods | 0 | 1 | 4 | 8 |
| 4. Menstrual blood contains clots and tissue | 0 | 1 | 4 | 8 |
| 5. Bleeding between periods can occur anytime | 0 | 1 | 4 | 8 |
| 6. Periods occur greater than every 35 days | (0)No | | | (8)Yes |
| 7. Intense upper stomach pain, lasting several hours at the time you ovulate (approximately day 14 of your cycle) | 0 | 1 | 4 | 8 |
| 8. Bleeding occurs at ovulation (approximately day 14 of your cycle) | 0 | 1 | 4 | 8 |
| 9. Monthly abdominal pain without bleeding | 0 | 1 | 4 | 8 |
| 10. Abundant cervical mucus | 0 | 1 | 4 | 8 |
| 11. Acne and/or oily skin | 0 | 1 | 4 | 8 |
| 12. Overwhelming urges for sexual intercourse | 0 | 1 | 4 | 8 |
| 13. Aggressive feelings | 0 | 1 | 4 | 8 |
| 14. Increased growth of dark facial and/or body hair | (0)No | | | (8)Yes |
| 15. Poor sense of smell | (0)No | | | (8)Yes |
| 16. Voice is becoming deeper | (0)No | | | (8)Yes |
| 17. Breasts seem to be getting smaller | (0)No | | | (8)Yes |
| 18. Receding hairline | (0)No | | | (8)Yes |
| **Total points** | | | | |

### SECTION E

| | No/Rarely | Occasionally | Often | Frequently |
|---|---|---|---|---|
| 1. Vaginal discharge | 0 | 1 | 4 | 8 |
| 2. Vaginal secretions are watery and thin | 0 | 1 | 4 | 8 |
| 3. Vaginal dryness | 0 | 1 | 4 | 8 |
| 4. Sexual intercourse is uncomfortable | 0 | 1 | 4 | 8 |

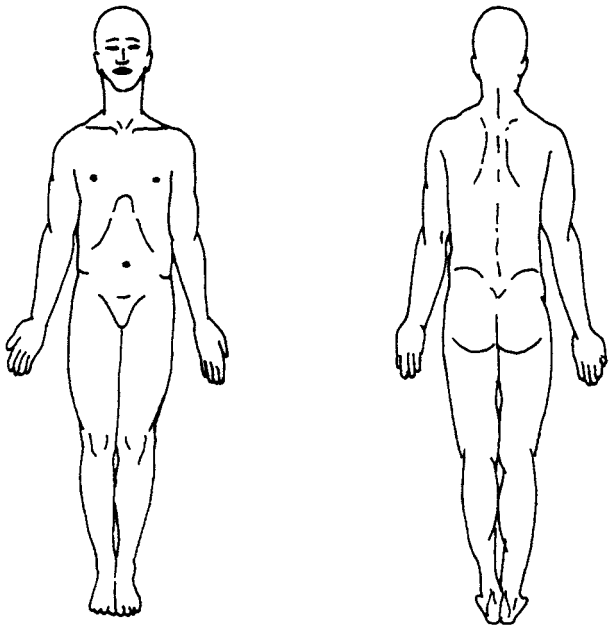
### SECTION E *(cont.)*

| | No/Rarely | Occasionally | Often | Frequently |
|---|---|---|---|---|
| 5. Interest in having sex is low | 0 | 1 | 4 | 8 |
| 6. Engorged breasts | 0 | 1 | 4 | 8 |
| 7. Breast tenderness, soreness | 0 | 1 | 4 | 8 |
| 8. Difficulty with orgasm | 0 | 1 | 4 | 8 |
| 9. Vaginal bleeding after sexual intercourse | 0 | 1 | 4 | 8 |
| 10. Do you skip periods? | (0)No | | | (8)Yes |
| 11. The length (number of days) of your period varies month to month, with the number of days of bleeding getting fewer | (0)No | | | (8)Yes |
| **Total points** | | | | |

### SECTION F

| | No/Rarely | Occasionally | Often | Frequently |
|---|---|---|---|---|
| 1. Sense of well-being fluctuates throughout the day for no apparent reason | 0 | 1 | 4 | 8 |
| 2. Sudden hot flashes | 0 | 1 | 4 | 8 |
| 3. Spontaneous sweating | 0 | 1 | 4 | 8 |
| 4. Chills | 0 | 1 | 4 | 8 |
| 5. Cold hands and feet | 0 | 1 | 4 | 8 |
| 6. Heart beats rapidly or feels like it is fluttering | 0 | 1 | 4 | 8 |
| 7. Numbness, tingling or prickling sensations | 0 | 1 | 4 | 8 |
| 8. Dizziness | 0 | 1 | 4 | 8 |
| 9. Mental fogginess, forgetful or distracted | 0 | 1 | 4 | 8 |
| 10. Inability to concentrate | 0 | 1 | 4 | 8 |
| 11. Depression, anxiety, nervousness and/or irritability | 0 | 1 | 4 | 8 |
| 12. Difficulty sleeping | 0 | 1 | 4 | 8 |
| 13. Conscious of new feelings of anger and frustration | 0 | 1 | 4 | 8 |
| 14. Skin, hair, vagina and/or eyes feel dry | 0 | 1 | 4 | 8 |
| 15. Stopped menstruating around six months ago, yet still experience some vaginal bleeding | (0)No | | | (8)Yes |
| **Total points** | | | | |

**Please mark an "X" to indicate areas where you feel pain, swelling or discomfort, or areas of your skin that have changed color or texture (e.g., moles, rashes, etc.). Describe what you feel or observe in your own words. Write anywhere in this area.**



## HEALTH HISTORY

Name _____ Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: Date began:

_____ _____

_____ _____

_____ _____

List current health problems for which you are being treated: _____

_____

_____

_____

What types of therapies have you tried for these problem(s) or to improve your health over-all:

❑ diet modification ❑ fasting ❑ vitamins/minerals ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs

❑ other _____

Do you experience any of these general symptoms EVERY DAY?

| | | | | |
|---|---|---|---|---|
| ❑ Debilitating fatigue | ❑ Shortness of breath | ❑ Insomnia | ❑ Constipation | ❑ Chronic pain/inflammation |
| ❑ Depression | ❑ Panic attacks | ❑ Nausea | ❑ Fecal incontinence | ❑ Bleeding |
| ❑ Disinterest in sex | ❑ Headaches | ❑ Vomiting | ❑ Urinary incontinence | ❑ Discharge |
| ❑ Disinterest in eating | ❑ Dizziness | ❑ Diarrhea | ❑ Low grade fever | ❑ Itching/rash |

Current medications (prescription or over-the-counter): _____

_____

_____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

Outcome _____

_____

_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

| Year | Surgery, Illness, Injury | Outcome |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)?

_____

What are your current health goals: _____

_____

_____

_____

_____

***Medical History***

❑ Arthritis
❑ Allergies/hay fever
❑ Asthma
❑ Alcoholism
❑ Alzheimer's disease
❑ Autoimmune disease
❑ Blood pressure problems
❑ Bronchitis
❑ Cancer
❑ Chronic fatigue syndrome
❑ Carpal tunnel syndrome
❑ Cholesterol, elevated
❑ Circulatory problems
❑ Colitis
❑ Dental problems
❑ Depression
❑ Diabetes
❑ Diverticular disease
❑ Drug addiction
❑ Eating disorder
❑ Epilepsy
❑ Emphysema
❑ Eyes, ears, nose, throat problems
❑ Environmental sensitivities
❑ Fibromyalgia
❑ Food intolerance
❑ Gastroesophageal reflux disease
❑ Genetic disorder
❑ Glaucoma
❑ Gout
❑ Heart disease
❑ Infection, chronic
❑ Inflammatory bowel disease
❑ Irritable bowel syndrome
❑ Kidney or bladder disease
❑ Learning disabilities
❑ Liver or gallbladder disease (stones)
❑ Mental illness
❑ Mental retardation
❑ Migraine headaches
❑ Neurological problems (Parkinson's, paralysis)
❑ Sinus problems
❑ Stroke
❑ Thyroid trouble
❑ Obesity
❑ Osteoporosis
❑ Pneumonia
❑ Sexually transmitted disease
❑ Seasonal affective disorder
❑ Skin problems
❑ Tuberculosis
❑ Ulcer
❑ Urinary tract infection
❑ Varicose veins
Other _____
_____

***Medical (Men)***

❑ Benign prostatic hyperplasia
❑ Prostate cancer
❑ Decreased sex drive
❑ Infertility
❑ Sexually transmitted disease
Other _____
_____

***Medical (Women)***

❑ Menstrual irregularities
❑ Endometriosis
❑ Infertility
❑ Fibrocystic breasts
❑ Fibroids/ovarian cysts
❑ Premenstrual syndrome (PMS)
❑ Breast cancer
❑ Pelvic inflammatory disease
❑ Vaginal infections
❑ Decreased sex drive
❑ Sexually transmitted disease
Other _____
Date of last GYN exam _____
Mammogram ❑ + ❑ –
PAP ❑ + ❑ –
Form of birth control _____
# of children _____
# of pregnancies _____
❑ C-section _____
Age of first period _____
Date - last menstrual cycle _____
Length of cycle _____ days
Interval of time between cycles _____days
Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____
❑ Surgical menopause
❑ Menopause

***Family Health History (Parents and Siblings)***

❑ Arthritis
❑ Asthma
❑ Alcoholism
❑ Alzheimer's disease
❑ Cancer
❑ Depression
❑ Diabetes
❑ Drug addiction
❑ Eating disorder
❑ Genetic disorder
❑ Glaucoma
❑ Heart disease
❑ Infertility
❑ Learning disabilities
❑ Mental illness
❑ Mental retardation
❑ Migraine headaches
❑ Neurological disorders (Parkinson's, paralysis)
❑ Obesity
❑ Osteoporosis
❑ Stroke
❑ Suicide
Other _____

***Health Habits***

❑ Tobacco:
Cigarettes: #/day _____
Cigars: #/day _____
❑ Alcohol:
Wine: #glasses/d or wk _____
Liquor: #ounces/d or wk _____
Beer: #glasses/d or wk _____
❑ Caffeine:
Coffee: #6 oz cups/d _____
Tea: #6 oz cups/d _____
Soda w/caffeine: #cans/d _____
Other sources _____
❑ Water: #glasses/d_____

***Exercise***

❑ 5-7 days per week
❑ 3-4 days per week
❑ 1-2 days per week
❑ 45 minutes or more duration per workout
❑ 30-45 minutes duration per workout
❑ Less than 30 minutes
❑ Walk - #days/wk _____
❑ Run, jog, other aerobic - #days/wk _____
❑ Weight lift - #days/wk_____
❑ Stretch - #days/wk_____
❑ Other _____

***Nutrition & Diet***

❑ Mixed food diet (animal and vegetable sources)
❑ Vegetarian
❑ Vegan
❑ Salt restriction
❑ Fat restriction
❑ Starch/carbohydrate restriction
❑ The Zone Diet
❑ Total calorie restriction
Specific food restrictions:
❑ dairy ❑ wheat ❑ eggs
❑ soy ❑ corn ❑ all gluten
Other _____

***Food Frequency***

Number of servings per day:
Fruits (citrus, melons, etc.) _____
Dark green or deep yellow/orange vegetables _____
Grains (unprocessed) _____
Beans, peas, legumes _____
Dairy, eggs _____
Meat, poultry, fish _____

***Eating Habits***

❑ Skip meals - which ones _____
_____
❑ One meal/day
❑ Two meals/day
❑ Three meals/day
❑ Graze (small frequent meals)
❑ Generally eat on the run
❑ Eat constantly whether hungry or not

***Current Supplements***

❑ Multivitamin/mineral
❑ Vitamin C
❑ Vitamin E
❑ EPA/DHA
❑ Evening Primrose/GLA
❑ Calcium, source _____
❑ Magnesium
❑ Zinc
❑ Minerals, describe _____
❑ Friendly flora (acidophilus)
❑ Digestive enzymes
❑ Amino acids
❑ CoQ10
❑ Antioxidants (e.g., lutein, resveratrol, etc.)
❑ Herbs
❑ Homeopathy
❑ Protein shakes
❑ Superfoods (e.g., bee pollen, phytonutrient blends)
❑ Liquid meals (Ensure)
Others _____
_____

***I Would Like To:***

*ENERGY - VITALITY*

❑ Feel more vital
❑ Have more energy
❑ Have more endurance
❑ Be less tired after lunch
❑ Sleep better
❑ Be free of pain
❑ Get less colds and flu
❑ Get rid of allergies
❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
❑ Stop using laxatives and stool softeners
❑ Improve sex drive

*BODY COMPOSITION*

❑ Loose weight
❑ Burn more body fat
❑ Be stronger
❑ Have better muscle tone
❑ Be more flexible

*STRESS, MENTAL, EMOTIONAL*

❑ Learn how to reduce stress
❑ Think more clearly and be more-focused
❑ Improve memory
❑ Be less depressed
❑ Be less moody
❑ Be less indecisive
❑ Feel more motivated

*LIFE ENRICHMENT*

❑ Reduce my risk of degenerative disease
❑ Slow down accelerated aging
❑ Maintain a healthier life longer
❑ Change from a "treating-illness" orientation to creating a wellness lifestyle


7/00, Rev 1/03, Rev 3/06
MET1392