

# 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

### SECTION A

	No/Rarely	Occasionally	Often	Frequently
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 <i>on your left side</i> , 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

### SECTION C (cont.)

	No/Rarely	Occasionally	Often	Frequently
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 <i>on your right side</i> , 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
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### 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.)****SECTION B**

	No/Rarely	Occasionally	Often	Frequently
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****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

**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	
<b>Total points</b>				

**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
<b>Total points</b>				

**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
<b>Total points</b>				

**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

**SECTION B (cont.)**

	No/Rarely	Occasionally	Often	Frequently
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	
<b>Total points</b>				

**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
<b>Total points</b>				

**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.)**

**SECTION A (cont.)**

	No/Rarely	Occasionally	Often	Frequently
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

**Total points**

**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**

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		

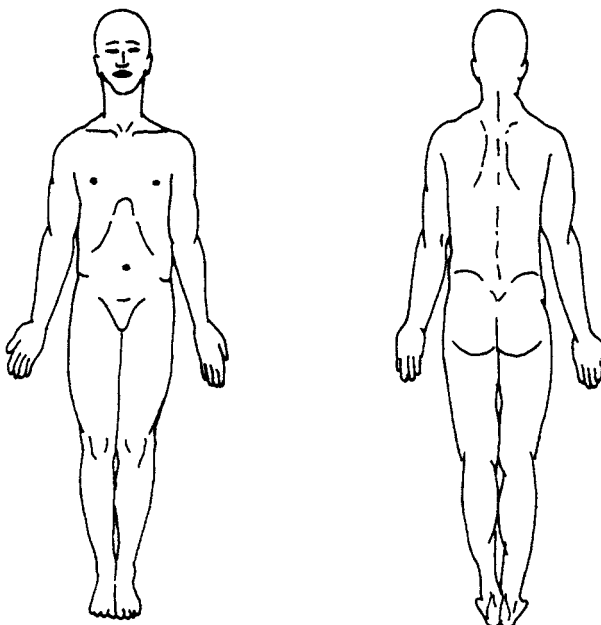
**Total points**

**SECTION F**

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 foginess, 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



**NUTRITION & IMMUNE STATUS**

Physical assessment of common markers of malnutrition, maldigestion, malabsorption, hypermetabolic stress syndrome and protein calorie malnutrition. Exam to be conducted by a healthcare professional.

**General Appearance:**

- Undernourished, skinny (especially the temporal muscles)

**Hair:**

- Dull, dry
- Thin, fine, straight
- Easily plucked
- Areas of lighter or darker spots
- Hair loss

**Face:**

- Pale complexion
- Generalized swelling
- Dark areas on cheeks
- Dark circles under eyes
- Lumpy or flaky skin around the nose and mouth
- Enlarged parotid glands

**Eyes:**

- Difficulty adjusting to the dark
- Dull appearance
- Dry and either pale or red membranes
- Triangular, shiny gray spots on conjunctivas
- Red and fissured eyelid corners
- Bloodshot ring around cornea

**Lips:**

- Red and swollen, especially at corners
- Cheilosis (fissures and chapping of lips)

**Tongue:**

- Swollen
- Purple and raw-looking with sores and abnormal papillae

**Teeth:**

- Missing, or emerging abnormally
- Visible cavities or dark spots
- Bleeding gums

**Nails:**

- Spoon-shaped
- Brittle
- Ridged

**Neck:**

- Swollen thyroid gland

**Skin:**

- Dry, flaky
- Swollen, with lighter and darker spots, some resembling bruises
- Tight and drawn, with poor turgor (elasticity)
- Dermatitis
- Retarded wound healing
- Skin lesions

**Smell and Taste:**

- Partial loss of taste
- Partial loss of smell

**Musculoskeletal System:**

- Muscle wasting
- Muscle weakness
- Muscle atrophy
- Knock-knee or bowlegs
- Bumps on ribs
- Swollen joints
- Musculoskeletal hemorrhages
- Stunted growth, loss of height
- Dowager's hump
- Tetany (muscle twitches and/or cramps)

**Cardiovascular System:**

- Heart rate above 100 beats/minute
- Arrhythmias
- Elevated blood pressure

**Abdomen:**

- Enlarged liver and spleen

**Reproductive System:**

- Decreased libido
- Amenorrhea
- Retarded development of the reproductive system

**Nervous System:**

- Irritability
- Mental confusion
- Abnormal behavior
- Depression
- Paresthesias (tingling) in hands and feet
- Loss of proprioception (unable to maintain balance with eyes closed)
- Decreased ankle and knee reflexes
- Paralysis (no spinal cord injury)
- Tremor

**Consider blood deficiency (pernicious anemia) with the following clinical picture:**

- Considerable weight loss without apparent cause
- Burning tongue
- General weakness, malaise and fatigue
- Numbness and tingling in the extremities
- Alternating constipation and diarrhea
- Abdominal pain
- Nausea and vomiting
- Bleeding gums
- Ataxia (incoordination and irregularity of voluntary, purposeful movements)
- Diplopia (double vision) and blurred vision
- Irritability
- Headache

**Ethnic Background:**

- White (non-Hispanic origin)
- Hispanic
- African American
- Asian
- Pacific Islander
- Native North American
- East Indian

# Health Appraisal Graph

NAME \_\_\_\_\_ INITIAL TEST DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ RETEST DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

Category	Initial Test Score					Retest Score										
	1	2	3	4	5	1	2	3	4	5						
<b>I</b> Gastrointestinal (GI)	A. Gastric Function	56	44	32	20	8	72	58	44	30	16	8	7	6	5	4
	B. GI Inflammation	72	56	40	24	8	80	64	48	32	16	8	7	6	5	4
	C. Small Intestine & Pancreas	80	64	48	32	16	80	64	48	32	16	8	7	6	5	4
	D. Colon	72	58	44	30	16	72	58	44	30	16	8	7	6	5	4
<b>II</b> Liver/GB	Hepatobiliary Function	120	94	68	42	16	120	94	68	42	16	8	7	6	5	4
	A. Thyroid	120	98	76	54	32	120	98	76	54	32	8	7	6	5	4
<b>III</b> Endocrine	B. Adrenal	96	72	48	24	16	96	72	48	24	16	8	7	6	5	4
	A. Diabetes	128	102	76	50	24	128	102	76	50	24	8	7	6	5	4
<b>IV</b> Glucose Regulation	B. Dysglycemia-E	80	66	52	38	24	80	66	52	38	24	8	7	6	5	4
	A. Dysglycemia-L	128	102	76	50	24	128	102	76	50	24	8	7	6	5	4
<b>V</b> Cardio-vascular	A. Heart	56	45	34	23	12	56	45	34	23	12	8	7	6	5	4
	B. Circulation	96	72	48	24	16	96	72	48	24	16	8	7	6	5	4
<b>VI</b> Mood	A. Depression	72	59	46	33	20	72	59	46	33	20	8	7	6	5	4
	B. Anxiety	112	89	66	43	20	112	89	66	43	20	8	7	6	5	4
	C. Anger	64	51	38	25	12	64	51	38	25	12	8	7	6	5	4
<b>VII</b> Immune	Eyes, Ears, Nose, Throat & Lungs	248	200	160	120	100	248	200	160	120	100	8	7	6	5	4
	Kidney & Bladder	96	80	64	48	32	96	80	64	48	32	8	7	6	5	4
	A. Bone Integrity	72	56	40	24	8	72	56	40	24	8	8	7	6	5	4
<b>IX</b> Musculoskeletal	B. Connective Tissue	104	80	56	32	8	104	80	56	32	8	8	7	6	5	4
	C. Muscle & Nerves	112	88	64	40	16	112	88	64	40	16	8	7	6	5	4
	A. Central Nervous System	128	100	72	44	16	128	100	72	44	16	8	7	6	5	4
<b>X</b> CNS & Brain	B. Cognition	72	62	52	42	32	72	62	52	42	32	8	7	6	5	4
	Prostate Health	64	50	36	22	8	64	50	36	22	8	8	7	6	5	4
<b>XI</b> Male	A. Premenstrual Balance	176	142	108	74	40	176	142	108	74	40	8	7	6	5	4
	B. Menstruation	80	64	48	32	16	80	64	48	32	16	8	7	6	5	4
	C. Reproductive Tissue Inflammation	76	60	44	28	12	76	60	44	28	12	8	7	6	5	4
	D. Hormone Balance	144	116	88	60	32	144	116	88	60	32	8	7	6	5	4
	E. Ovarian Function	88	74	60	46	32	88	74	60	46	32	8	7	6	5	4
<b>XII</b> Female	F. Estrogen/ Progesterone Decline	120	96	72	48	24	120	96	72	48	24	8	7	6	5	4

**HIGH PRIORITY**

**MODERATE PRIORITY**

**LOW PRIORITY**

Initial Test Score

Retest Score