HEALTH APPRAISAL - COMPREHENSIVE

NAME______________________________ DATE______________________

CIRCLE the number which best describes the ***frequency*** of your symptoms. If you do not know the answer to the question, leave it blank. When you are finished, please add the number of points in each section and enter the number in the **Total Points** box. The score for YES is the number inside the parenthesis ( ).

(0) never or rarely (1) twice a week or less (2) three to six times a week (3) daily

PART I

Section A

1. Indigestion, "sour stomach"	0	1	2	3
2. Excessive belching, burping and/or bloating	0	1	2	3
3. Gas immediately following a meal	0	1	2	3
4. Sense of fullness during and after meals	0	1	2	3
5. Poor appetite, disinterest in food	0	1	2	3
6. Offensive breath	0	1	2	3
7. Bad taste in mouth	0	1	2	3
8. Partial loss of taste or smell	0	1	2	3
9. Difficult bowel movements	0	1	2	3
10. Difficulty swallowing	0	1	2	3
11. Unintentional weight loss	N			Y (5)
12. History of anemia, unresponsive to iron	N			Y (5)
13. Vegetarian (no eggs, dairy)	N			Y (3)
14. Picky eater	N			Y (3)
15. Spoon shaped nails	N			Y (3)
16. Sores in corner of mouth	N			Y (3)
17. Smooth tongue	N			Y (3)

Total Points________

Section B

1. Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
2. Pain, tenderness, soreness on left side under rib cage	0	1	2	3
3. Bloated	0	1	2	3
4. Excessive passage of gas	0	1	2	3
5. Abdominal cramps, aches	0	1	2	3
6. Nausea and/or vomiting	0	1	2	3
7. Dry, flaky skin, dry brittle hair	0	1	2	3
8. Difficulty gaining weight	0	1	2	3
9. Weakness and fatigue	0	1	2	3
10. Specific foods/beverages aggravate indigestion	0	1	2	3
11. Roughage and fiber causes constipation	0	1	2	3
12. Three or more large bowel movements daily	0	1	2	3
13. Alternating constipation and diarrhea	0	1	2	3
14. Stool poorly formed	0	1	2	3
15. Stool - undigested food	0	1	2	3
16. Stool - greasy, shiny	0	1	2	3
17. Stool yellowish, foul smelling	0	1	2	3
18. Mucus in stool	0	1	2	3
19. Black stool	0	1	2	3
20. Rectal spasms	0	1	2	3
21. Dark urine	0	1	2	3
22. Bone and back pain	0	1	2	3
23. Pounding heart	0	1	2	3
24. Iron deficiency anemia	N			Y (3)

Total Points________

Section C

1. Stomach pain, burning, aching 1-4 hours after eating	0	1	2	3
2. Feeling hungry an hour or two after eating	0	1	2	3
3. Strong emotions, thought, smell of food aggravates stomach	0	1	2	3
4. Heartburn, especially when lying down or bending forward	0	1	2	3
5. Heartburn due to spicy and fatty foods, chocolate, peppers, citrus, alcohol, caffeine	0	1	2	3
6. Difficulty or pain when swallowing	0	1	2	3
7. Chest pain, difficulty breathing, lung infections	0	1	2	3
8. Constipation, difficult bowel movements	0	1	2	3
9. Black, tarry stool	0	1	2	3
10. Unexplained weight gain	N			Y (3)
11. Temporary relief from antacids, carbonated beverages, cream/milk/food	N			Y (5)
12. Digestive problems subside with rest and relaxation	N			Y (5)

Total Points________

Section D

1. Lower abdominal pain, cramping and/or spasms	0	1	2	3
2. Lower abdominal pain relief by passing stool or gas	0	1	2	3
3. Raw fruits, vegetables and stress aggravate bowel pain	0	1	2	3
4. Diarrhea (loose watery stool)	0	1	2	3
5. More than three bowel movements daily	0	1	2	3
6. Excessive gas and bloating	0	1	2	3
7. Painful, difficult, straining during bowel movements	0	1	2	3
8. Hard, dry or small stool	0	1	2	3
9. Extremely narrow stools, thin stool	0	1	2	3
10. Alternating diarrhea/constipation	0	1	2	3
11. Mucus and pus in stool	0	1	2	3
12. Feeling that bowels do not empty completely	0	1	2	3
13. Rectal pain or cramps	0	1	2	3
14. Bright red blood following bowel movement	0	1	2	3
15. Anal itching	0	1	2	3
16. Irritable, moody	0	1	2	3
17. Rash under breast, armpit, around naval or groin area	N			Y (5)
18. Feel ill in damp, moldy settings or rainy weather	N			Y (3)

Total Points________

PART II

Section A

1. Moderate to severe pain under right side of rib cage	0	1	2	3
2. Abdominal pain worse with deep breathing	0	1	2	3
3. Bitter fluid repeats after eating	0	1	2	3
4. Bloated, full feeling	0	1	2	3
5. Belching, heartburn, gas	0	1	2	3
6. Fatty foods cause indigestion	0	1	2	3
7. Nausea and/or vomiting	0	1	2	3
8. Feel restless, agitated, angry	0	1	2	3

PART II (continued)

Section A (continued)

9. Unexplained itchy skin worse at night	0	1	2	3
10. Yellowish cast to skin, eyes	0	1	2	3
11. Stool color alternates from clay colored to normal brown	0	1	2	3
12. General feeling of poor health	0	1	2	3
13. Fatigue, weakness, exhaustion	0	1	2	3
14. Unable to concentrate, irritable, confused	0	1	2	3
15. Aching muscles	0	1	2	3
16. Trembling hands	0	1	2	3
17. Weight gain due to water retention	0	1	2	3
18. Swollen feet and/or legs	0	1	2	3
19. Bleeding tendencies in gums, nose	0	1	2	3
20. Loss of chest and armpit hair	0	1	2	3
21. Reddened skin, especially palms	0	1	2	3
22. Dark urine, diminished flow	0	1	2	3
23. Dry, flaky skin and/or hair	N			Y (3)
24. Loss of appetite and weight	N			Y (3)
25. Easy bruising	N			Y (3)
26. Thinning of pubic hair	N			Y (3)
27. Feeling of extreme dryness	N			Y (3)
28. Loss of skin elasticity	N			Y (3)

Total Points_________

Section B

1. Tired, sluggish	0	1	2	3
2. Feel cold - hands, feet, all over	0	1	2	3
3. Tight sensation in neck	0	1	2	3
4. Difficult, infrequent bowel movements	0	1	2	3
5. Dryness, discoloration skin, hair	0	1	2	3
6. Thick, brittle nails	0	1	2	3
7. Puffy face, hands and feet	0	1	2	3
8. Swollen upper eyelids	0	1	2	3
9. Eyeballs move involuntarily	0	1	2	3
10. Muscles weak, cramp and/or tremble	0	1	2	3
11. Slow mental processes, forgetfulness	0	1	2	3
12. Slow heart beats	0	1	2	3
13. Abdominal swelling	0	1	2	3
14. Unsteady gait, movements	0	1	2	3
15. Lack of interest in sex	0	1	2	3
16. Gain weight easily	N			Y (5)
17. Swelling of the neck	N			Y (5)
18. Outer third of eyebrow thins	N			Y (3)
19. Thinning hair on scalp, face and genitals	N			Y (3)
20. Loss of appetite	N			Y (3)
21. Premenstrual tension	N			Y (3)
22. Infertility	N			Y (3)
23. Excessive menstrual bleeding	N			Y (3)
24. Absence of periods	N			Y(3)

Total Points_________

PART III

Section A

1. Progressive, mild fatigue after exertion or stress	0	1	2	3
2. General weakness	0	1	2	3
3. Blurred vision, dizzy when rising	0	1	2	3
4. Depression	0	1	2	3
5. Rapid mood swings	0	1	2	3
6. Irritable	0	1	2	3
7. Dark circles under the eyes	0	1	2	3
8. Abdominal pain, indigestion	0	1	2	3
9. Bouts of nausea, vomiting	0	1	2	3
10. Diarrhea or constipation	0	1	2	3
11. Blotchy skin (white patches)	0	1	2	3
12. Craving for salty foods	0	1	2	3
13. Decreased appetite	N			Y (3)
14. Gradual weight loss	N			Y (3)
15. Tan skin, no sun	N			Y (3)
16. Gradual loss of body hair	N			Y (3)
17. Black freckles on upper forehead, face, neck	N			Y (3)
18. Sensitive to minor changes in weather and surroundings	N			Y (5)

Total Points_________

Section B

1. Catch colds easily	0	1	2	3
2. Infections–eyes, ears,nose throat, lungs, skin	0	1	2	3
3. Diarrhea	0	1	2	3
4. Puffy face	0	1	2	3
5. Dark areas on cheeks, under eyes	0	1	2	3
6. Difficulty seeing at night	0	1	2	3
7. Eyes tear, burn, discharge	0	1	2	3
8. Ears, continuously drain	0	1	2	3
9. Nasal congestion or discharge - thick, yellow, green	0	1	2	3
10. Sore throat or post-nasal drip	0	1	2	3
11. Cough with mucus	0	1	2	3
12. Inflamed or bleeding gums	0	1	2	3
13. Cold sores, fever blisters	0	1	2	3
14. Gums swelling, bleeding	0	1	2	3
15. Unexplained weight loss of 10 pounds in last three months	N			Y (3)
16. Lack of appetite	N			Y (3)

Section B (continued)

17. Nail discolorations	N			Y (3)
18. Bumpy skin on back of arms	N			Y (3)
19. Wounds heal slowly	N			Y (3)
20. Hair is easily plucked out, or falls out, grows slow	N			Y (3)
21. Lips are red and swollen	N			Y (3)
22. Tongue is red, swollen, raw looking	N			Y (3)
23. Impaired taste and smell	N			Y (3)
24. Neck, armpit, groin swelling	N			Y (5)

Total Points_________

Section C

1. Muscles fatigue quickly	0	1	2	3
2. Moody, irritable, tired	0	1	2	3
3. Severe fatigue	0	1	2	3
4. Severe joint pain, redness swelling	0	1	2	3
5. Chronic pain, stiffness throughout body	0	1	2	3
6. Migraine headaches	0	1	2	3
7. Specific food(s) worsen pain, inflammation, stiffness	0	1	2	3
8. Sensitive to light (skin or eyes)	0	1	2	3
9. Dark circles under eyes	0	1	2	3
10. Swollen-looking face or body	0	1	2	3
11. Localized or general itching - eyes, ears, throat, nose, skin	0	1	2	3
12. Clear, watery discharge from nose, eyes	0	1	2	3
13. Extreme dryness of eyes, nasal passages, mouth	0	1	2	3
14. Sneezing	0	1	2	3
15. Cough or wheezing	0	1	2	3
16. Moldy, damp environments trigger sickness	0	1	2	3
17. Post nasal drip with certain foods	0	1	2	3
18. Heart palpitations after eating certain foods	0	1	2	3
19. Weight loss, muscle weakness	N			Y (3)
20. Scalp hair falls out easily, in clumps	N			Y (3)
21. Hair loss, entire body	N			Y (5)
22. Easy bruising	N			Y (3)
23. Nails - loosened, pitted, discolored	N			Y (5)

Total Points_________

PART IV

Section A

1. Sense of being overly tired	0	1	2	3
2. Prolonged recovery after exercise	0	1	2	3
3. Coldness, especially in hands and feet	0	1	2	3
4. Difficulty breathing on exertion, palpitations	0	1	2	3
5. Headache, dizziness, spots before eyes	0	1	2	3
6. Irritable	0	1	2	3
7. Forgetful, poor concentration	0	1	2	3
8. Mild yellowing of eyes or skin	0	1	2	3
9. Ringing in ears	0	1	2	3
10. Susceptible to infections	0	1	2	3
11. Jaundice and dark urine	0	1	2	3
12. Black stool (no iron supplements)	0	1	2	3
13. Unusual cravings for clay, dirt, ice	0	1	2	3
14. Fingernails are flattened, spoonshaped, brittle, thin	N			Y (5)
15. White patches on skin	N			Y (3)
16. Pale lips, gums, eyelids nail beds	N			Y (3)
17. Red, sore tongue	N			Y (3)
18. Mouth, throat, rectum ulcers	N			Y (3)
19. Unusual bruising	N			Y (3)
20. Spontaneous bleeding - nose, mouth, gums, rectum or vagina	N			Y (3)
21. Small red dots under the skin	N			Y (3)
22. Sores in the corner of mouth	N			Y (3)
23. Smooth tongue	N			Y (3)

Total Points________

Section B

1. Nosebleeds	0	1	2	3
2. Headache, typically in morning	0	1	2	3
3. Weakness, fatigue, nervous	0	1	2	3
4. Ringing in ears	0	1	2	3
5. Dizziness, drowsiness	0	1	2	3
6. Blushing-no apparent cause	0	1	2	3
7. Numbness, tingling in hands and feet	0	1	2	3
8. Blurred vision	0	1	2	3

Total Points________

Section C

1. Feel jittery	0	1	2	3
2. Heartburn that moves to neck, jaws, left shoulder and arm	0	1	2	3
3. First effort of the day causes pain around chest	0	1	2	3
4. Dizziness	0	1	2	3
5. Choking, smothering sensation	0	1	2	3
6. Exhaust with minor exertion	0	1	2	3

Section C (continued)

7. Heart pounds easily	0	1	2	3
8. Heavy sweating (no exertion)	0	1	2	3
9. Mild or severe chest pain	0	1	2	3
10. Difficulty catching breath especially during exercise	0	1	2	3
11. Wheezing or dry cough	0	1	2	3
12. Heart palpitations - slow, rapid or irregular	0	1	2	3
13. Swelling in feet, ankle, legs comes and goes	0	1	2	3
14. Veins on neck are prominent	0	1	2	3

Total Points________

Section D

1. Fluid retention	0	1	2	3
2. Numbness, tingling, pricking sensation in hands, feet	0	1	2	3
3. Muscle pain in the calves or thighs when walking	0	1	2	3
4. Muscle pain at rest	0	1	2	3
5. Cold feet	0	1	2	3
6. Headaches	0	1	2	3
7. Dizziness, everything spins	0	1	2	3
8. Poor concentration	0	1	2	3
9. Slurred speech	0	1	2	3
10. Ringing in ears	0	1	2	3
11. Brief moments of hearing loss	0	1	2	3
12. Nausea comes and goes quickly	0	1	2	3
13. Falling without known cause	0	1	2	3
14. Brief difficulty swallowing	0	1	2	3
15. Brief difficulty speaking	0	1	2	3
16. Stammering or twitching of tongue	0	1	2	3
17. Double vision	0	1	2	3
18. Difficulty understanding spoken or written word	0	1	2	3
19. Brief loss of muscular coordination in legs, arms	0	1	2	3
20. Inability to recognize persons or things that pass very quickly	0	1	2	3
21. Inability to feel pain or temperature, usually on one side, that disappears quickly	0	1	2	3
22. One leg or arm-shiny, hairless skin	N			Y (5)
23. Discolored or blue toes	N			Y (5)
24. Open sores on feet and legs	N			Y (5)
25. Fingers and toes numb in response to cold weather even when protected	N			Y (5)

Total Points________

PART V

Section A

Missing meals or fasting is associated with the following:

1. Sudden anxiety associated with hunger	0	1	2	3
2. Tingling sensation in hands	0	1	2	3
3. Palpitations	0	1	2	3
4. Feel shaky, jittery, tremors	0	1	2	3
5. Weakness	0	1	2	3
6. Profuse perspiration, clammy skin	0	1	2	3
7. Nightmares	0	1	2	3
8. Awake from sleep restless	0	1	2	3
9. Agitated, easily upset, nervous	0	1	2	3
10. Poor memory, forgetful	0	1	2	3
11. Confusion, disoriented	0	1	2	3
12. Dizziness, feel faint	0	1	2	3
13. Feeling cold, numbness	0	1	2	3
14. Mild headache	0	1	2	3

Section A (continued)

15. Blurred or double vision	0	1	2	3
16. Lack of coordination	0	1	2	3

Total Points________

Section B

1. Excessive, frequent urination	0	1	2	3
2. Increased thirst and appetite	0	1	2	3
3. Blurred vision, failing eyesight	0	1	2	3
4. Fatigue, drowsiness	0	1	2	3
5. Crave sweets, but eating sweets does not relieve craving	0	1	2	3
6. Feel hungry for air (can't get enough)	0	1	2	3
7. Breath smells sweet	0	1	2	3
8. Depressed	0	1	2	3
9. Tingling, numbness, prickling sensation in extremities	0	1	2	3
10. Profuse sweating	0	1	2	3

ART V (continued)

Item				
1. Dribble after voiding	0	1	2	3
2. Impotency	0	1	2	3
3. Dizziness when standing from sitting position	0	1	2	3
4. Slurred speech	0	1	2	3
5. Unintentional weight loss	N			Y (3)
16. Reoccurring persistent infection bladder, skin or gums	N			Y (3)
17. Boils and leg sores	N			Y (3)
18. Very slow wound healing	N			Y (3)
19. Excessive weight gain	N			Y (3)

Total Points_________

ART VI

Item				
1. Weakness and fatigue	0	1	2	3
2. Chest discomfort, pain	0	1	2	3
3. Sudden breathing difficulty	0	1	2	3
4. Shortness of breath	0	1	2	3
5. Shallow breathing	0	1	2	3
6. Noisy rattling sounds when breathing in or out	0	1	2	3
7. Cough - dry or moist	0	1	2	3
8. Rapid heartbeats	0	1	2	3
9. Excessive perspiration	0	1	2	3
0. Anxiety, restlessness	0	1	2	3
1. Consistent low grade temperature (100-101°)	0	1	2	3
2. Bluish nails and lips	0	1	2	3
13. Post nasal drip	0	1	2	3
14. Sputum - thick, clear, yellow	0	1	2	3
15. Sputum - smells offensive	0	1	2	3
16. Bloody sputum	0	1	2	3
17. Bad breath	0	1	2	3
18. Wheezing	0	1	2	3
19. Loud snoring	0	1	2	3
20. Sleepy during day	0	1	2	3
21. Morning headache	0	1	2	3
22. Difficulty concentrating	0	1	2	3
23. Unexplained weight loss	N			Y (3)
24. Infections settle in lungs	N			Y (3)
25. Flu symptoms last longer than 5 days	N			Y (3)

Total Points_________

ART VII

Item				
1. Retain fluid throughout body	0	1	2	3
2. Mild lower back pain	0	1	2	3
3. Frequent urge to urinate, but only small amounts pass	0	1	2	3
4. Interruption of urine stream	0	1	2	3
5. Excessive urination	0	1	2	3
6. Excessive urination at night	0	1	2	3
7. Burning when urinating	0	1	2	3
8. Frequent urination with urgency	0	1	2	3
9. Rarely need to urinate	0	1	2	3
0. Difficulty passing urine	0	1	2	3
1. Dripping after urination	0	1	2	3
12. Can't hold urine	0	1	2	3
13. Bloody, cloudy and/or darkened urine	0	1	2	3
14. Strong smelling urine	0	1	2	3
15. Joint and muscle pain	0	1	2	3
16. Tingling in joints	0	1	2	3
17. Dark circles under eyes	0	1	2	3
18. Grey, blackish caste to skin	0	1	2	3
19. Back or leg pains associated with dripping after urination	N			Y (5)
20. Poor skin elasticity, dryness	N			Y (3)

Total Points_________

ART VIII (Men Only)

ection A

Item				
1. Frequent or urgent need to urinate	0	1	2	3
2. Delayed, weak, or interrupted urinary stream	0	1	2	3
3. Pain or burning upon urination	0	1	2	3
4. Urge to urinate several times a night	0	1	2	3
5. Rose colored (bloody) urine	0	1	2	3
6. Difficulty urinating	0	1	2	3
7. A sense of bladder fullness	0	1	2	3
8. Ejaculation causes pain	0	1	2	3
9. Blood in the semen	0	1	2	3
0. Lack of sex drive	0	1	2	3
1. Impotency	0	1	2	3
2. Pain or fatigue in the legs or back	0	1	2	3
3. Dripping after urination	0	1	2	3
4. Increased straining with small amounts of urine passed	0	1	2	3
5. Anemia	N			Y (3)

Total Points_________

Section B

Item				
1. Itchy patches around inner thigh and groin	0	1	2	3
2. Itching at night	0	1	2	3
3. Painful testicles	0	1	2	3
4. Difficulty attaining and/or maintaining an erection	0	1	2	3
5. Low sexual drive	0	1	2	3
6. Premature ejaculation	0	1	2	3
7. Low energy level or stamina	0	1	2	3
8. Inflammation on the head of penis	N			Y (5)
9. Genital and/or rectal rash or irritation	N			Y (5)
10. Distorted nail growth	N			Y (3)
11. Loss of pubic or armpit hair	N			Y (3)
12. Infertile	N			Y (3)
13. Low sperm count, low sperm motility	N			Y (3)
14. Unexplained weight gain	N			Y (3)
15. Testicles appear smaller	N			Y (3)
16. Development of breasts or nipple tenderness	N			Y (3)
17. Feeling of heaviness or hardness in testicle	N			Y (3)
18. Sparse beard or slow hair growth	N			Y (3)
19. Decreased body hair	N			Y (3)
20. Fine wrinkling in corner of mouth or around eyes	N			Y (3)

Total Points_________

PART IX (Women Only)

Section A

Circle, if you experience any of these symptoms within 3 days to two weeks (ovulation) prior to menstruation:

Symptom				
1. Insomnia	0	1	2	3
2. Abdominal bloating	0	1	2	3
3. Breast tenderness, swelling	0	1	2	3
4. Breast lumps appear	0	1	2	3
5. Heart palpitations	0	1	2	3
6. Sweating and flushing	0	1	2	3
7. Depressed, irritable, nervous	0	1	2	3
8. Easy to anger, resentful	0	1	2	3
9. Easily overwhelmed	0	1	2	3
10. Nausea and/or vomiting	0	1	2	3
11. Diarrhea or constipation	0	1	2	3
12. Headache	0	1	2	3
13. Food cravings, binge eating	0	1	2	3
14. Back pain	0	1	2	3
15. Numbness, tingling in hands and feet	0	1	2	3
16. Clumsiness	0	1	2	3
17. Feeling hopeless, sad	0	1	2	3
18. Weight gain - water	N			Y (3)
19. Suicidal	N			Y (10)

Total Points________

Section B

Symptom				
1. Vaginal dryness, pain	0	1	2	3
2. Painful intercourse	0	1	2	3
3. Engorged breasts	0	1	2	3
4. Milk production (not nursing)	0	1	2	3
5. Disinterest in sex	0	1	2	3
6. Blurred vision	0	1	2	3
7. Headache	0	1	2	3
8. Acne and/or oily skin	0	1	2	3
9. Aggressive feelings	0	1	2	3
10. Overwhelming urges for sexual intercourse	0	1	2	3
11. Absence of menstrual flow for six or more months	N			Y (20)
12. Occasionally skip periods	N			Y (5)
13. Menstruation began after 16 years of age	N			Y (3)
14. Breasts shrinking	N			Y (5)
15. Thinning pubic and armpit hair	N			Y (5)
16. Unable to get pregnant	N			Y (10)
17. Miscarriage	N			Y (3)
18. Excess facial hair	N			Y (5)
19. Poor sense of smell	N			Y (3)
20. Monthly abdominal pain without bleeding	N			Y (5)

Total Points________

Section C

Symptom				
1. Painful intercourse	0	1	2	3
2. Menstrual type pain between menses	0	1	2	3
3. Irregular time intervals between periods	N			Y (5)
4. Extended menses greater than 32 days	N			Y (10)
5. Shortened menses (less than every 24 days)	N			Y (5)
6. Vaginal bleeding between periods	N			Y (10)
7. Vaginal discharge between periods	N			Y (5)
8. Pain during periods is getting progressively worse	N			Y (5)

Section C (continued)

Circle, if you experience any of these symptoms during your period:

Symptom				
9. Pain, cramps	0	1	2	3
10. Unusual fatigue, can't work	0	1	2	3
11. Irritable and depressed	0	1	2	3
12. Constipation and/or diarrhea	0	1	2	3
13. Lower abdominal pain, bloating	0	1	2	3
14. Nausea and/or vomiting	0	1	2	3
15. Lower backache	0	1	2	3
16. Pelvic and/or rectal pressure	0	1	2	3
17. Urinary difficulties	0	1	2	3
18. Frequent urination	N			Y (5)
19. Scanty blood flow	N			Y (3)
20. Heavy blood flow	N			Y (3)

Total Points________

Section D

Symptom				
1. Lumps are painful, tender	0	1	2	3
2. Clear, gray, or yellow vaginal discharge	0	1	2	3
3. Vaginal bleeding after sex or between periods	0	1	2	3
4. Burning or itching of the external genitalia	0	1	2	3
5. Urgent, painful urination	0	1	2	3
6. Lower abdominal or back pain	0	1	2	3
7. Heavy, watery and bloody vaginal discharge	0	1	2	3
8. Heavy menstrual flow	0	1	2	3
9. Pelvic cramps	0	1	2	3
10. Thin, scant, white vaginal discharge	0	1	2	3
11. Greenish, yellow, or offensive discharge	0	1	2	3
12. Cheesy white discharge	0	1	2	3
13. Breast lumps or swelling	N			Y (10)
14. Lumps hurt just before period	N			Y (5)
15. Swelling under armpit	N			Y (5)
16. Change in breast size, shape	N			Y (5)
17. White or slightly bloody vaginal discharge, one week prior to period	N			Y (10)

Total Points________

Section E

Symptom				
1. Irregular menstrual cycle	0	1	2	3
2. Dry skin, hair, vagina	0	1	2	3
3. Disinterest in sex	0	1	2	3
4. Mood swings, irritable	0	1	2	3
5. Depression, anxiety, nervousness	0	1	2	3
6. Craving for sweets, binge eating	0	1	2	3
7. Headaches or dizziness	0	1	2	3
8. Painful intercourse	0	1	2	3
9. Sudden hot flashes	0	1	2	3
10. Spontaneous sweating	0	1	2	3
11. Shortness of breath and/or heart palpitations	0	1	2	3
12. Unpredictable vaginal bleeding	0	1	2	3
13. Difficulty holding urine	0	1	2	3
14. Difficulty sleeping	0	1	2	3
15. Mental fogginess	0	1	2	3
16. Vaginal pain and/or itching	0	1	2	3
17. Thin, scant white vaginal discharge	0	1	2	3
18. Low back and/or hip pain	0	1	2	3
19. Breast tenderness, pain or tingling, pricking sensation	0	1	2	3
20. Easy bruising, loss of skin tone	0	1	2	3
21. Thinning armpit and pubic hair	N			Y (5)
22. Stopped menstruating	N			Y (20)
23. Breasts beginning to shrink, sag	N			Y (10)
24. Abnormal growth of hair above lip	N			Y (3)

Total Points________

PART X

Section A

1. Generalized bone tenderness and achiness	0	1	2	3
2. Localized bone pain	0	1	2	3
3. Bone deformity or swelling	0	1	2	3
4. Shins hurt during or after exercises	0	1	2	3
5. Low back or hip pain	0	1	2	3
6. Difficulty sitting straight	0	1	2	3
7. Limp, walking difficulties	0	1	2	3
8. Crunching or creaking sounds when move joints	0	1	2	3
9. Hands, feet, throat spasm or feel numb	0	1	2	3
10. Joint pain and stiffness - especially spine, hips, knees	0	1	2	3
11. Hearing loss, headaches, ringing in ears	0	1	2	3
12. Cavities	N			Y (5)
13. Tooth loss due to gum disease	N			Y (5)
14. Established bone loss	N			Y (10)
15. Calcium deposits	N			Y (5)
16. Spinal curvature	N			Y (10)
17. Recent loss of height	N			Y (10)
18. Bow legs	N			Y (5)
19. Stooped posture	N			Y (5)
20. Hump at base of neck	N			Y (5)
21. Irregular patches of increased pigmentation	N			Y (3)
22. Unexplained bone fracture	N			Y (10)

Total Points_________

Section B

1. Muscle aches and pains	0	1	2	3
2. Muscle stiffness, tension	0	1	2	3
3. Specific points on body feel sore when presses	0	1	2	3
4. Headaches	0	1	2	3
5. Fatigue, tired, sluggish	0	1	2	3
6. Difficulty sleeping	0	1	2	3
7. Feel unrefreshed upon awakening	0	1	2	3
8. Difficulty speaking/swallowing	0	1	2	3
9. Muscle cramps or spasm	0	1	2	3
10. Muscles twitch or tremble - eyelids, thumb, calf muscle	0	1	2	3
11. Irresistible urge to move legs	0	1	2	3
12. Legs move during sleep	0	1	2	3
13. Unpleasant crawling sensation inside the calves, while lying down	0	1	2	3
14. Numbing, tingling sensation	0	1	2	3
15. Excessive joint mobility	0	1	2	3
16. Unable to fully straighten or extend legs and/or arms	0	1	2	3
17. Upper or lower back pain	0	1	2	3
18. Loss of muscle strength	N			Y (3)
19. Muscle loss, wasting	N			Y (3)

Total Points_________

Section C

1. Joint stiffness, soreness, swelling	0	1	2	3
2. Red, swollen painful joints	0	1	2	3
3. Joint stiffness improves when resting, worsens with movement	0	1	2	3
4. Dry mouth	0	1	2	3
5. Dry painful eyes	0	1	2	3
6. Joint stiffness worsens with rest, improves with movement	0	1	2	3
7. Cracking joints	0	1	2	3
8. Limp	0	1	2	3
9. Shooting, aching, tingling pain down the back of leg	0	1	2	3

Section C (continued)

10. Joint pain involves one or a few joints	0	1	2	3
11. Joints hurt when moving or when carrying weight	0	1	2	3
12. Limited range of motion	0	1	2	3
13. Difficulty standing up from sitting position	0	1	2	3
14. Walks slowly	0	1	2	3
15. Headache	0	1	2	3
16. Difficulty chewing food or opening mouth	0	1	2	3
17. Intermittent pain, ache on one side of head spreading to cheek, temple, lower jaw, ear,neck and shoulder	0	1	2	3
18. Numbness, prickling, tingling sensation in the neck,shoulder and arms	0	1	2	3
19. Injure, strain, sprain easily	0	1	2	3
20. Discomfort or pain in neck, shoulder or arm	0	1	2	3
21. Involuntary muscle spasms	0	1	2	3
22. Deliberate movement with hands are difficult	0	1	2	3
23. Red painless skin lumps on elbows, knees, toes, ear, nose, back of scalp	N			Y (5)
24. Knobby overgrowths on the joints closest to the fingertips	N			Y (5)
25. Muscle loss around inflamed joint	N			Y (10)
26. Double jointed	N			Y (3)
27. One leg shorter than the other	N			Y (5)

Total Points_________

Section D Neurological

1. Head feels heavy	0	1	2	3
2. Light headedness/fainting	0	1	2	3
3. Ringing/buzzing in ears	0	1	2	3
4. Trembling hands	0	1	2	3
5. Limbs feel too heavy to hold up	0	1	2	3
6. Loss of feeling in hands and/or feet (toes)	0	1	2	3
7. Tingling sensation followed by numbness, or pain begins in hands and feet and spreads toward the center of your body	0	1	2	3
8. Unsteady gait, lose balance	0	1	2	3
9. Muscles feel weak	0	1	2	3
10. Weak grip with spasm and arm weakness	0	1	2	3
11. Exhaustion on slightest effort	0	1	2	3
12. Need for 10-12 hours sleep	0	1	2	3
13. Muscular weakness begins in leg and moves upward	0	1	2	3
14. Difficulty walking, moving around, handling small objects	0	1	2	3
15. Nervous, anxious	0	1	2	3
16. Convulsions	0	1	2	3
17. Confused, forgetful	0	1	2	3
18. Slowed or slurred speech	0	1	2	3
19. Difficulty breathing	0	1	2	3
20. Blurred vision	0	1	2	3
21. Eyelids droop	0	1	2	3
22. Impaired hearing, eyesight, sense of touch, smell, taste	N			Y (10)
23. Accident prone - trip, stumble, feel clumsy	N			Y (5)

Total Points_________

HEALTH HISTORY

Name ______________________ Date of Birth __________ Today's 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 __________

Date of last physical exam __________ Practitioner name and phone number ______________________

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

Outcome ______________________

What types of therapy have you tried for this problem(s):

❑ diet modification ❑ fasting ❑ vitamin/mineral ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs

❑ other ______________________

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

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

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

Year	Operation, 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 __________

❑ 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, farmer, miner) ______________________

❑ Corrective lenses ❑ Dentures ❑ Hearing aid ❑ Medical devices/prosthetics/implants, describe: ______________________

Recent changes in your ability to: ❑ see ❑ hear ❑ taste ❑ smell ❑ feel hot/cold sensations

❑ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Strong dislike for any one of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Do you: ❑ Prefer warmth (i.e., food, drinks, weather etc.) ❑ Prefer cold (i.e., food, drinks, weather, etc.) ❑ No preference

Is your sleep disturbed at the same time each night? ______ If yes, what time? ______

Time of day you feel the most energy or the least symptoms:

❑ 7 a.m. - 9 a.m. ❑ 9 a.m. - 11 a.m. ❑ 11 a.m. - 1 p.m.
❑ 1 p.m. - 3 p.m. ❑ 3 p.m. - 5 p.m. ❑ 5 p.m. - 7 p.m.
❑ 7 p.m. - 9 p.m. ❑ 9 p.m. - 11 p.m. ❑ 11 p.m. - 1 a.m.
❑ 1 a.m. - 3 a.m. ❑ 3 a.m. - 5 a.m. ❑ 5 a.m. - 7 a.m.

Time of day you feel the worst or your symptoms are aggravated:

❑ 7 a.m. - 9 a.m. ❑ 9 a.m. - 11 a.m. ❑ 11 a.m. - 1 p.m.
❑ 1 p.m. - 3 p.m. ❑ 3 p.m. - 5 p.m. ❑ 5 p.m. - 7 p.m.
❑ 7 p.m. - 9 p.m. ❑ 9 p.m. - 11 p.m. ❑ 11 p.m. - 1 a.m.
❑ 1 a.m. - 3 a.m. ❑ 3 a.m. - 5 a.m. ❑ 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERYDAY?

❑ 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

Medical History

- ❑ Arthritis
- ❑ Allergies/hayfever
- ❑ 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)

- ❑ BPH
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ STD

Other ______________________

____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ PMS
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ STD

Other ______________________

Age of first period ______

Date of last gynecological exam ____

Mammogram ❑ + ❑ –

PAP ❑ + ❑ –

Form of birth control ____________

\# of children ____________

\# of pregnancies ____________

- ❑ C-section ____________
- ❑ Surgical menopause
- ❑ Menopause

Date of 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) ____________

Family Health History (parents and siblings)

- ❑ Arthritis, rheumatoid
- ❑ 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
- ❑ Run, jog, jump rope
- ❑ Weight lift
- ❑ Swim
- ❑ Box
- ❑ Yoga

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

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 breakfast
- ❑ Two meals/day
- ❑ One meal/day
- ❑ Graze (small frequent meals)
- ❑ Food rotation
- ❑ Eat constantly whether hungry or not
- ❑ Generally eat on the run
- ❑ Add salt to food

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, resveritrol, etc.)
- ❑ Herbs - teas
- ❑ Herbs - extracts
- ❑ Chinese herbs
- ❑ Ayurvedic herbs
- ❑ Homeopathy
- ❑ Bach flowers
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals (e.g., Ensure)

Other ____________

Would you like to:

- ❑ Have more energy
- ❑ Be stronger
- ❑ Have more endurance
- ❑ Increase your sex drive
- ❑ Be thinner
- ❑ Be more muscular
- ❑ Improve your complexion
- ❑ Have stronger nails
- ❑ Have healthier hair
- ❑ Be less moody
- ❑ Be less depressed
- ❑ Be less indecisive
- ❑ Feel more motivated
- ❑ Be more organized
- ❑ Think more clearly and be more focused
- ❑ Improve memory
- ❑ Do better on tests in school
- ❑ Not be dependent on over-the-counter medications like aspirin, Tylenol, Benadryl, sleeping aids, etc.
- ❑ Stop using laxatives or stool softeners
- ❑ Be free of pain
- ❑ Sleep better
- ❑ Have agreeable breath
- ❑ Have agreeable body odor
- ❑ Have stronger teeth
- ❑ Get less colds and flus
- ❑ Get rid of your allergies
- ❑ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)