HEALTH APPRAISAL QUESTIONNAIRE Revised Sept 2006 Name: _____ Date: _____

Mark in the box which of the following medications you are taking. Use P if you have taken them in the past.

- ☐ Antacids
- ☐ Antibiotics
- ☐ Antidepressants
- ☐ Antidiabetic/Insulin
- ☐ Antifungal
- ☐ Anti-inflammatories
- ☐ Aspirin / Tylenol
- ☐ Chemotherapy
- ☐ Cortisone
- ☐ Heart Medications
- ☐ High Blood Pressure
- ☐ Hormones
- ☐ Laxatives
- ☐ Lithium
- ☐ Oral Contraceptives
- ☐ Radiation
- ☐ Relaxants
- ☐ Sleeping pills
- ☐ Thyroid
- ☐ Ulcer Medications
- ☐ Recreational Drugs (please list)
- ☐ Other (please list)

Mark in the box if you:

- ☐ Diet often
- ☐ Do not exercise regularly
- ☐ Salt food without tasting
- ☐ Are under excessive stress
- ☐ Are exposed to chemicals at work
- ☐ Are exposed to cigarette smoke

Mark in the box if you often (more than 2 x / wk) eat, drink or use:

- ☐ Alcohol
- ☐ Candy
- ☐ Butter
- ☐ Vitamins, minerals & other supplements (please list)
- ☐ Carbonated Beverages
- ☐ cigarettes
- ☐ Herbal teas
- ☐ Coffee / regular tea
- ☐ Fast food restaurants
- ☐ Purified water
- ☐ Fried foods
- ☐ Luncheon meats
- ☐ Margarine
- ☐ Whole grain foods
- ☐ Refined sugars
- ☐ Aspartame
- ☐ Other artificial sweeteners
- ☐ Oils: list kind

INSTRUCTIONS: Answer **ONLY** if you have the symptom. Do not circle if you do not have that symptom. For each question, circle the number which best describes the intensity of your symptom. **1** = Mild (occasional, slight) **2** = Moderate (more often, obvious) **3** = Severe (frequent, disabling)

PART II DIGESTION

Section A: Hypoacidity

1. Burping	1	2	3
2. Fullness for extended time after meals	1	2	3
3. Bloating	1	2	3
4. Poor appetite	1	2	3
5. Stomach upsets easily	1	2	3
6. History of constipation	1	2	3
7. Known food allergies	1	2	3
8. Lack of interest in eating	1	2	3

Section B: Small Intestine

1. Abdominal cramps	1	2	3
2. Indigestion 1 - 3 hours after eating	1	2	3
3. Fatigue after eating	1	2	3
4. Lower bowel gas	1	2	3
5. Alternating constipation / diarrhea	1	2	3
6. Diarrhea	1	2	3
7. Roughage and fiber causes constipation	1	2	3
8. Mucous in stools	1	2	3
9. Stool poorly formed	1	2	3
10. Shiny stool	1	2	3
11. Three or more large bowel movements daily	1	2	3
12. Foul smelling stool	1	2	3
13. Dry, flaky skin and/or dry brittle hair	1	2	3
14. Pain in left side under rib cage	1	2	3
15. Acne	1	2	3
16. Food allergies	1	2	3
17. Difficulty gaining weight	1	2	3

Section C: Hyperacidity

1. Stomach pains		1	2	3
2. Stomach pains just before and/or after meals		1	2	3
3. Dependency on antacids		1	2	3
4. Chronic abdominal pain		1	2	3
5. Butterfly sensations in stomach		1	2	3
6. Difficulty belching		1	2	3
7. Stomach pain when emotionally upset		1	2	3
8. Sudden, acute indigestion	No			Yes
9. Relief of symptoms by carbonated beverages	No			Yes
10. Relief of stomach pain by drinking cream/milk	No			Yes
11. History of ulcer or gastritis	No			Yes
12. Current ulcer	No			Yes 12
13. Black stool	No			Yes 10
(taking iron supplements?)	No			Yes

Section D: Colon

1. Seasonal diarrhea		1	2	3
2. Frequent and recurrent infections (colds)		1	2	3
3. Bladder and kidney infections		1	2	3
4. Vaginal cramps		1	2	3
5. Abdominal cramps		1	2	3
6. Toe and fingernail fungus		1	2	3
7. Alternating constipation / diarrhea		1	2	3
8. Constipation		1	2	3
9. History of antibiotic use	No			Yes
10. Meat eater	No			Yes
11. Rapidly failing vision	No			Yes

PART III FAT METABOLISM

Section A: Liver / Gallbladder

1. Intolerance to greasy foods	1	2	3	
2. Headaches after eating	1	2	3	
3. Light colored stool	1	2	3	
4. Foul smelling stool	1	2	3	
5. Less than one bowel movement daily	1	2	3	
6. Constipation	1	2	3	
7. Hard stool	1	2	3	
8. Sour taste in mouth	1	2	3	
9. Grey colored skin	1	2	3	
10. Yellow in whites of eyes	1	2	3	
11. Bad breath	1	2	3	
12. Body odor	1	2	3	
13. Fatigue and sleepiness after eating	1	2	3	
14. Pain in right side under rib cage	1	2	3	
15. Painful to pass stool	1	2	3	
16. Retain water	1	2	3	
17. Big toe painful	1	2	3	
18. Pain radiates along outside of leg	1	2	3	
19. Dry skin and/or hair	1	2	3	
20. Red blood in stool	No		Yes	6
21. Have had jaundice or hepatitis	No		Yes	
22. High blood cholesterol	No		Yes	10
23. Is your cholesterol level elevated? (above 5)	No		Yes	
24. Is your cholesterol level elevated? (above 1.5)	No		Yes	

Section B: Thyroid

1. Sensitive to the cold	1	2	3	
2. Cold hands and feet	1	2	3	
3. Constipation	1	2	3	
5. Chronic fatigue	1	2	3	
6. Trouble waking up in the morning	1	2	3	
7. Depressed, apathetic	1	2	3	
8. Sugar causes irritability and mood swings	1	2	3	
9. Low sex drive	1	2	3	
10. Swollen eyes (bulging)	1	2	3	
11. Racing heart / trembling fingers	1	2	3	
12. Thick skin and fingernails	1	2	3	
13. Dry skin	1	2	3	
14. Puffy, wrinkly skin	1	2	3	
15. Muscle pain or stiffness	1	2	3	
16. Premenstrual tension	1	2	3	
17. Excessive menstrual bleeding	1	2	3	
18. Infertility	No		Yes	
19. Thinning / loss of outside portion of eyebrow	No		Yes	
20. Anemia unaffected by taking iron	No		Yes	
21. Armpit temperature below 97.6 F / 36.4 C (or oral temperature below 98.6 F / 37 C)	No		Yes	
22. Gain weight easily	No		Yes	

PART IV IMMUNE FUNCTION

Section A: Hypoadrenal

1. Feel tired in the afternoon	1	2	3
2. Dizziness upon standing	1	2	3
3. Low blood pressure	1	2	3
4. Cannot tolerate much exercise	1	2	3
5. Frequently feel weak or shaky	1	2	3
6. Itchy, red or inflamed eyes	1	2	3
7. Dark circles under the eyes	1	2	3
8. Eyes sensitive to bright light	1	2	3
9. Sensitive to exhaust fumes, smoke, smog	1	2	3
10. petrochemicals	1	2	3
11. Periodic constipation	1	2	3
12. Depression or rapid mood swings	1	2	3
13. Lack of mental alertness	1	2	3
14. Headaches	1	2	3
15. Catch colds easily when weather changes	1	2	3
16. Difficulty breathing	1	2	3
17. Water retention	1	2	3
18. Hemorrhoids	1	2	3
19. Ringing in the ears	1	2	3

Section B: Hypoimmune

1. Inflamed or bleeding gums	1	2	3
2. Running, dripping nose	1	2	3
3. Nose bleeds	1	2	3
4. Loss of smell	1	2	3
5. Get boils or sty's	1	2	3
6. Throat infections	1	2	3
7. Cold sores, fever blisters, herpes	1	2	3
8. Catch colds or flu easily	1	2	3
9. Slow to recover from colds or flu	1	2	3
10. Poor wound healing	1	2	3
11. Swollen lymph glands	1	2	3
12. Ear infection	1	2	3
13. Hair grows slowly	1	2	3
14. Hair falls out	1	2	3
15. Loss of taste	1	2	3
16. Bumpy skin on back or arms	1	2	3

Section C: Hyperimmune / Allergy

1. Itching of nose or eyes	1	2	3	5
2. Watery eyes	1	2	3	5
3. Discharge from eyes	1	2	3	
4. Puffiness or dark circles under eyes	1	2	3	
5. Itching or roof of mouth or throat	1	2	3	
6. Mucous in throat	1	2	3	
7. Post nasal drip	1	2	3	
8. Running nose	1	2	3	
9. Nasal congestion	1	2	3	
10. Sneezing	1	2	3	
11. Breathe through mouth	1	2	3	
12. Chronic lung congestion / asthma / bronchitis	1	2	3	
13. Wheezing	1	2	3	
14. Swollen tongue	1	2	3	
15. Difficulty swallowing	1	2	3	
16. Ear discharge or ears stuffed up	1	2	3	
17. Entire body aches, painful to touch	1	2	3	
18. Swollen joints	1	2	3	
19. Chronic pain	1	2	3	
20. Food sensitivity or allergy	1	2	3	
21. Certain foods make you sick, depressed, jittery	1	2	3	
22. Painful stomach and/or intestine	1	2	3	
23. Alternating constipation and diarrhea	1	2	3	
24. Skin rashes, eczema or psoriasis	1	2	3	
25. Hyperactivity	1	2	3	
26. Migraine headaches	No		Yes	10
27. Use aspirin, Tylenol regularly	No		Yes	
28. Bedwetting	No		Yes	10

PART V CARDIOVASCULAR

Section A: Heart

1. Chest pain while walking	1	2	3	
2. Heaviness in legs	1	2	3	
3. Calf muscles cramp while walking	1	2	3	
4. Heart pounds easily	1	2	3	
5. Heart misses beats or has extra beats	1	2	3	
6. Rapid beating heart	1	2	3	
7. Feel jittery	1	2	3	
8. Swelling of feet and ankles	1	2	3	
9. Heartburn after eating	1	2	3	
10. Pain in left arm	1	2	3	
11. Exhaust with minor exertion	1	2	3	
12. Difficulty breathing at night in bed	1	2	3	
13. Do you do aerobic exercise?	No		Yes	
14. Have you ever exercised regularly	No		Yes	
15. Bright red nose	No		Yes	
16. Drink 5 or more cups of coffee daily	No		Yes	
17. Severe cough	No		Yes	
18. Has a doctor ever told you that you have heart trouble?	No		Yes	6

Section B: Circulation

1. Cold hands and feet	1	2	3	
2. Slurred speech	1	2	3	
3. Calf muscles cramp while walking	1	2	3	
4. Headaches	1	2	3	
5. Numbness in extremities	1	2	3	
6. Poor concentration	1	2	3	
7. Ringing in ears	1	2	3	
8. Ear canal hair	No		Yes	
9. Tingling and/or burning hands or feet	No		Yes	
10. Spider veins on nose and/or face	No		Yes	
11. Heart attack	No		Yes	
12. Stroke	No		Yes	
13. Vertical wrinkle in lower ear lobe	No		Yes	

Section C: Hypertension

1. Pain when getting up in the morning in back of head and neck	1	2	3	
2. Dizziness	1	2	3	
3. Vertigo	1	2	3	
4. Blushing with no apparent cause	1	2	3	
5. Is your blood pressure high?	No		Yes	10

PART VI SUGAR TOLERANCE

Section A: Hypoglycemia

1. Dizziness/loss of vision when standing suddenly	1	2	3	
2. Crave sweets	1	2	3	
3. Headaches relieved by eating sweets or alcohol	1	2	3	
4. Often feel shaky or jittery	1	2	3	
5. Have times of feeling faint	1	2	3	
6. Irritable if a meal missed	1	2	3	
7. Feel tired or weak if a meal is missed	1	2	3	
8. Feel tired 1 to 3 hours after eating	1	2	3	
9. Calmer after eating	1	2	3	
10. Wake up in middle of night craving sweets	1	2	3	
11. Heart palpitations after eating sweets	1	2	3	
12. Need to drink coffee to get started	1	2	3	
13. Impatient, moody, nervous	1	2	3	
14. Poor memory, forgetful	1	2	3	
15. Poor concentration	1	2	3	

Section B: Hyperglycemia / Diabetes

1. Night sweats	1	2	3	7. Overweight	1	2	3
2. Increased thirst	1	2	3	8. Feel energized from exercise	1	2	3
3. Lowered resistance to infection	1	2	3	9. Failing eyesight	1	2	3
4. Fatigue	1	2	3	10. Sugar in urine	1	2	3
5. Boils and leg sores	1	2	3	11. Family history of diabetes	1	2	3
6. Lesions, cuts take a long time to heal	1	2	3	12. Crave sweets, but eating sweets does not relieve craving	1	2	3

PART VII LUNGS

1. Chest pain	1	2	3	9. Rattling mucous when you breathe	1	2	3
2. Chronic cough	1	2	3	10. Sensitive to smog	1	2	3
3. Difficulty breathing	1	2	3	11. Infections settle in lungs	1	2	3
4. Coughing up blood	1	2	3	12. Live or work around people who smoke	1	2	3
5. Coughing up phlegm	1	2	3	13. Bronchitis (now / in past)	No	Yes	10
6. Pain around ribs	1	2	3	14. Exposed to chemicals and radiation	No	Yes	6
7. Shortness of breath	1	2	3	15. Smoker now	No	Yes	6
8. Wheezing / asthma	1	2	3	Smoker in past? Quit how long ago ?	No	Yes	

PART VIII UROLOGICAL

1. Rarely need to urinate	1	2	3	11. Rose colored (bloody) urine	1	2	3
2. Difficulty passing urine	1	2	3	12. Cloudy urine	1	2	3
3. General water retention	1	2	3	13. Strong smelling urine	1	2	3
4. Frequent urination	1	2	3	14. Back or leg pains associated with dripping after urination	1	2	3
5. Pain / burning when passing urine	1	2	3	15. Back pain in kidney area	1	2	3
6. Urination when you cough or sneeze	1	2	3	16. Used antibiotics to control urinary tract infections?	No	Yes	
7. Dripping after urination	1	2	3	17. If yes, when did you last use them?			
8. Can't hold urine	1	2	3	Treatment durations?			
9. For women, frequent vaginal infections	1	2	3				
10. History of kidney or bladder infections	1	2	3				
How frequently?							

PART IX (Males only)

Section A: Prostate

1. A sense of bladder fullness	1	2	3
2. Increased straining with only small amounts of urine passed	1	2	3
3. Wake up to urinate at night	1	2	3
4. Pain or fatigue in the legs or back	1	2	3
5. Lack of sex drive	1	2	3
6. Ejaculation causes pain	1	2	3

Section B: Reproduction

1. Difficulty attaining &/or maintaining an erection	1	2	3	
2. Low sex drive	1	2	3	
3. Premature ejaculation	1	2	3	
4. Pain / coldness in genital area	1	2	3	
5. Low sperm count	No		Yes	5
6. Infertile	No		Yes	5
Had vasectomy?	No		Yes	
7. Varicose veins on scrotum	No		Yes	

Section C: Genital Infection

1. Discharge from penis	1	2	3	
2. Past or present rash on penis	1	2	3	
3. Swollen genitals	1	2	3	
4. Swelling in groin	1	2	3	
5. Venereal disease (gonorrhea, syphilis, herpes or other)	No		Yes	
Have V.D. now?	Had in past?			

PART X (Females only)

Section A: Premenstrual Symptoms - A208 For Section A, please answer for the time prior to menstruation.

In general, how many days prior do you have these symptoms? _____

1. Monthly weight gain, water retention		1	2	3	
2. Bloating and swelling		1	2	3	
3. Tender breast		1	2	3	
4. Depression		1	2	3	
5. Moodiness / Irritability		1	2	3	
6. Anxiety		1	2	3	
7. Easily distracted		1	2	3	
8. Anger		1	2	3	
9. Suicidal feeling	No			Yes	10
10. Nausea and/or vomiting		1	2	3	
11. Headaches		1	2	3	
12. Leg cramps		1	2	3	
13. Low backache		1	2	3	
14. Asthma attacks	No			Yes	10

Section B: Amenorrhea

1. Vaginal itching		1	2	3	
2. Vaginal discharge		1	2	3	
3. Low or not desire for se		1	2	3	
4. Dislike for intercourse		1	2	3	
5. Over 15 years or age and have not begun menstruation	No			Yes	
6. Missed periods	No			Yes	
7. Unable to get pregnant	No			Yes	
8. Miscarriages	No			Yes	
at what month? _____					
9. Abortion	No			Yes	

Section C: Menstruation For Section C only, answer only if you experience any of these symptoms during menstruation.

1. Menstrual pain	1	2	3	
2. Low abdominal pain	1	2	3	
3. Pelvic soreness	1	2	3	
4. Dull ache radiating to low back or legs	1	2	3	
5. Have to lie down on 1st or 2nd day of period	1	2	3	
6. Have to take medication on day 1 or 2	1	2	3	
7. Pain during period is progressively getting worse	1	2	3	
8. Pain and cramps without blood flow	1	2	3	
9. Light scanty blood flow	1	2	3	
10. Heavy menstrual bleeding	1	2	3	
11. Diarrhea / constipation (circle which one)	1	2	3	
12. Abdominal bloating	1	2	3	
13. Nausea and/or vomiting	1	2	3	
14. Headaches	1	2	3	
15. Increased urinary frequency	1	2	3	
16. Craving for sweets	1	2	3	
17. Insomnia	1	2	3	
18. Anxiety about menstrual cycle	1	2	3	

Section D: Fibrocystic Problems

1. Pubic area sore		1	2	3	
2. Pain in ovaries		1	2	3	
3. Vaginal bumps and sores		1	2	3	
4. Breasts sore to touch		1	2	3	
5. Breasts painful		1	2	3	
6. Premenstrual breast pain or discomfort		1	2	3	
7. General water retention / swollen feeling		1	2	3	
8. Recent pap smear was abnormal	No			Yes	15
9. Ovarian cysts	No			Yes	10
10. Uterine cysts	No			Yes	10
11. Breast lumps	No			Yes	10
12. Family history of breast cancer	No			Yes	
13. Birth control pills	No			Yes	
How long? _____ When? _____					
14. Mother used D.E.S. (hormones) while pregnant	No			Yes	

Section E: Menopause

1. Hot flashes		1	2	3	
2. Night sweats		1	2	3	
3. Sweating throughout the day		1	2	3	
4. Depressing / mood swings		1	2	3	
5. Insomnia / can't get to sleep		1	2	3	
6. Waking up in night (can't get back to sleep?)		1	2	3	
7. Heavy bleeding for longer than 10 days / month		1	2	3	
8. Painful intercourse		1	2	3	
9. Vaginal pain		1	2	3	
10. Vaginal itching		1	2	3	
11. Dryness of skin, hair and vagina		1	2	3	
12. Craving for sweets		1	2	3	
13. Memory loss		1	2	3	
14. Osteoporosis (bone loss)	No			Yes	
15. Joint pain		1	2	3	
16. Hysterectomy	No			Yes	
17. Ovaries removed	No			Yes	
18. Periods stopped	No			Yes	
Last period was approximately when? _____					

PART XI MUSCULOSKELETAL

Section A: Bone Integrity

1. Eat meat		1	2	3	
2. Drink carbonated beverages (# / week)		1-3	4-7	7+	
3. Use antacid (# / week)		1-3	4-7	7+	
4. Pain in fingers		1	2	3	
5. Bones sore / painful		1	2	3	
6. Arthritis		1	2	3	
7. Joint or bone deformity	No			Yes	
8. Calcium deposits	No			Yes	
9. Cavities (many fillings)	No			Yes	
10. Dentures	No			Yes	
11. Gum disease	No			Yes	
12. Bone loss (jaw, spine, hip)	No			Yes	
13. Recent bone fracture	No			Yes	
14. Told you have osteoporosis / osteomalacia	No			Yes	5
15. Hysterectomy	No			Yes	
16. Ovaries removed	No			Yes	
17. Post-menopausal. Last period ___ mo ___ yr	No			Yes	

Section B: Muscle

1. Muscle cramps		1	2	3	
2. Muscle spasms		1	2	3	
3. Tightness in neck and shoulder muscles		1	2	3	
4. Pain in neck and/or shoulders		1	2	3	
5. Pain in arms, hands		1	2	3	
6. Unable to sit straight		1	2	3	
7. Back pain, where?		1	2	3	
8. Stiff all over		1	2	3	
9. Stiff in morning		1	2	3	
10. Leg cramps at night		1	2	3	

Section C: Connective Tissue

		1	2	3	
1. Over flexible joints (double-Jointed)		1	2	3	
2. Athletic injury		1	2	3	
3. Injure easily	No			Yes	
4. Swollen knees / elbows / other joints		1	2	3	
5. Bursitis		1	2	3	
6. Tendonitis		1	2	3	
7. Joint pain, where?		1	2	3	
8. Back pain		1	2	3	
9. "Slipped" disc	No			Yes	5
10. Herniated disc	No			Yes	10
11. Loss in height	No			Yes	

PART XII NEUROLOGICAL

1. Head feels heavy		1	2	3	
2. Light headedness / fainting		1	2	3	
3. Loss of balance		1	2	3	
4. Dizziness		1	2	3	
5. Ringing / buzzing in ears		1	2	3	
6. Trembling hands		1	2	3	
7. Loss of feeling in hands and/or feet (toes)		1	2	3	
8. Exhaustion on slightest effort		1	2	3	
9. Limbs feel too heavy to hold up		1	2	3	
10. Loss of grip strength		1	2	3	
11. Tingling pain sensation		1	2	3	
12. Uncoordinated		1	2	3	
13. Nervousness	No	1	2	3	
14. Convulsions	No			Yes	10
15. Accident prone	No			Yes	
16. Loss of muscle tone	No			Yes	
17. Need for 10 - 12 hours of sleep	No			Yes	
18. Have had shingles, where?				Yes	

PART XIII SLEEP PATTERNS

1. Can't fall asleep		1	2	3	
2. Awake frequently throughout night	No			Yes	
3. Wake up middle of night, can't fall back to sleep	No			Yes	
4. Restless, uneasy sleeper		1	2	3	
5. Nightmares		1	2	3	
6. Intense dreams		1	2	3	
7. Sleep walk	No			Yes	
8. Leg cramps / restless legs at night		1	2	3	