HEALTH APPRAISAL QUESTIONNAIRE

Name: _____ Date: _____

This questionnaire helps us to assess your current overall health. It will allow us to 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.

PART I

Read the following questions and fill in the number that applies:

KEY: 0(or leave blank)=Do not consume or use 2=Consume or use weekly
1=Consume or use 2-3 times/month 3=Consume or use daily

DIET

1._____Alcohol
2._____Artificial sweeteners
3._____Candy or other sweets
4._____Carbonated beverages
5._____Chewing tobacco
6._____Cigarettes
7._____Cigars/pipes
8._____Coffee
9._____Eat fast food regularly
10.____Fried foods
11.____Lunch meats/hot dogs
12.____Margarine
13.____Milk products
14.____Non-herbal tea
15.____Refined flour/bakery
16.____ Refined sugar
17.____Vitamins & minerals
18.____Water, distilled
19.____Water, tap
20.____Water, well
21.____Diet often

LIFESTYLE

22.____Times you exercise per week (1=once/week, 2=2-4 times/week, 3=5 times/week)
23.____Changed jobs (3=within last 2 mos, 2=within last 6 mos, 1=within last 12 mos)
24.____Divorced (3=within last 6 mos, 2=within last yr, 1=within last 2 yrs)
25.____Work over 60 hours/week (3=always, 2=usually, 1=occasionally, 0=never)

MEDICATIONS

Indicate any medications you're currently taking or have taken in the last month.

26.____Antacids
27.____Antibiotics
28.____Anticonvulsants
29.____Antidepressants
30.____Antifungals
31.____Aspirin/Ibuprofen
32.____Astma inhalers
33.____Beta blockers
34.____Chemotherapy
35.____Cortisone
36.____Diabetic medications
37.____Diuretics
38.____Estrogen/progesterone
39.____Heart medications
40.____High blood pressure
41.____Hormone Therapy
42.____Insulin
43.____ Laxatives
44.____Oral/implant contraceptives
45.____Radiation exposure
46.____Recreational drugs
47.____Relaxants/sleeping pills
48.____Thyroid medication
49.____Tylenol/acetaminophen
50.____Ulcer medications

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PART II

Read the following questions and fill in the number that applies:
(How significant is the symptom? How true is the statement? 0 means not at all, 3 means extremely true.)

KEY: 0(or leave blank)=No/Do not have the symptom/Symptom does not occur
1=Yes/It is a minor or mild symptom/It rarely occurs (once/month or less)
2=It is a moderate symptom/It occasionally occurs (weekly)
3=It is a severe symptom/It frequently occurs (daily)

Section 1 – Upper Gastrointestinal System

51.____Belching or gas within 1 hour of a meal
52.____Heartburn or acid reflux
53.____Bloating shortly after a meal
54.____Are you a vegan (no dairy/meat/fish/eggs)
55.____Bad breath (halitosis)
56.____Loss of taste for a meal
57.____Sweat has a strong odor
58.____Stomach is upset by taking vitamins
59.____Sense of excess fullness after meals
60.____Do you feel like skipping breakfast
61.____Do you feel better if you don't eat
62.____Sleepy after meals
63.____Fingernails chip, peel or break easily
64.____Anemia unresponsive to iron
65.____Stomach pain or cramps
66.____Diarrhea shortly after meals
67.____Diarrhea, chronic
68.____Black or tarry stools
69.____Undigested food in stools

Section 2- Liver and Gallbladder

70.____Pain between shoulder blades
71.____Stomach upset by greasy foods
72.____Greasy or shiny stools
73.____Nausea
74.____Motion sickness(sea,car,plane)
75.____History of morning sickness (1=yes, 0=no)
76.____ Light or clay colored stools
77.____Dry skin, itchy feet, skin peels on feet
78.____ Headache over the eye
79.____Gallbladder attacks (past or present)
80.____Gallbladder removed (1=yes, 0=no)
81. ____Bitter taste in mouth, esp.after meals
82.____Become sick if drinking wine
83.____If drinking alcohol, become easily intoxicated
84.____Alcoholic beverages per week (0=<3/week, 1=<7/week, 2=<14/week, 3=>14/week)
85.____Recovering alcoholic (1=yes, 0=no)
86.____ Hangovers after drinking alcohol
87.____History of drug or alcohol abuse (1=yes, 0=no)
88.____History of hepatitis (1=yes, 0=no)
89.____Long term us of prescription medications (1=yes, 0=no)
90.____Sensitive to chemicals (perfume, cleaning solvents, insecticides, exhaust, etc.)
91.____Sensitive to tobacco smoke
92.____Exposure to diesel fumes
93.____Pain under right side of rib cage
94.____Hemorrhoids or varicose veins
95.____Nutrasweet(aspartame) consumption
96.____Bothered by Nutrasweet (aspartame)
97.____Chronic Fatigue or Fibromyalgia

Section 3 - Small Intestine

98._____Food allergies
99._____Abdominal bloating 1-2 hours after eating
100.____Specific foods make you feel tired or bloated (1=yes, 0=no)
101.____Pulse speeds after eating
102.____Airborne allergies
103.____Experience hives
104.____Sinus congestions, "stuffy head"
105.____Crave bread or noodles
106.____Alternating constipation and diarrhea
107.____Crohn's disease (1=yes, 0=no)
108.____Wheat or grain sensitivity
109.____Dairy sensitivity
110.____Are there foods you could not give up (1=yes, 0=no)
111.____Asthma, sinus infections, stuffy nose
112.____Bizarre vivid or nightmarish dreams
113.____Use over-the-counter pain medications
114.____Feel spacey or unreal

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Section 4 – Large Intestine

115.____Anus itches
116.____Coated tongue
117.____Feel worse in moldy or musty place
118.____Taken any antibiotic for a combined time of (1=<1 month, 2=<3months, 3=>3 months)
119.____Fungus or yeast infections
120.____Ring worm, "jock itch", "athletes foot", nail fungus
121.____Eating sugar, starch or drinking alcohol increases yeast symptoms
122.____Stools hard or difficult to pass
123.____History of parasites (1=yes, 0=no)
124.____Less than one bowel movement per day
125.____Stools have corners or edges are flat or ribbon shaped
126.____Stools are not well formed (loose)
127.____Irritable bowel or mucous colitis
128.____Blood in stool
129.____Mucous in stools
130.____Excessive foul smelling lower bowel gas
131.____Bad breath or strong body odors
132.____Painful to press along outer sides of thighs (Iliotibial Band)
133.____Cramping in lower abdominal region
134.____Dark circles under eyes

Section 5 – Mineral Needs

135.____History of Carpal Tunnel Syndrome (1=yes, 0=no)
136.____History of lower right abdominal pain (1=yes, 0=no)
137.____History of stress fractures
138.____Bone loss (reduced density on bone scan)
139.____Are you shorter than you used to be (1=yes, 0=no)
140.____Calf, foot or toe cramps at rest
141.____Cold sores/ fever blisters/herpes lesions
142.____Frequent fevers
143.____Frequent skin rashes and/or hives
144.____Have you ever had a herniated disc (1=yes, 0=no)
145.____Excessively flexible joints, "double jointed"
146.____Joints pop or click
147.____Pain or swelling in joints
148.____Bursitis or tendonitis
149.____History of bone spurs (1=yes, 0=no)
150.____Morning stiffness
151.____Vomiting or nausea
152.____Crave chocolate
153.____Feet have a strong odor
154.____Tendency to anemia
155.____Whites of eyes (sclera)blue tinted
156.____Hoarseness
157.____Difficulty swallowing
158.____Lump in throat
159.____Dry mouth, eyes and/or nose
160.____Gag easily
161.____White spots on fingernails
162.____Cuts heal slowly and/or scar easily
163.____Decreased sense of taste or smell

Section 6 – Essential Fatty Acids

164.____Aspirin is an effective pain reliever (1=yes, 0=no)
165.____Crave fatty or greasy foods
166.____Low or reduced fat diet (past or present)
167.____Tension headaches at base of skull
168.____Headaches when out in the hot sun
169.____Sunburn easily or suffer sun poisoning
170.____Muscles easily fatigued
171.____Dry flaky skin and/or dandruff

Section 7 – Sugar Handling

172.____Awaken a few hours after falling asleep, hard to get back to sleep
173.____Crave sweets
174.____Eat desserts or sugary snacks
175.____Binge or uncontrolled eating
176.____Excessive appetite
177.____Crave coffee or sugar in the afternoon
178.____Sleepy in afternoon
179.____Fatigue that is relieved by eating
180.____Headache if meals are skipped or delayed
181.____Irritable before meals
182.____Shaky if meals are delayed
183.____Family members with diabetes (0=none, 1=2 or less, 2= 2-4, 3= more than 4)
184.____Frequent thirst
185.____Frequent urination

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Section 8 – Vitamin Need

186.____Muscles become easily fatigued
187.____Feel worse, sore after moderate exercise
188.____Vulnerable to insect bites
189.____Loss of muscle tone, heaviness in arms/legs
190.____Enlarged heart or heart failure
191.____Pulse slow/below 65 (1=yes, 0=no)
192.____Ringing in the ears/Tinnitus
193.____Numbness, tingling or itching in extremities
194.____Depressed
195.____Fear of impending doom
196.____Worrier, apprehensive, anxious
197.____Nervous or agitated
198.____Feelings of insecurity
199.____Heart races
200.____Can hear heart beat on pillow at night
201.____Whole body or limbs jerk as falling asleep
202.____Night sweats
203.____Restless leg syndrome
204.____Cheilosis (cracks at corner of mouth)
205.____Fragile skin, easily chafed, as in shaving
206.____Polyps or warts
207.____MSG sensitivity
208.____Wake up without remembering dreams
209.____Take birth control pills
210.____Small bumps on back of arms
211.____Strong light at night irritates eyes
212.____Nose bleeds and/or tend to bruise easily
213.____Bleeding gums especially when brushing teeth

Section 9 – Adrenal

214.____Tend to be a night person
215.____Difficulty falling asleep
216.____Slow starter in the morning
217.____Keyed up, trouble calming down
218.____High blood pressure (normal 120/80)
219.____Headache after exercising
220.____Feeling wired or jittery if drinking coffee
221.____Clench or grind teeth
222.____Calm on the outside, troubled inside
223.____Chronic low back pain, worse with fatigue
224.____Become dizzy when standing up suddenly
225.____Difficulty maintaining manipulative correction
226.____Pain after manipulative correction
227.____Arthritic tendencies
228.____Crave salty foods
229.____Salt foods before tasting
230.____Perspire easily
231.____Chronic fatigue, or get drowsy often
232.____Afternoon yawning
233.____Afternoon headache
234.____Asthma, wheezing or difficulty breathing
235.____Pain on the medial or inner side of the knee
236.____Tendency to sprain ankles or "shin splints"
237.____Tendency to need to wear sunglasses
238.____Allergies and/or hives
239.____Weakness, dizziness

Section 10 – Pituitary

240.____Over 6'6" tall (mature height)
241.____Early sexual development (before age 10) (1=yes, 0=no)
242.____Increased libido
243.____Splitting type headache
244.____Memory failing
245.____Inability to tolerate sugar
246.____Under 4'10" (mature height)
247.____Decreased libido
248.____Abnormal thirst
249.____Weight gain around hips or waist
250.____Menstrual disorders
251.____Delayed (after age 13) sexual development (1=yes, 0=no)
252.____Tendency to ulcers or colitis

Section 11 – Thyroid

253.____Allergic to iodine
254.____Difficulty gaining weight, even

with large appetite
255.____Nervous, emotional, can't work under pressure
256.____Inward trembling
257.____Flush easily
258.____Fast pulse at rest
259.____Intolerance to high temperatures
260.____Difficulty losing weight
261.____Mentally sluggish, reduced initiative
262.____Easily fatigued, sleepy during the day
263.____Sensitive to cold, poor circulation (cold hands and feet)
264.____Constipation, chronic
265.____Excessive hair loss and/or coarse hair
266.____Morning headaches, wear off during the day
267.____Loss of lateral 1/3 of eyebrow
268.____Seasonal sadness

Section 12 – Men Only

269.____Prostate problems
270.____Urination difficult or dribbling
271.____Difficult to start and stop urine stream
272.____Pain or burning with urination
273.____Waking to urinate at night
274.____Interruption of stream during urination
275.____Pain on inside of legs or heels
276.____Feeling of incomplete bowel evacuation
277.____Decreased sexual function

Section 13 – Women Only

278.____Depression during periods
279.____Mood swings associated with periods (PMS)
280.____Crave chocolate around periods
281.____Breast tenderness associated with cycle
282.____Excessive menstrual flow
283.____Scanty blood flow during periods
284.____Occasional skipped periods
285.____Variations in menstrual cycle
286.____Endometriosis
287.____Uterine fibroids
288.____Breast fibroids, benign masses
289.____Painful intercourse (dyspareunia)
290.____Vaginal discharge
291.____Vaginal dryness
292.____Vaginal itchiness
293.____Gain weight around hips, thighs,buttocks
294.____Excess facial or body hair
295.____Hot flashes
296.____Night sweats (In menopausal women)
297.____Thinning skin

Section 14 – Cardiovascular

298.____Aware of heavy and/or irregular breathing
299.____Discomfort at high altitudes
300.____"Air hunger" and/or yawn frequently
301.____Compelled to open windows in a closed room
302.____Shortness of breath with moderate exertion
303.____Ankles swell, especially at end of day
304.____Cough at night
305.____Blush or face turns red for no reason
306.____Dull pain or tightness in chest and/or radiate into right arm, worse with exertion
307.____Muscle cramps with exertion

Section 15 – Kidney and Bladder

308.____Pain in mid back region
309.____Dark circles under eyes and/or puffy eyes
310.____History of kidney stones (1=yes, 2=no)
311.____Cloudy, bloody or darkened urine
312.____Urine has a strong odor

Section 16 – Immune System

313.____Runny or drippy nose
314.____Catch colds at the beginning of winter
315.____Mucous producing cough
316.____Frequent infections (ear, sinus, lung, skin, bladder, kidney, etc.)
317.____Frequent colds or flu
318.____ Never get sick (3=not in last 7yrs, 2=not in last 4yrs, 1=not in last 2yrs)
319.____Acne (adult)
320.____Itchy skin/dermatitis
321.____Cysts, boils, rashes

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322.____History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue, other chronic viral condition (1=yes, 2=no)