HEALTH APPRAISAL QUESTIONAIRE

Name _____ Date _____

PART 1: *Please check any of the following medications you are currently taking:*

Antacids	☐ Yes	☐ No	Cortisone	☐ Yes	☐ No	Lithium	☐ Yes	☐ No
Antibiotics/Antifungal	☐ Yes	☐ No	Anti-Inflammatories	☐ Yes	☐ No	Oral Contraceptives	☐ Yes	☐ No
Antidepressants	☐ Yes	☐ No	Heart Medications	☐ Yes	☐ No	Radiation	☐ Yes	☐ No
Antidiabetic/Insulin	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Relaxants/ Sleeping pills	☐ Yes	☐ No
Aspirin/Tylenol	☐ Yes	☐ No	Hormones	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Laxatives	☐ Yes	☐ No	Recreational Drugs	☐ Yes	☐ No

Thyroid: _____ Other: _____

Please check any of the following if you eat, drink, or use:

Alcohol	☐ Yes	☐ No	Coffee	☐ Yes	☐ No	Margarine	☐ Yes	☐ No
Candy	☐ Yes	☐ No	Distilled Water	☐ Yes	☐ No	Refined Sugars	☐ Yes	☐ No
Carbonated Beverages	☐ Yes	☐ No	Fried Foods	☐ Yes	☐ No	Saccharine (sweet & low)	☐ Yes	☐ No
Cigarettes	☐ Yes	☐ No	Luncheon Meats	☐ Yes	☐ No	Chewing Tobacco	☐ Yes	☐ No

Vitamins and/or Minerals (please list): _____

_____

_____

Please check any that apply to you:

Diet Often	☐ Yes	☐ No	Salt Food without Tasting	☐ Yes	☐ No	Exposed to Chemicals at Work	☐ Yes	☐ No
Do Not Exercise	☐ Yes	☐ No	Under Excessive Stress	☐ Yes	☐ No	Exposed to Cigarette Smoke	☐ Yes	☐ No

PART 2: *Please check the number that best describe the intensity of your symptoms. If you do not know the answer to a question, leave it blank.*

0 = Symptom Not Present 1= Mild 2= Moderate 3= Severe

SECTION A:	0	1	2	3	SECTION B:	0	1	2	3
1. Burping	☐	☐	☐	☐	1. Abdominal cramps	☐	☐	☐	☐
2. Fullness for extended time after meals	☐	☐	☐	☐	2. Indigestion 1-3 hours after eating	☐	☐	☐	☐
3. Bloating	☐	☐	☐	☐	3. Fatigue after eating	☐	☐	☐	☐
4. Poor appetite	☐	☐	☐	☐	4. Lower-bowel gas	☐	☐	☐	☐
5. Stomach upsets easily	☐	☐	☐	☐	5. Alternating constipation & diarrhea	☐	☐	☐	☐
6. History of constipation	☐	☐	☐	☐	6. Diarrhea	☐	☐	☐	☐
7. Known food allergies	☐	☐	☐	☐	7. Roughage & fiber causes constipation	☐	☐	☐	☐

SECTION B: (continued)	0	1	2	3
8. Mucous in stools	☐	☐	☐	☐
9. Stool poorly formed	☐	☐	☐	☐
10. Shiny stool	☐	☐	☐	☐
11. Three + large bowel movements daily	☐	☐	☐	☐
12. Foul smelling stool	☐	☐	☐	☐
13. Dry skin and/or brittle hair	☐	☐	☐	☐
14. Pain in left side under rib cage	☐	☐	☐	☐
15. Acne	☐	☐	☐	☐
16. Food allergies	☐	☐	☐	☐

SECTION C:	0	1	2	3
1. Stomach pain	☐	☐	☐	☐
2. Stomach pain just before/after meals	☐	☐	☐	☐
3. Dependency on antacids	☐	☐	☐	☐
4. Chronic abdominal pain	☐	☐	☐	☐
5. Butterfly sensations in stomach	☐	☐	☐	☐
6. Difficulty belching	☐	☐	☐	☐
7. Stomach pain when emotionally upset	☐	☐	☐	☐
8. Sudden, acute indigestion	☐	☐	☐	☐
9. Relief of symptoms by carbonation	☐	☐	☐	☐
10. Relief of symptoms with cream/milk	☐	☐	☐	☐
11. History of ulcers or gastritis	☐	☐	☐	☐
12. Current ulcer	☐	☐	☐	☐
13. Black stool when not taking Iron	☐	☐	☐	☐

SECTION D:	0	1	2	3
1. Seasonal diarrhea	☐	☐	☐	☐
2. Frequent and current infections/colds	☐	☐	☐	☐
3. Bladder and kidney infections	☐	☐	☐	☐
4. Vaginal yeast infections	☐	☐	☐	☐
5. Abdominal cramps	☐	☐	☐	☐
6. Toe and fingernail fungus	☐	☐	☐	☐
7. Alternating constipation and diarrhea	☐	☐	☐	☐
8. Constipation	☐	☐	☐	☐
9. History of antibiotic use	☐	☐	☐	☐
10. Meat eater	☐	☐	☐	☐
11. Rapidly failing vision	☐	☐	☐	☐

PART 3: *Continue through parts 3 - 13. Some questions are repeated. Answer each question. (Females skip part 9, Males skip part 10)*

SECTION A:	0	1	2	3
1. Intolerance to greasy food	☐	☐	☐	☐
2. Headaches after eating	☐	☐	☐	☐
3. Light-colored stool	☐	☐	☐	☐
4. Foul-smelling stool	☐	☐	☐	☐
5. Less than one bowel movement daily	☐	☐	☐	☐
6. Constipation	☐	☐	☐	☐
7. Hard Stool	☐	☐	☐	☐
8. Sour taste in mouth	☐	☐	☐	☐
9. Grey-colored skin	☐	☐	☐	☐
10. Yellow in whites of eyes	☐	☐	☐	☐
11. Bad breath	☐	☐	☐	☐
12. Body odor	☐	☐	☐	☐
13. Fatigue and sleepiness after eating	☐	☐	☐	☐
14. Pain in right side under rib cage	☐	☐	☐	☐
15. Painful to pass stool	☐	☐	☐	☐
16. Retain water	☐	☐	☐	☐
17. Big toe painful	☐	☐	☐	☐
18. Pain radiates along outside of leg	☐	☐	☐	☐
19. Dry skin/hair	☐	☐	☐	☐
20. Red blood in stool	☐	☐	☐	☐
21. Have had jaundice or hepatitis	☐	☐	☐	☐
22. High blood pressure/low HDL chol.	☐	☐	☐	☐
23. Cholesterol level above 215	☐	☐	☐	☐
24. Triglyceride level above 115	☐	☐	☐	☐

SECTION B:	0	1	2	3
1. Swollen eyes	☐	☐	☐	☐
2. Strong-smelling urine	☐	☐	☐	☐
3. Thick skin & fingernails	☐	☐	☐	☐
4. Dry skin	☐	☐	☐	☐
5. Sensitive to the cold	☐	☐	☐	☐
6. Cold hands and feet.	☐	☐	☐	☐
7. Excessive menstrual bleeding	☐	☐	☐	☐
8. Chronic fatigue	☐	☐	☐	☐
9. Trouble waking up in the morning	☐	☐	☐	☐
10. Depressed/Apathetic	☐	☐	☐	☐
11. Low sex drive	☐	☐	☐	☐
12. Puffy or wrinkly skin	☐	☐	☐	☐
13. Irritability caused by sugar	☐	☐	☐	☐
14. Premenstrual tension	☐	☐	☐	☐

SECTION B: (continued)

	0	1	2	3
15. Constipation	☐	☐	☐	☐
16. Thinning/loss of outer part of eyebrow	☐	☐	☐	☐
17. Gain weight easily	☐	☐	☐	☐
18. Anemia unaffected by Iron	☐	☐	☐	☐
19. Armpit temperature below 97.6F	☐	☐	☐	☐
20. Slow reflexes	☐	☐	☐	☐
21. Infertility	☐	☐	☐	☐

PART 4:

SECTION A:

	0	1	2	3
1. Sensitive to exhaust, smoke, and smog	☐	☐	☐	☐
2. Periodic constipation	☐	☐	☐	☐
3. Intolerant of exercise	☐	☐	☐	☐
4. Depression or rapid mood swings	☐	☐	☐	☐
5. Dark circles under eyes	☐	☐	☐	☐
6. Dizziness upon standing	☐	☐	☐	☐
7. Lack of mental alertness	☐	☐	☐	☐
8. Catch colds when weather changes	☐	☐	☐	☐
9. Difficulty breathing	☐	☐	☐	☐
10. Water retention	☐	☐	☐	☐
11. Eyes sensitive to bright light	☐	☐	☐	☐
12. Feel weak & shaky	☐	☐	☐	☐

SECTION B:

	0	1	2	3
1. Inflamed or bleeding gums	☐	☐	☐	☐
2. Runny nose	☐	☐	☐	☐
3. Get boils or styes	☐	☐	☐	☐
4. Nose bleeds	☐	☐	☐	☐
5. Loss of smell	☐	☐	☐	☐
6. Throat infections	☐	☐	☐	☐
7. Cold sores/fever blisters	☐	☐	☐	☐
8. Loss of taste	☐	☐	☐	☐
9. Poor wound healing	☐	☐	☐	☐
10. Hair falls out	☐	☐	☐	☐
11. Swollen lymph glands	☐	☐	☐	☐
12. Ear infections	☐	☐	☐	☐
13. Hair grows slowly	☐	☐	☐	☐
14. Slow to recover from colds or flu	☐	☐	☐	☐
15. Catch colds or flu easily	☐	☐	☐	☐
16. Bumpy skin on backs of arms	☐	☐	☐	☐

SECTION C:

	0	1	2	3
1. Eczema and psoriasis	☐	☐	☐	☐
2. Asthma/Bronchitis	☐	☐	☐	☐
3. Migraine headaches	☐	☐	☐	☐
4. Entire body aches, painful to touch	☐	☐	☐	☐
5. Swollen joints	☐	☐	☐	☐
6. Food sensitivities or allergies	☐	☐	☐	☐
7. Feel sick, depressed from certain foods	☐	☐	☐	☐
8. Chronic pain	☐	☐	☐	☐
9. Painful stomach/intestines	☐	☐	☐	☐
10. Alternating constipation and diarrhea	☐	☐	☐	☐
11. Mucous in throat	☐	☐	☐	☐
12. Post-nasal drip	☐	☐	☐	☐
13. Discharge from eyes	☐	☐	☐	☐
14. Itchy eyes	☐	☐	☐	☐
15. Puffiness/dark circles under eyes	☐	☐	☐	☐
16. Ear discharge or stuffy ears	☐	☐	☐	☐
17. Sinusitis or rhinitis	☐	☐	☐	☐
18. Runny nose	☐	☐	☐	☐
19. Breathe through mouth	☐	☐	☐	☐
20. Swollen tongue	☐	☐	☐	☐
21. Difficulty swallowing	☐	☐	☐	☐
22. Bedwetting	☐	☐	☐	☐
23. Hyperactivity	☐	☐	☐	☐
24. Chronic lung congestion	☐ No	☐ Yes		
25. Use aspirin or Tylenol regularly	☐ No	☐ Yes		
26. Use cortisone or prednisone	☐ No	☐ Yes		
27. Total hair loss (Alopecia)	☐ No	☐ Yes		

PART 5:

SECTION A:	0	1	2	3
1. Shortness of breath	☐	☐	☐	☐
2. Chest pain while walking	☐	☐	☐	☐
3. Heaviness in legs	☐	☐	☐	☐
4. Calf muscles cramp while walking	☐	☐	☐	☐
5. Heart pound easily	☐	☐	☐	☐
6. Feel jittery	☐	☐	☐	☐
7. Heart misses beats or has extra beats	☐	☐	☐	☐
8. Swelling of feet and ankles	☐	☐	☐	☐
9. Rapidly beating heart	☐	☐	☐	☐
10. Heartburn after eating	☐	☐	☐	☐
11. Pain in left arm	☐	☐	☐	☐
12. Exhausted after minor exertion	☐	☐	☐	☐
13. Do you do aerobic exercise?	☐ No	☐ Yes		
14. Have you ever exercised regularly?	☐ No	☐ Yes		
15. Bright red nose	☐ No	☐ Yes		
16. At rest, heart beats per minute (leave blank if under 80 BPM)	☐ 80-90	☐ 90+		

SECTION B:	0	1	2	3
1. Cold hands and feet	☐	☐	☐	☐
2. Slurred speech	☐	☐	☐	☐
3. Calf muscles cramp while walking	☐	☐	☐	☐
4. Headaches	☐	☐	☐	☐
5. Numbness in extremities	☐	☐	☐	☐
6. Poor concentration	☐	☐	☐	☐
7. Ringing in ears	☐	☐	☐	☐
8. Ear canal hair	☐ No	☐ Yes		
9. Heart attack	☐ No	☐ Yes		
10. Stroke	☐ No	☐ Yes		
11. Vertical wrinkle in lower ear lobe	☐ No	☐ Yes		

SECTION C:	0	1	2	3
1. Pain in morning in back of head/neck	☐	☐	☐	☐
2. Dizziness	☐	☐	☐	☐
3. Vertigo	☐	☐	☐	☐
4. Fatigue easily	☐	☐	☐	☐
5. Blushing with no apparent cause	☐	☐	☐	☐
6. Is your blood pressure high?	☐ No	☐ Yes		

PART 6:

SECTION A:	0	1	2	3
1. Dizziness when standing suddenly	☐	☐	☐	☐
2. Loss of vision when standing suddenly	☐	☐	☐	☐
3. Crave sweets	☐	☐	☐	☐
4. Headaches eased by sweets/alcohol	☐	☐	☐	☐
5. Feel shaky	☐	☐	☐	☐
6. Irritable if a meal is missed	☐	☐	☐	☐
7. Wake up in night craving sweets	☐	☐	☐	☐
8. Feel tired or weak if a meal is missed	☐	☐	☐	☐
9. Heart palpitations after eating sweets	☐	☐	☐	☐
10. Need to drink coffee to get started	☐	☐	☐	☐
11. Impatient, moody, nervous	☐	☐	☐	☐
12. Feel tired 1-2 hours after eating	☐	☐	☐	☐
13. Poor memory	☐	☐	☐	☐
14. Poor concentration	☐	☐	☐	☐
15. Forgetful	☐	☐	☐	☐
16. Calmer after eating	☐ No	☐ Yes		

SECTION B:	0	1	2	3
1. Night sweats	☐	☐	☐	☐
2. Increased thirst	☐	☐	☐	☐
3. Lowered resistance to infection	☐	☐	☐	☐
4. Fatigue	☐	☐	☐	☐
5. Boils and leg sores	☐	☐	☐	☐
6. Lesion/cut that takes a long time to heal	☐	☐	☐	☐
7. Overweight	☐	☐	☐	☐
8. Feel pick-up from exercise	☐	☐	☐	☐
9. Failing eyesight	☐	☐	☐	☐
10. Crave sweets, but eating sweets does not relieve the craving	☐	☐	☐	☐
11. Family history of diabetes	☐	☐	☐	☐
12. Sugar in urine	☐	☐	☐	☐

PART 7:

SECTION A:

	0	1	2	3
1. Chest pain	☐	☐	☐	☐
2. Chronic cough	☐	☐	☐	☐
3. Difficulty breathing	☐	☐	☐	☐
4. Coughing up blood	☐	☐	☐	☐
5. Coughing up phlegm	☐	☐	☐	☐
6. Pain around ribs	☐	☐	☐	☐
7. Shortness of breath	☐	☐	☐	☐
8. Rattling mucous when you breathe	☐	☐	☐	☐
9. Sensitive to smog	☐	☐	☐	☐
10. Infections settle in lungs	☐	☐	☐	☐
11. Work around people who smoke	☐	☐	☐	☐
12. Bronchitis	☐	☐	☐	☐

13. Exposed to chemicals & radiation ☐ No ☐ Yes

14. Do you smoke? ☐ No ☐ Yes

What do you smoke? _____

Amount per day: _____

PART 8:

SECTION A:

	0	1	2	3
1. Frequent urination	☐	☐	☐	☐
2. Frequent bladder infections	☐	☐	☐	☐
3. Rarely need to urinate	☐	☐	☐	☐
4. Urination when you cough or sneeze	☐	☐	☐	☐
5. Painful/burns when you urinate	☐	☐	☐	☐
6. Difficulty passing urine	☐	☐	☐	☐
7. Dripping after urination	☐	☐	☐	☐
8. Can't hold urine	☐	☐	☐	☐
9. Rose-colored/bloody urine	☐	☐	☐	☐
10. Cloudy urine	☐	☐	☐	☐
11. Strong-smelling urine	☐	☐	☐	☐
12. Back/leg pains associated with dripping after urination	☐	☐	☐	☐

13. History of bladder infections ☐ No ☐ Yes

14. Have you used antibiotics to control urinary tract infections? ☐ No ☐ Yes

if yes, when were they last used? _____

Treatment duration: _____

PART 9: *(Males only)*

SECTION A:

	0	1	2	3
1. Difficulty urinating	☐	☐	☐	☐
2. A sense of bladder fullness	☐	☐	☐	☐
3. Increasing straining with smaller and smaller amounts of urine passing	☐	☐	☐	☐
4. Rose-colored/bloody urine	☐	☐	☐	☐
5. Painful/burns when you urinate	☐	☐	☐	☐
6. Wake up at night to urinate	☐	☐	☐	☐
7. Dripping after urination	☐	☐	☐	☐
8. Pain or fatigue in legs or back	☐	☐	☐	☐
9. Lack of sex drive	☐	☐	☐	☐
10. Painful ejaculation	☐	☐	☐	☐

SECTION B:

	0	1	2	3
1. Difficulty attaining/maintaining erection	☐	☐	☐	☐
2. Anxiety/fear of sexual intimacy	☐	☐	☐	☐
3. Premature ejaculation	☐	☐	☐	☐
4. Pain/coldness in genital area	☐	☐	☐	☐

5. Infertile ☐ No ☐ Yes

6. Varicose veins on scrotum ☐ No ☐ Yes

7. Low sperm count ☐ No ☐ Yes

SECTION C:

	0	1	2	3
1. Discharge from penis	☐	☐	☐	☐
2. Past or present rash on penis	☐	☐	☐	☐
3. Swollen genitals	☐	☐	☐	☐
4. Swelling in groin	☐	☐	☐	☐

5. Venereal disease (gonorrhea, syphilis Herpes, or other) ☐ No ☐ Yes

Have now? _____

Have had in past? _____

PART 10: ***(Females only)***

SECTION A: 0 1 2 3

Check if you experience any of these symptoms within approximately two weeks (ovulation) prior to menstruation. *(this section only)*

1. Monthly weight gain ☐ ☐ ☐ ☐
2. Moodiness/Irritability ☐ ☐ ☐ ☐
3. Bloating and swelling ☐ ☐ ☐ ☐
4. Nausea/vomiting ☐ ☐ ☐ ☐
5. Suicidal feeling ☐ ☐ ☐ ☐
6. Anxiety ☐ ☐ ☐ ☐
7. Leg cramps and tenderness ☐ ☐ ☐ ☐
8. Asthma attacks ☐ ☐ ☐ ☐
9. Headaches ☐ ☐ ☐ ☐
10. Easily distracted ☐ ☐ ☐ ☐
11. Anger ☐ ☐ ☐ ☐
12. Tender breasts ☐ ☐ ☐ ☐
13. Lower-back aches ☐ ☐ ☐ ☐

Other: _____

SECTION B: 0 1 2 3

1. Vaginal itching ☐ ☐ ☐ ☐
2. Vaginal discharge ☐ ☐ ☐ ☐
3.Little or no desire for sex ☐ ☐ ☐ ☐
4. Dislike for intercourse ☐ ☐ ☐ ☐
5. Missed periods ☐ No ☐ Yes
6. Over 15 years of age and have not began menstruation. ☐ No ☐ Yes
7. Unable to get pregnant ☐ No ☐ Yes
8. Miscarriages ☐ No ☐ Yes

   How many?_____

9. Abortions ☐ No ☐ Yes

   How many?_____

SECTION C: 0 1 2 3

Check if you experience any of these symptoms during menstruation. (*this section only)*

1. Low abdominal pain ☐ ☐ ☐ ☐
2. Dull ache radiating to low back/legs ☐ ☐ ☐ ☐
3. Increased urinary frequency ☐ ☐ ☐ ☐
4. Pelvic soreness ☐ ☐ ☐ ☐
5. Diarrhea ☐ ☐ ☐ ☐
6. Headaches ☐ ☐ ☐ ☐
7. Abdominal bloating ☐ ☐ ☐ ☐
8. Menstrual pain ☐ ☐ ☐ ☐
9. Nausea/vomiting ☐ ☐ ☐ ☐
10. Have to lie down first day or two ☐ ☐ ☐ ☐
11. Craving for sweets ☐ ☐ ☐ ☐
12. Insomnia ☐ ☐ ☐ ☐
13. Light scanty blood flow ☐ ☐ ☐ ☐
14. Pain and cramps without blood flow ☐ ☐ ☐ ☐
15. Heavy menstrual bleeding ☐ ☐ ☐ ☐
16. Anxiety about menstrual cycle ☐ ☐ ☐ ☐
17. Menstrual pain getting worse with time ☐ ☐ ☐ ☐

SECTION D: 0 1 2 3

1. Vaginal bumps and sores ☐ ☐ ☐ ☐
2. Pubic area sore ☐ ☐ ☐ ☐
3. Ovarian cysts ☐ ☐ ☐ ☐
4. Uterine Cysts ☐ ☐ ☐ ☐
5. Pain in ovaries ☐ ☐ ☐ ☐
6. Breast lumps ☐ ☐ ☐ ☐
7. Breasts sore to touch ☐ ☐ ☐ ☐
8. Breasts painful ☐ ☐ ☐ ☐
9. Water retention ☐ ☐ ☐ ☐
10. Swollen feeling ☐ ☐ ☐ ☐
11. Premenstrual breast pain/discomfort ☐ ☐ ☐ ☐
12. Mother used DES while pregnant ☐ No ☐ Yes
13. Recent pap smear positive ☐ No ☐ Yes
14. Family history of breast cancer ☐ No ☐ Yes
15. Form of birth control:

☐ None ☐ Pill ☐ IUD ☐ Sponge

☐ Diaphragm ☐ Foam ☐ Other

PART 10: ***(continued, Females only)***

SECTION E:

	0	1	2	3
1. Hot flashes	☐	☐	☐	☐
2. Night sweats	☐	☐	☐	☐
3. Hysterectomy	☐ No	☐ Yes		
4. Depression/Mood Swings	☐	☐	☐	☐
5. Insomnia	☐	☐	☐	☐
6. Craving Sweets	☐	☐	☐	☐
7. Heavy bleeding two weeks/month	☐	☐	☐	☐
8. Sweating throughout day	☐	☐	☐	☐
9. Dry skin, hair, and vagina	☐	☐	☐	☐
10. Painful intercourse	☐	☐	☐	☐
11. Vaginal Pain	☐	☐	☐	☐
12. Vaginal Itching	☐	☐	☐	☐
13. Osteoporosis (bone loss)	☐ No	☐ Yes		

PART 11:

SECTION A:

	0	1	2	3
1. Pain in fingers	☐	☐	☐	☐
2. Bones sore/painful	☐	☐	☐	☐
3. Eat Meat	☐	☐	☐	☐
4. Cavities	☐	☐	☐	☐
5. Arthritis	☐	☐	☐	☐
6. Drink carbonated beverages OZ/week _____	☐ No	☐ Yes		
7. Gum disease	☐ No	☐ Yes		
8. Bone loss	☐ No	☐ Yes		
9. Calcium deposits	☐ No	☐ Yes		
10. Use antacids	☐ No	☐ Yes		
11. Dentures	☐ No	☐ Yes		
12. Bone deformity	☐ No	☐ Yes		
13. Osteoporosis/Osteomalacia	☐ No	☐ Yes		
14. Recent bone fracture	☐ No	☐ Yes		
15. Post-menopausal	☐ No	☐ Yes		

SECTION B:

	0	1	2	3
1. Muscle spasms	☐	☐	☐	☐
2. Tightness in shoulder muscles	☐	☐	☐	☐
3. Muscle cramps	☐	☐	☐	☐
4. Pain in arms and hands	☐	☐	☐	☐
5. Leg cramps at night	☐	☐	☐	☐
6. Stiff all over	☐	☐	☐	☐
7. Stiff in moving	☐	☐	☐	☐
8. Unable to sit straight	☐	☐	☐	☐
9. Pain in neck and shoulders	☐	☐	☐	☐

SECTION C:

	0	1	2	3
1. Over flexible joints (double-jointed)	☐	☐	☐	☐
2. Back Pain	☐	☐	☐	☐
3. Swollen knees/elbows	☐	☐	☐	☐
4. Athletic injury	☐	☐	☐	☐
5. Bursitis	☐	☐	☐	☐
6. Tendonitis	☐	☐	☐	☐
7. Joint pain	☐	☐	☐	☐
8. Slipped disc	☐ No	☐ Yes		
9. Herniated disc	☐ No	☐ Yes		
10. Loss in height	☐ No	☐ Yes		
11. Injure easily	☐ No	☐ Yes		

PART 12:

SECTION A:

	0	1	2	3
1. Head feels heavy	☐	☐	☐	☐
2. Light-headedness/fainting	☐	☐	☐	☐
3. Loss of balance	☐	☐	☐	☐
4. Dizziness	☐	☐	☐	☐
5. Ringing/buzzing in ears	☐	☐	☐	☐
6. Trembling hands	☐	☐	☐	☐
7. Loss of feeling in hands/feet	☐	☐	☐	☐
8. Exhaustion after slightest effort	☐	☐	☐	☐
9. Limbs feel too heavy to hold up	☐	☐	☐	☐
10. Loss of grip strength	☐	☐	☐	☐
11. Tingling pain sensation	☐	☐	☐	☐
12. Convulsions	☐	☐	☐	☐
13. Incoordination	☐	☐	☐	☐
14. Nervousness	☐	☐	☐	☐
15. Accident prone	☐	☐	☐	☐
16. Loss of muscle tone	☐	☐	☐	☐
17. Need to sleep 10-12 hours	☐	☐	☐	☐
18. Have had shingles	☐	☐	☐	☐

PART 13:

SECTION A:	0	1	2	3
1. Nightmares	☐	☐	☐	☐
2. Can't fall asleep	☐	☐	☐	☐
3. Intense dreams	☐	☐	☐	☐
4. Leg cramps/restless legs at night	☐	☐	☐	☐
5. Restless, uneasy sleep	☐	☐	☐	☐

6. Awake frequently throughout night ☐ No ☐ Yes

7. Wake up during night, can't fall back asleep ☐ No ☐ Yes

8. Sleep walk ☐ No ☐ Yes

Do you have any other symptoms that have not been covered in this questionnaire? _____