Natural Elements Health Center
Dr. Christine Schlenker

14094 9th Ave SE , Milaca, MN 56353
Tel: 320.983.2333 Fax: 320.983.5444

Today's Date:_____/_____/_____

Your Name:_____Name you prefer to be called:_____
Address: _____Apt#:_____ City _____, St._____ Zip_____
Sex: ____M ____F Birthdate: _____/_____/____ E-mail:_____
SS # (insurance purposes):_____ Occupation:_____

Best Place to reach you: ◊Home ◊ Work ◊ Cell ( )_____ AM PM Anytime

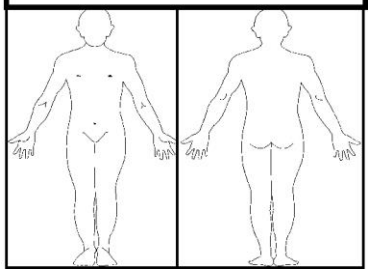
Spouse's/Partner's Name (if applicable): _____ Spouse's Birthdate (insurance purposes):____/____/___
Children's Names and ages (if applicable): _____
Emergency Contact Name:_____ Phone:_____
Are your symptoms related to an accident? Y N ____automobile _____work ____other date __/__/__
___I HAVE NO INSURANCE COVERAGE AT THIS TIME
Relationship to insured: __self __spouse __child __other:_____
Primary Care Doctor- name and facility:_____
May we contact him or her about your care? Y N Were you referred by him or her? Y or N
How did you hear about us?: _____

On a Scale of 0—10, I rate my discomfort as follows:
(zero being no pain, 10 being the worst pain I have ever felt=ER visit)

Neck or Shoulder Pain	0 1 2 3 4 5 6 7 8 9 10	No pain … Severe pain
Midback Pain	0 1 2 3 4 5 6 7 8 9 10	No pain … Severe pain
Low Back or Leg Pain	0 1 2 3 4 5 6 7 8 9 10	No pain … Severe pain
Other:_____	0 1 2 3 4 5 6 7 8 9 10	No pain … Severe pain

Complaints:
1) _____
2) _____
3) _____
Date of Injury ____/____/_____ How did they start ?
_____
_____
_____

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING BELOW



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	___Change in wart or mole
__Depression	__Panic attacks	__Nausea	__Fecal incontinence	__Bleeding	___Nagging cough/ hoarseness
__Disinterest in sex	__Headaches	__Vomiting	__Urinary incontinence	__Discharge	___Blood in stool or urine
__Disinterest in eating	__Dizziness	__Diarrhea	__Low grade fever	__Itching/rash	

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

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

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you consider yourself: __underweight __overweight __just right **Your weight today:** _____

How often do you experience your symptoms?
__Constantly (100% of day)
__Frequently (51-75% of day)
__Occasionally (26-50% of day)
__Intermittently (0-25% of day)
How would you describe your symptoms?
__Sharp __Shooting __Dull Ache __Burning __Numb __Tingling
Other:_____
How are your symptoms changing?
__Getting Better __Not Changing __Getting Worse

Does your pain ever wake you from a sound sleep? Yes ___ No ___
Are you losing weight now without trying? Yes ___ No ___
Do you have a headache or head pain that is unlike any you have had before?. Yes ___ No ___
Have you even been or are you now being pressured or forced to engage in any type of Sexual activity? Yes___ No___

Patient Signature:_____ Date:____/____/_____

** By signing above, all information on this intake form is true and accurate to the best of my knowledge.

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 q + q —
PAP q + q —
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
__ Lose 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

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Phone: 320.983.2333 Fax: 320.983.5444 staff@naturalelementshealth.com

TERMS OF ACCEPTANCE

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spine, or within the extremities, which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral and extremity subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

** Possible Adverse Reactions to an Adjustment:

- **Soreness:** I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
- **Dizziness:** Temporary symptoms like dizziness and nausea can occur but are relatively rare.
- **Fractures/Joint Injury:** I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.
- **Stroke:** Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments.
- **Nutritional Supplements:** If I have a medical condition and taking prescription medication, I agree to discuss with my medical doctor any nutritional supplement that has been prescribed or taken from Natural Elements.

I, have read and fully understand the above statements.
All questions regarding the doctor's objectives pertaining to the care in this office have been answered to my complete satisfaction.
I, therefore, accept chiropractic care on this basis.

Signature:_____ Date:_____

HIPPA Regulations Natural Elements will Follow to Ensure your Protection

Your Rights

- The right to request restrictions on certain uses and disclosure of your protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree to a requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.

In 2009 all healthcare professionals are required by law to send their bills, correspondence, and related billing information electronically. Natural Elements uses the billing services of Medical Business Consulting, a company also required to follow HIPPA regulations noted by the Dept. Of Health and Human Services (federal level). Information that will be electronically submitted is:
Beneficiary's name, date of birth, address, Beneficiary's health insurance identification and claim number, Date(s) of service, Diagnosis/nature of illness, Procedure/services performed
Contact Information
If you think your privacy rights have been violated by us, or disagree with a decision we made about access to your personal health information, you may contact:
The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Ave. S.W., Washington, D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-9775
I have received a read copy of the notice of privacy practices. This acknowledgement applies to:

Signature_____ Date:_____

If you do not call in by the designated times or "no show" for your appointment, you will be charged the rate of service for the appointment and will be required to pay for the missed appointment before scheduling another.
Exceptions: Medical Emergencies, illness & funeral

Signature: _____Date:_____

FINANCIAL POLICY

Release of Information: My signature below authorizes Natural Elements Health Center, Inc. , it's employees, and/or agents to release any information concerning my health and healthcare services to my insurance companies, pre-paid health plan or Medicare. I authorize the use of the signature below and all insurance submissions.

Returned Check Policy: All returned check's will be a $30.00 non-sufficient funds charge.

Signature:_____ Date:_____

Client Bill of Rights for Massage

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, or prescribe or treat any physical or mental illness, and that nothing said in the coarse of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand there shall be no liability on the practitioner's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Please check the box indicating that you have read this policy and sign.

☐ Signature: _____ Date: _____

****For Doctor Use Only****

PATIENT STATUS AT TIME OF INFORMED CONSENT AND TERMS OF ACCEPTANCE PROCESS
BASED ON MY PERSONAL OBSERVATIONS, MEDICAL HISTORY AND DIRECT CONVERSATION WITH THE PATIENT, I CONCLUDE THAT THROUGHOUT THE CONSENT PROCESS THE PATIENT WAS:

[ ] OF LEGAL AGE [ ] ORIENTED X 3 [ ] COHERENT AND LUCID
[ ] PROFICIENT IN UNDERSTANDING THE ENGLISH LANGUAGE
[ ] ASSISTED IN UNDERSTANDING BY AN INTERPRETER (INTERPRETER'S NAME:_____)
[ ] UNABLE TO GIVE LEGAL CONSENT
[ ] CONSENT GIVEN THRU LEGAL GUARDIAN _____ _____
NAME RELATIONSHIP

I CERTIFY THAT THE ABOVE ACCURATELY DESCRIBES THE ABOVE NAMED PATIENT'S STATUS DURING THE INFORMED CONSENT PROCESS.

_____ _____
DATE SIGNATURE OF DOCTOR

Bowel Transit Time

How quickly you eliminate waste through your intestinal tract is an important indicator of your health. To feel your best and help prevent degenerative diseases, your bowel transit time (the time it takes to digest a particular food and eliminate the waste products) should be 12 to 24 hours. Shorter transit times suggest you may not be digesting properly. Longer transit times mean you are being exposed to toxins from your digestive tract. Interestingly, research shows a correlation between gallstones and longer transit times. Having a long transit time may make you feel bloated, constipated and /or lethargic.

Directions:

1. Have a bowel movement
2. After a bowel movement, take all 10 charcoal capsules or 2 beets all at once. Children 12 and under take 5 charcoal capsules (all at once) or 1 beet.
3. Document the date and time that you take the charcoal capsules.
4. Document the date and time that you see the same charcoal color as the capsule in your stool.
5. Total transit time in hours:_____

Things to consider:

1. Children/adults who have difficulty swallowing capsules you may open all the capsules and put into a single serving of pudding or yogurt. The charcoal is tasteless and harmless; it will turn the pudding or yogurt black.
2. **DO NOT PANIC** if the transit time is longer than listed above, it just means Dr. Christine will help you get your bowel running in a more efficient way. Call our staff @ 320-983-2333 with any questions.

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www.NaturalElementsHealth.com
320-983-2333

Daily Record of Food Intake

Each day, record all the items you eat and drink. Be sure to include the approximate amount of each item. When you have completed this form, return it to our office for evaluation.

Name: _____

DAY ONE DATE:_____

Breakfast (time:)	**Lunch** (time:)	**Dinner** (time:)
Meat & Dairy _____	_____	_____
Vegetables & Fruit _____	_____	_____
Breads, Cereals, Grains _____	_____	_____
Fats (Butter, Oils, etc) _____	_____	_____
Candy, Sweets, Junkfood _____	_____	_____
Water Intake _____	_____	_____
Other Drinks _____	_____	_____
Mid-Morning Snack (time:)	**Mid-Day Snack** (time:)	**Nighttime Snack** (time:)
Snack _____	_____	_____
Bowel Movements (# and type):	**Hours of Sleep**:	**Quality of Sleep**:(best)1 2 3(poor)
_____	_____	_____

DAY TWO DATE:_____

Breakfast (time:)	**Lunch** (time:)	**Dinner** (time:)
Meat & Dairy _____	_____	_____
Vegetables & Fruit _____	_____	_____
Breads, Cereals, Grains _____	_____	_____
Fats (Butter, Oils, etc) _____	_____	_____
Candy, Sweets, Junkfood _____	_____	_____
Water Intake _____	_____	_____
Other Drinks _____	_____	_____
Mid-Morning Snack (time:)	**Mid-Day Snack** (time:)	**Nighttime Snack** (time:)
Snack _____	_____	_____
Bowel Movements (# and type):	**Hours of Sleep**:	**Quality of Sleep**:(best)1 2 3(poor)
_____	_____	_____

DAY THREE DATE:_____

Breakfast (time:)	**Lunch** (time:)	**Dinner** (time:)
Meat & Dairy _____	_____	_____
Vegetables & Fruit _____	_____	_____
Breads, Cereals, Grains _____	_____	_____
Fats (Butter, Oils, etc) _____	_____	_____
Candy, Sweets, Junkfood _____	_____	_____
Water Intake _____	_____	_____
Other Drinks _____	_____	_____
Mid-Morning Snack (time:)	**Mid-Day Snack** (time:)	**Nighttime Snack** (time:)
Snack _____	_____	_____
Bowel Movements (# and type):	**Hours of Sleep**:	**Quality of Sleep**:(best)1 2 3(poor)
_____	_____	_____

Identi- T™ Stress Assessment

Name _____ **Age** _____ **Sex**_____ **Date**_____

Stress is a normal part of life. Every day, we're faced with stimuli, called stressors, which can elicit the body's "fight or flight" response, setting off a cascade of physiological reactions and resulting in emotions ranging from mild to intense. But while occasional stress is natural and even healthy, chronic or acute stress can be harmful.

Please take a few moments to discover your body's response to situations you perceive as stressful. By honestly assessing how you feel, your healthcare provider can create a natural stress relief program for your individual needs.

Directions:

Please read each statement and circle the number 0, 1, 2, or 3 that best describes your feelings or reactions throughout the course of the day. Determine the subtotal score for each section, then determine the total scores for sections A-C and C-E. Some questions may appear redundant between sections. There's a reason for each question. Don't spend much time on any one question.

0 = Never true 1= Seldom true 2= Sometimes true 3= Often true

When under stress for two weeks or longer, I…

Section A:

1. Get wound up when I get tired and have trouble calming down	0	1	2	3
2. Feel driven, appear energetic but feel "burned out" and exhausted	0	1	2	3
3. Feel restless, agitated, anxious, and uneasy	0	1	2	3
4. Feel easily overwhelmed by emotion	0	1	2	3
5. Feel emotional — cry easily or laugh inappropriately	0	1	2	3
6. Experience heart palpitations or a pounding in my chest	0	1	2	3
7. Am short of breath	0	1	2	3
8. Am constipated	0	1	2	3
9. Feel warm, over-heated, and dry all over	0	1	2	3
10. Get mouth sores or sore tongue	0	1	2	3
11. Get hot flashes	0	1	2	3
12. Sleep less than seven hours a night	0	1	2	3
13. Have trouble falling asleep and staying asleep	0	1	2	3
14. Worry about high blood pressure, cholesterol, and triglycerides	0	1	2	3
15. Forget to eat and feel little hunger	0	1	2	3

Total points: _____

Section B:

1. Find myself worrying about things big and small	0	1	2	3
2. Feel like I can't stop worrying, even though I want to	0	1	2	3
3. Feel impulsive, pent up, and ready to explode	0	1	2	3
4. Get muscle spasms	0	1	2	3
5. Feel aggressive, unyielding, or inflexible when pressed for time	0	1	2	3
6. See, hear, and smell things that others do not	0	1	2	3
7. Stay awake replaying the events of the day or planning for tomorrow	0	1	2	3
8. Have upsetting thoughts or images enter my mind again and again	0	1	2	3
9. Have a hard time stopping myself from doing things again and again like checking on things or rearranging objects over and over	0	1	2	3
10. Worry a lot about terrible things that could happen if I'm not careful	0	1	2	3

Total points: _____

Section C:

1. Have muscle and joint pains	0	1	2	3
2. Have muscle weakness	0	1	2	3
3. Crave salt or salty things	0	1	2	3
4. Have multiple points on my body that when touched are tender or painful	0	1	2	3
5. Have dark circles under my eyes	0	1	2	3
6. Feel a sudden sense of anxiety when I get hungry	0	1	2	3
7. Use medications to manage pain	0	1	2	3
8. Get dizzy when rising or standing up from a kneeling or sitting position	0	1	2	3
9. Have diarrhea or bouts of nausea with or without vomiting for no apparent reason	0	1	2	3
10. Have headaches	0	1	2	3

Total points: _____

Section D:

1. Have trouble organizing my thoughts	0	1	2	3
2. Get easily distracted and lose focus	0	1	2	3
3. Have difficulty making decisions and mistrust my judgment	0	1	2	3
4. Feel depressed and apathetic	0	1	2	3
5. Lack the motivation and energy to stay on task and pay attention	0	1	2	3
6. Am forgetful	0	1	2	3
7. Feel unsettled, restless, and anxious	0	1	2	3
8. Wake up tired and unrefreshed	0	1	2	3
9. Experience heartburn and indigestion	0	1	2	3
10. Catch colds or infections easily	0	1	2	3

Total points: _____

Section E:

1. Feel tired for no apparent reason	0	1	2	3
2. Experience lingering mild fatigue after exertion or physical activity	0	1	2	3
3. Find it difficult to concentrate and complete tasks	0	1	2	3
4. Feel depressed and apathetic	0	1	2	3
5. Feel cold or chilled – hands, feet, or all over – for no apparent reason	0	1	2	3
6. Have little or no interest in sex	.0	1	2	3
7. Sweat spontaneously during the day	0	1	2	3
8. Feel puffy and retain fluids	0	1	2	3
9. Sleep more than nine hours a night	0	1	2	3
10. Have poor muscle tone	0	1	2	3
11. Have trouble losing weight	0	1	2	3
12. Wake up tired even though I seem to get plenty of sleep	0	1	2	3
13. Have no energy and feel physically weak	0	1	2	3
14. Am susceptible to colds and the flu	0	1	2	3
15. Feel dragged down by multiple symptoms, such as poor digestion and body aches	0	1	2	3

Total points: _____

Add points from sections A, B & C	**Total for A, B, & C:** _____
Add points from sections C, D & E	**Total for C, D, & E:** _____

LIfestyle and Health Status:

1. Circle the level of stress you experience on the scale of 1-10, 10 being the worst:
   a. 1 2 3 4 5 6 7 8 9 10
2. What do you consider to be the major causes of your stress (for example — spouse, family, friends, work, finances, wedding, pregnancy, legal, commute):
   _____
3. I eat breakfast _____ times a week. My typical breakfast is: _____
4. I take a multiple vitamin/mineral _____ days per week. I take a fish oil supplement _____ days per week
5. I participate in 30 minutes of physical activity such as walking, aerobics (e.g., running), resistance training (e.g., weights, pilates), sports (e.g. biking), or yoga:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
6. I smoke _____ cigarettes daily.
7. I drink two or more 8 ounce cups of caffeinated coffee or other caffeinated beverages like energy/diet drinks, colas, or black or green teas:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
8. I drink two or more ounces of alcoholic beverages:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
9. List your current health problems and any over-the-counter or prescription medications that you are now taking:

Current health problem(s)	Date of onset	List all current medication(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 describe 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

	No/Rarely	Occasionally	Often	Frequently
SECTION A				
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 *on your left side*, 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

	No/Rarely	Occasionally	Often	Frequently
SECTION C (cont.)				
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 *on your right side*, 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

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.)

	No/Rarely	Occasionally	Often	Frequently
SECTION B				
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

	No/Rarely	Occasionally	Often	Frequently
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

	No/Rarely	Occasionally	Often	Frequently
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

	No/Rarely	Occasionally	Often	Frequently
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

	No/Rarely	Occasionally	Often	Frequently
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	

Total points

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

Total points

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

Total points

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

	No/Rarely	Occasionally	Often	Frequently
SECTION B (cont.)				
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	

Total points

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

Total points

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

	No/Rarely	Occasionally	Often	Frequently

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

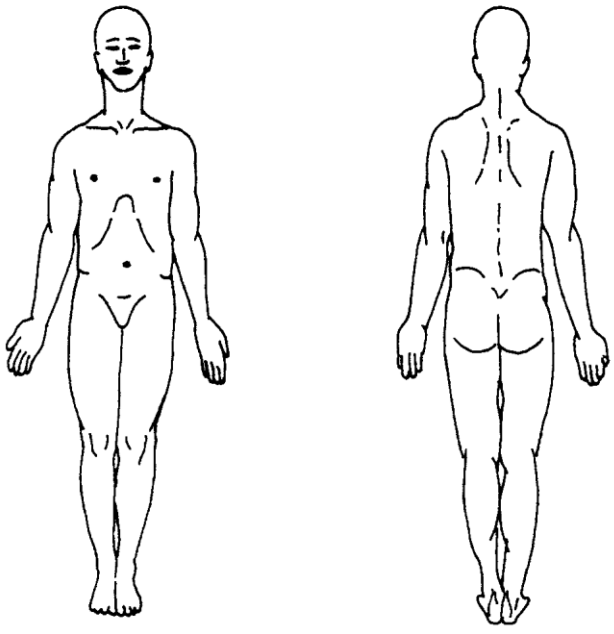
Total points

PART XII (cont.)

	No/Rarely	Occasionally	Often	Frequently
SECTION D				
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				

	No/Rarely	Occasionally	Often	Frequently
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.)				
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 fogginess, 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.



Natural Elements Health Medical Symptoms Questionnaire HAQ Detoxification Indicator (MSQ)

Patient Name: _____ Date: _____ Week: _____

Rate each of the following symptoms based upon your typical health profile for: ☐ Past 30 days ☐ Past 48 hours

Point Scale 0 - Never or almost never have the symptom
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
Total: _____

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision (does not include near or far-sightedness)
Total: _____

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
Total: _____

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
Total:

MOUTH THROAT
_____ Chronic Coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores
Total: _____

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
Total: _____

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
Total: _____

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
Total: _____

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
Total: _____

JOINTS MUSCLEs
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
Total: _____

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
Underweight
Total: _____

ENERGY ACTIVITY
Fatigue, sluggishness
Apathy, lethargy
Hyperactivity
Restlessness
Total:

POOR MEMORY
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
Total: _____

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
Total: _____

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
Total: _____

GRAND TOTAL: _____

YEAST QUESTIONNAIRE--Adult

In section A circle the score for each YES answer. For Sections B and C score as indicated. Record total scores at the end of the questionnaire.

Section A -- History

1. Have you ever taken tetracycline (Sumycin, Panmycin, Vibramycin, Minocin, etc.) or other antibiotics for acne one month or longer?..... 35
2. Have you, at any time in your life, taken other "broad-spectrum" antibiotics for respiratory, urinary, or other infections for two months or longer or in shorter courses four or more times in a one year period?..... 35
3. Have you taken a "broad spectrum" antibiotic – even in a single course?..... 6
4. Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis, or other problems affecting your reproductive organs?..... 25
5. Have you been pregnant: Two or more times?..... 5
   One time? 3
6. Have you taken birth control pills:
   More than two years?..... 15
   Six months to two years?..... 8
7. Have you taken prednisone, Decadron, or other cortisone-type drugs for more than two weeks?..... 15
   Two weeks or less?..... 6
8. Does exposure to perfumes, insecticides, fabric shop odors, and other chemicals provoke:
   Moderate to severe symptoms?..... 20
   Mild symptoms? 5
9. Are your symptoms worse on damp, muggy days or in moldy places? 20
10. Have you had athlete's foot, ring worm, jock itch or other chronic fungus infections of skin or nails:
    Severe or persistent? 20
    Mild to Moderate?..... 10
11. Do you crave sugar? 10
12. Do you crave bread? 10
13. Do you crave alcoholic beverages?..... 10
14. Does tobacco smoke really bother you?..... 10

Section B – Major Symptoms

Enter the appropriate score for each symptom below.
Occasional or mild……3 points
Frequent and/or moderately severe .....6 points
Severe and/or disabling.....9 points

1. Fatigue and lethargy ____
2. Feeling of being drained ____
3. Poor memory ____
4. Feeling "spacey" or "unreal" ____
5. Depression ____
6. Numbness, burning, or tingling ____
7. Muscle aches ____
8. Muscle weakness or paralysis ____
9. Pain and/or swelling in joints ____
10. Abdominal pain ____
11. Constipation ____
12. Diarrhea ____
13. Bloating ____
14. Troublesome vaginal discharge ____
15. Persistent vaginal burning or itching ____
16. Prostatitis ____
17. Impotence ____
18. Loss of sexual desire ____
19. Endometriosis ____
20. Cramps and/or other menstrual irregularities ____
21. Premenstrual tension ____
22. Spots in front of the eyes ____
23. Erratic vision ____

Section C -- Other Symptoms

Enter the appropriate score for each symptom below.
Occasional or mild……1 points
Frequent and/or moderately severe.....2 points
Severe and/or disabling.....3 points

1. Drowsiness ____
2. Irritability or jitteriness ____
3. Incoordination ____
4. Inability to concentrate ____
5. Frequent mood swings ____
6. Headache ____
7. Dizziness/loss of balance ____
8. Pressure above ears feeling of head swelling ____
9. Itching ____
10. Rashes ____
11. Heartburn ____
12. Indigestion ____
13. Belching and/or intestinal gas ____
14. Mucus in stools ____
15. Hemorrhoids ____
16. Dry mouth ____
17. Rash or blisters in mouth ____
18. Bad breath ____
19. Endometriosis ____
20. Nasal congestion or discharge ____
21. Postnasal drip ____
22. Nasal itching ____
23. Sore or dry throat ____
24. Cough ____
25. Pain or tightness in chest ____
26. Wheezing or shortness of breath ____
27. Urinary urgency or frequency ____
28. Burning on urination ____
29. Failing vision ____
30. Burning or tearing of eyes ____
31. Recurrent infections or fluid in ears ____
32. Ear pain or deafness ____

Scores: Section A _____ Section B _____ Section C _____

GRAND TOTAL SCORE: _____

The GRAND TOTAL SCORE will help to determine if your health problems are yeast connected. Scores in women will run higher because more questions apply only to women than to men.

Yeast connected health problems are almost CERTAINLY PRESENT in women with scores over 180, and in men with scores over 140.

Yeast connected health problems are PROBABLY PRESENT in women with scores over 120 and in men with scores over 90.

Yeast connected problems are POSSIBLY PRESENT in women with scores over 60 and in men with scores over 40.

Scores less than 60 in women and 40 in men: yeasts are less apt to cause health problems.