

NUTRABALANCE HEALTH APPRAISAL QUESTIONNAIRE

INSTRUCTIONS:

Circle the number which best describes the intensity of your symptoms at this time or from your past history where indicated.
Total the scores for each section.

If you do not know the answer to a question, leave it blank.

0 = Symptom is not present 1 = Mild 2 = Moderate 3 = Severe
N = No Y = Yes

SCORING:

Add up the score for each section and write the totals in the spaces below. Be sure to enter your name, age, etc.
Answer 0-3 use corresponding number for points. Answers N = 0 points and Y = 3 points (*unless otherwise indicated.)

Name _____ Age _____ Sex _____ Date ____/____/____

PART	SECTION	TOTALS
PART I	SECTION A	
PART I	SECTION B	
PART I	SECTION C	
PART I	SECTION D	
PART II	SECTION A	
PART II	SECTION B	
PART III	COMPLETE	
PART IV	SECTION A	
PART IV	SECTION B	
PART IV	SECTION C	
PART V (MALES ONLY)		
PART V	SECTION A	
PART V	SECTION B	
PART V	SECTION C	
PART VI (FEMALES ONLY)		
PART VI	SECTION A	
PART VI	SECTION B	
PART VI	SECTION C	
PART VI	SECTION D	
PART VI	SECTION E	
PART VII	SECTION A	
PART VII	SECTION B	
PART VII	SECTION C	

PART	SECTION	TOTALS
PART VIII	SECTION A	
PART VIII	SECTION B	
PART VIII	SECTION C	
PART IX	SECTION A	
PART IX	SECTION B	
PART IX	SECTION C	
PART IX	SECTION D	
PART IX	SECTION E	
PART X	SECTION A	
PART X	SECTION B	
PART XI	COMPLETE	
PART XII	COMPLETE	
PART XIII	COMPLETE	
PART XIV	COMPLETE	
PART XV	COMPLETE	
PART XVI	COMPLETE	
PART XVII	COMPLETE	
PART XVIII	COMPLETE	
PART XIX	COMPLETE	

PART I SECTION A

1. Temperature sensitivity.....	0	1	2	3	12. High or low blood pressure*.....	N	Y	*	5
2. Hypersensitive to odors/chemicals.....	0	1	2	3	13. History of birth defects.....	N	Y		
3. Excessive/deficient appetite.....	0	1	2	3	14. Multiple birth defects.....	N	Y		
4. Chronic headaches.....	0	1	2	3	15. Exceptional number of fevers.....	N	Y		
5. Recurrent dizziness/light headedness.....	0	1	2	3	16. Poor sense of smell.....	N	Y		
6. Memory problems.....	0	1	2	3	17. Chronic spontaneous abortions.....	N	Y		
7. Chronic hot or cold flashes.....	0	1	2	3	18. Decreased/excessive libido*.....	N	Y	*	5
8. Type A behavior/outburst.....	0	1	2	3	19. Seizures/convulsions.....	N	Y		
9. Excessive Thirst.....	0	1	2	3					
10. Excessive sleep or insomnia.....	0	1	2	3	TOTAL FOR SECTION I A: _____				
11. History of heart disease.....	N	Y							

PART I SECTION B

1. Decreased scalp hair.....	0	1	2	3	12. Psychological disturbances.....	0	1	2	3
2. Increased body hair.....	0	1	2	3	13. Obesity.....	N	Y		
3. Chronic headaches.....	0	1	2	3	14. Impotence.....	N	Y		
4. Crave protein.....	0	1	2	3	15. Hyper/hypoglycemia.....	N	Y		
5. Complete energy drop.....	0	1	2	3	16. Under 4'10" or over 6'6".....	N	Y		
6. Menstrual irregularities.....	0	1	2	3	17. Large or small boned.....	N	Y		
7. Dry or oily skin/hair.....	0	1	2	3	18. Use of birth control hormones*.....	N	Y	*	5
8. Hyper pigmentation of skin.....	0	1	2	3	19. Infertility*.....	N	Y	*	5
9. Visual disturbances.....	0	1	2	3	20. Delayed sexual development.....	N	Y		
10. Hyperactivity/chronic fatigue.....	0	1	2	3					
11. Water retention.....	0	1	2	3	TOTAL FOR SECTION I B: _____				

PART I SECTION C

1. Extremely sensitive to environment.....	0	1	2	3	12. Dull exaggerated senses.....	0	1	2	3
2. Migraine headaches.....	0	1	2	3	13. Extremely sensitive to sunlight.....	0	1	2	3
3. Epileptic seizures.....	0	1	2	3	14. History of severe shock/trauma.....	0	1	2	3
4. Emotional ups and downs.....	0	1	2	3	15. Recurrent fatigue.....	0	1	2	3
5. Multiple allergies.....	0	1	2	3	16. Menstrual disturbances.....	0	1	2	3
6. Impotency.....	0	1	2	3	17. Fatigue during winter months*.....	N	Y	*	10
7. Reduced sexual drive.....	0	1	2	3	18. Infertility.....	N	Y		
8. Excessive sexual drive.....	0	1	2	3	19. Early sexual development.....	N	Y		
9. Recurrent anxiety.....	0	1	2	3	20. Abnormal sleep patterns.....	N	Y		
10. Recurrent depression.....	0	1	2	3					
11. Visual problems.....	0	1	2	3	TOTAL FOR SECTION I C: _____				

PART I SECTION D

1. Loss of balance.....	0	1	2	3	13. Restless/uneasy sleeper.....	0	1	2	3
2. Ringing/bussing in ears.....	0	1	2	3	14. Stroke*.....	0	1	2	3
3. Trembling hands.....	0	1	2	3	15. Accident prone.....	N	Y	*	5
4. Loss of feeling in hands and/or feet.....	0	1	2	3	16. Loss if muscle tone.....	N	Y		
5. Limbs feel heavy to hold up.....	0	1	2	3	17. Neurologic disorder.....	N	Y		
6. Loss of grip strength.....	0	1	2	3	18. Have had shingles.....	N	Y		
7. Tingling pain sensation.....	0	1	2	3	19. Psychiatric disorder.....	N	Y		
8. Uncoordinated.....	0	1	2	3	20. Use of Psycho-Pharmaceutical drugs*.....	N	Y	*	5
9. Nervousness.....	0	1	2	3	21. Sleep walk.....	N	Y		
10. Nightmares.....	0	1	2	3	22. Regular use of sleeping pills*.....	N	Y	*	5
11. Intense dreams.....	0	1	2	3					
12. Leg cramps/restless legs at night.....	0	1	2	3	TOTAL FOR SECTION I D: _____				

PART II SECTION A

1. Frequent urination.....	0	1	2	3	14. Excessive thirst/dehydration.....	0	1	2	3
2. Frequent bladder/kidney infections.....	0	1	2	3	15. Joint swelling.....	0	1	2	3
3. Rarely need to urinate.....	0	1	2	3	16. History of kidney disorders*.....	N	Y	*	5
4. Painful/burning when urinating.....	0	1	2	3	17. Miscarriage/delivery problems.....	N	Y		
5. Difficulty passing urine.....	0	1	2	3	18. Hemorrhoids.....	N	Y		
6. Dripping after urination.....	0	1	2	3	19. High blood pressure*.....	N	Y	*	5
7. Can't hold urine.....	0	1	2	3	20. Crave salt*.....	N	Y	*	5
8. Strong smelling urine.....	0	1	2	3	21. Breast feeding difficulties.....	N	Y		
9. Water retention/bloating.....	0	1	2	3	22. Menstrual problems.....	N	Y		
10. Flushed skin.....	0	1	2	3	23. Use of diuretics (water pills)*.....	N	Y	*	5
11. Blue nose, fingers, toes.....	0	1	2	3					
12. Chronic headaches.....	0	1	2	3	TOTAL FOR SECTION II A: _____				
13. Heart/circulatory problems.....	0	1	2	3					

PART II SECTION B

1. Little urinary output.....	0	1	2	3	16. High blood pressure.....	N	Y		
2. Unexplained weight gain.....	0	1	2	3	17. History of kidney disease or infection*.....	N	Y	*	10
3. Water retention/leg swelling.....	0	1	2	3	18. Protein or white blood cells in the urine (foamy white)*.....	N	Y	*	5
4. Edema (swelling) around eyes & face.....	0	1	2	3	19. History of recent strep throat.....	N	Y		
5. Headaches or fatigue.....	0	1	2	3	20. History of kidney stones*.....	N	Y	*	10
6. Visual difficulties.....	0	1	2	3	21. Fever of undetermined origin.....	N	Y		
7. Blood in the urine.....	0	1	2	3	22. History of diabetes.....	N	Y		
8. Smoky or "coke colored" urine.....	0	1	2	3	23. Pressure or swelling above pubic bone.....	N	Y		
9. Abdominal pain or swelling.....	0	1	2	3	24. History of prostate infection or swelling....	N	Y		
10. Lower flank (back) pain or mass.....	0	1	2	3	25. History of congestive heart or liver disease	N	Y		
11. Repeated night time urination.....	0	1	2	3	26. Use of diuretics (water pills)*.....	N	Y	*	10
12. Nausea or loss of appetite.....	0	1	2	3	27. Bed wetting*.....	N	Y	*	5
13. Urgency or frequency of urination.....	0	1	2	3					
14. Painful urination.....	0	1	2	3	TOTAL FOR SECTION II B: _____				
15. Anemia.....	N	Y							

PART III COMPLETE

1. Swollen eyes (bulging).....	1	2	3		13. Premenstrual Tension.....	1	2	3	
2. Thick skin and fingernails.....	1	2	3		14. Constipation/chronic diarrhea.....	1	2	3	
3. Dry skin.....	1	2	3		15. Heat intolerance.....	1	2	3	
4. Sensitive to the cold.....	1	2	3		16. Changes in the hair texture.....	N	Y		
5. Cold hands and feet.....	1	2	3		17. Gain or lose weight easily.....	N	Y	*	5
6. Excessive menstrual bleeding.....	1	2	3		18. Anemia unaffected by iron.....	N	Y		
7. Chronic fatigue.....	1	2	3		19. Axillary (armpit) temperatures below 97.6	N	Y	*	5
8. Heart palpitations/hyperactivity.....	1	2	3		20. Slow reflexes.....	N	Y		
9. Depressed/apathetic.....	1	2	3		21. Take thyroid medication.....	N	Y	*	5
10. Low sex drive.....	1	2	3		22. Present thyroid condition.....	N	Y	*	5
11. Puffy/wrinkly skin.....	1	2	3						
12. Sugar causes irritability and mood swings...	1	2	3		TOTAL FOR SECTION III: _____				

PART IV SECTION A

1. Sensitive to exhaust fumes, smoke, smog, Petrochemicals.....	0	1	2	3	15. Dizziness/vertigo.....	0	1	2	3
2. Periodic constipation/diarrhea.....	0	1	2	3	16. Excessive thirst.....	0	1	2	3
3. Cannot tolerate much exercise.....	0	1	2	3	17. Chronic fatigue/hyperactivity.....	0	1	2	3
4. Depression or rapid mood swings.....	0	1	2	3	18. Puffiness in the face and body.....	0	1	2	3
5. Dark circles under the eyes.....	0	1	2	3	19. Excessive salt/sugar craving.....	0	1	2	3
6. Dizziness.....	0	1	2	3	20. Hypoglycemia.....	0	1	2	3
7. Lack of mental alertness.....	0	1	2	3	21. Phobias/recurrent anxiety.....	0	1	2	3
8. Catch colds easily when weather changes.....	0	1	2	3	22. Headaches.....	0	1	2	3
9. Difficulty breathing.....	0	1	2	3	23. Kidney problems.....	0	1	2	3
10. Water retention.....	0	1	2	3	24. Is your blood pressure high?Low?*	N	Y	*	5
11. Eyes sensitive to bright light.....	0	1	2	3	25. Allergies/asthma.....	N	Y	*	5
12. Feel weak and shaky.....	0	1	2	3	26. Use oral cortisone/prednisone*	N	Y	*	10
13. Muscle weakness.....	0	1	2	3	27. Chronic drug/alcohol abuse*	N	Y	*	5
14. Pain in the morning in back of head/neck....	0	1	2	3	28. Osteoporosis.....	N	Y		
					TOTAL FOR SECTION IV A: _____				

PART IV SECTION B

1. Shortness of breath on exertion.....	0	1	2	3	10. Exhaustion with minor exertion.....	0	1	2	3
2. Chest pain while walking.....	0	1	2	3	11. At rest, heat beats per minute (Under 75=0, 75=1, 80=2, 85+=3).....	0	1	2	3
3. Calf muscles cramp while walking.....	0	1	2	3	12. Don't do aerobic exercise.....	N	Y		
4. Heart pounds easily/palpitations.....	0	1	2	3	13. Don't exercise regularly*	N	Y	*	5
5. Heart skips beats or has extra beats.....	0	1	2	3	14. Bright red nose.....	N	Y		
6. Swelling of feet and ankles.....	0	1	2	3	15. Use of heart medication/pacemaker*.....	N	Y	*	5
7. Rapid beating heart.....	0	1	2	3					
8. Heartburn after eating.....	0	1	2	3	TOTAL FOR SECTION IV B: _____				
9. Pain in left arm.....	0	1	2	3					

PART IV SECTION C

1. Cold hands and feet.....	0	1	2	3	9. Heart attack/angina*.....	N	Y	*	10
2. Varicose veins.....	0	1	2	3	10. Stroke*.....	N	Y	*	10
3. Calf muscles cramp while walking.....	0	1	2	3	11. Vertical wrinkle in lower ear lobe.....	N	Y		
4. Headaches (throbbing).....	0	1	2	3	12. Is your blood pressure high?Low?.....	N	Y	*	5
5. Numbness/blue color of extremities.....	0	1	2	3	13. Dizziness/easy fatigue.....	N	Y		
6. Poor concentration.....	0	1	2	3	14. Abnormal EKG*.....	N	Y	*	5
7. Ringing in ears.....	0	1	2	3					
8. Frequent nose bleeds.....	N	Y			TOTAL FOR SECTION IV C: _____				

PART V SECTION A (MALES ONLY)

1. Difficulty urinating.....	0	1	2	3	6. Lack of sex drive.....	0	1	2	3
2. A sense of bladder fullness.....	0	1	2	3	7. Ejaculation causes pain.....	0	1	2	3
3. Increased straining with smaller and smaller amounts of urine passed.....	0	1	2	3	8. History of prostate infections*.....	N	Y	*	5
4. Rose colored (bloody) urine.....	0	1	2	3	9. Pain in rectum.....	N	Y		
5. Pain or burning while urinating.....	0	1	2	3	TOTAL FOR SECTION V A: _____				

PART V SECTION B (MALES ONLY)

1. Difficulty attaining/maintaining an erection	0	1	2	3	5. Acne.....	0	1	2	3
2. Anxiety or fear of sexual intimacy with women.....	0	1	2	3	6. Infertile/low sperm count*.....	N	Y	*	5
3. Premature ejaculation.....	0	1	2	3	7. Varicose veins on scrotum.....	N	Y		
4. Pain/coldness in genital area.....	0	1	2	3	8. Vasectomy*.....	N	Y	*	5
					TOTAL FOR SECTION V B: _____				

PART V SECTION C (MALES ONLY)

1. Discharge from penis.....	0	1	2	3	5. Venereal disease (gonorrhea, syphilis, herpes, or other)*.....	N	Y	*	5
2. Past or present rash on penis.....	0	1	2	3	6. Cancer of sexual organs*.....	N	Y	*	10
3. Swollen genitals.....	0	1	2	3	TOTAL FOR SECTION V C: _____				
4. Swelling in groin.....	0	1	2	3					

PART VI SECTION A (FEMALES ONLY)

Circle if you experience any of these symptoms within approximately 2 weeks (ovulation) prior to menstruation (Section A only)

1. Monthly weight gain.....	0	1	2	3	10. Easily Distracted/poor concentration.....	0	1	2	3
2. Depression.....	0	1	2	3	11. Anger/hostility.....	0	1	2	3
3. Bloating and swelling.....	0	1	2	3	12. Tender breast.....	0	1	2	3
4. Moodiness /irritability.....	0	1	2	3	13. Low backache.....	0	1	2	3
5. Nausea and/or vomiting.....	0	1	2	3	14. Acne.....	0	1	2	3
6. Anxiety/irritability.....	0	1	2	3	15. Constipation.....	0	1	2	3
7. Leg cramps and tenderness.....	0	1	2	3					
8. Craving for sugar/salt.....	0	1	2	3	TOTAL FOR SECTION VI A: _____				
9. Headaches.....	0	1	2	3					

PART VI SECTION B (FEMALES ONLY)

1. Vaginal itching/dryness.....	0	1	2	3	7. Unable to get pregnant/infertility*.....	N	Y	*	10
2. Vaginal discharge/infection.....	0	1	2	3	8. Miscarriages/abortion/tubal ligation.....	N	Y		
3. Low or no desire for sex.....	0	1	2	3	9. Cancer of the reproductive organs*.....	N	Y	*	10
4. Dislike for intercourse.....	0	1	2	3	10. Pelvic inflammatory disease (PID)*.....	N	Y	*	5
5. Missed periods.....	N	Y							
6. Over 15 years of age and have not begun menstruation*.....	N	Y	*	5	TOTAL FOR SECTION VI B: _____				

PART VI SECTION C (FEMALES ONLY)

Circle if you experience any of these symptoms during menstruation. (Section C only)

1. Low abdominal pain.....	0	1	2	3	11. Craving for sweets.....	0	1	2	3
2. Dull ache radiating to low back or legs.....	0	1	2	3	12. Insomnia.....	0	1	2	3
3. Increased urinary frequency.....	0	1	2	3	13. Light scanty blood flow.....	0	1	2	3
4. Pelvic soreness.....	0	1	2	3	14. Pain and cramps without blood flow.....	0	1	2	3
5. Diarrhea.....	0	1	2	3	15. Heavy menstrual bleeding.....	0	1	2	3
6. Headaches.....	0	1	2	3	16. Anxiety about menstrual cycle.....	0	1	2	3
7. Abdominal bloating.....	0	1	2	3	17. Pain during period is progressively getting worse with time.....	0	1	2	3
8. Menstrual pain/endometriosis.....	0	1	2	3					
9. Nausea and/or vomiting.....	0	1	2	3	TOTAL FOR SECTION VI C: _____				
10. Have to lie down on first 1 or 2 days of period.....	0	1	2	3					

PART VI SECTION D (FEMALES ONLY)

1. Vaginal bumps and sores.....	0	1	2	3	9. Family history of breast cancer*.....	N	Y	*	5
2. Pubic area sore.....	0	1	2	3	10. Birth control pills/IUD.....	N	Y		
3. Pain in ovaries.....	0	1	2	3	11. History of breast cancer (self)*.....	N	Y	*	10
4. Breasts sore to touch.....	0	1	2	3	12. Ovarian cysts*.....	N	Y	*	5
5. Breasts painful/fibrocystic breasts.....	0	1	2	3	13. Uterine cysts*.....	N	Y	*	5
6. Water retention/swollen feeling.....	0	1	2	3	14. Breast lumps/discharge*.....	N	Y	*	5
7. Mother used D.E.S. (hormones) while pregnant.....	N	Y							
8. Recent Pap smear positive*.....	N	Y	*	10	TOTAL FOR SECTION VI D: _____				

PART VI SECTION E (FEMALES ONLY)

1. Hot flashes.....	0	1	2	3	8. Painful intercourse.....	0	1	2	3
2. Night sweats.....	0	1	2	3	9. Vaginal pain/itching.....	0	1	2	3
3. Depression/Mood swings.....	0	1	2	3	10. Use estrogen/progesterone*.....	N	Y	*	5
4. Insomnia.....	0	1	2	3	11. Osteoporosis*.....	N	Y	*	10
5. Heavy bleeding two weeks/month.....	0	1	2	3	12. Hysterectomy*.....	N	Y	*	5
6. Sweating throughout day.....	0	1	2	3					
7. Dryness of skin, hair and vagina.....	0	1	2	3	TOTAL FOR SECTION VI E: _____				

PART VII SECTION A

1. Pain in fingers.....	0	1	2	3	10. Dentures.....	N	Y		
2. Tightness in shoulder muscles.....	0	1	2	3	11. Bone deformity.....	N	Y		
3. Cavities.....	0	1	2	3	12. Osteoporosis/osteomalacia*.....	N	Y	*	10
4. Arthritis.....	N	Y			13. Recent bone fracture.....	N	Y		
5. Drink carbonated beverages/soda.....	N	Y			14. Are you postmenopausal?*	N	Y	*	5
6. Gum disease.....	N	Y	*	5	15. History of calcium deficiency*.....	N	Y	*	5
7. Bone loss*.....	N	Y	*	5					
8. Calcium deposits*.....	N	Y			TOTAL FOR SECTION VII A: _____				
9. Use antacids.....									

PART VII SECTION B

1. Muscle spasms/tetany.....	0	1	2	3	7. Stiff in morning.....	0	1	2	3
2. Tightness in shoulder muscles.....	0	1	2	3	8. Unable to sit straight.....	0	1	2	3
3. Muscle cramps.....	0	1	2	3	9. Pain in neck and/or shoulders.....	0	1	2	3
4. Pain in arms and hands.....	0	1	2	3	10. Pain or popping in jaw.....	0	1	2	3
5. Leg cramps at night.....	0	1	2	3					
6. Stiff all over.....	0	1	2	3	TOTAL FOR SECTION VII B: _____				

PART VII SECTION C

1. Over flexible joints (double jointed).....	0	1	2	3	8. Vertebral subluxations.....	N	Y		
2. Back pain/bone pain.....	0	1	2	3	9. Herniated disc*.....	N	Y	*	5
3. Swollen knees/elbows.....	0	1	2	3	10. Loss in height.....	N	Y		
4. Athletic injury.....	0	1	2	3	11. Injure easily.....	N	Y		
5. Bursitis.....	0	1	2	3	12. Connective tissue disease*.....	N	Y	*	10
6. Tendonitis.....	0	1	2	3					
7. Joint pain.....	0	1	2	3	TOTAL FOR SECTION VII C: _____				

PART VIII SECTION A

1. Dizziness when standing suddenly.....	0	1	2	3	9. Heart palpitations/cold sweats.....	0	1	2	3
2. Loss of vision when standing suddenly.....	0	1	2	3	10. Need to drink coffee to get started.....	0	1	2	3
3. Crave sweets/alcohol.....	0	1	2	3	11. Impatient, moody, nervous.....	0	1	2	3
4. Headaches relieved by eating sweets or alcohol.....	0	1	2	3	12. Feel tired 1 to 3 hours after eating.....	0	1	2	3
5. Feel shaky.....	0	1	2	3	13. Poor memory/concentration.....	0	1	2	3
6. Irritable if a meal is missed.....	0	1	2	3	14. Hypoglycemia by glucose tolerance test*..	N	Y	*	10
7. Wake up in the middle of the night craving sweets.....	0	1	2	3	15. Calmer after eating*.....	N	Y	*	5
8. Feel tired or weak if a meal is missed.....	0	1	2	3	TOTAL FOR SECTION VIII A: _____				

PART VIII SECTION B

1. Night sweats.....	0	1	2	3	9. Crave sweets but eating sweets does not relieve symptoms.....	0	1	2	3
2. Increased thirst/appetite.....	0	1	2	3	10. Diabetes controlled by oral meds/diet*....	N	Y	*	5
3. Lowered resistance to infection.....	0	1	2	3	11. Family history of diabetes.....	N	Y		
4. Fatigue.....	0	1	2	3	12. Insulin controlled diabetes*.....	N	Y	*	10
5. Boils and leg sores.....	0	1	2	3	13. Excessive urination.....	N	Y		
6. Lesions, cuts take a long time to heal.....	0	1	2	3					
7. Overweight.....	0	1	2	3	TOTAL FOR SECTION VIII B: _____				
8. Muscle weakness.....	0	1	2	3					

PART VIII SECTION C

1. Frequent indigestion.....	0	1	2	3	7. Pancreatic disease*.....	N	Y	*	10
2. Fullness in the abdomen.....	0	1	2	3	8. Use of pancreatic enzymes.....	N	Y		
3. Chronic digestive disturbances.....	0	1	2	3	9. Weight loss (sudden).....	N	Y		
4. Foul smelling stools.....	0	1	2	3	10. Severe abdominal pain radiating in the back*.....	N	Y	*	5
5. Chronic diarrhea.....	0	1	2	3					
6. Chronic alcohol abuse*.....	N	Y	*	5	TOTAL FOR SECTION VIII C: _____				

PART IX SECTION A

1. Burping.....	0	1	2	3	7. Known food allergies*.....	N	Y	*	5
2. Fullness for extended time after meals.....	0	1	2	3	8. Excessive gas (flatus)*.....	N	Y	*	5
3. Bloating.....	0	1	2	3	9. Indigestion.....	N	Y		
4. Poor appetite.....	0	1	2	3	10. Regurgitation of food eaten*.....	N	Y	*	5
5. Stomach upsets easily.....	0	1	2	3					
6. History of constipation*.....	N	Y	*	5	TOTAL FOR SECTION IX A: _____				

PART IX SECTION B

1. Abdominal cramps.....	0	1	2	3	10. Shiny stool.....	0	1	2	3
2. Indigestion 1-3 hours after eating.....	0	1	2	3	11. 3 or more large bowel movements daily...	0	1	2	3
3. Fatigue after eating.....	0	1	2	3	12. Foul smelling stool.....	0	1	2	3
4. Lower bowel gas.....	0	1	2	3	13. Dry flaky skin or dry brittle hair.....	0	1	2	3
5. Alternation constipation and diarrhea.....	0	1	2	3	14. Pain in left side under rib cage.....	0	1	2	3
6. Diarrhea (chronic).....	0	1	2	3	15. Acne.....	0	1	2	3
7. Roughage and fiber causes constipation....	0	1	2	3	16. Food allergies*.....	N	Y	*	5
8. Mucus in stools.....	0	1	2	3					
9. Stool poorly formed.....	0	1	2	3	TOTAL FOR SECTION IX B: _____				

PART IX SECTION C

1. Stomach pains/heartburn.....	0	1	2	3	10. Relief of symptoms by carbonated beverages.....	N	Y		
2. Stomach pains just before and/or after meals.....	0	1	2	3	11. Relief of stomach pain by drinking cream/milk.....	N	Y		
3. Dependency on antacids.....	0	1	2	3	12. History of ulcer or gastritis*.....	N	Y	*	5
4. Chronic abdominal pains.....	0	1	2	3	13. Current ulcer or gastritis.....	N	Y		
5. Butterfly sensation in stomach.....	0	1	2	3	14. Black stool when not taking iron supplements.....	N	Y		
6. Difficulty belching.....	0	1	2	3	15. Regurgitation or hiatal hernia*.....	N	Y	*	5
7. Stomach pains when emotionally upset....	0	1	2	3					
8. Chronic bad breath.....	0	1	2	3	TOTAL FOR SECTION IX C: _____				
9. Sudden, acute indigestion.....	N	Y							

PART IX SECTION D

1. Seasonal diarrhea.....	0	1	2	3	10. Meat eater (red meat, pork, lamb).....	N	Y		
2. Frequent recurrent infections (colds).....	0	1	2	3	11. Rapidly failing vision.....	N	Y		
3. Bladder and kidney infections.....	0	1	2	3	12. History of colon cancer*.....	N	Y	*	10
4. Vaginal yeast infections.....	0	1	2	3	13. Colitis/irritable bowel*.....	N	Y	*	5
5. Abdominal cramps.....	0	1	2	3	14. Bloody diarrhea*.....	N	Y	*	10
6. Toe and fingernail fungus (white growth)...	0	1	2	3	15. Diverticulitis*.....	N	Y	*	5
7. Alternation diarrhea/constipation.....	0	1	2	3	16. Diverticulosis.....	N	Y		
8. Constipation/hemorrhoids.....	0	1	2	3					
9. History of frequent antibiotic use.....	N	Y			TOTAL FOR SECTION IX D: _____				

PART IX SECTION E

1. Excessive stomach acid.....	0	1	2	3	8. Dizziness.....	0	1	2	3
2. Chronic diarrhea/constipation.....	0	1	2	3	9. Duodenal or peptic ulcer*.....	N	Y	*	5
3. Heartburn.....	0	1	2	3	10. History of kidney stones.....	N	Y		
4. Lack of appetite.....	0	1	2	3	11. History of hiatal hernia*.....	N	Y	*	5
5. Easy bruising.....	0	1	2	3	12. Food allergies*.....	N	Y	*	5
6. Recurrent depression.....	0	1	2	3					
7. Chronic fatigue.....	0	1	2	3	TOTAL FOR SECTION IX E: _____				

PART X SECTION A

1. Intolerance to fried foods.....	0	1	2	3	15. Painful to pass stool.....	0	1	2	3
2. Headache after eating.....	0	1	2	3	16. Retain water (bloating).....	0	1	2	3
3. Light colored stool.....	0	1	2	3	17. Big toe painful or gout.....	0	1	2	3
4. Foul smelling stool.....	0	1	2	3	18. Dry skin or hair/skin eruptions.....	0	1	2	3
5. Easily bruisable.....	0	1	2	3	19. Alcoholism/chronic drug abuse*.....	N	Y	*	5
6. Constipation.....	0	1	2	3	20. Red blood in stool.....	N	Y		
7. Hard stool.....	0	1	2	3	21. Have had jaundice or hepatitis*.....	N	Y	*	10
8. Sour taste in mouth/bad breath.....	0	1	2	3	22. High cholesterol and low HDL*.....	N	Y	*	5
9. Grey colored skin.....	0	1	2	3	23. Cholesterol level is above 200*.....	N	Y	*	5
10. Yellow in whites of eyes.....	0	1	2	3	24. Cholesterol level is above 300*.....	N	Y	*	10
11. Acne/skin eruptions.....	0	1	2	3	25. Triglyceride level is above 150*.....	N	Y	*	5
12. Body odor.....	0	1	2	3					
13. Fatigue and sleepiness.....	0	1	2	3	TOTAL FOR SECTION X A: _____				
14. Pain in right side under rib cage.....	0	1	2	3					

PART X SECTION B

1. Chronic fatigue.....	0	1	2	3	8. Blood disorders*.....	N	Y	*	5
2. Toxic feeling.....	0	1	2	3	9. Enlarged spleen*.....	N	Y	*	5
3. Left upper abdominal pain.....	0	1	2	3	10. Chronic swollen lymph nodes.....	N	Y		
4. Removal of spleen*.....	N	Y	*	5	11. Bleeding disorders*.....	N	Y	*	5
5. History of mononucleosis.....	N	Y			12. Leukemia/lymphoma*.....	N	Y	*	10
6. History of Hodgkins disease*.....	N	Y	*	10					
7. Recurrent/chronic anemia*.....	N	Y	*	5	TOTAL FOR SECTION X B: _____				

PART XI COMPLETE

1. Inflamed or bleeding gums.....	0	1	2	3	22. Ear discharge or ears stuffed up.....	0	1	2	3
2. Running nose.....	0	1	2	3	23. Mouth breather.....	0	1	2	3
3. Get boils/styes/cysts.....	0	1	2	3	24. History of mononucleosis.....	0	1	2	3
4. Throat infections.....	0	1	2	3	25. Recurrent tonsillitis.....	0	1	2	3
5. Cold sores, fever blister.....	0	1	2	3	26. Chronic lung congestion/cough.....	0	1	2	3
6. Poor wound healing.....	0	1	2	3	27. Candida/yeast infection*.....	N	Y	*	10
7. Hives/rashes.....	0	1	2	3	28. Recurrent parasite infection*.....	N	Y	*	5
8. Swollen lymph glands.....	0	1	2	3	29. Sexually transmitted disease.....	N	Y		
9. Ear infections.....	0	1	2	3	30. Eczema or psoriasis.....	N	Y		
10. Acne.....	0	1	2	3	31. Asthma/bronchitis*.....	N	Y	*	10
11. Slow to recover from cold and flu.....	0	1	2	3	32. Migraine headaches.....	N	Y		
12. Catch colds or flu easily.....	0	1	2	3	33. History of cancer/chemotherapy*.....	N	Y	*	10
13. Muscle aches.....	0	1	2	3	34. Colitis (present or past)*.....	N	Y	*	5
14. Swollen joints/joint pain.....	0	1	2	3	35. Recurrent kidney/bladder infections*.....	N	Y	*	5
15. Food sensitivity or allergy.....	0	1	2	3	36. Rheumatoid arthritis/Auto immune disorder*.....	N	Y	*	10
16. Certain foods make you sick, depressed, jittery.....	0	1	2	3	37. Silicon breast implants*.....	N	Y	*	5
17. Chronic pain.....	0	1	2	3	38. Use cortisone/Prednisone*.....	N	Y	*	5
18. Mucus in throat.....	0	1	2	3	39. Allergies*.....	N	Y	*	5
19. Post nasal drip.....	0	1	2	3	40. Sinusitis/Rhinitis/Hay Fever.....	N	Y		
20. Discharge from eyes or redness.....	0	1	2	3					
21. Eyes itch/puffiness.....	0	1	2	3	TOTAL FOR SECTION XI COMPLETE: _____				

PART XII COMPLETE

1. Nervousness/shakes.....	0	1	2	3	14. Too short/too tall.....	0	1	2	3
2. Sweaty palms.....	0	1	2	3	15. Feeling toxic.....	N	Y		
3. Rapid heart beat/irregular.....	0	1	2	3	16. Feeling unhealthy.....	N	Y		
4. Palpitations.....	0	1	2	3	17. Sick a lot of the time*.....	N	Y	*	10
5. Overweight (for you).....	0	1	2	3	18. Recurrent infections*.....	N	Y	*	5
6. Can't breathe deeply.....	0	1	2	3	19. Chronic fatigue*.....	N	Y	*	5
7. Visual disturbances.....	0	1	2	3	20. Thyroid problems.....	N	Y		
8. Low back pain.....	0	1	2	3	21. High blood pressure*.....	N	Y	*	5
9. Neck tension/pain.....	0	1	2	3	22. Migraine type headaches*.....	N	Y	*	5
10. Muscle aches/cramps.....	0	1	2	3	23. Tension headaches.....				
11. Digestive difficulties.....	0	1	2	3					
12. Heartburn.....	0	1	2	3	TOTAL FOR SECTION XII COMPLETE: _____				
13. Stress diarrhea.....	0	1	2	3					

PART XIII COMPLETE

(This section is related to exercise)

1. Not enough exercise.....	0	1	2	3	11. Don't feel I need it*.....	N	Y	*	5
2. Too tired to exercise.....	0	1	2	3	12. Only exercise outdoors.....	N	Y		
3. Not enough time to exercise.....	0	1	2	3	13. Let it go down in the winter.....	N	Y		
4. Can't fit it in my schedule.....	0	1	2	3	14. Mainly in the summer.....	N	Y		
5. Less than 3-4 times weekly.....	N	Y			15. Feel like I'm too old*.....	N	Y	*	5
6. Less than 2-3 times weekly.....	N	Y			16. Never got in the habit*.....	N	Y	*	5
7. Less than 1-2 times weekly.....	N	Y			17. Mainly stop and go exercise.....	N	Y		
8. Weight lifting only.....	N	Y			18. Don't have an indoor exercise.....	N	Y		
9. Aerobics not included.....	N	Y							
10. Get enough at work*.....	N	Y	*	5	TOTAL FOR SECTION XIII COMPLETE: _____				

PART XIV COMPLETE

1. Lack of motivation to do much when I get home.....	0	1	2	3	12. Lack of support from family.....	0	1	2	3
2. Feel guilty about not exercising.....	0	1	2	3	13. Lack of support from spouse.....	0	1	2	3
3. Little drive to accomplish much.....	0	1	2	3	14. I'm afraid to take risks.....	0	1	2	3
4. Life is a boring routine.....	0	1	2	3	15. Sometimes I feel I'm working against myself.....	0	1	2	3
5. Too much work/too little pay.....	0	1	2	3	16. I tend to procrastinate.....	0	1	2	3
6. Gulp down my food quickly.....	0	1	2	3	17. With my behavior sometimes I sabotage myself*.....	N	Y	*	5
7. Don't relax after eating.....	0	1	2	3	18. Others find my behavior difficult to accept.....	0	1	2	
8. Dining atmosphere is tense.....	0	1	2	3	19. I feel like my life lacks purpose*.....	N	Y	*	10
9. Don't exercise enough.....	0	1	2	3					
10. Nothing to really work for.....	0	1	2	3	TOTAL FOR SECTION XIV COMPLETE: _____				
11. Lack of support from friends.....	0	1	2	3					

PART XV COMPLETE

1. Difficulty with spouse.....	0	1	2	3	13. I'm independent and don't need others...	N	Y		
2. Misunderstood by others.....	0	1	2	3	14. I nag others.....	N	Y		
3. Needs are not being met.....	0	1	2	3	15. I'm nagged by my spouse*.....	N	Y	*	5
4. Lose friendships easily.....	0	1	2	3	16. I don't feel listened to*.....	N	Y	*	5
5. Little contact with family members.....	0	1	2	3	17. I don't listen well.....	N	Y		
6. Don't have love in my life.....	0	1	2	3	18. I am very aggressive to get my way.....	N	Y		
7. Problems relating to my children.....	0	1	2	3	19. I give in to avoid conflict*.....	N	Y	*	5
8. I probably give too much to others.....	0	1	2	3	20. I feel uncomfortable expressing my needs.	N	Y		
9. I feel the need to please people to be liked...	0	1	2	3	21. I don't know my own needs well enough...	N	Y		
10. I hold back to protect myself.....	0	1	2	3	22. My marriage has lost its satisfaction.....	N	Y		
11. I tend to rescue people at my expense.....	0	1	2	3	23. I think about leaving my partner*.....	Y	Y	*	10
12. I feel withdrawn from my primary relationship partner.....	0	1	2	3	TOTAL FOR SECTION XV COMPLETE: _____				

PART XVI COMPLETE

1. Outbursts of anger.....	0	1	2	3	15. Cry easily.....	0	1	2	3
2. Short/quick tempered.....	0	1	2	3	16. Hard to get to sleep or stay asleep.....	0	1	2	3
3. Feel like I'm not good enough.....	0	1	2	3	17. Feel discouraged about the future.....	0	1	2	3
4. Feel sad a lot.....	0	1	2	3	18. Feel like a failure.....	0	1	2	3
5. Can't get motivated.....	0	1	2	3	19. Don't enjoy things like I used to.....	N	Y		
6. Low energy.....	0	1	2	3	20. I feel guilty often*.....	N	Y	*	5
7. Feel nervous a lot.....	0	1	2	3	21. I feel like I'm being punished.....	N	Y		
8. Feel worthless/hopeless.....	0	1	2	3	22. I'm critical of myself*.....	N	Y	*	5
9. Overwhelmed by problems.....	0	1	2	3	23. I have thoughts of killing myself*.....	N	Y	*	10
10. Sleepy during the day.....	0	1	2	3	24. Poor appetite.....	N	Y		
11. Feel anxious or "on edge".....	0	1	2	3	25. Loss of interest in sex.....	N	Y		
12. Irritable.....	0	1	2	3					
13. Worrying.....	0	1	2	3	TOTAL FOR SECTION XVI COMPLETE: _____				
14. Feel uptight.....	0	1	2	3					

PART XVII COMPLETE

1. Don't get enough sleep.....	0	1	2	3	10. Can't fall asleep easily.....	N	Y		
2. Don't get enough relaxation.....	0	1	2	3	11. Can't stay asleep.....	N	Y		
3. Can't get enough sleep.....	0	1	2	3	12. Wake up early and lie in bed*.....	N	Y	*	5
4. Haven't learned how to relax.....	0	1	2	3	13. Toss and turn all night*.....	N	Y	*	5
5. Don't stop to smell the flowers.....	0	1	2	3	14. Work too hard and don't get enough rest..	N	Y		
6. Can't enjoy the simple things in life.....	0	1	2	3	15. Find leisure time boring*.....	N	Y	*	10
7. Feel torn in different directions.....	0	1	2	3	16. Too many irons in the fire.....	N	Y		
8. Now way to "tune out" the stress.....	0	1	2	3					
9. Chronic insomnia.....	N	Y			TOTAL FOR SECTION XVII COMPLETE: _____				

PART XVIII COMPLETE

1. Feel "moody" most of the time.....	0	1	2	3	12. I get irritated easily.....	N	Y		
2. Get the "winter blues".....	0	1	2	3	13. Often feel sorry for myself*.....	N	Y	*	5
3. Moody after eating sugar.....	0	1	2	3	14. Find it hard to feel content.....	N	Y		
4. When I'm sad, it can easily turn to anger.....	0	1	2	3	15. Often feel helpless and uneasy*.....	N	Y	*	5
5. Blunted response to humor/jokes.....	0	1	2	3	16. Feel heavy most of the time.....	N	Y		
6. Laugh inappropriately.....	0	1	2	3	17. Suffer from mood depression*.....	N	Y	*	10
7. Emotions wander a lot.....	0	1	2	3	18. Hard to sustain a positive outlook.....	N	Y		
8. Don't get close to other people.....	0	1	2	3	19. Susceptible to frequent mood swings*.....	N	Y	*	5
9. Afraid to hug or be hugged.....	0	1	2	3					
10. Often get "giggly".....	0	1	2	3	TOTAL FOR SECTION XVIII COMPLETE: _____				
11. Feel uncomfortable with comedy.....	N	Y							

PART XIX COMPLETE

1. Learn tasks slowly.....	0	1	2	3	14. Must be successful in everything I do*.....	N	Y	*	5
2. Don't fit in well with my friends.....	0	1	2	3	15. Depend greatly on certain people.....	N	Y		
3. Make the same mistakes.....	0	1	2	3	16. Get disturbed over situations I don't like...	N	Y		
4. Fall short of my expectations.....	0	1	2	3	17. Avoid facing my problems.....	N	Y		
5. Often seem out of place.....	0	1	2	3	18. Can't find my place in life*.....	N	Y	*	5
6. Can't get along with the opposite sex.....	0	1	2	3	19. Need everyone to like me.....	N	Y		
7. Unhappy with my boss/employer.....	0	1	2	3	20. Have too many irons in the fire.....	N	Y		
8. Need a career change.....	0	1	2	3	21. Have trouble overcoming past negative influences*.....	N	Y	*	5
9. Often become annoyed.....	0	1	2	3	22. Avoid things I can't do well*.....	N	Y	*	10
10. Difficult to do unpleasant chores.....	0	1	2	3		Y	Y		
11. Ignore things that annoy me.....	0	1	2	3	TOTAL FOR SECTION XIX COMPLETE: _____				
12. Can't stand to take chances.....	0	1	2	3					
13. Trouble accepting things the way they are...	0	1	2	3					

This completes your questionnaire. Please total all the sections and enter the totals in the spaces provided on page 1.