

Naturopathic Adult Health Assessment

Patient Name: _____ Date of birth: _____ Sex: M F Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Occupation: _____ Employer: _____

Please check any medical treatments you have received:

- Acupuncture Chiropractic Herbal Medicine Mind/Body Therapy Physical Therapy
- Biofeedback Counseling Homeopathy Naturopathic Medicine Therapeutic Massage
- Other treatments: _____

Living Situation: Married Single Divorced Widowed Children (number): _____ Children's Ages: _____

PRIMARY HEALTH CONCERNS:

In your opinion, what are your most important health concerns?

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

What are your current health goals? _____

On a scale of 1 – 10, how would you rate your current overall state of health? _____

Over the past year has your state of health: Improved Worsened Stayed the Same

Blood Type: A B AB O (+) (-) Unsure?

Ht: _____ Wt: _____ Wt at 20 yr: _____

Over the past year have you gained weight: Yes (amount): _____ No

Is there any condition, trauma, or incident after which you have never been totally well again? _____

Have you ever been exposed to toxic chemicals, solvents or other possible toxins? Yes No If Yes, please explain:

HEALTH HISTORY – ADULTHOOD:

Please indicate whether you or an immediate relative has ever had the following diseases or conditions:

Disease	Self	Age at onset	Which Relative?
Angina/MI/Heart Attack			
High Blood Pressure			
Stroke			
Blood Clot			
High Cholesterol			
Obesity			
Thyroid Disease			
Diabetes			
Ulcer, GI Bleeding			
Irritable Bowel Syndrome			
Inflammatory Bowel Disease			
Celiac Disease			
Heartburn/Reflux			
Asthma			
Hay Fever/Allergies			
Tuberculosis			
Pneumonia			
Psoriasis			
Eczema			
Liver disease/hepatitis			

Disease	Self	Age at onset	Which Relative?
Substance addiction			
Epilepsy/Seizures			
Alzheimer’s Disease			
Parkinson’s			
Headache			
Anemia			
Mononucleosis			
Depression			
Chronic Fatigue			
Fibromyalgia			
Nervous Exhaustion			
Glaucoma			
Macular Degeneration			
Arthritis/Rheumatism			
Cancer Specify: _____			
Kidney, bladder			
Osteoporosis			
Gout			
Venereal Disease (STDs) Specify _____			
HIV/AIDS			

CURRENT MEDICATIONS AND DOSE

CURRENT SUPPLEMENTS AND DOSE

HEALTH MAINTENANCE: Please list any significant findings and the date of your last visit for the following exams:

Significant Findings	Date of Last Visit
Routine Exam _____	_____
Pap/Pelvic _____	_____
Breast/Mammogram _____	_____
Prostate Exam _____	_____
Hemocult _____	_____
Flexible Sigmoidoscopy _____	_____
Retinal Eye Exam _____	_____

Describe any dental work done: _____

HEALTH HISTORY – CHILDHOOD (check all that apply):

- Measles Whooping Cough Diabetes Mumps Strep/Tonsillitis
- Chicken Pox Polio Appendicitis Rubella Diphtheria
- Other: _____

At the time of your birth, did you experience any unusual birth trauma: Yes No

PSYCHOLOGICAL:

How would you rate your overall level of stress (with 1 being No Stress, and 10 being Unbearable Stress)?

- 1 2 3 4 5 6 7 8 9 10

What types of things cause you stress? _____

What symptoms of stress have you experienced? _____

Please list any significant stressors you have experienced (e.g., accidents, divorce, death, or change/loss of job):

Type of stressor:

Month/Year:

Do you follow any spiritual practices? Yes No If Yes, what are they? _____

Do you practice any form of meditation or relaxation techniques? Yes No If Yes, what types and how often? _____

How would you describe your sleep patterns?

Normal

Irregular

Heavy

Light

Dream-filled

How do you characterize your relationships (spouses/partners, family, friends, co-workers, etc)? _____

Have you ever been diagnosed with a psychiatric condition? Yes No If Yes, when and how were you treated?

Name: _____

Dates: _____

Food Plan Instructions:

- Please record, in honesty, what you eat for a few days. It will benefit you more to be real and not ideal!
- Include condiments, drinks, snacks, supplements (vitamins/minerals/herbs/homeopathic remedies).
- Include any comments, symptoms (emotional/mental/physical), energy levels, etc at the end of each column for each day.
- Be specific in your recordings by including what type of food was eaten (“white bread” or “whole wheat bread”), the quantity (cups, tsp, oz, etc), how it was prepared (baked, boiled, deep fried, etc) and the time of day it was eaten.

	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						

How many meals do you generally eat each day? One Two Three More than three

How often do you skip meals? Never Once or twice a month Once a week More than once a week

Where do you usually buy your food? _____

Who cooks the food you eat? _____

List the foods you exclude from your diet and why: _____

List any foods you crave, regardless of their nutritional value: _____

List any foods to which you are allergic to or have a bad reaction to and how you react: _____

Are you thirsty? No Yes Amount of plain water you drink each day _____

What type of water do you drink? Distilled water Filtered Spring Well Deionized Tap

At what temperature do you prefer to drink liquids? Hot Cold Room temp

Health Appraisal Questionnaire

Instructions: Circle the number which best describes the intensity of your symptoms. If you do not know the answer, leave it blank.

0 = Symptom is not present 1 = Mild 2 = Moderate 3 = Severe

PART 1

SECTION A:

1. Burping0 1 2 3
2. Fullness for extended time after meals0 1 2 3
3. Bloating0 1 2 3
4. Poor appetite0 1 2 3
5. Stomach0 1 2 3
6. History of constipation0 1 2 3
7. Known food allergies0 1 2 3

SECTION B:

1. Abdominal cramps0 1 2 3
2. Indigestion 1-3 hours after eating0 1 2 3
3. Fatigue after eating0 1 2 3
4. Lower bowel gas0 1 2 3
5. Alternating constipation and diarrhea0 1 2 3
6. Diarrhea0 1 2 3
7. Roughage and fiber causes constipation0 1 2 3
8. Mucous in stools0 1 2 3
9. Stool poorly formed0 1 2 3
10. Shiny stool0 1 2 3
11. Three or more large bowel movements daily0 1 2 3
12. Foul smelling stool0 1 2 3
13. Dry, flaky skin and/or brittle hair0 1 2 3
14. Pain in left side under rib cage0 1 2 3
15. Acne0 1 2 3
16. Food allergies0 1 2 3
17. Difficulty gaining weight0 1 2 3

SECTION C:

1. Stomach pains0 1 2 3
2. Stomach pains just before and/or after meals0 1 2 3
3. Dependency on antacids0 1 2 3
4. Chronic abdominal pain0 1 2 3
5. Butterfly sensations in stomach0 1 2 3
6. Difficulty belching0 1 2 3
7. Stomach pain when emotionally upset0 1 2 3
8. Sudden, acute indigestionNO YES
9. Relief of symptoms by carbonated beveragesNO YES
10. Relief of stomach pain by drinking cream/milkNO YES
11. History of ulcer or gastritisNO YES
12. Current ulcerNO YES (10)
13. Black stool when not taking iron supplementsNO YES (10)

SECTION D:

1. Seasonal diarrhea0 1 2 3
2. Frequent and recurrent infections (colds)0 1 2 3
3. Bladder and kidney infections0 1 2 3
4. Vaginal yeast infection0 1 2 3
5. Abdominal cramps0 1 2 3
6. Toe and fingernail fungus0 1 2 3
7. Alternating diarrhea/constipation0 1 2 3
8. Constipation0 1 2 3
9. History of antibioticNO YES
10. Meat eaterNO YES
11. Rapidly failing visionNO YES

PART 2

SECTION A:

1. Difficulty breathing at night0 1 2 3
2. Chest pain while walking0 1 2 3
3. Heaviness in legs0 1 2 3
4. Calf muscles cramp while walking0 1 2 3
5. Heart pounds easily0 1 2 3
6. Feel jittery0 1 2 3
7. Heart misses beats or as extra beats0 1 2 3
8. Swelling of feet and ankles0 1 2 3
9. Rapid beating heart0 1 2 3
10. Heartburn after eating0 1 2 3
11. Pain in left arm0 1 2 3
12. Exhaustion with minor exertion0 1 2 3
13. Do you do aerobic exerciseYES NO
14. Have you ever exercised regularlyYES NO
15. Drink 5 or more cups of coffee dailyNO YES
16. Severe coughNO YES
17. Has a doctor ever told you that you have heart troubleNO YES(6)

SECTION B:

1. Cold hands and feet0 1 2 3
2. Slurred speech0 1 2 3
3. Calf muscles cramp while walking0 1 2 3
4. Headaches0 1 2 3
5. Numbness in extremities0 1 2 3
6. Poor concentration0 1 2 3
7. Ringing in ears0 1 2 3
8. Ear canal hair0 1 2 3
9. Tingling and/or burning in hands or feet0 1 2 3
10. Spider veins on nose and/or face0 1 2 3

SECTION C:

1. Pain when getting up in morning in back of head and neck0 1 2 3
2. Dizziness0 1 2 3
3. Vertigo0 1 2 3
4. Blushing with no apparent cause0 1 2 3
5. Is your blood pressure high?NO YES (10)

PART 3

SECTION A:

1. Dizziness when standing suddenly0 1 2 3
2. Loss of vision when standing suddenly0 1 2 3
3. Crave sweets0 1 2 3
4. Headaches relieved by eating sweets or alcohol0 1 2 3
5. Feel shaky or jittery0 1 2 3
6. Irritable if a meal is missed0 1 2 3
7. Wake up in middle of night craving sweets0 1 2 3
8. Feel tired or weak if a meal is missed0 1 2 3
9. Hear palpitations after eating sweets0 1 2 3
10. Need to drink coffee to get started0 1 2 3
11. Impatient, moody, nervous0 1 2 3
12. Feel tired 1 to 3 hours after eating0 1 2 3
13. Poor memory0 1 2 3
14. Feel faint0 1 2 3

15. Poor concentration0 1 2 3
16. Forgetful0 1 2 3
17. Calmer after eating0 1 2 3

SECTION B:

1. Night sweats0 1 2 3
2. Increased thirst0 1 2 3
3. Lowered resistance to infection0 1 2 3
4. Fatigue0 1 2 3
5. Boils and leg sores0 1 2 3
6. Lesions, cuts take a long time to heal0 1 2 3
7. Overweight0 1 2 3
8. Feel pick up from exercise0 1 2 3
9. Failing eyesight0 1 2 3
10. Crave sweets, but eating sweets does not relieve symptoms0 1 2 3
11. Family history of diabetes0 1 2 3
12. Sugar in urine0 1 2 3

PART 4**SECTION A:**

1. Intolerance to greasy foods	0	1	2	3
2. Headaches after eating	0	1	2	3
3. Light colored stool	0	1	2	3
4. Foul smelling stool	0	1	2	3
5. Less than one bowel movement daily.....	0	1	2	3
6. Constipation	0	1	2	3
7. Hard stool.....	0	1	2	3
8. Sour taste in mouth	0	1	2	3
9. Grey colored skin.....	0	1	2	3
10. Yellow in whites of eyes	0	1	2	3
11. Bad breath.....	0	1	2	3
12. Body odor	0	1	2	3
13. Fatigue and sleepiness after eating.....	0	1	2	3
14. Pain in right side under rib cage.....	0	1	2	3
15. Painful to pass stool	0	1	2	3
16. Retain water	0	1	2	3
17. Big toe painful	0	1	2	3
18. Pain radiates along outside of leg.....	0	1	2	3
19. Dry skin/hair	0	1	2	3
20. Red blood in stool.....	NO		YES ⁽⁶⁾	
21. Have had jaundice or hepatitis	0	1	2	3
22. High blood cholesterol level and low HDL cholesterol.....	0	1	2	3
23. Is your cholesterol level above 200.....	NO	UNKNOWN	YES	
24. Is your triglyceride level above 115	NO	UNKNOWN	YES	

SECTION B:

1. Swollen eyes (bulging)	0	1	2	3
2. Strong smelling urine.....	0	1	2	3
3. Thick skin and finger nails.....	0	1	2	3
4. Dry skin	0	1	2	3
5. Sensitive to the cold.....	0	1	2	3
6. Cold hands and feet	0	1	2	3
7. Excessive menstrual bleeding	0	1	2	3
8. Chronic fatigue.....	0	1	2	3
9. Trouble waking up in the morning.....	0	1	2	3
10. Depressed, apathetic	0	1	2	3
11. Low sex drive	0	1	2	3
12. Puffy, wrinkly skin	0	1	2	3
13. Sugar causes irritability and mood swings.....	0	1	2	3
14. Premenstrual tension.....	0	1	2	3
15. Constipation.....	0	1	2	3
16. Thinning or loss of outside portion of eyebrow	0	1	2	3
17. Gain weight easily	0	1	2	3
18. Anemia unaffected by iron	0	1	2	3
19. Axillary (armpit) temperature below 97.6°F.....	0	1	2	3
20. Slow reflexes	0	1	2	3
21. Infertility.....	0	1	2	3

PART 5**SECTION A:**

1. Sensitive to exhaust fumes, smoke, smog, petrochemicals	0	1	2	3
2. Periodic constipation.....	0	1	2	3
3. Cannot tolerate exercise	0	1	2	3
4. Depression or rapid mood swings	0	1	2	3
5. Dark circles under the eyes	0	1	2	3
6. Dizziness upon standing.....	0	1	2	3
7. Lack of mental alertness.....	0	1	2	3
8. Catch colds easily when weather changes	0	1	2	3
9. Headaches.....	0	1	2	3
10. Difficulty breathing.....	0	1	2	3
11. Water retention.....	0	1	2	3
12. Eyes sensitive to bright light.....	0	1	2	3
13. Feel weak and shaky	0	1	2	3

SECTION B:

1. Inflamed and bleeding gums	0	1	2	3
2. Running nose	0	1	2	3
3. Get boils or styes.....	0	1	2	3
4. Nose bleeds.....	0	1	2	3
5. Loss of smell.....	0	1	2	3
6. Throat infections	0	1	2	3
7. Cold sores, fever blisters.....	0	1	2	3
8. Loss of taste	0	1	2	3
9. Poor wound healing	0	1	2	3
10. Hair falls out	0	1	2	3
11. Swollen lymph glands.....	0	1	2	3
12. Ear infection.....	0	1	2	3
13. Hair grows slowly	0	1	2	3

14. Slow to recover from cold or flu.....	0	1	2	3
15. Catch colds or flu easily	0	1	2	3
16. Bumpy skin on back of arms	0	1	2	3

SECTION C:

1. Itching of nose or eyes.....	0	1	2	3 ⁽⁵⁾
2. Itching of roof of mouth or throat.....	0	1	2	3 ⁽⁵⁾
3. Migraine headaches	NO		YES ⁽¹⁰⁾	
4. Entire body aches, painful to touch	0	1	2	3
5. Swollen joints.....	0	1	2	3
6. Food sensitivity or allergy	0	1	2	3
7. Certain foods make you sick, depressed, jittery.....	0	1	2	3
8. Chronic pain	0	1	2	3
9. Painful stomach and/or intestine.....	0	1	2	3
10. Alternating constipation and diarrhea.....	0	1	2	3
11. Mucous in throat.....	0	1	2	3
12. Post nasal drip	0	1	2	3
13. Discharge from eyes.....	0	1	2	3
14. Watery eyes	0	1	2	3
15. Puffiness or dark circles under eyes	0	1	2	3
16. Ear discharge or ears stuffed up.....	0	1	2	3
17. Nasal congestion	0	1	2	3
18. Running nose.....	0	1	2	3
19. Breathe through mouth.....	0	1	2	3
20. Swollen tongue.....	0	1	2	3
21. Difficulty swallowing.....	0	1	2	3
22. Bedwetting	NO		YES ⁽⁵⁾	
23. Hyperactivity.....	0	1	2	3
24. Chronic lung congestion.....	0	1	2	3
25. Use of aspirin, tylenol regularly	NO		YES	
26. Wheezing	0	1	2	3
27. Skin rashes	0	1	2	3
28. Sneezing.....	0	1	2	3

PART 6

1. Chest pain	0	1	2	3
2. Chronic cough.....	0	1	2	3
3. Difficulty breathing.....	0	1	2	3
4. Coughing up blood.....	0	1	2	3
5. Coughing up phlegm.....	0	1	2	3
6. Pain around ribs	0	1	2	3
7. Shortness of breath.....	0	1	2	3

8. Rattling mucous when you breathe.....	0	1	2	3
9. Sensitive to smog	0	1	2	3
10. Infections settle in lungs.....	0	1	2	3
11. Live or work around people who smoke.....	0	1	2	3
12. Bronchitis	0	1	2	3
13. Exposed to chemicals and radiation.....	0	1	2	3
14. Smoker	0	1	2	3

PART 7

- | | | | | | | | |
|--|---|---|---|--|---|---|----|
| 1. Frequent urination.....0 | 1 | 2 | 3 | 11. Strong smelling urine0 | 1 | 2 | 3 |
| 2. Frequent bladder infections.....0 | 1 | 2 | 3 | 12. Back or leg pains associated with | | | |
| 3. Rarely need to urinate0 | 1 | 2 | 3 | dripping after urination.....0 | 1 | 2 | 3 |
| 4. Urination when you cough or sneeze0 | 1 | 2 | 3 | 13. History of kidney or bladder infections0 | 1 | 2 | 3 |
| 5. Painful/burning when passing urine0 | 1 | 2 | 3 | 14. Have used antibiotics to control | | | |
| 6. Difficulty passing urine.....0 | 1 | 2 | 3 | urinary tract infections.....YES | | | NO |
| 7. Dripping after urination.....0 | 1 | 2 | 3 | IF YES, WHEN DID YOU LAST USE THEM? | | | |
| 8. Can't hold urine0 | 1 | 2 | 3 | TREATMENT DURATION _____ | | | |
| 9. Rose colored (bloody urine).....0 | 1 | 2 | 3 | 15. Back pain in the kidney area.....0 | 1 | 2 | 3 |
| 10. Cloudy urine0 | 1 | 2 | 3 | 16. General water retention0 | 1 | 2 | 3 |

PART 8 (Males Only)

SECTION A:

- | | | | |
|---|---|---|---|
| 1. Difficulty urinating0 | 1 | 2 | 3 |
| 2. A sense of bladder fullness.....0 | 1 | 2 | 3 |
| 3. Increased straining with smaller and smaller | | | |
| amounts of urine passed.....0 | 1 | 2 | 3 |
| 4. Rose colored (bloody) urine.....0 | 1 | 2 | 3 |
| 5. Pain or burning while urinating.....0 | 1 | 2 | 3 |
| 6. Wake up to urinate at night0 | 1 | 2 | 3 |
| 7. Dripping after urination.....0 | 1 | 2 | 3 |
| 8. Pain or fatigue in the legs or back0 | 1 | 2 | 3 |
| 9. Lack of sex drive.....0 | 1 | 2 | 3 |
| 10. Ejaculation causes pain0 | 1 | 2 | 3 |

SECTION B:

- | | | | |
|---|---|---|---|
| 1. Difficulty attaining and/or maintaining an erection ...0 | 1 | 2 | 3 |
| 2. Low sexual drive0 | 1 | 2 | 3 |
| 3. Premature ejaculation0 | 1 | 2 | 3 |
| 4. Pain/coldness in genital area.....0 | 1 | 2 | 3 |
| 5. Infertile.....0 | 1 | 2 | 3 |
| 6. Varicose veins on scrotum.....0 | 1 | 2 | 3 |
| 7. Low sperm count.....0 | 1 | 2 | 3 |

SECTION C:

- | | | | |
|--|---|---|--------------------|
| 1. Discharge from penis.....0 | 1 | 2 | 3 |
| 2. Past or present rash on penis.....0 | 1 | 2 | 3 |
| 3. Swollen genitals0 | 1 | 2 | 3 |
| 4. Swelling in groin0 | 1 | 2 | 3 |
| 5. Venereal disease (gonorrhea, syphilis | | | |
| Herpes or other).....NO | | | YES |
| Have V.D. now? _____ | | | Had in past? _____ |

PART 9 (Females Only)

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

- | | | | |
|-------------------------------------|---|---|---|
| 1. Monthly weight gain0 | 1 | 2 | 3 |
| 2. Depression0 | 1 | 2 | 3 |
| 3. Moodiness/irritability.....0 | 1 | 2 | 3 |
| 4. Bloating and swelling.....0 | 1 | 2 | 3 |
| 5. Nausea and/or vomiting0 | 1 | 2 | 3 |
| 6. Suicidal feeling0 | 1 | 2 | 3 |
| 7. Anxiety0 | 1 | 2 | 3 |
| 8. Leg cramps and tenderness0 | 1 | 2 | 3 |
| 9. Asthma attacks.....0 | 1 | 2 | 3 |
| 10. Headaches.....0 | 1 | 2 | 3 |
| 11. Easily distracted.....0 | 1 | 2 | 3 |
| 12. Anger0 | 1 | 2 | 3 |
| 13. Tender breast.....0 | 1 | 2 | 3 |
| 14. Low backache0 | 1 | 2 | 3 |
| 15. Other _____ | 1 | 2 | 3 |
| 16. Age of onset of menses _____ | | | |
| 17. Date of last menses _____ | | | |

- | | | | |
|---|---|---|---|
| 9. Nausea and/or vomiting.....0 | 1 | 2 | 3 |
| 10. Have to lie down on first 1 or 2 days of period.....0 | 1 | 2 | 3 |
| 11. Craving for sweets.....0 | 1 | 2 | 3 |
| 12. Insomnia.....0 | 1 | 2 | 3 |
| 13. Light scanty blood flow0 | 1 | 2 | 3 |
| 14. Pain and cramps without blood flow0 | 1 | 2 | 3 |
| 15. Heavy menstrual bleeding0 | 1 | 2 | 3 |
| 16. Anxiety about menstrual cycle0 | 1 | 2 | 3 |
| 17. Pain during period is progressively getting | | | |
| worse with time0 | 1 | 2 | 3 |

SECTION D:

- | | | | |
|---|---|---|----------|
| 1. Vaginal bumps and sores0 | 1 | 2 | 3 |
| 2. Pubic area sore.....0 | 1 | 2 | 3 |
| 3. Ovarian cystsNO | | | YES (10) |
| 4. Uterine cystsNO | | | YES (10) |
| 5. Pain in ovaries.....0 | 1 | 2 | 3 |
| 6. Breast lumpsNO | | | YES |
| 7. Breasts sore to touch0 | 1 | 2 | 3 |
| 8. Breasts painful0 | 1 | 2 | 3 |
| 9. Water retention0 | 1 | 2 | 3 |
| 10. Swollen feeling.....0 | 1 | 2 | 3 |
| 11. Premenstrual breast pain or discomfort.....0 | 1 | 2 | 3 |
| 12. Mother used D.E.S. (hormones) while pregnantNO | | | YES |
| 13. Recent pap smear positive.....NO | | | YES (15) |
| 14. Family history of breast cancer.....NO | | | YES |
| 15. Form of birth control: ___None ___Pill ___IUD ___Sponge | | | |
| ___Diaphragm ___Foam Other _____ | | | |

SECTION B:

- | | | | |
|--------------------------------------|---|---|---------------------|
| 1. Vaginal itching.....0 | 1 | 2 | 3 |
| 2. Vaginal discharge.....0 | 1 | 2 | 3 |
| 3. Low or no desire for sex.....0 | 1 | 2 | 3 |
| 4. Dislike for intercourse.....0 | 1 | 2 | 3 |
| 5. Missed periodsNO | | | YES |
| 6. Over 15 years of age and have not | | | |
| begun menstruationNO | | | YES |
| 7. Unable to get pregnantNO | | | YES |
| 8. Miscarriages.....NO | | | YES HOW MANY? _____ |
| 9. Abortion.....NO | | | YES HOW MANY? _____ |

SECTION C: Check if you experience any of these symptoms during menstruation (Section C only)

- | | | | |
|---|---|---|---|
| 1. Low abdominal pain.....0 | 1 | 2 | 3 |
| 2. Dull ache radiating to low back or legs0 | 1 | 2 | 3 |
| 3. Increased urinary frequency0 | 1 | 2 | 3 |
| 4. Pelvic soreness0 | 1 | 2 | 3 |
| 5. Diarrhea0 | 1 | 2 | 3 |
| 6. Headaches0 | 1 | 2 | 3 |
| 7. Abdominal bloating.....0 | 1 | 2 | 3 |
| 8. Menstrual pain0 | 1 | 2 | 3 |

SECTION E:

- | | | | |
|---|---|---|---|
| 1. Hot flashes0 | 1 | 2 | 3 |
| 2. Night sweats.....0 | 1 | 2 | 3 |
| 3. Hysterectomy.....0 | 1 | 2 | 3 |
| 4. Depression/mood swings0 | 1 | 2 | 3 |
| 5. Insomnia0 | 1 | 2 | 3 |
| 6. Craving for sweets0 | 1 | 2 | 3 |
| 7. Heavy bleeding two weeks/month0 | 1 | 2 | 3 |
| 8. Sweating throughout day0 | 1 | 2 | 3 |
| 9. Dryness of skin, hair, and vagina0 | 1 | 2 | 3 |
| 10. Painful intercourse0 | 1 | 2 | 3 |
| 11. Vaginal pain.....0 | 1 | 2 | 3 |
| 12. Vaginal itching.....0 | 1 | 2 | 3 |
| 13. Osteoporosis (bone loss).....0 | 1 | 2 | 3 |

PART 10

1. Muscle spasms.....	0	1	2	3	6. Stiff all over.....	0	1	2	3
2. Tightness in shoulder muscles.....	0	1	2	3	7. Stiff in morning.....	0	1	2	3
3. Muscle cramps.....	0	1	2	3	8. Unable to sit straight.....	0	1	2	3
4. Pain in arms, hands.....	0	1	2	3	9. Pain in neck and/or shoulders.....	0	1	2	3
5. Leg cramps at nights.....	0	1	2	3	10. Back pain.....	0	1	2	3
					11. Joint pain.....	0	1	2	3

PART 11

1. Head feels heavy.....	0	1	2	3	10. Loss of grip strength.....	0	1	2	3
2. Light headedness/fainting.....	0	1	2	3	11. Tingling pain sensation.....	0	1	2	3
3. Loss of balance.....	0	1	2	3	12. Convulsions.....	NO	YES	(10)	
4. Dizziness.....	0	1	2	3	13. Uncoordination.....	0	1	2	3
5. Ringing/buzzing in ears.....	0	1	2	3	14. Nervousness.....	0	1	2	3
6. Trembling hands.....	0	1	2	3	15. Accident prone.....	NO	YES		
7. Loss of feeling in hands and/or feet (toes).....	0	1	2	3	16. Loss of muscle tone.....	NO	YES		
8. Exhaustion on slightest effort.....	0	1	2	3	17. Need for 10-12 hours sleep.....	NO	YES		
9. Limbs feel too heavy to hold up.....	0	1	2	3	18. Have had shingles.....	NO	YES		

PART 12**SECTION A: Over the last year, I have experienced:**

1. Becoming forgetful.....	0	1	2	3
2. Lapses in memory.....	0	1	2	3
3. Becoming less attentive.....	0	1	2	3
4. Less interest in normal activities.....	0	1	2	3
5. Feeling less sharp.....	0	1	2	3
6. Difficulty remembering people's names.....	0	1	2	3
7. Difficulty making decisions.....	0	1	2	3
8. Problems finding the right words to communicate.....	0	1	2	3
9. Difficulty solving routine problems.....	0	1	2	3
10. Difficulty learning new things.....	0	1	2	3
11. Problems writing, reading, or organizing thoughts.....	0	1	2	3
12. Difficulty following instructions.....	0	1	2	3

SECTION B: I experience:

1. Lack of interest in normal activities.....	0	1	2	3
2. Loss of energy.....	0	1	2	3
3. Oversleeping or sleepiness.....	0	1	2	3
4. Sense of sadness for no apparent reason.....	0	1	2	3
5. Increased appetite, especially for carbohydrates.....	0	1	2	3
6. Fatigue.....	0	1	2	3
7. Symptoms that usually get worse in the winter.....	0	1	2	3
8. Weight gain or weight loss.....	0	1	2	3
9. Difficulty concentrating and processing information, especially in the afternoon.....	0	1	2	3
10. Diminished sexual desire.....	0	1	2	3

SECTION C: I frequently

1. Feel tense and have trouble relaxing.....	0	1	2	3
2. Have headaches and other aches and pains.....	0	1	2	3
3. Get crabby or grouchy.....	0	1	2	3
4. Have trouble falling asleep or staying asleep.....	0	1	2	3
5. Sweat and have hot flashes in anticipation of events.....	0	1	2	3
6. Feel irritable or short tempered.....	0	1	2	3
7. Have trouble letting go of things.....	0	1	2	3
8. Get angry for no apparent reason.....	0	1	2	3
9. Women only: Get worse symptoms prior to getting my period.....	0	1	2	3

SECTION D: I often:

1. Feel overly active and compelled to do things, like being driven by a motor.....	0	1	2	3
2. Have difficulty relaxing and unwinding when I have time to myself.....	0	1	2	3
3. Misplace and have difficulty finding things.....	0	1	2	3
4. Crave caffeine and stimulants to keep me going.....	0	1	2	3
5. Delay getting started when I have a task or work that requires a lot of thought.....	0	1	2	3
6. Get easily distracted by activity or noise around me.....	0	1	2	3
7. Have difficulty keeping my attention when doing boring and repetitive work.....	0	1	2	3
8. Fidget or squirm with my hands and feet when I have to sit down for a long time.....	0	1	2	3
9. Leave my seat in meetings or other situations in which I am expected to remain seated.....	0	1	2	3
10. Have problems remembering appointments or obligations.....	0	1	2	3
11. Have difficulty concentrating on what people say to me, even when they are speaking directly to me.....	0	1	2	3
12. Move around and kick in my sleep.....	0	1	2	3

SECTION E: I experience:

1. Waking up frequently during the night with difficulty returning to sleep.....	0	1	2	3
2. Looking forward to catching up on my sleep on the weekends.....	0	1	2	3
3. Taking more than 30 minutes to fall asleep at night.....	0	1	2	3
4. Stomach problems or nausea.....	0	1	2	3
5. Waking up repeatedly throughout the night.....	0	1	2	3
6. Waking up groggy and not well rested.....	0	1	2	3
7. Preferring to go to sleep later than midnight and waking up late, after 10:00 a.m.....	0	1	2	3
8. Preferring an early bedtime – going to sleep between 7 p.m. and 9 p.m. and waking up early, around 5:00 a.m.....	0	1	2	3
9. Jet lag.....	0	1	2	3
10. Difficulty turning off my thoughts when I lay down to sleep.....	0	1	2	3