

Name _____

Date _____

HEALTH APPRAISAL QUESTIONNAIRE

Revised Sept 2006

5

Mark in box which of the following medications you are taking. Use P if you have taken them in the past.

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Anti-inflammatories | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation | <input type="checkbox"/> Recreational Drugs (Please list) |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Aspirin / Tylenol | <input type="checkbox"/> Hormones | <input type="checkbox"/> Relaxants | <input type="checkbox"/> Other (please list) |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Laxatives | <input type="checkbox"/> Sleeping pills | |
| <input type="checkbox"/> Antidiabetic / Insulin | <input type="checkbox"/> Cortisone | <input type="checkbox"/> Lithium | <input type="checkbox"/> Thyroid | |
| <input type="checkbox"/> Antifungals | <input type="checkbox"/> Heart Medications | <input type="checkbox"/> Oral Contraceptives | <input type="checkbox"/> Ulcer Medications | |

Mark in the box if you:

- | | | |
|---|---|---|
| <input type="checkbox"/> Diet often | <input type="checkbox"/> Salt food without tasting | <input type="checkbox"/> Are exposed to chemicals at work |
| <input type="checkbox"/> Do not exercise regularly | <input type="checkbox"/> Are under excessive stress | <input type="checkbox"/> Are exposed to cigarette smoke |

Mark in the box if you often (more than 2 x / wk.) eat, drink or use:

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Carbonated Beverages | <input type="checkbox"/> Coffee / regular tea | <input type="checkbox"/> Fried foods | <input type="checkbox"/> Refined sugars |
| <input type="checkbox"/> Candy | <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Fast food | <input type="checkbox"/> Luncheon meats | <input type="checkbox"/> Aspartame |
| <input type="checkbox"/> Butter | <input type="checkbox"/> Herbal teas | <input type="checkbox"/> Purified water | <input type="checkbox"/> Margarine | <input type="checkbox"/> Other artificial sweeteners |
| <input type="checkbox"/> Vitamins, minerals & other supplements (please list) | | | <input type="checkbox"/> Whole grain foods | <input type="checkbox"/> Oils: List kind |

INSTRUCTIONS: Answer ONLY if you have the symptom. Do not circle if you do not have that symptom.

For each question, circle the number which best describes the intensity of your symptom.

1 = Mild (occasional, slight) **2 = Moderate** (more often, obvious) **3 = Severe** (frequent, disabling)

PART II DIGESTION

Section A: Hypoacidity

1. Burping	1	2	3
2. Fullness for extended time after meals	1	2	3
3. Bloating	1	2	3
4. Poor appetite	1	2	3
5. Stomach upsets easily	1	2	3
6. History of constipation	1	2	3
7. Known food allergies	1	2	3
8. Lack of interest in eating	1	2	3

Section B: Small Intestine

1. Abdominal cramps	1	2	3
2. Indigestion 1-3 hours after eating	1	2	3
3. Fatigue after eating	1	2	3
4. Lower bowel gas	1	2	3
5. Alternating constipation / diarrhea	1	2	3
6. Diarrhea	1	2	3
7. Roughage and fiber causes constipation	1	2	3
8. Mucous in stools	1	2	3
9. Stool poorly formed	1	2	3
10. Shiny stool	1	2	3
11. Three or more large bowel movements daily	1	2	3
12. Foul smelling stool	1	2	3
13. Dry, flaky skin and/or dry brittle hair	1	2	3
14. Pain in left side under rib cage	1	2	3
15. Acne	1	2	3
16. Food allergies	1	2	3
17. Difficulty gaining weight	1	2	3

Section C: Hyperacidity

1. Stomach pains	1	2	3
2. Stomach pains just before and/or after meals	1	2	3
3. Dependency on antacids	1	2	3
4. Chronic abdominal pain	1	2	3
5. Butterfly sensations in stomach	1	2	3
6. Difficulty belching	1	2	3
7. Stomach pain when emotionally upset	1	2	3
8. Sudden, acute indigestion	No		Yes
9. Relief of symptoms by carbonated beverages	No		Yes
10. Relief of stomach pain by drinking cream/milk	No		Yes
11. History of ulcer or gastritis	No		Yes
12. Current ulcer	No		Yes ¹⁰
13. Black stool (Are you taking iron supplements?)	No		Yes ¹⁰

Section D: Colon

1. Seasonal diarrhea	1	2	3
2. Frequent and recurrent infections (colds)	1	2	3
3. Bladder and kidney infections	1	2	3
4. Vaginal cramps	1	2	3
5. Abdominal cramps	1	2	3
6. Toe and fingernail fungus	1	2	3
7. Alternating constipation / diarrhea	1	2	3
8. Constipation	1	2	3
9. History of antibiotic use	No		Yes
10. Meat eater	No		Yes
11. Rapidly failing vision	No		Yes

PART III FAT METABOLISM

Section A: Liver / Gallbladder

1. Intolerance to greasy foods	1	2	3
2. Headaches after eating	1	2	3
3. Light coloured stool	1	2	3
4. Foul smelling stool	1	2	3
5. Less than one bowel movement daily	1	2	3
6. Constipation	1	2	3
7. Hard stool	1	2	3
8. Sour taste in mouth	1	2	3
9. Grey coloured skin	1	2	3
10. Yellow in whites of eyes	1	2	3
11. Bad breath	1	2	3

12. Body odour	1	2	3
13. Fatigue and sleepiness after eating	1	2	3
14. Pain in right side under rib cage	1	2	3
15. Painful to pass stool	1	2	3
16. Retain water	1	2	3
17. Big toe painful	1	2	3
18. Pain radiates along outside of leg	1	2	3
19. Dry skin and / or hair	1	2	3
20. Red blood in stool	No		Yes ⁶
21. Have had jaundice or hepatitis	No		Yes
22. Is your cholesterol level elevated? (above 5)	No		Yes ¹⁰
23. Is your triglyceride level elevated? (above 1.5)	No		Yes

Section B: Thyroid

1. Sensitive to the cold	1	2	3
2. Cold hands and feet	1	2	3
3. Strong smelling urine	1	2	3
4. Constipation	1	2	3
5. Chronic fatigue	1	2	3
6. Trouble waking up in the morning	1	2	3
7. Depressed, apathetic	1	2	3
8. Sugar causes irritability and mood swings	1	2	3
9. Low sex drive	1	2	3
10. Swollen eyes (bulging)	1	2	3
11. Racing heart / trembling fingers	1	2	3

12. Thick skin and fingernails	1	2	3
13. Dry skin	1	2	3
14. Puffy, wrinkly skin	1	2	3
15. Muscle pain or stiffness	1	2	3
16. Premenstrual tension	1	2	3
17. Excessive menstrual bleeding	1	2	3
18. Infertility	No		Yes
19. Thinning / loss of outside portion of eyebrow	No		Yes
20. Anemia unaffected by taking iron	No		Yes
21. Armpit temperature below 97.6 F / 36.4C (or oral temperature below 98.6 F / 37 C)	No		Yes
22. Gain weight easily	No		Yes

PART IV IMMUNE FUNCTION**Section A: Hypoadrenal**

1. Feel tired in the afternoon	1	2	3
2. Dizziness upon standing	1	2	3
3. Low blood pressure	1	2	3
4. Cannot tolerate much exercise	1	2	3
5. Frequently feel weak or shaky	1	2	3
6. Itchy, red or inflamed eyes	1	2	3
7. Dark circles under the eyes	1	2	3
8. Eyes sensitive to bright light	1	2	3
9. Sensitive to exhaust fumes, smoke, smog petrochemicals	1	2	3
10. Periodic constipation	1	2	3
11. Depression or rapid mood swings	1	2	3
12. Lack of mental alertness	1	2	3
13. Headaches	1	2	3
14. Catch colds easily when weather changes	1	2	3
15. Difficulty breathing	1	2	3
16. Water retention	1	2	3
17. Hemorrhoids	1	2	3
18. Ringing in the ears	1	2	3

14. Hair falls out	1	2	3
15. Loss of taste	1	2	3
16. Bumpy skin on back of arms	1	2	3

Section C: Hyperimmune / Allergy

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

Section B: Hypoimmune

1. Inflamed or bleeding gums	1	2	3
2. Running, dripping nose	1	2	3
3. Nose bleeds	1	2	3
4. Loss of smell	1	2	3
5. Get boils or styes	1	2	3
6. Throat infections	1	2	3
7. Cold sores, fever blisters, herpes	1	2	3
8. Catch colds or flu easily	1	2	3
9. Slow to recover from colds or flu	1	2	3
10. Poor wound healing	1	2	3
11. Swollen lymph glands	1	2	3
12. Ear infection	1	2	3
13. Hair grows slowly	1	2	3

PART V CARDIOVASCULAR**Section A: Heart**

1. Chest pain while walking	1	2	3	
2. Heaviness in legs	1	2	3	
3. Calf muscles cramp while walking	1	2	3	
4. Heart pounds easily	1	2	3	
5. Heart misses beats or has extra beats	1	2	3	
6. Rapid beating heart	1	2	3	
7. Feel jittery	1	2	3	
8. Swelling of feet and ankles	1	2	3	
9. Heartburn after eating	1	2	3	
10. Pain in left arm	1	2	3	
11. Exhaust with minor exertion	1	2	3	
12. Difficulty breathing at night in bed	1	2	3	
13. Do you do aerobic exercise?	Yes		No	
14. Have you ever exercised regularly	Yes		No	
15. Bright red nose	No		Yes	
16. Drink 5 or more cups of coffee daily	No		Yes	
17. Severe cough	No		Yes	
18. Has a doctor ever told you that you have heart trouble?	No		Yes	6

Section B: Circulation

1. Cold hands and feet	1	2	3
2. Slurred speech	1	2	3
3. Calf muscles cramp while walking	1	2	3
4. Headaches	1	2	3
5. Numbness in extremities	1	2	3
6. Poor concentration	1	2	3
7. Ringing in ears	1	2	3
8. Ear canal hair	No		Yes
9. Tingling and / or burning hands or feet	No		Yes
10. Spider veins on nose and / or face	No		Yes
11. Heart attack	No		Yes
12. Stroke	No		Yes
13. Vertical wrinkle in lower ear lobe	No		Yes

Section C: Hypertension

1. Pain when getting up in morning in back of head and neck	1	2	3	
2. Dizziness	1	2	3	
3. Vertigo	1	2	3	
4. Blushing with no apparent cause	1	2	3	
5. Is your blood pressure high?	No		Yes	10

Section A: Hypoglycemia

1. Dizziness/loss of vision when standing suddenly	1	2	3
2. Crave sweets	1	2	3
3. Headaches relieved by eating sweets or alcohol	1	2	3
4. Often feel shaky or jittery	1	2	3
5. Have times of feeling faint	1	2	3
6. Irritable if a meal is missed	1	2	3
7. Feel tired or weak if a meal is missed	1	2	3
8. Feel tired 1 to 3 hours after eating	1	2	3
9. Calmer after eating	1	2	3
10. Wake up in middle of night craving sweets	1	2	3
11. Heart palpitations after eating sweets	1	2	3
12. Need to drink coffee to get started	1	2	3
13. Impatient, moody, nervous	1	2	3
14. Poor memory, forgetful	1	2	3
15. Poor concentration	1	2	3

PART VII LUNGS

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

PART VIII UROLOGICAL

1. Rarely need to urinate	1	2	3
2. Difficulty passing urine	1	2	3
3. General water retention	1	2	3
4. Frequent urination	1	2	3
5. Pain / burning when passing urine	1	2	3
6. Urination when you cough or sneeze	1	2	3
7. Dripping after urination	1	2	3
8. Can't hold urine	1	2	3
9. For women, frequent vaginal infections	1	2	3
10. History of kidney or bladder infections	1	2	3
How frequently?			

PART IX (Males only - Please answer this section and then proceed to next page.)

Section A: Prostate

1. A sense of bladder fullness	1	2	3
2. Increased straining with only small amounts of urine passed	1	2	3
3. Wake up to urinate at night	1	2	3
4. Pain or fatigue in the legs or back	1	2	3
5. Lack of sex drive	1	2	3
6. Ejaculation causes pain	1	2	3

Section B: Reproduction

1. Difficulty attaining & / or maintaining an erection	1	2	3
2. Low sex drive	1	2	3
3. Premature ejaculation	1	2	3
4. Pain / coldness in genital area	1	2	3

PART X (Females only) Please read and answer all questions in Sections A-E, regardless of your age.

Section A: Premenstrual Symptoms - For section A, please answer for the time prior to menstruation.

In general, how many days prior do you have these symptoms? _____

1. Monthly weight gain, water retention	1	2	3
2. Bloating and swelling	1	2	3
3. Tender breast	1	2	3
4. Depression	1	2	3
5. Moodiness / irritability	1	2	3
6. Anxiety	1	2	3
7. Easily distracted	1	2	3
8. Anger	1	2	3
9. Suicidal feeling	No		Yes 10
10. Nausea and / or vomiting	1	2	3
11. Headaches	1	2	3
12. Leg cramps	1	2	3
13. Low backache	1	2	3

Section B: Hyperglycemia / Diabetes

1. Night sweats	1	2	3
2. Increased thirst	1	2	3
3. Lowered resistance to infection	1	2	3
4. Fatigue	1	2	3
5. Boils and leg sores	1	2	3
6. Lesions, cuts take a long time to heal	1	2	3
7. Overweight	1	2	3
8. Feel energized from exercise	1	2	3
9. Failing eyesight	1	2	3
10. Sugar in urine	1	2	3
11. Family history of diabetes	1	2	3
12. Crave sweets, but eating sweets does not relieve craving	No		Yes

9. Rattling mucous when you breathe	1	2	3
10. Sensitive to smog	1	2	3
11. Infections settle in lungs	1	2	3
12. Live or work around people who smoke	1	2	3
13. Bronchitis (now / in past)	No		Yes 10
14. Exposed to chemicals and radiation	No		Yes 6
15. Smoker now	No		Yes 6
Smoker in past? Quit how long ago _____?	No		Yes

11. Rose coloured (bloody) urine	1	2	3
12. Cloudy urine	1	2	3
13. Strong smelling urine	1	2	3
14. Back or leg pains associated with dripping after urination	1	2	3
15. Back pain in kidney area	1	2	3
16. Used antibiotics to control urinary tract infections?	No		Yes
17. If YES, when did you last use them? _____ Treatment durations? _____			

5. Low sperm count	No		Yes 5
6. Infertile	No		Yes 5
Had vasectomy?	No		Yes
7. Varicose veins on scrotum	No		Yes

Section C: Genital Infection

1. Discharge from penis	1	2	3
2. Past or present rash on penis	1	2	3
3. Swollen genitals	1	2	3
4. Swelling in groin	1	2	3
5. Venereal disease (gonorrhea, syphilis, herpes or other)	No		Yes
Have V.D. now? _____ Had in past? _____			

Section B: Amenorrhea

1. Vaginal itching	1	2	3
2. Vaginal discharge	1	2	3
3. Low or no desire for sex	1	2	3
4. Dislike for intercourse	1	2	3
5. Over 15 years of age and have not begun menstruation	No		Yes
6. Missed periods	No		Yes
7. Unable to get pregnant	No		Yes
8. Miscarriages at what month? _____	No		Yes
9. Abortion	No		Yes

Section C: Menstruation For Section C only, answer **only** if you experience any of these symptoms **during** menstruation.

1. Menstrual pain	1	2	3
2. Low abdominal pain	1	2	3
3. Pelvic soreness	1	2	3
4. Dull ache radiating to low back or legs	1	2	3
5. Have to lie down on 1st or 2nd day of period	1	2	3
6. Have to take medication on day 1 or 2	1	2	3
7. Pain during period is progressively getting worse	1	2	3
8. Pain and cramps without blood flow	1	2	3
9. Light scanty blood flow	1	2	3
10. Heavy menstrual bleeding	1	2	3
11. Diarrhea / constipation (circle which one)	1	2	3
12. Abdominal bloating	1	2	3
13. Nausea and / or vomiting	1	2	3
14. Headaches	1	2	3
15. Increased urinary frequency	1	2	3
16. Craving for sweets	1	2	3
17. Insomnia	1	2	3
18. Anxiety about menstrual cycle	1	2	3

Section D: Fibrocystic Problems

1. Pubic area sore	1	2	3
2. Pain in ovaries	1	2	3
3. Vaginal bumps and sores	1	2	3
4. Breasts sore to touch	1	2	3
5. Breasts painful	1	2	3
6. Premenstrual breast pain or discomfort	1	2	3
7. General water retention / swollen feeling	1	2	3
8. Recent pap smear was abnormal	No		Yes 15

PART XI MUSCULOSKELETAL

Section A: Bone Integrity

1. Eat meat	1	2	3
2. Drink carbonated beverages (# / week)	1-3	4-7	7+
3. Use antacid (# / week)	1-3	4-7	7+
4. Pain in fingers	1	2	3
5. Bones sore / painful	1	2	3
6. Arthritis	1	2	3
7. Joint or bone deformity	No		Yes
8. Calcium deposits	No		Yes
9. Cavities (many fillings)	No		Yes
10. Dentures	No		Yes
11. Gum disease	No		Yes
12. Bone loss (jaw, spine, hip)	No		Yes
13. Recent bone fracture	No		Yes
14. Told you have osteoporosis / osteomalacia	No		Yes 5
15. Hysterectomy	No		Yes
15. Ovaries removed	No		Yes
16. Post-menopausal. Last period ____mos____yrs	No		Yes

SECTION B: Muscle

1. Muscle cramps	1	2	3
2. Muscle spasms	1	2	3

PART XII NEUROLOGICAL

1. Head feels heavy	1	2	3
2. Light headedness / fainting	1	2	3
3. Loss of balance	1	2	3
4. Dizziness	1	2	3
5. Ringing / buzzing in ears	1	2	3
6. Trembling hands	1	2	3
7. Loss of feeling in hands and/or feet (toes)	1	2	3
8. Exhaustion on slightest effort	1	2	3
9. Limbs feel too heavy to hold up	1	2	3

PART XIII SLEEP PATTERNS

1. Can't fall asleep	1	2	3
2. Awake frequently throughout night	No		Yes
3. Wake up middle of night, can't fall back to sleep	No		Yes
4. Restless, uneasy sleeper	1	2	3

9. Ovarian cysts	No		Yes 10
10. Uterine cysts	No		Yes 10
11. Breast lumps	No		Yes 10
12. Family history of breast cancer	No		Yes
13. Birth control pills	No		Yes
How long? _____ When? _____			
14. Mother used D.E.S. (hormones) while pregnant	No		Yes

Section E: Menopause

1. Hot flashes	1	2	3
2. Night sweats	1	2	3
3. Sweating throughout day	1	2	3
4. Depression / mood swings	1	2	3
5. Insomnia / can't get to sleep	1	2	3
6. Waking up in night (can't get back to sleep?)	1	2	3
7. Heavy bleeding for longer than 10 days / mo.	1	2	3
8. Painful intercourse	1	2	3
9. Vaginal pain	1	2	3
10. Vaginal itching	1	2	3
11. Dryness of skin, hair, and vagina	1	2	3
12. Craving for sweets	1	2	3
13. Memory loss	1	2	3
14. Osteoporosis (bone loss)	No		Yes
15. Joint pain	1	2	3
16. Hysterectomy	No		Yes
17. Ovaries removed	No		Yes
18. Periods stopped	No		Yes
Last period was approx when			

3. Tightness in neck & shoulder muscles	1	2	3
4. Pain in neck and / or shoulders	1	2	3
5. Pain in arms, hands	1	2	3
6. Unable to sit straight	1	2	3
7. Back pain. Where? _____	1	2	3
8. Stiff all over	1	2	3
9. Stiff in morning	1	2	3
10. Leg cramps at night	1	2	3

SECTION C: Connective Tissue

1. Overflexible joints (double-jointed)	1	2	3
2. Athletic injury	1	2	3
3. Injure easily	No		Yes
4. Swollen knees / elbows / other joints	1	2	3
5. Bursitis	1	2	3
6. Tendonitis	1	2	3
7. Joint pain. Where? _____	1	2	3
8. Back pain.	1	2	3
9. "Slipped" disc	No		Yes 5
10. Herniated disc	No		Yes 10
11. Loss in height	No		Yes

10. Loss of grip strength	1	2	3
11. Tingling pain sensation	1	2	3
12. Uncoordinated	1	2	3
13. Nervousness	1	2	3
14. Convulsions	No		Yes 10
15. Accident prone	No		Yes
16. Loss of muscle tone	No		Yes
17. Need for 10-12 hours sleep	No		Yes
18. Have had shingles. Where? _____	No		Yes

5. Nightmares	1	2	3
6. Intense dreams	1	2	3
7. Sleep walk	No		Yes
8. Leg cramps / restless legs at night	1	2	3

Name: _____

Date: _____

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Candida Questionnaire

The total score will help you and your naturopathic doctor decide if your health problems are yeast-connected. Scores in women will run higher, as seven items in the questionnaire apply exclusively to women, while only two apply exclusively to men.

SECTION A: HISTORY

For each of your symptoms, circle the number in the point score column. Add and record total at the end of this section.

Have you taken tetracyclines or other antibiotics for acne for 1 month (or longer)	25
Have you at any time in your life taken other antibiotics for respiratory, urinary, or other infections (for 2 months or longer, or in shorter courses 4 or more times in a 1-year period)?	20
Have you taken any antibiotic drug, even one course?	6
Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis, or other problems affecting your reproductive organs?	25
Have you ever been pregnant:	5
2 or more times?	3
1 time?	
Birth control pills:	15
for more than 2 years?	6
for 6 months to 2 years?	15
for more than 2 weeks?	6
for two weeks or less?	
Exposure to perfumes, insecticides, fabrics, shop odors, and other chemicals provoke:	20
moderate to severe symptoms?	5
mild symptoms?	
Symptoms worse on damp, muggy days or in mouldy places?	20
Athlete's foot, ringworm, other chronic fungal infections of the skin or nails?	20
severe to persistent?	10
mild to moderate?	
Sugar cravings	10
Cravings for breads	10
Cravings for alcoholic beverages	10
Bothered by tobacco smoke	10
TOTAL SCORE - SECTION A	
Bring score for Section B from the next page.	
TOTAL SCORE - SECTION B	
Bring score for Section C from the next page.	
TOTAL SCORE - SECTION C	
TOTAL SCORE	

Yeast-connected health problems are **almost certainly** present in

women with scores **over 180**

men with scores over 140.

Yeast-connected health problems are **possibly present** in

women with scores **over 60**

men with scores over 40.

Yeast is **less apt** to be the cause of health problems in

women with scores **less than 60**

men with scores less than 40.

For each symptom, enter the appropriate number in the point score column:

	Occasional or mild	1
	Frequent or moderately severe	2
	Severe or disabling	3

Add total score at end of sections B & C.

Transfer scores for SECTIONS B & C to Page 1.

SECTION B: MAJOR SYMPTOMS	1	2	3
Fatigue or lethargy			
Felling of being "drained"			
Poor memory			
Feeling "spacey" or unreal			
Depression			
Numbness, burning or tingling			
Muscle aches			
Muscle weakness or paralysis			
Pain and/or swelling in joints			
Abdominal pain			
Constipation			
Diarrhea			
Bloating			
Troublesome vaginal discharge			
Persistent vaginal itching or burning			
Prostatitis			
Impotence			
Loss of sexual drive			
Endometriosis			
Cramps and/or other menstrual irregularities			
Pre-menstrual tension			
Spots in front of eyes			
Erratic vision			
Subtotal			
Multiply Subtotal by 3: Subtotal x 3 =			
TOTAL SCORE - SECTION B			

SECTION C: OTHER SYMPTOMS	1	2	3
Drowsiness			
Irritability or jitteriness			
Lack of coordination			
Inability to concentrate			
Frequent mood swings			
Headache			
Dizziness/loss of balance			
Pressure above ears, feeling of head swelling and tingling			
Itching			
Other rashes			
Indigestion			
Belching and intestinal gas			
Mucous in stools			
Hemorrhoids			
Dry mouth			
Rash or blisters in mouth			
Bad breath			
Joint swelling or arthritis			
Nasal congestion or discharge			
Postnasal drip			
Nasal itching			
Sore or dry mouth			
Cough			
Pain or tightness in chest			
Wheezing or shortness of breath			
Urgency or urinary frequency			
Burning on urination			
Failing vision			
Burning or tearing of eyes			
Recurrent ear infections or fluid in ears			
Ear pain or deafness			
TOTAL SCORE - SECTION C			