HEALTH APPRAISAL QUESTIONNAIRE

Name _____ **Date** _____

DIRECTIONS

This questionnaire asks you to assess how you have been feeling **during the lost 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. Toke all the time you need to complete ,this questionnaire.

For each question, circle the number that best describes 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 on d 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 mare 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

SECTION A

	Never	Occasionally	Often	Frequently
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. Bod 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 oppetite	0	1	4	8

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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 on 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 pori of your chest, especially when lying down or bending forword	0	1	4	8
6. Digestive problems that subside with rest and reloxotion	(0)Ne			(8)ve,
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

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SECTION C

1. When massaging under your rib cage on your *Jeft 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 norrow to loose) within the course of a day	0	1	4	8

SECTION C (conl.)

6. Stool odor is embarrassing	0	1	4	8
7. Undigested food in your stool	0	1	4	8
8. Three or more lorge bowel movements doily	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 row 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, hord 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)Ne			(8)ve,
9. An almost continual need to have a bowel movement	(0)Ne			(8)ve,

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 nircht that may move to your back or right shou der	0	1	4	8
4. Bitler fluid repeats after eating	0	1	4	8
5. Feel abdominal discomfort or nauseo when eating rich, fatty or fried foods	0	1	4	8
6. Throbbing tem~les and/or dull poin in foreheod ossociatea wit 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

	Never	Occasionally	Often	Always
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	(O)No			(8lve,
16. Yellowish cost to eyes	(O)No			(8lYe,

Total points ____

PART III

SECTION A

1. Feel cold or chilled-hands, feet or allover-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 heort 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	(O)No			(8lve,
11. Have you noticed recently that your voice is deepening?	(OlNo			(8)ve,
12. Thick, brittle nails	(O)No			(8lve,
13. Weight gain for no apparent reason	(OlNo			(8)ve,
14. Outer third of your eyebrow is thinning or disappearing	(O)No			(8)Ve,
15. Swell ing of the neck	(O)No			(8)ve,

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. Diizy when rising or standing up from a kneeling position	0	1	4	8
6. Dark bluish or block circles under your eyes	0	1	4	8
7. Have bouts of nousea with or without vomiting	0	1	4	8
8. Catch colds or infections easily	(O)No			(8)ve,
9. Wounds heal slowly	(OlNo			(8)ve,
10. Your body or ports of your body feel tender, sore, sensitive to the touch, hot and/or painful	0	1	4	8
11. Feel puffy, and swollen allover 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., doily carrot juice intoke) or supplements	(O)No			(8lve,

Total points ____

PART IV

SECTION A

When you miss meals or go without food for extended periods of time, do you experience any of the following symptoms?

	Never	Occasionally	Often	Always
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 ~~nds	0	1	4	8
4. A sensation of your heart beating too quickly or forcefully	0	1	4	8
5. Shaky, iittery, 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. Woke 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
1 1. 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

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 allover	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	(O)No			(8)Ve,
9. Sores heal slowly	(O)No			(8lVel
10. Loss of hair on your legs	(0) No			(8)Ve,

Total points ____

PART V

SECTION A

1. Feel iittery	0	1	4	8
2. First effort of the day causes Join, pressure, tightness or heaviness aroun 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.)

	Not a problem	Slight problem	Moderate problem	Severe problem
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 sensotion 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 chan~es in your ability to feel pain or differentiate etween sensations of hot or cold	(0)No			(8)Ye,
11. Body hair (on arms, hands, fingers, legs and loes) is thinning or has disappeared	(0)No			(8)Ye,
12. Do you notice a decline in your ability to make decisions, concentrate, focus allention or follow directions?	(0)No			(8)Ye,

Total points ____

PART VI

SECTION A

1. Family, friends, wank, 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 ond 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)Ye,
8. Lately you've noticed on inability to think clearly or concentrate	(0)No			(8)Ye,
9. Difficulty making decisions and/or clarifying and achieving your goals	(0)No			(8)Ye,

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 bock in your mind?	0	1	4	8

	Not a problem	Slight problem	Moderate problem	Severe problem
SECTION B *(cont.)*				
12. Do you become suddenly scared for no reason?	0	1	4	8
13. Do you break out in a cold sweot?	0	1	4	8
14. "But1erflies in your stomach," nausea and/or diarrhea	0	1	4	8

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 wont 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)Ye,
7. Does your nose run?	0	1	4	8
8. Nosebleeds	(0)No			(8)Ye,
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)Ye,
13. Do frequent colds keep you miserable all winter?	(0)No			(8)Ye,
14. Flu symptoms lost longer than 5 days	(0)No			(8)Ye,
15. Do infections sellie in your lungs?	(0)No			(8)Ye,
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 maller 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 problem	Moderate problem	Severe problem	Very severe problem
29. Do you have difficulty concentrating?	0	1	4	8
30. Eyes, ear nose, throat and lung symptoms seem associated with specific foods like dairy or wheat products	(0)No			(8)ve,
31. Eyes, ears, nose, throat and lung symptoms are associated with seasonal changes	(0)No			(8)ve,

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 rase color	0	1	4	8
11. Sudden urge to void causes involuntory 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

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 invalvin~ one or more areas (fingers, hands, wrists, elbows, s oulders, 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

SECTION B *(cant.)*				
8. intermittent poin or oche on one side of heod spreading to cheek, temple, lower jow, 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 poin down the back of leg	0	1	4	8
12. Is it difficult to reoch up and ~et a 5-paund obiect like a bag of flour from just a ove your head?	(0)No			(8)ves
13. Injure, strain or sprain easily	(0)No			(8)ve,

SECTION C

1. Muscles stiff, sore, tense and/or achy	0	1	4	8
2. Burning, throbbing, shaoting or stabbing muscle poin	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 foreorm 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 sittinPr' rolling over in bed and/or turning your head ram 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. Pe0'ble tell you to speak up because they have trou le heoring you	0	1	4	8
10. Speaking and farming wards does not feel automatic	0	1	4	8
11. Need 10-12 hours of sleep to feel rested	0	1	4	8