



***COMPREHENSIVE  
HEALTH ASSESSMENT  
QUESTIONNAIRE***

# GENERAL INFORMATION

Name: _____	Referred by: _____
Address: _____	Home Phone: _____
_____	Work Phone: _____
City	State
_____	Zip
_____	_____

## PERSONAL

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_  
 Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Desired Wt: \_\_\_\_\_ Frame Size:  Small  Medium  Large \_\_\_\_\_  
 Blood pressure reading (when last taken): \_\_\_\_\_ Date: \_\_\_\_\_ Blood Type: \_\_\_\_\_  
 Marital Status (check):  Single  Married  Divorced  Separated  
 Number of children: \_\_\_\_\_ Age of Youngest: \_\_\_\_\_

## LIFESTYLE

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Is your occupation/lifestyle:  Strenuous  Moderate  Light  Sedentary  
 Do you smoke: \_\_\_\_\_ How much/often? \_\_\_\_\_ How many years? \_\_\_\_\_  
 If you've quit, when did you quit? \_\_\_\_\_  
 How many years did you smoke? \_\_\_\_\_ How much/often? \_\_\_\_\_

## PRESCRIPTION DRUGS, NON-PRESCRIPTION DRUGS, & SUPPLEMENTS

*Please list any prescription drugs, non-prescription drugs, and supplements that you take regularly.*

Name	What are you taking this for?	If you've quit, when did you quit?	How long did you take them?

## MEDICAL HISTORY

Please list any major surgeries: \_\_\_\_\_  
 What have you been diagnosed as having? \_\_\_\_\_  
 Have you had a recent blood test, urinalysis, or other diagnostic test? \* \_\_\_\_\_ If no, most recent date: \_\_\_\_\_  
 \*Please bring a copy of the results of any recent (within the last year) tests on your first visit. If you have not had any recent tests, you may be asked to get one.  
 Please list any diagnosed allergies: \_\_\_\_\_  
 Major illnesses: \_\_\_\_\_

## CONCERNS/SYMPTOMS

What is the primary reason you came to us for analysis? \_\_\_\_\_

Main Complaint	Date of Onset	When does it occur?	How often does it occur?	What do you think is causing symptom?

# GENERAL INFORMATION

## RESIDENTIAL VISITATION EXPOSURE

List other states or other countries you have visited or lived in:

County/State	What year?	How long were you there?	Did you experience any problems/symptoms while there or after leaving? If so, please list.

## FAMILY HISTORY

Check any health conditions listed per family member:

Relative	Current age or age at death	Born via C-section	Arthritis	Asthma	Cancer	Diabetes	Heart disease	Tuberculosis	Kidney Disease	Liver Disease	Vascular Disease	Neurological Disease	Psychiatric Disorders	Lung Disease	Skin Disease (Eczema, Psoriasis)	Other	Cause of Death (if applicable)	List any other Chronic Symptoms	State & County of Residence
Maternal grandmother																			
Maternal grandfather																			
Paternal grandmother																			
Paternal grandfather																			
Mother																			
Father																			
Brothers/Sisters:																			
Children:																			

## WORK HISTORY

This section is to determine your exposure risks to chemicals, pesticides, insecticides, cosmetics, heavy metals, electromagnetic fields, etc., at your current and previous jobs.

Company/Employer	Job Title	Length of Employment (include end date)	Work duties (were you exposed to chemicals, inks, dyes, glues, computers, cleaning supplies, etc.?)

*Additional Questions for*  
**LAB TEST INTERPRETATION**

**Instructions:** Please complete for each patient doing a lab test

<b>Pharmacist's Name:</b>			
<b>Patient's Name:</b>		<b>Date:</b>	
<b>Height:</b>	<b>Weight:</b>	<b>Age:</b>	<b>Sex:</b>
<b>List ANY and ALL medications/drugs presently taking:</b>			
<b>Do you use any of the following?</b> (circle all that apply)			
DHEA	Pregnenolone	Cortisol/Corticosteroids	Progesterone
Androstenedione	Anabolic steroids	NSAIDS	Other:
<b>Are your menstrual cycles normal?</b> Explain:			
<b>Do you have?</b> (circle all that apply)			
PMS	Hot Flashes	Night Sweats	Endometriosis
Ovarian Cysts	Uterine Fibroids	Fibrocystic Breast Syndrome	Yeast Infections
Irregular Periods	Prostate Problems	Other:	
<b>Have you been diagnosed with any of the following chronic illnesses?</b> (circle all that apply)			
Chronic Fatigue	Fibromyalgia	Rheumatoid Arthritis	Crohn's Disease
Irritable Bowel	Lupus	Psoriasis/Eczema	Cancer
Allergies	Other:		

**List any nutritional products you are presently taking:** \_\_\_\_\_

**Have you been diagnosed with high blood pressure?** \_\_\_\_\_ **Reading:**     /

**Do you have chronic pain?** (describe) \_\_\_\_\_

**Do you have blood sugar imbalances or diabetes?** \_\_\_\_\_

**Describe your normal diet, i.e., # of meals/day** \_\_\_\_\_

**When do you normally eat?** \_\_\_\_\_

**What do you normally eat?** \_\_\_\_\_

**How are your sleep patterns?** (describe) \_\_\_\_\_

**Are you under any stress?** (physical, emotional, job, home, other) \_\_\_\_\_

**Do you have any diagnosed illnesses?** (describe) \_\_\_\_\_

**Can you provide any recent lab tests?** \_\_\_\_\_

**What are your MAIN COMPLAINTS?** \_\_\_\_\_

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Part 1

Instructions: Place a check mark by each of the following items that apply.

Medications You Take:

- Acetaminophen
- AIDS
- Antacids
- Antibiotic/Antifungal
- Antidepressant
- Antidiabetic/Insulin
- Aspirin
- Chemotherapy
- Cortisone/Anti-inflammatory/NSAIDS
- Heart Medications
- High Blood Pressure
- Hormones
- Laxatives
- Lithium
- Oral Contraceptives
- Prostate
- Radiation
- Recreational Drugs
- Specify:
- Relaxants/Sleeping Pills
- Thyroid
- Ulcer Medications
- Other (list):

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- Vitamins and/or Minerals (list):

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You Eat, Drink, or Use:

- Alcohol
- Carbonated Beverages
- Coffee
- Tea, non-herbal
- Water, distilled
- Water, tap
- Aspartame
- Candy
- Fast Food Restaurants Regularly
- Fried Foods
- Luncheon Meats
- Margarine
- Refined Sugars
- Saccharin
- Chew Tobacco
- Smoke Cigarettes
- Smoke Pipe
- Antiperspirants w/aluminum
- Hair dyes containing lead

You:

- Diet Often
- Do not Exercise Regularly
- Salt food without tasting
- Are under excessive stress
- Are exposed to chemicals at work
- Are exposed to cigarette smoke
- Live within 10 miles of an industrial plant
- Live in an area high in EMFs (within ¼ mile of an electrical transformer or distribution center)

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Part 2

Instructions: Circle yes or no to the following questions. If you do not know the answer to a question, leave it blank.

Where requested, circle the number which best describes the intensity of your symptoms:

1= Mild    2=Moderate    3=Severe

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- |  |    |                    |
|--|----|--------------------|
| 1. Have you ever taken tetracyclines (or other antibiotics) for acne for a period of 2 months or longer?   | No | Yes                |
| 2. Have you ever taken "broad spectrum" antibiotics (including Keflex <sup>®</sup> , ampicillin, amoxicillin, Celcor <sup>®</sup> , Bactrim <sup>®</sup> and Septra <sup>®</sup> ) for respiratory, urinary, or other infections for a period of 2 months or longer, or in shorter courses 4 or more times in a single year? | No | Yes                |
| 3. Have you, at any time in your life, been troubled by persistent vaginal problems or had 3 or more episodes of vaginitis in a year?  | No | Yes                |
| 4. Have you ever been pregnant?<br>If yes, how many times?   | No | Yes<br>_____       |
| 5. Have you ever taken birth control pills for longer than a year at a time?   | No | Yes                |
| 6. Have you taken prednisone, Decadron <sup>®</sup> , or other cortisone-type drugs?<br>If yes, have you taken them for more than 2 weeks?   | No | Yes<br>_____       |
| 7. Have you been exposed to antibiotics because of your job? (For example, nurses or pharmacists)  | No | Yes                |
| 8. Have you ever had mononucleosis?  | No | Yes                |
| 9. Have you been diagnosed with ADD/LD or Autism?  | No | Yes                |
| 10. Does exposure to perfumes, insecticides, fabric store odors and other chemicals bother you?<br>If yes, rate the symptoms from mild to severe:  | No | Yes<br>1    2    3 |
| 11. Do damp, muggy days or moldy places provoke symptoms?<br>If yes, rate the symptoms:  | No | Yes<br>1    2    3 |

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12. Have you had persistent athlete's foot, "jock itch" or other chronic infections of the skin or nails?	No	Yes
	1	2 3
If yes, rate the infections:		
13. Do you crave sugar?	No	Yes
	1	2 3
If yes, rate the cravings:		
14. Do you crave bread?	No	Yes
	1	2 3
If yes, rate the cravings:		
15. Do you crave alcoholic beverages?	No	Yes
	1	2 3
If yes, rate the cravings:		
16. Does tobacco smoke really bother you?	No	Yes
	1	2 3
If yes, rate the irritation:		
17. Do you have allergies?	No	Yes
	1	2 3
If yes, rate the symptoms:		

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Part 3

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

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

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Section A

1. Burping .....	0	1	2	3
2. Fullness for extended time after meals.....	0	1	2	3
3. Bloating.....	0	1	2	3
4. Stomach upsets easily.....	0	1	2	3
5. Poor appetite.....	0	1	2	3
6. Known food allergies.....	0	1	2	3
7. Constipation.....	0	1	2	3

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Section B

1. Abdominal cramps.....	0	1	2	3
2. Pain in left side under rib cage.....	0	1	2	3
3. Indigestion 1-3 hours after eating .....	0	1	2	3
4. Fatigue after eating .....	0	1	2	3
5. Roughage and fiber causes indigestion .....	0	1	2	3
6. Lower bowel gas.....	0	1	2	3
7. Alternating constipation and diarrhea.....	0	1	2	3
8. Diarrhea .....	0	1	2	3
9. Mucous in stool.....	0	1	2	3
10. Undigested food in stool.....	0	1	2	3
11. Stool poorly formed .....	0	1	2	3
12. Shiny stool.....	0	1	2	3
13. Foul smelling stool.....	0	1	2	3
14. 3 or more large bowel movements daily .....	0	1	2	3
15. Dry, flaky skin and/or brittle hair .....	0	1	2	3
16. Acne.....	0	1	2	3
17. Food allergies .....	0	1	2	3
18. Difficulty gaining weight.....	0	1	2	3

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Section C

1. Chronic stomach pains .....	0	1	2	3
2. Stomach pains just before and/or after meals.....	0	1	2	3
3. Stomach pain when emotionally upset .....	0	1	2	3
4. Wake up at night with stomach pain.....	0	1	2	3
5. Sudden or acute indigestion .....	0	1	2	3
6. Butterfly sensations in stomach.....	0	1	2	3
7. Relief of stomach pain by drinking carbonated beverages .....	0	1	2	3
8. Relief of stomach pain by drinking cream or milk .....	0	1	2	3
9. Relief of stomach pain temporarily by eating.....	0	1	2	3
10. Difficulty belching.....	0	1	2	3
11. Black stool when not taking iron supplements.....	No		Yes	
12. History of ulcer or gastritis .....	No		Yes	
13. Current ulcer .....	No		Yes	
14. Dependency on antacids .....	No		Yes	
15. History of chronic aspirin or NSAID use.....	No		Yes	

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Section D

1. Frequent and recurrent infections (colds) .....	0	1	2	3
2. Bladder and kidney infections.....	0	1	2	3
3. Vaginal yeast infection.....	0	1	2	3
4. Toenail or fingernail fungus.....	0	1	2	3
5. Abdominal cramps.....	0	1	2	3
6. Seasonal diarrhea .....	0	1	2	3
7. Alternating constipation and diarrhea .....	0	1	2	3
8. Constipation.....	0	1	2	3
9. Mucous in stools.....	0	1	2	3
10. Hard or difficult bowel movements.....	0	1	2	3
11. Fullness in the lower abdomen .....	0	1	2	3
12. Flatulence (gas) .....	0	1	2	3
13. History of antibiotic use.....	0	1	2	3
14. Meat eater .....	0	1	2	3
15. Rapidly failing vision .....	0	1	2	3

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Part 4

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

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

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Section A

1. Intolerance to greasy foods .....	0	1	2	3
2. Onions, cabbage, radishes or cucumbers cause bloating, gas, distress .....	0	1	2	3
3. Headaches after eating.....	0	1	2	3
4. Fatigue and sleepiness after eating .....	0	1	2	3
5. Pain in right side under rib cage.....	0	1	2	3
6. Light colored stool .....	0	1	2	3
7. Foul smelling stool.....	0	1	2	3
8. Less than one bowel movement daily .....	0	1	2	3
9. Constipation.....	0	1	2	3
10. Hard stool .....	0	1	2	3
11. Stool is yellow or clay colored, foul odor.....	0	1	2	3
12. Painful to pass stool.....	0	1	2	3
13. Grey colored skin.....	0	1	2	3
14. Skin oily on nose and forehead .....	0	1	2	3
15. Yellow in whites of eyes .....	0	1	2	3
16. Yellow cast to the tongue.....	0	1	2	3
17. Sour taste in mouth.....	0	1	2	3
18. Bad breath .....	0	1	2	3
19. Body odor.....	0	1	2	3
20. Dry skin or hair.....	0	1	2	3
21. Big toe painful .....	0	1	2	3
22. Pain radiates along outside of leg .....	0	1	2	3
23. Retain water .....	0	1	2	3
24. Red blood in stool.....	No		Yes	
25. Have had jaundice or hepatitis.....	No		Yes	
26. High blood cholesterol AND low HDL cholesterol? .....	No		Yes	
27. Is your cholesterol level above 200? .....	No		Yes	
28. Is your triglyceride level above 115? .....	No		Yes	

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Section B

1. Tachycardia, abnormally rapid heartbeat .....	0	1	2	3
2. Nervousness, increased activity, hyperactivity.....	0	1	2	3
3. Irritability.....	0	1	2	3
4. Insomnia .....	0	1	2	3
5. Easily flushed .....	0	1	2	3
6. Intolerant to high temperatures .....	0	1	2	3
7. Strong drive followed by exhaustion .....	0	1	2	3
8. Erratic, "flighty" behavior.....	0	1	2	3
9. Fine features, thin skin, thin hair.....	0	1	2	3
10. Warm, fine, moist skin .....	0	1	2	3
11. Protruding tongue quivers, hands shake or tremor .....	0	1	2	3
12. Protruding eyeballs.....	0	1	2	3
13. Menstrual problems.....	0	1	2	3
14. Difficulty with weight gain (overweight) .....	0	1	2	3
15. Good appetite but fail to gain weight.....	0	1	2	3

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Section C

1. Trouble waking up in the morning.....	0	1	2	3
2. Start slow in the morning, gain speed in afternoon.....	0	1	2	3
3. Headache on waking which wears off with the day.....	0	1	2	3
4. Dizzy or nauseated in morning .....	0	1	2	3
5. Muscles stiff in morning, feel need to limber up .....	0	1	2	3
6. Feel "creaky" after sitting for period of time .....	0	1	2	3
7. Heart sometimes seems to miss beats or turn "flip flops".....	0	1	2	3
8. Dry skin.....	0	1	2	3
9. Yellowish tint to skin, particularly on hands or feet .....	0	1	2	3
10. Hair scanty, dry, brittle, lusterless .....	0	1	2	3
11. Thinning or loss of outside portion of eyebrow .....	0	1	2	3
12. Large lower lip.....	0	1	2	3
13. Tend to have cold hands or feet.....	0	1	2	3
14. Sensitivity to cold, prefer warm to cool climate.....	0	1	2	3
15. Difficulty concentrating, easily distracted .....	0	1	2	3
16. Failing memory, forgetfulness .....	0	1	2	3

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Section C (continued)

17. "Go to pieces" easily, cry easily, dislike working under pressure, dislike being watched .....	0	1	2	3
18. Sugar intake causes irritability and mood swings.....	0	1	2	3
19. Slow reflexes .....	0	1	2	3
20. Low pulse rate.....	0	1	2	3
21. Gain weigh easily, fail to lose weight on diets.....	0	1	2	3
22. Diminished sex drive .....	0	1	2	3
23. Dizzy when changing up and down positions.....	0	1	2	3
24. Depression .....	0	1	2	3
25. Sleeplessness or restlessness.....	0	1	2	3
26. Menstrual problems.....	0	1	2	3
27. PMS.....	0	1	2	3
28. Infertility.....	0	1	2	3
29. Ringing in the ears .....	0	1	2	3
30. Headaches.....	0	1	2	3
31. These symptoms worsen at night: Coughing, hoarseness, muscle cramps .....	0	1	2	3
32. Motion sickness when traveling.....	0	1	2	3
33. Clogged sinuses .....	0	1	2	3
34. Recurrent infections.....	0	1	2	3
35. Bowel movements usually less than one daily.....	0	1	2	3
36. Basal Temperature Test: Record morning temperature by placing thermometer under armpit for 10 minutes while still in bed. Read and record for 4 days. Women: don't do during ovulation.				

Day 1\_\_\_\_\_ Day 2\_\_\_\_\_ Day 3\_\_\_\_\_ Day 4\_\_\_\_\_

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Section D

1. Sex drive reduced or absent .....	0	1	2	3
2. Abnormal thirst .....	0	1	2	3
3. Weight gain around hips or waist.....	0	1	2	3
4. Tendency to ulcers or colitis .....	0	1	2	3
5. Increased ability to eat sugar without symptoms.....	0	1	2	3
6. Menstrual disorders (women) .....	0	1	2	3
Lack of menstruation (young girls) .....	0	1	2	3

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Part 5

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

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

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Section A

1. Allergies .....	0	1	2	3
2. Eyes sensitive to bright light .....	0	1	2	3
3. Sensitive to exhaust fumes, smoke, smog, petrochemicals.....	0	1	2	3
4. Oversensitive to sugar, causes energy boost then drop .....	0	1	2	3
5. Easily shaken or startled, heart pounds from unexpected noise .....	0	1	2	3
6. Emotional upsets cause complete exhaustion .....	0	1	2	3
7. Tightness or lump in throat, hurts when emotionally disturbed .....	0	1	2	3
8. Get goose bumps easily.....	0	1	2	3
9. Feel weak and shaky.....	0	1	2	3
10. Depression or rapid mood swings.....	0	1	2	3
11. Dizziness upon standing.....	0	1	2	3
12. Lack of mental alertness.....	0	1	2	3
13. Perfectionist who sets high standards.....	0	1	2	3
14. Cannot tolerate much exercise .....	0	1	2	3
15. Catch colds easily when weather changes .....	0	1	2	3
16. Headaches.....	0	1	2	3
17. Difficulty breathing .....	0	1	2	3
18. Water retention .....	0	1	2	3
19. Periodic constipation.....	0	1	2	3
20. Dark circles under eyes .....	0	1	2	3

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Section B

1. Nose runs or drips.....	0	1	2	3
2. Nose bleeds.....	0	1	2	3
3. Loss of smell .....	0	1	2	3
4. Throat infections or chronic sore throat.....	0	1	2	3
5. Loss of taste.....	0	1	2	3
6. Cold sores or fever blisters.....	0	1	2	3

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Section B (continued)

7. Chronic/swollen lymph glands .....	0	1	2	3
8. Inflamed or bleeding gums .....	0	1	2	3
9. Ear infections .....	0	1	2	3
10. Hair falls out .....	0	1	2	3
11. Hair grows slowly.....	0	1	2	3
12. Slow to recover from cold or flu .....	0	1	2	3
13. Catch colds or flu easily .....	0	1	2	3
14. Poor wound healing.....	0	1	2	3
15. Get boils or styes.....	0	1	2	3
16. Bumpy skin on back of arms.....	0	1	2	3

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Section C

1. Itching of nose or eyes .....	0	1	2	3
2. Discharge from eyes.....	0	1	2	3
3. Watery eyes.....	0	1	2	3
4. Puffiness or dark circles under eyes.....	0	1	2	3
5. Itching of roof of mouth or throat.....	0	1	2	3
6. Mucous in throat.....	0	1	2	3
7. Postnasal drip .....	0	1	2	3
8. Nasal congestion.....	0	1	2	3
9. Nose runs or drips.....	0	1	2	3
10. Sneezing .....	0	1	2	3
11. Breathing through mouth.....	0	1	2	3
12. Swollen tongue.....	0	1	2	3
13. Difficulty swallowing .....	0	1	2	3
14. Ear discharge or ears stuffed up.....	0	1	2	3
15. Migraine headaches .....	0	1	2	3
16. Chronic lung congestion.....	0	1	2	3
17. Wheezing.....	0	1	2	3
18. Food sensitivity or allergy.....	0	1	2	3
19. Painful stomach and/or intestine .....	0	1	2	3
20. Alternating constipation and diarrhea .....	0	1	2	3
21. Certain foods make you sick, depressed, jittery.....	0	1	2	3
22. Entire body aches, painful to touch.....	0	1	2	3

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Section C (continued)

23. Swollen joints.....	0	1	2	3
24. Skin rashes.....	0	1	2	3
25. Chronic pain.....	0	1	2	3
26. Hyperactivity.....	0	1	2	3
27. Bedwetting .....	0	1	2	3
28. Use aspirin or Tylenol® regularly .....	0	1	2	3

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Section D

1. Very susceptible to infections.....	0	1	2	3
2. Flu-like symptoms often occur .....	0	1	2	3
3. Swollen glands in arm pit, groin, tonsils.....	0	1	2	3
4. Feeling of puffiness in throat.....	0	1	2	3
5. Soreness on both sides of neck at shoulder level .....	0	1	2	3
6. Irregular heartbeat .....	0	1	2	3
7. More than usual number of cavities.....	0	1	2	3
8. Look older than chronological age .....	0	1	2	3
9. Have you had your spleen removed? .....	No		Yes	

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Part 6

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

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

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Section A

1. Heart pounds easily.....	0	1	2	3
2. Heart misses beats or has extra beats.....	0	1	2	3
3. Chest pain while walking.....	0	1	2	3
4. Pain in left arm.....	0	1	2	3
5. Heartburn after eating.....	0	1	2	3
6. Calf muscles cramp while walking.....	0	1	2	3
7. Heaviness in legs.....	0	1	2	3
8. Swelling of feet and ankles.....	0	1	2	3
9. Difficulty breathing at night.....	0	1	2	3
10. Feel jittery.....	0	1	2	3
11. Exhaust with minor exertion.....	0	1	2	3
12. Severe cough.....	0	1	2	3
13. Do aerobic exercise.....	No		Yes	
14. Have never exercised regularly.....	No		Yes	
15. Do you drink 5 or more cups of coffee daily.....	No		Yes	
16. Has a doctor ever told you that you have heart trouble?.....	No		Yes	

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Section B

1. Feeling of heavy or aching legs.....	0	1	2	3
2. Restless legs or feet, especially in the evening.....	0	1	2	3
3. Calf muscles cramp while walking.....	0	1	2	3
4. Cold hands and feet.....	0	1	2	3
5. Tingling and/or burning in hands or feet.....	0	1	2	3
6. Numbness in extremities.....	0	1	2	3
7. Headaches.....	0	1	2	3
8. Slurred speech.....	0	1	2	3
9. Poor concentration.....	0	1	2	3
10. Ringing in ears.....	0	1	2	3

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Section B (continued)

11. Ear canal hair .....	0	1	2	3
12. Spider veins on nose and/or face .....	0	1	2	3
13. Varicose veins.....	0	1	2	3

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Section C

1. Pain in back of head or neck when getting up in morning .....	0	1	2	3
2. Dizziness .....	0	1	2	3
3. Vertigo.....	0	1	2	3
4. Blushing with no apparent cause .....	0	1	2	3
5. Is your blood pressure high? .....	No		Yes	
6. Is your LDL cholesterol above 130? .....	No		Yes	
7. Is your total cholesterol above 200? .....	No		Yes	
8. Is your triglyceride level above 115? .....	No		Yes	

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Part 7

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

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

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Section A

1. Dizziness when standing suddenly.....	0	1	2	3
2. Loss of vision when standing suddenly.....	0	1	2	3
3. Feel shaky or jittery .....	0	1	2	3
4. Irritable if a meal is missed .....	0	1	2	3
5. Feel tired or weak if a meal is missed .....	0	1	2	3
6. Impatient, moody, nervous.....	0	1	2	3
7. Feel tired 1-3 hours after eating.....	0	1	2	3
8. Crave sweets or carbohydrates excessively.....	0	1	2	3
9. Calmer after eating.....	0	1	2	3
10. Headaches relieved by eating sweets or drinking alcohol.....	0	1	2	3
11. Heart palpitations after eating sweets.....	0	1	2	3
12. Need to drink coffee to get started .....	0	1	2	3
13. Wake up in middle of night craving sweets.....	0	1	2	3
14. Feel faint.....	0	1	2	3
15. Poor memory.....	0	1	2	3
16. Poor concentration.....	0	1	2	3

---

Section B

1. Night sweats.....	0	1	2	3
2. Increased thirst .....	0	1	2	3
3. Lowered resistance to infection .....	0	1	2	3
4. Fatigue .....	0	1	2	3
5. Boils and/or leg sores.....	0	1	2	3
6. Wounds or cuts take a long time to heal.....	0	1	2	3
7. Poor circulation.....	0	1	2	3
8. Failing eyesight .....	0	1	2	3
9. Chronic yeast infections or toenail fungus.....	0	1	2	3
10. Feel pick up from exercise.....	0	1	2	3

---

Section B (continued)

11. Overweight.....	0	1	2	3
12. Crave sweets, but eating sweets does not relieve symptoms.....	0	1	2	3
13. Sugar in urine.....	0	1	2	3
14. Family history of diabetes .....	0	1	2	3

---

Part 8

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

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

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Section A

1. Difficulty breathing .....	0	1	2	3
2. Chest pain with deep breath.....	0	1	2	3
3. Shortness of breath.....	0	1	2	3
4. Periodic wheezing .....	0	1	2	3
5. Rattling mucous when you breathe.....	0	1	2	3
6. Chronic cough .....	0	1	2	3
7. Coughing up blood.....	0	1	2	3
8. Coughing up phlegm.....	0	1	2	3
9. Infections settle in lungs.....	0	1	2	3
10. Pain around ribs.....	0	1	2	3
11. Live or work around people who smoke.....	0	1	2	3
12. Sensitive to smog.....	0	1	2	3
13. Exposed to chemicals and radiation .....	0	1	2	3
14. Exposed to asbestos.....	0	1	2	3
15. Do you have chronic bronchitis? .....	No		Yes	
16. Do you smoke?.....	No		Yes	

---

Part 9 – Males Only

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

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

---

Section A

1. A feeling of bladder fullness .....	0	1	2	3
2. Difficulty urinating.....	0	1	2	3
3. Increased straining with smaller and smaller amount of urine.....	0	1	2	3
4. Pain or burning while urinating.....	0	1	2	3
5. Wake up at night to urinate.....	0	1	2	3
6. Dripping after urination .....	0	1	2	3
7. Rose colored (bloody) urine.....	0	1	2	3
8. Pain or fatigue in the legs or back .....	0	1	2	3
9. Lack of sex drive.....	0	1	2	3
10. Ejaculation causes pain .....	0	1	2	3
11. Past or present rash on penis.....	0	1	2	3
12. Cloudy urine .....	0	1	2	3
13. Strong smelling urine.....	0	1	2	3
14. Back pain in the kidney area .....	0	1	2	3
15. History of kidney or bladder infections .....	No		Yes	
16. Have used antibiotics to control urinary tract infections.....	No		Yes	

Date last used \_\_\_\_\_ Treatment duration \_\_\_\_\_

---

Section B

1. Difficulty attaining and/or maintaining an erection.....	0	1	2	3
2. Low sex drive.....	0	1	2	3
3. Premature ejaculation.....	0	1	2	3
4. Pain or coldness in genital area .....	0	1	2	3
5. Can't hold urine.....	0	1	2	3
6. General water retention.....	0	1	2	3
7. Varicose veins on scrotum.....	No		Yes	
8. Low sperm count.....	No		Yes	
9. Infertile.....	No		Yes	

---

Section C

1. Discharge from penis.....	0	1	2	3
2. Swollen genitals.....	0	1	2	3
3. Swelling in groin.....	0	1	2	3
4. Frequent urination.....	0	1	2	3
5. Rarely need to urinate.....	0	1	2	3
6. Difficulty passing urine.....	0	1	2	3
7. Dripping after urination.....	0	1	2	3
8. Have venereal disease (gonorrhea, syphilis, herpes or other) now .....	No		Yes	
9. Have had venereal disease (gonorrhea, syphilis, herpes or other) in past.....	No		Yes	

---

Part 10 – Females Only

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

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

---

Section A: Circle if you experience any of these symptoms at any time.

- |  |    |   |     |   |
|--|----|---|-----|---|
| 1. Frequent Urination.....   | 0  | 1 | 2   | 3 |
| 2. Urination when you cough or sneeze.....                         | 0  | 1 | 2   | 3 |
| 3. Pain or burning while urinating.....                            | 0  | 1 | 2   | 3 |
| 4. Difficulty passing urine.....                                   | 0  | 1 | 2   | 3 |
| 5. Can't hold urine.....   | 0  | 1 | 2   | 3 |
| 6. Rose colored (bloody) urine.....                                | 0  | 1 | 2   | 3 |
| 7. Cloudy urine.....   | 0  | 1 | 2   | 3 |
| 8. Strong smelling urine.....                                      | 0  | 1 | 2   | 3 |
| 9. Back or leg pains associated with dripping after urination..... | 0  | 1 | 2   | 3 |
| 10. Back pain in the kidney area.....                              | 0  | 1 | 2   | 3 |
| 11. History of kidney or bladder infections.....                   | No |   | Yes |   |
| 12. Have used antibiotics to control urinary tract infections..... | No |   | Yes |   |
- Date last used \_\_\_\_\_ Treatment duration \_\_\_\_\_
- 

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

- |                                    |   |   |   |   |
|------------------------------------|---|---|---|---|
| 1. Monthly weight gain.....        | 0 | 1 | 2 | 3 |
| 2. Bloating and swelling.....      | 0 | 1 | 2 | 3 |
| 3. Nausea and/or vomiting.....     | 0 | 1 | 2 | 3 |
| 4. Depression.....                 | 0 | 1 | 2 | 3 |
| 5. Moodiness or irritability.....  | 0 | 1 | 2 | 3 |
| 6. Easily angered.....             | 0 | 1 | 2 | 3 |
| 7. Anxiety.....                    | 0 | 1 | 2 | 3 |
| 8. Tender breasts.....             | 0 | 1 | 2 | 3 |
| 9. Headaches.....                  | 0 | 1 | 2 | 3 |
| 10. Leg cramps and tenderness..... | 0 | 1 | 2 | 3 |
| 11. Low backache.....              | 0 | 1 | 2 | 3 |
| 12. Asthma attacks.....            | 0 | 1 | 2 | 3 |

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Section B (continued)

13. Tendency to yeast infections .....	0	1	2	3
14. General water retention.....	0	1	2	3
15. Other: _____	0	1	2	3
16. Suicidal feelings.....	No		Yes	

---

Section C: Circle if you experience any of these symptoms at any time.

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 of intercourse .....	0	1	2	3
5. Missed periods .....	0	1	2	3
6. Tendency to yeast infections .....	0	1	2	3
7. Over 15 years of age and have not begun menstruation .....	0	1	2	3
8. Unable to get pregnant .....	0	1	2	3
9. Miscarriages                      If yes, how many? _____	No		Yes	
10. Children                              If yes, how many? _____	No		Yes	

---

Section D: Circle if you experience any of these symptoms during menstruation

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

---

Section E: Circle if you experience any of these symptoms at any time.

1. Vaginal bumps and sores.....	0	1	2	3
2. Pubic area sores .....	0	1	2	3
3. Pain in ovaries.....	0	1	2	3
4. Breasts are sore to touch.....	0	1	2	3
5. Breasts painful.....	0	1	2	3
6. Water retention .....	0	1	2	3
7. Swollen feeling.....	0	1	2	3
8. Premenstrual breast pain or discomfort .....	0	1	2	3
9. Ovarian cysts.....	No		Yes	
10. Uterine cysts.....	No		Yes	
11. Breast lumps.....	No		Yes	
12. Mother used D.E.S. (hormones) while pregnant .....	No		Yes	
13. Recent pap smear positive.....	No		Yes	
14. History of breast cancer .....	0	1	2	3
15. Form of birth control: ____ None ____Pill ____IUD ____Sponge ____ Diaphragm ____Foam _____Other				

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Section F: Circle if you experience any of these symptoms at any time.

1. Hot flashes .....	0	1	2	3
2. Night sweats.....	0	1	2	3
3. Sweating throughout day .....	0	1	2	3
4. Depression or mood swings.....	0	1	2	3
5. Insomnia .....	0	1	2	3
6. Craving for sweets.....	0	1	2	3
7. Heavy bleeding two weeks in a month.....	0	1	2	3
8. Vaginal pain.....	0	1	2	3
9. Vaginal bleeding.....	0	1	2	3
10. Dryness of skin, hair, vagina.....	0	1	2	3
11. Painful intercourse .....	0	1	2	3
12. Osteoporosis (bone loss) .....	0	1	2	3
13. Hysterectomy .....	No		Yes	

---

Part 11

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

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

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Section A

1. Eat meat.....	0	1	2	3
2. Cavities.....	0	1	2	3
3. Gum disease .....	0	1	2	3
4. Pain in fingers.....	0	1	2	3
5. Bones sore or painful .....	0	1	2	3
6. Arthritis .....	0	1	2	3
7. Bone deformities.....	0	1	2	3
8. Bone loss .....	0	1	2	3
9. Calcium deposits.....	0	1	2	3
10. Dentures .....	No		Yes	
11. Recent bone fracture.....	No		Yes	
12. Drink carbonated beverages or soda..... If yes, how many cans or glasses per week? _____	No		Yes	
13. Use antacids..... If yes, how many per week? _____	No		Yes	
14. Told you have osteoporosis or osteomalacia.....	No		Yes	
15. Are you postmenopausal? .....	No		Yes	

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Section B

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

---

Section C

1. Over flexible joints (double jointed) .....	0	1	2	3
2. Bursitis.....	0	1	2	3
3. Tendonitis.....	0	1	2	3
4. Swollen knees or elbows.....	0	1	2	3
5. Joint pain.....	0	1	2	3
6. Back pain .....	0	1	2	3
7. Loss in height .....	0	1	2	3
8. Injure easily.....	0	1	2	3
9. Athletic injury .....	0	1	2	3
10. Slipped disc .....	No		Yes	
11. Herniated disc .....	No		Yes	

---

Part 12

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

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

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Section A

1. Head feels heavy .....	0	1	2	3
2. Light headedness or fainting .....	0	1	2	3
3. Dizziness .....	0	1	2	3
4. Ringing or buzzing in ears .....	0	1	2	3
5. Tingling pain sensation .....	0	1	2	3
6. Loss of feeling in hands and/or feet (toes) .....	0	1	2	3
7. Trembling hands .....	0	1	2	3
8. Limbs feel too heavy to hold up.....	0	1	2	3
9. Loss of grip strength.....	0	1	2	3
10. Burning sensation in limbs.....	0	1	2	3
11. Restless legs or arms at night .....	0	1	2	3
12. Loss of balance .....	0	1	2	3
13. Poor coordination.....	0	1	2	3
14. Accident prone.....	0	1	2	3
15. Exhaustion on slightest effort .....	0	1	2	3
16. Nervousness .....	0	1	2	3
17. Loss of muscle tone .....	0	1	2	3
18. Need 10 to 12 hours of sleep .....	0	1	2	3
19. Have had shingles .....	0	1	2	3
20. Convulsions.....	0	1	2	3

---

Part 13

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

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

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Section A

- |  |   |   |   |   |
|--|---|---|---|---|
| 1. Can't fall asleep .....   | 0 | 1 | 2 | 3 |
| 2. Replay events from day over and over in mind preventing sleep ..... | 0 | 1 | 2 | 3 |
| 3. Intense dreams.....   | 0 | 1 | 2 | 3 |
| 4. Nightmares .....  | 0 | 1 | 2 | 3 |
| 5. Awake frequently throughout night .....                             | 0 | 1 | 2 | 3 |
| 6. Wake up in the middle of night, can't fall back to sleep .....      | 0 | 1 | 2 | 3 |
| 7. Restless, uneasy sleeper .....                                      | 0 | 1 | 2 | 3 |
| 8. Leg cramps or restless leg at night .....                           | 0 | 1 | 2 | 3 |
| 9. Sleepwalk .....   | 0 | 1 | 2 | 3 |

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Part 14

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

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

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Section A

1. Rough skin.....	0	1	2	3
2. Excessive perspiration.....	0	1	2	3
3. Loss of former taste or craving for meat.....	0	1	2	3
4. Nausea or inclination to vomit .....	0	1	2	3
5. Potatoes disagree .....	0	1	2	3
6. Belching accompanied by head colds.....	0	1	2	3
7. Constipation accompanied by throbbing headaches .....	0	1	2	3
8. Numbness, stiffness, or loss of sensation in arms or legs.....	0	1	2	3
9. Stitching or burning pain in head with dizziness, relieved by eating .....	0	1	2	3
10. Poor or failing memory .....	0	1	2	3
11. High blood pressure.....	0	1	2	3
12. ADD/LD or autism .....	No		Yes	
13. Kidney disorders.....	No		Yes	
14. Do you use aluminum cookware? .....	No		Yes	
15. Do you consume aluminum-based baking powder regularly? .....	No		Yes	
16. Do you use deodorant containing aluminum?.....	No		Yes	

---

Section B

1. High or low blood pressure .....	0	1	2	3
2. Iron deficiency anemia .....	0	1	2	3
3. Do you eat refined foods? .....	0	1	2	3
4. Do you eat shell fish? .....	0	1	2	3
5. Emphysema.....	No		Yes	
6. Kidney disease.....	No		Yes	
7. Does your home have galvanized pipes .....	No		Yes	
8. Do you live in an area high in air pollution? .....	No		Yes	
9. Do you smoke? .....	No		Yes	
10. Do you drink more than 3 cups of coffee or tea daily? .....	No		Yes	

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Section C

1. Nausea or vomiting.....	0	1	2	3
2. Abdominal pain .....	0	1	2	3
3. Irritation of gastrointestinal tract.....	0	1	2	3
4. Diarrhea .....	0	1	2	3
5. Excessive hair loss .....	0	1	2	3
6. Hyperactivity.....	0	1	2	3
7. Depression .....	0	1	2	3
8. Autism .....	0	1	2	3

---

Section D

1. Constipation.....	0	1	2	3
2. Cramps or vague abdominal aches or discomfort.....	0	1	2	3
3. Vomiting .....	0	1	2	3
4. Headaches.....	0	1	2	3
5. Dizziness .....	0	1	2	3
6. Convulsions or seizures.....	0	1	2	3
7. Paralysis .....	0	1	2	3
8. Hand tremors.....	0	1	2	3
9. Poor coordination.....	0	1	2	3
10. Irritability or nervousness .....	0	1	2	3
11. Lack of apathy, depression, lack of ambition.....	0	1	2	3
12. Hyperactivity (in children) .....	0	1	2	3
13. Sallow complexion (grayish, greenish-yellow color) .....	0	1	2	3
14. Frequent colds or infections .....	0	1	2	3
15. Mild psychoneurosis or personality change .....	0	1	2	3
16. Signs of bone thinning .....	0	1	2	3
17. Prostate problems.....	0	1	2	3
18. Drink unfiltered water .....	0	1	2	3
19. Do you eat canned food daily? .....	No		Yes	
20. Do you smoke? .....	No		Yes	
21. ADD/LD or Autism (in child).....	No		Yes	

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Section E

1. Tremors .....	0	1	2	3
2. Poor coordination.....	0	1	2	3
3. Loss of ability to speak.....	0	1	2	3
4. Poor memory.....	0	1	2	3
5. Inflamed gums.....	0	1	2	3
6. Metallic taste in mouth.....	0	1	2	3
7. Headaches.....	0	1	2	3
8. Depression or uncontrollable crying.....	0	1	2	3
9. Loss of self-confidence .....	0	1	2	3
10. Mental disturbances or personality changes .....	0	1	2	3
11. Prone to high blood pressure .....	0	1	2	3
12. Diabetic tendencies.....	0	1	2	3
13. Decreased appetite.....	0	1	2	3
14. Food cravings.....	0	1	2	3
15. Facial and back pain .....	0	1	2	3
16. Allergic tendencies.....	0	1	2	3
17. Eat unwashed produce at home.....	0	1	2	3
18. Eat lake fish.....	0	1	2	3
19. Do you use makeup? .....	No		Yes	
20. Do you live in an industrialized area? .....	No		Yes	
21. Do you use fabric softener? .....	No		Yes	
22. Do you have more than 6 fillings in your mouth or presence of crowns that may cap amalgam fillings? .....	No		Yes	
23. Do you eat more than 1 can of tuna a week?.....	No		Yes	

---

Section F

1. High blood pressure.....	0	1	2	3
2. Irregular heartbeat .....	0	1	2	3
3. Irritability.....	0	1	2	3
4. Nausea or vomiting.....	0	1	2	3
5. Convulsions.....	0	1	2	3
6. Tremors .....	0	1	2	3
7. Ringing sound in ears.....	0	1	2	3
8. Frequent urination .....	0	1	2	3
9. Underweight or difficulty gaining weight .....	0	1	2	3

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Section G

1. High blood pressure.....	0	1	2	3
2. Shingles or Hives.....	0	1	2	3
3. Anemia.....	0	1	2	3

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Section H

1. Discoloration of teeth (whitish, yellowish, or brownish mottling) .....	0	1	2	3
2. Pitting of teeth.....	0	1	2	3
3. Pain and aching of bones and spine.....	0	1	2	3
4. Nausea or vomiting.....	0	1	2	3

---

Section I

1. Excitement .....	0	1	2	3
2. Confusion .....	0	1	2	3
3. Depression.....	0	1	2	3
4. Muscle twitching .....	0	1	2	3
5. Spasmodic muscle contractions.....	0	1	2	3
6. Abdominal cramps.....	0	1	2	3
7. Palpitations.....	0	1	2	3
8. Rapid breathing .....	0	1	2	3

---

Section J

1. High blood pressure.....	0	1	2	3
2. Migraine headaches .....	0	1	2	3
3. Stools dry or shrunken .....	0	1	2	3
4. Excess fluid retention or edema .....	0	1	2	3
5. Stomach ulcers .....	0	1	2	3
6. Convulsions or seizures.....	0	1	2	3

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Section K

1. Muscle soreness after moderate exercise.....	0	1	2	3
2. Loss of muscle tone or "heaviness" in arms or legs.....	0	1	2	3
3. Enlarged heart and/or heart failure.....	0	1	2	3
4. Pulse slow (below 65) or irregular pulse.....	0	1	2	3
5. Susceptibility to insect bites (especially fleas and mosquitoes).....	0	1	2	3
6. Worrier, feel insecure and/or highly emotional.....	0	1	2	3

---

Section L

1. Excess fluid retention (edema) in extremities.....	0	1	2	3
2. Frequent nausea or dizziness.....	0	1	2	3
3. Cataracts.....	0	1	2	3
4. Cuticles tear easily.....	0	1	2	3
5. Lowered resistance to infection.....	0	1	2	3
6. Anemia.....	0	1	2	3
7. Poor coordination.....	0	1	2	3
8. Overall weakness.....	0	1	2	3
9. Muscle wasting.....	0	1	2	3
10. Impaired growth.....	0	1	2	3
11. Low hormone levels.....	0	1	2	3
12. Premature aging.....	0	1	2	3