HEALTH HISTORY

Name _____ Date of Birth _____ Today's Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit Date began

_____ _____

_____ _____

Date of last physical exam _____ Practitioner name and phone number_____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis)

_____

Outcome _____

What types of therapy have you tried for this problem(s):

❑ diet modification ❑ fasting ❑ vitamin/mineral ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs

❑ other _____

List current health problems for which you are being treated: _____

_____

Current medications (prescription or over-the-counter): _____

_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Operation, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right Your weight today _____

❑ Unintentional weight loss or gain of 10 pounds or more in the last three months

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)

_____

❑ Corrective lenses ❑ Dentures ❑ Hearing aid ❑ Medical devices/prosthetics/implants, describe: _____

Recent changes in your ability to: ❑ see ❑ hear ❑ taste ❑ smell ❑ feel hot/cold sensations

❑ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Strong dislike for any one of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Do you: ❑ Prefer warmth (i.e., food, drinks, weather etc.) ❑ Prefer cold (i.e., food, drinks, weather, etc.) ❑ No preference

Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

Time of day you feel the most energy or the least symptoms:

❑ 7 a.m. - 9 a.m. ❑ 9 a.m. - 11 a.m. ❑ 11 a.m. - 1 p.m.
❑ 1 p.m. - 3 p.m. ❑ 3 p.m. - 5 p.m. ❑ 5 p.m. - 7 p.m.
❑ 7 p.m. - 9 p.m. ❑ 9 p.m. - 11 p.m. ❑ 11 p.m. - 1 a.m.
❑ 1 a.m. - 3 a.m. ❑ 3 a.m. - 5 a.m. ❑ 5 a.m. - 7 a.m.

Time of day you feel the worst or your symptoms are aggravated:

❑ 7 a.m. - 9 a.m. ❑ 9 a.m. - 11 a.m. ❑ 11 a.m. - 1 p.m.
❑ 1 p.m. - 3 p.m. ❑ 3 p.m. - 5 p.m. ❑ 5 p.m. - 7 p.m.
❑ 7 p.m. - 9 p.m. ❑ 9 p.m. - 11 p.m. ❑ 11 p.m. - 1 a.m.
❑ 1 a.m. - 3 a.m. ❑ 3 a.m. - 5 a.m. ❑ 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERYDAY?

❑ Debilitating fatigue	❑ Shortness of breath	❑ Insomnia	❑ Constipation	❑ Chronic pain/inflammation
❑ Depression	❑ Panic attacks	❑ Nausea	❑ Fecal incontinence	❑ Bleeding
❑ Disinterest in sex	❑ Headaches	❑ Vomiting	❑ Urinary incontinence	❑ Discharge
❑ Disinterest in eating	❑ Dizziness	❑ Diarrhea	❑ Low grade fever	❑ Itching/rash

Medical History

- ❑ Arthritis
- ❑ Allergies/hayfever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other _____

_____

Medical (Men)

- ❑ BPH
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ STD

Other _____

_____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ PMS
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ STD

Other _____

Age of first period _____

Date of last gynecological exam ____

Mammogram ❑ + ❑ –

PAP ❑ + ❑ –

Form of birth control _____

# of children _____

# of pregnancies _____

❑ C-section _____

- ❑ Surgical menopause
- ❑ Menopause

Date of last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Health History (parents and siblings)

- ❑ Arthritis, rheumatoid
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other _____

Health Habits

❑ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

❑ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

❑ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine: #cans/d _____

Other sources _____

❑ Water: #glasses/d_____

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk
- ❑ Run, jog, jump rope
- ❑ Weight lift
- ❑ Swim
- ❑ Box
- ❑ Yoga

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs

❑ soy ❑ corn ❑ all gluten

Other _____

Food Frequency

Servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

- ❑ Skip breakfast
- ❑ Two meals/day
- ❑ One meal/day
- ❑ Graze (small frequent meals)
- ❑ Food rotation
- ❑ Eat constantly whether hungry or not
- ❑ Generally eat on the run
- ❑ Add salt to food

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source _____
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe _____
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveritrol, etc.)
- ❑ Herbs - teas
- ❑ Herbs - extracts
- ❑ Chinese herbs
- ❑ Ayurvedic herbs
- ❑ Homeopathy
- ❑ Bach flowers
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals (e.g., Ensure)

Other _____

Would you like to:

- ❑ Have more energy
- ❑ Be stronger
- ❑ Have more endurance
- ❑ Increase your sex drive
- ❑ Be thinner
- ❑ Be more muscular
- ❑ Improve your complexion
- ❑ Have stronger nails
- ❑ Have healthier hair
- ❑ Be less moody
- ❑ Be less depressed
- ❑ Be less indecisive
- ❑ Feel more motivated
- ❑ Be more organized
- ❑ Think more clearly and be more focused
- ❑ Improve memory
- ❑ Do better on tests in school
- ❑ Not be dependent on over-the-counter medications like aspirin, Tylenol, Benadryl, sleeping aids, etc.
- ❑ Stop using laxatives or stool softeners
- ❑ Be free of pain
- ❑ Sleep better
- ❑ Have agreeable breath
- ❑ Have agreeable body odor
- ❑ Have stronger teeth
- ❑ Get less colds and flus
- ❑ Get rid of your allergies
- ❑ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

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MET427 7/00

CHIROKINETICS

CULTIVATING YOUR HEALTH POTENTIAL

Dysbiosis Questionnaire

Please read this prior to completing the Patient Response

Dysbiosis refers to the condition where the normal healthy population of beneficial bacteria in the intestines has been disrupted, leaving it open to the overgrowth of yeast, fungi, parasites, and potentially harmful strains of bacteria. This intestinal imbalance in turn adversely effects other important organ systems via toxic stress and interfering with nutrient absorption and utilization.

Please write your name on every sheet.

Use a black marker or a pen (ensure that marker does not go through to the next sheet)

Answer all questions – leave answers blank if you never have the symptoms or if you are unsure.

Please return all sheets even if no answers are required.

Please avoid writing in extra comments or stroking through any sections that are left blank.

Section A - circle the Point Score in that section. Total your score and record it in the box at the end of the section. Then move on to Section B and C and score as directed.

1399 Ygnacio Valley Road, Suite 31 Walnut Creek, CA 94598 925-930-0708 fx 925-930-9921 E-mail drbergman@chirokinetics.com

SECTION A: HISTORY	POINT SCORE
1. Have you taken any tetracycline or any other antibiotics for skin, acne or any thing else for a month or longer?	25
2. Have you, at any time in your life, taken other "broad spectrum" antibiotics for respiratory, urinary or other infections in shorter courses 4 or more times in a 1 year period?	20
3. Have you taken a "broad spectrum" antibiotic — even a single dose?	6
4. Have you, at any time in your life, been bothered by recurrent or persistent prostatitis, vaginitis or other problems affecting your reproductive organs?	25
5. Have you taken birth control pills	
For more than 5 years	25
For more than 2 years	15
For 6 months to 2 years	8
6. Have you been pregnant	
2 or more times	5
1 time	3
7. Have you taken prednisome, Decadron or other cortisone type drugs	
For more than 6 months	25
For more than 2 weeks	15
For 2 weeks or less	6
8. Does exposure to perfumes, insecticides, fabric shop odors and other chemicals provoke	20
Moderate to Severe symptoms	5
Mild symptoms	
9. Are your symptoms worse on damp muggy days or in moldy places?	20
10. Have you had athlete's foot, ring worm, "jock itch" or other chronic fungus infections of the skin or nails?	
Severe / persistent	20
Mild to Moderate	10
11. Do you crave sugar?	10
12. Do you crave breads?	10
13. Do you crave alcoholic beverages?	10
14. Does tobacco smoke really bother you?	10
15. Have you ever had parasite infection, dysentery, or unexplained episode of prolonged diarrhea and or intestinal distress?	15
16. Have you ever consumed chlorinated (or chemically treated) drinking water for 3 or more months?	15
17. Do you consume commercially raised flesh foods (Antibiotic fed) on a regular basis?	15
18. Do you eat processed foods regularly?	20
19. Do you drink coffee or consume alcohol daily?	20
20. Do you have or have you ever had an ulcer, colitis, crohn's disease or diverticulitis?	35
21. Were you breast fed? If No.	35
If yes, but for less than 3 months.	20

Total Score Section A _____

SECTION B: MAJOR SYMPTOMS	POINT SCORE
For each of your symptoms, enter the appropriate figure in the Point Score column:	
If a symptom is occasional or mild = 3pts	
If a symptom is frequent or moderate = 6pts	
If a symptom is severe or disabling = 9pts	
Add total score in the box at the end of this section	
1. Fatigue or lethargy	_____
2. Feeling of being drained	_____
3. Poor memory	_____
4. Feeling "spacey" or "unreal"	_____
5. Depression	_____
6. Numbness, burning or tingling	_____
7. Muscle aches	_____
8. Muscle weakness or paralysis	_____
9. Pain and /or swelling in joints	_____
10. Abdominal pain	_____
11. Constipation	_____
12. Diarrhea	_____
13. Bloating	_____
14. Troublesome vaginal discharge	_____
15. Persistent vaginal burning or itching	_____
16. Prostatitis	_____
17. Impotence	_____
18. Loss of sexual drive	_____
19. Endometriosis	_____
20. Cramps / Menstrual irregularities	_____
21. Premenstrual tension	_____
22. Spots in front of eyes	_____
23. Erratic vision	_____
24. Eczema, dermatitis, psoriasis	_____

Total Score Section B _____

Patient Name_____

1399 Ygnacio Valley Road, Suite 31 Walnut Creek, CA 94598 925-930-0708 fx 925-930-9921 E-mail drbergman@chirokinetics.com

SECTION C: OTHER SYMPTOMS **POINT SCORE**

For each of your symptoms, enter the appropriate figure in the Point Score column:
If a symptom is occasional or mild = 3pts
If a symptom is frequent or moderate = 6pts
If a symptom is severe or disabling = 9pts
Add total score in the box at the end of this section

1. Drowsiness _____
2. Irritability or jitteriness _____
3. Incoordination _____
4. Inability to concentrate _____
5. Frequent mood swings _____
6. Headaches _____
7. Dizziness / loss of balance _____
8. Pressure in head, behind ears or head tingling _____
9. Itching _____
10. Other rashes _____
11. Heartburn _____
12. Indigestion _____
13. Belching and intestinal gas _____
14. Mucus in stools _____
15. Hemorrhoids _____
16. Dry mouth _____
17. Rash or blisters in mouth _____
18. Bad breath _____
19. Nasal congestion or discharge _____
20. Postnasal drip _____
21. Nasal itching _____
22. Sore or dry throat _____
23. Joint swelling or arthritis _____
24. Cough _____
25. Wheezing or shortness of breath _____
26. Pain or tightness of breath _____
27. Urgency or urinary frequency _____
28. Burning on urination _____
29. Failing vision _____
30. Burning or tearing of eyes _____
31. Recurrent infection or fluid in ears _____
32. Ear pain or hearing loss _____

Total Score, Section C _____

GRAND TOTAL SCORE

The Grand Total Score will help you and your physician decide if your health problems are Dysbiosis related.

Scores in women will run higher as 7 items in the questionnaire apply exclusively to women, while only 2 apply exclusively to men.

Scores

Definite Dysbiosis condition
Women - over 180
Men - over 140

Probable Dysbiosis condition
Women - over 120
Men - over 80

Unlikely Dysbiosis condition
Women - less than 60
Men - less than 40

Total Score, Section A _____

Total Score, Section B _____

Total Score, Section C _____

GRAND TOTAL SCORE _____

Patient Name_____

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HEALTH APPRAISAL QUESTIONNAIRE

Name _____ **Date** _____

DIRECTIONS

This questionnaire asks you to assess how you have been feeling **during the last four months**. This information will help to 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. Take all the time you need to complete this questionnaire.

Please circle the number that best describes your symptoms. PLEASE LEAVE THE QUESTION BLANK if you never experience the symptom.

1 = Rarely—symptom is familiar to you but you perceive it as insignificant (monthly or less)

2 = Occasionally—symptom comes and 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 more 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 symptoms require a YES or a NO response. **1 = NO** **8 = YES**

PART I

	Rarely	Occasionally	Often	Frequently
SECTION A				
1. Food repeats on you after you eat	1	2	4	8
2. Excessive burping and belching following meals	1	2	4	8
3. Stomach spasms and cramping during or after eating	1	2	4	8
4. A sensation that food just sits in your stomach creating uncomfortable fullness, pressure and bloating during or after a meal	1	2	4	8
5. Bad taste in your mouth	1	2	4	8
6. Small amounts of food fill you up immediately	1	2	4	8
7. Skip meals or eat erratically because you have no appetite	1	2	4	8
Total points				
SECTION B				
1. Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt	1	2	4	8
2. Feel hungry an hour or two after eating a good-sized meal	1	2	4	8
3. Stomach pain, burning and/or aching over a period of 1-4 hours after eating	1	2	4	8
4. Stomach pain, burning and/or aching relieved by eating food, drinking carbonated beverage, cream or milk, or taking antacids	1	2	4	8
5. Burning sensation in the lower part of your chest, especially when lying down or bending forward	1	2	4	8
6. Painful indigestion even when relaxed or on vacation	1	2	4	8
7. Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache	1	2	4	8
8. Feel a sense of nausea when you eat	1	2	4	8
9. Difficulty or pain when swallowing food or beverage	1	2	4	8
Total points				
SECTION C				
1. When massaging under your rib cage *on your left side*, there is pain, tenderness or soreness	1	2	4	8
2. Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal	1	2	4	8
3. Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement	1	2	4	8
4. Specific foods/beverages aggravate indigestion	1	2	4	8
5. The consistency or form of your stool changes (e.g., from narrow to loose) within the course of a day	1	2	4	8

	Rarely	Occasionally	Often	Frequently
SECTION C *(cont.)*				
6. Stool odor is embarrassing	1	2	4	8
7. Undigested food in your stool	1	2	4	8
8. Three or more large bowel movements daily	1	2	4	8
9. Diarrhea (frequent loose, watery stool)	1	2	4	8
10. Bowel movement shortly after eating (within 1 hour)	1	2	4	8
Total points				
SECTION D				
1. Discomfort, pain or cramps in your colon (lower abdominal area)	1	2	4	8
2. Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas	1	2	4	8
3. Generally constipated (or straining during bowel movements)	1	2	4	8
4. Stool is small, hard and dry	1	2	4	8
5. Pass mucous in your stool	1	2	4	8
6. Alternate between constipation and diarrhea	1	2	4	8
7. Rectal pain, itching or cramping	1	2	4	8
8. No urge to have a bowel movement	1			8
9. An almost continual need to have a bowel movement	1			8
Total points				

PART II

1. When massaging under your rib cage *on your right side*, there is pain, tenderness or soreness	1	2	4	8
2. Abdominal pain worsens with deep breathing	1	2	4	8
3. Pain at night that may move to your back or right shoulder	1	2	4	8
4. Bitter fluid repeats after eating	1	2	4	8
5. Feel abdominal discomfort or nausea when eating rich, fatty or fried foods	1	2	4	8
6. Throbbing temples and/or dull pain in forehead associated with overeating	1	2	4	8
7. Unexplained itchy skin worse at night	1	2	4	8
8. Stool color alternates from clay colored to normal brown	1	2	4	8
9. General feeling of poor health	1	2	4	8

PART II

	Rarely	Occasionally	Often	Frequently
10. Aching muscles not due to exercise	1	2	4	8
11. Retain fluid and feel swollen around the abdominal area	1	2	4	8
12. Reddened skin, especially palms	1	2	4	8
13. Very strong body odor	1	2	4	8
14. Are you embarrassed by your breath?	1	2	4	8
15. Bruise easily	1			8
16. Yellowish cast to eyes	1			8

Total points ____

PART III

SECTION A

1. Feel cold or chilled—hands, feet, all over—for no apparent reason	1	2	4	8
2. Your upper eyelids look swollen	1	2	4	8
3. Muscles are weak, cramp and/or tremble	1	2	4	8
4. Are you forgetful?	1	2	4	8
5. Do you feel like your heart beats slowly?	1	2	4	8
6. Reaction time seems slowed down	1	2	4	8
7. In general, are you disinterested in sex because your desire is low?	1	2	4	8
8. Feel slow-moving, sluggish	1	2	4	8
9. Constipation	1	2	4	8
10. Dryness, discoloration of skin and/or hair	1			8
11. Have you noticed recently that your voice is deepening?	1			8
12. Thick, brittle nails	1			8
13. Weight gain for no apparent reason	1			8
14. Outer third of your eyebrow is thinning or disappearing	1			8
15. Swelling of the neck	1			8

Total points ____

SECTION B

1. Lingering mild fatigue after exertion or stress	1	2	4	8
2. Do you find that you get tired and exhaust very easily?	1	2	4	8
3. Craving for salty foods	1	2	4	8
4. Sensitive to minor changes in weather and surroundings	1	2	4	8
5. Dizzy when rising or standing up from a kneeling position	1	2	4	8
6. Dark bluish or black circles under your eyes	1	2	4	8
7. Have bouts of nausea with or without vomiting	1	2	4	8
8. Catch colds or infections easily	1	2	4	8
9. Wounds heal slowly	1	2	4	8
10. Your body or parts of your body feel tender, sore, sensitive to the touch, hot and/or painful	1	2	4	8
11. Feel puffy and swollen all over your body	1	2	4	8
12. Skin is gradually tanning without exposure to sun or the ingestion of high levels of carotene-rich foods (e.g., daily carrot juice intake) or supplements	1			8

Total points ____

PART IV

	Rarely	Occasionally	Often	Frequently

SECTION A

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

1. A sense of weakness	1	2	4	8
2. A sudden sense of anxiety when you get hungry	1	2	4	8
3. Tingling sensation in your hands	1	2	4	8
4. A sensation of your heart beating too quickly or forcefully	1	2	4	8
5. Shaky, jittery, hands trembling	1	2	4	8
6. Sudden profuse sweating and/or your skin feels clammy	1	2	4	8
7. Nightmares possibly associated with going to bed on an empty stomach	1	2	4	8
8. Wake up at night feeling restless	1	2	4	8
9. Agitation, easily upset, nervous	1	2	4	8
10. Poor memory, forgetful	1	2	4	8
11. Confused or disoriented	1	2	4	8
12. Dizzy, faint	1	2	4	8
13. Cold or numb	1	2	4	8
14. Mild headaches or head pounding	1	2	4	8
15. Blurred vision or double vision	1	2	4	8
16. Feel clumsy and uncoordinated	1	2	4	8

Total points ____

SECTION B

1. Frequent urination day and night	1	2	4	8
2. Unusual thirst—feeling like you can't drink enough water	1	2	4	8
3. Unusual hunger—eating all the time	1	2	4	8
4. Vision blurs	1	2	4	8
5. Feel itchy all over	1	2	4	8
6. Tingling or numbness in your feet	1	2	4	8
7. Sores heal slowly	1	2	4	8
8. Sense of drowsiness, lethargy during the day not associated with missing meals or not sleeping	1	2	4	8
9. 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	1			8
10. Loss of hair on your legs	1			8

Total points ____

PART V

SECTION A

1. Feel jittery	1	2	4	8
2. First effort of the day causes pain, pressure, tightness or heaviness around the chest	1	2	4	8
3. Exhaustion with minor exertion	1	2	4	8
4. Heavy sweating (no exertion, no hot flashes)	1	2	4	8
5. Difficulty catching breath, especially during exercise	1	2	4	8
6. Heart pounding, sensation of heart beating too quickly, too slowly or irregularly	1	2	4	8
7. Swelling in feet, ankles and/or legs comes and goes for no apparent reason	1	2	4	8

Total points ____

PART V

SECTION B

	Rarely	Occasionally	Often	Frequently
1. Muscle pain at rest	1	2	4	8
2. Cramp-like pains in your ankles, calves or legs	1	2	4	8
3. Cold feet and/or toes appear blue	1	2	4	8
4. Brief moments of hearing loss	1	2	4	8
5. Nausea comes and goes quickly unrelated to eating	1	2	4	8
6. Feel worse standing: legs get heavy and fatigued	1	2	4	8
7. Leg discomfort or fatigue relieved by elevating legs	1	2	4	8
8. Fingers and toes numb in cold weather even when protected	1	2	4	8
9. Notice changes in your ability to feel pain or discriminate sensations of hot or cold	1			8
10. Body hair (on arms, hands, fingers, legs and toes) is thinning or has disappeared	1			8
11. Not as coordinated as you used to be	1			8
12. Do you notice a decline in your ability to make decisions, concentrate, focus attention or follow directions?	1			8

Total points ____

PART VI

SECTION A

	Rarely	Occasionally	Often	Frequently
1. Family, friends, work, hobbies or activities you hold dear are no longer of interest	1	2	4	8
2. Do you cry?	1	2	4	8
3. Does life look entirely hopeless?	1	2	4	8
4. Would you describe yourself as feeling miserable and sad, unhappy or blue?	1	2	4	8
5. Do you find it hard to make the best of difficult situations?	1	2	4	8
6. Sleep problems—too much or too little	1	2	4	8
7. Changes in your appetite and weight	1			8
8. Lately you've noticed an inability to think clearly or concentrate	1			8
9. Difficulty making decisions and/or clarifying and achieving your goals	1			8

Total points ____

SECTION B

	Rarely	Occasionally	Often	Frequently
1. Does worrying get you down?	1	2	4	8
2. Does every little thing get on your nerves and wear you out?	1	2	4	8
3. Would you consider yourself a nervous person?	1	2	4	8
4. Do you feel easily agitated?	1	2	4	8
5. Do you shake and tremble?	1	2	4	8
6. Are you keyed up and jittery?	1	2	4	8
7. Do you tremble or feel weak when someone shouts at you?	1	2	4	8
8. Do you become scared at sudden movements or noises at night?	1	2	4	8
9. Do you find yourself sighing a lot?	1	2	4	8
10. Are you awakened out of your sleep by frightening dreams?	1	2	4	8
11. Do frightening thoughts keep coming back in your mind?	1	2	4	8

SECTION B *(cont.)*

	Rarely	Occasionally	Often	Frequently
12. Do you become suddenly scared for no good reason?	1	2	4	8
13. Do you break out in a cold sweat?	1	2	4	8
14. "Butterflies in your stomach", nausea and/or diarrhea	1	2	4	8

Total points ____

SECTION C

1. Do you feel pent up and ready to explode?	1	2	4	8
2. Are you prone to noisy and emotional outbursts?	1	2	4	8
3. Do you do things on impulse?	1	2	4	8
4. Are you easily upset or irritated?	1	2	4	8
5. Do you go to pieces if you don't control yourself?	1	2	4	8
6. Do little annoyances get on your nerves and make you angry?	1	2	4	8
7. Does it make you angry to have anyone tell you what to do?	1	2	4	8
8. Do you flare up in anger if you can't have what you want right away?	1	2	4	8

Total points ____

PART VII

1. Eyes water or tear	1	2	4	8
2. Mucous discharge from the eyes	1	2	4	8
3. Ears ache, itch, feel congested or sore	1	2	4	8
4. Discharge from ears	1	2	4	8
5. Hoarse voice	1	2	4	8
6. Do you have to clear your throat frequently?	1	2	4	8
7. Do you often feel a choking lump in your throat?	1	2	4	8
8. Is your nose continually congested?	1	2	4	8
9. Are you prone to loud snoring?	1			8
10. Does your nose run constantly?	1			8
11. Nosebleeds	1			8
12. Do you suffer from severe colds?	1			8
13. Do frequent colds keep you miserable all winter?	1			8
14. Flu symptoms last longer than 5 days	1			8
15. Do infections settle in your lungs?	1			8
16. Chest discomfort or pain	1	2	4	8
17. Do you experience sudden breathing difficulties?	1	2	4	8
18. Do you struggle with shortness of breath?	1	2	4	8
19. Difficulty exhaling (breathing out)	1	2	4	8
20. Breathlessness followed by coughing during exertion, no matter how slight	1	2	4	8
21. Inability to breathe comfortably while lying down	1	2	4	8
22. Do you cough up lots of phlegm?	1	2	4	8
23. Can you hear noisy rattling sounds when breathing in and out?	1	2	4	8
24. Are you troubled with coughing?	1	2	4	8
25. Do you wheeze?	1	2	4	8
26. Do you have severe soaking sweats at night?	1	2	4	8
27. Do your lips and/or nails have a bluish hue?	1	2	4	8
28. Are you sleepy during the day?	1	2	4	8

PART VII

	Rarely	Occasionally	Often	Frequently
29. Do you have difficulty concentrating?	1	2	4	8
30. Eyes, ears, nose, throat and lung symptoms seem associated with specific foods like dairy or wheat products	1			8
31. Eyes, ears, nose, throat and lung symptoms are associated with seasonal change	1			8

Total points ____

PART VIII

1. Involuntary loss of urine when you cough, lift something or strain during an activity	1	2	4	8
2. Mild lower back ache or pain	1	2	4	8
3. Abdominal achiness or pain	1	2	4	8
4. Pain or burning when urinating	1	2	4	8
5. Rarely feel the urge to urinate	1	2	4	8
6. Feel the need to urinate less than every two hours day or night	1	2	4	8
7. Strong smelling urine	1	2	4	8
8. Back or leg pains are associated with dripping after urination	1	2	4	8
9. Sore or painful genitals	1	2	4	8
10. Urine is a rose color	1	2	4	8
11. Sudden urge to void causes involuntary loss of urine	1	2	4	8
12. Generalized sense of water retention throughout your body	1	2	4	8

Total points ____

PART IX

SECTION A

1. Bones throughout your entire body ache, feel tender or sore	1	2	4	8
2. Localized bone pain	1	2	4	8
3. Hands, feet or throat get tight, spasm or feel numb	1	2	4	8
4. Difficulty sitting straight	1	2	4	8
5. Upper back pain	1	2	4	8
6. Lower back pain	1	2	4	8
7. Pain when sitting down or walking	1	2	4	8
8. Find yourself limping or favoring one leg	1	2	4	8
9. Shins hurt during or after exercise	1	2	4	8

Total points ____

SECTION B

1. Are you stiff in the morning when you wake up?	1	2	4	8
2. Difficulty bending down and picking up clothing or anything from the floor	1	2	4	8
3. Joint swelling, pain or stiffness involving one or more areas (fingers, hands, wrists, elbows, shoulders, toes, arches, feet, ankles, knees, ankles)	1	2	4	8
4. Joints hurt when moving or when carrying weight	1	2	4	8
5. A routine exercise program, like daily walking, causes your knees to swell or hurt	1	2	4	8
6. Difficulty opening jars that were previously easy to open	1	2	4	8
7. Discomfort, numbness, prickling or tingling sensation, or pain in neck, shoulder or arm	1	2	4	8

	Rarely	Occasionally	Often	Frequently
SECTION B *(cont.)*				
8. Intermittent pain or ache on one side of head spreading to cheek, temple, lower jaw, ear, neck and shoulder	1	2	4	8
9. Difficulty chewing food or opening mouth	1	2	4	8
10. Difficulty standing up from a sitting position	1	2	4	8
11. Shooting, aching, tingling pain down the back of leg	1	2	4	8
12. Is it difficult to reach up and get a 5-pound object like a bag of flour from just above your head?	1			8
13. Injure, strain or sprain easily	1			8

Total points ____

SECTION C

1. Muscles stiff, sore, tense and/or ache	1	2	4	8
2. Burning, throbbing shooting or stabbing muscle pain	1	2	4	8
3. Muscle cramps or spasms (involuntary, after exertion/exercise)	1	2	4	8
4. Is muscle pain or stiffness greater in the morning than other times of the day?	1	2	4	8
5. Specific points on body feel sore when pressed	1	2	4	8
6. Feel unrefreshed upon awakening	1	2	4	8
7. Headaches	1	2	4	8
8. Pain at the sides of your head or in your face especially when awakening	1	2	4	8
9. Your jaw clicks or pops	1	2	4	8
10. Muscle twitch or tremor—eyelids, thumb, calf muscle	1	2	4	8
11. Irresistible urge to move legs	1	2	4	8
12. Legs move during sleep	1	2	4	8
13. Unpleasant crawling sensation inside calves when lying down	1	2	4	8
14. Hand and wrist numbness or pain (e.g., interferes with writing, buttoning or unbuttoning your clothes)	1	2	4	8
15. Feeling of "pins and needles" in your thumb and first three fingers	1	2	4	8
16. Pain in forearm and sometimes in shoulder	1	2	4	8

Total points ____

PART X

SECTION A

1. Head feels heavy	1	2	4	8
2. Dizziness	1	2	4	8
3. Difficulty bending over, standing up from sitting, rolling over in bed and/or turning your head from side to side	1	2	4	8
4. Your hands tremble, ever so slightly, for no apparent reason	1	2	4	8
5. When walking you feel like you're wearing heavy weights on your feet	1	2	4	8
6. Bump into things, trip, stumble and feel clumsy	1	2	4	8
7. Difficulty breathing	1	2	4	8
8. Difficulty swallowing	1	2	4	8
9. People tell you to speak up because they have trouble hearing you	1	2	4	8
10. Speaking and forming words does not feel automatic	1	2	4	8
11. Need 10-12 hours of sleep to feel rested	1	2	4	8

PART X

	Rarely	Occasionally	Often	Frequently
SECTION A *(cont.)*				
12. Lack strength (your grip is weak, holding your head or picking your arms up takes effort)	1	2	4	8
13. Hands get tired when you write and your handwriting is less legible and smaller than it used to be	1			8
14. Muscles in arms and legs seem softer and smaller	1			8
15. Is your eyesight, sense of smell and taste or ability to hear not as sharp as it used to be?	1			8
16. Do you find yourself moving slower than you used to?	1			8
Total points				
SECTION B				
1. Difficulty absorbing new information	1	2	4	8
2. Tend to forget things	1	2	4	8
3. Trouble thinking or concentrating	1	2	4	8
4. Easily distracted	1	2	4	8
5. Do you have a tendency to become frustrated quickly?	1	2	4	8
6. Inability to sit still for any length of time, even at mealtime	1	2	4	8
7. Finishing tasks is easier said than done	1	2	4	8
8. Do you have more trouble solving problems or managing your time than usual?	1	2	4	8
9. Low tolerance for stress and otherwise ordinary problems	1	2	4	8
Total points				

PART XI

Men Only

1. Sensation of not emptying your bladder completely	1	2	4	8
2. Need to urinate less than 2 hours after you have finished urinating	1	2	4	8
3. Find yourself needing to stop and start again several times while urinating	1	2	4	8
4. Find it difficult to postpone urination	1	2	4	8
5. Have a weak urinary stream	1	2	4	8
6. Need to push or strain to begin urinating	1	2	4	8
7. Dripping after urination	1	2	4	8
8. Urge to urinate several times a night	1	2	4	8
Total points				

PART XII

Women Only

(Menopausal women should skip to Sections E and F)

	Rarely	Occasionally	Often	Frequently
SECTION A				
Do you experience any of these symptoms within three days to two weeks *prior to menstruation?*				
[A]				
1. Anxious, irritable or restless	1	2	4	8
2. Numbness, tingling in hands and feet	1	2	4	8
3. Easy to anger, resentful	1	2	4	8
4. Aggressive or hostile toward family/friends	1	2	4	8
SECTION A *(cont.)*				
[B]				
5. Abdominal bloating, feeling swollen (e.g., feet)	1	2	4	8
6. Temporary weight gain	1	2	4	8
7. Breast tenderness, swelling	1	2	4	8
8. Appearance of breast lumps	1	2	4	8
9. Discharge from nipples	1	2	4	8
10. Nausea and/or vomiting	1	2	4	8
11. Diarrhea or constipation	1	2	4	8
12. Aches and pains (back, joints, etc.)	1	2	4	8
[C]				
13. Craving for sweets	1	2	4	8
14. Increased appetite or binge eating	1	2	4	8
15. Headaches				
16. Being easily overwhelmed, shaky or clumsy	1	2	4	8
17. Heart pounding	1	2	4	8
18. Dizziness or fainting	1	2	4	8
[D]				
19. Confused and forgetful to the point that work suffers	1	2	4	8
20. Overwhelmed with feelings of sadness and worthlessness	1	2	4	8
21. Difficulty sleeping or falling asleep	1	2	4	8
22. Engaging in self destructive behavior	1	2	4	8
Total points				
SECTION B				
Do you experience any of these symptoms *during your period?*				
1. Cramping in lower abdomen or pelvic area	1	2	4	8
2. Pain is sharp and/or dull or intermittent	1	2	4	8
3. Bloating and sense of abdominal fullness	1	2	4	8
4. Diarrhea or constipation	1	2	4	8
5. Nausea and/or vomiting	1	2	3	4
6. Low back and/or legs ache	1	2	4	8
7. Headaches	1	2	4	8
8. Unusual fatigue (take naps) resulting in missed work	1	2	4	8
9. Painful and/or swollen breasts	1	2	4	8
10. Scanty blood flow	1	2	4	8
Total points				
SECTION C				
1. Painful or difficult sexual intercourse	1	2	4	8
2. Low abdominal pain throughout the month	1	2	4	8
3. Low back ache or pain throughout the month	1	2	4	8
4. Pelvic pressure or pain while sitting down or standing up, relieved by lying down	1	2	4	8
5. Painful bowel movements	1	2	4	8
6. Constipated or difficult bowel movements	1	2	4	8
7. Rectal pain	1	2	4	8
8. Painful or difficult (straining) urination	1	2	4	8
9. Abnormal vaginal discharge	1	2	4	8
10. Offensive vaginal discharge	1	2	4	8
11. Vaginal itching or burning with or without intercourse	1	2	4	8
12. Pain during periods is getting progressively worse	1			8
Total points				

PART XII

SECTION D

	Rarely	Occasionally	Often	Frequently
1. Absence of periods for six months or longer	1			8
2. Periods occur irregularly (e.g., 3 to 6 times a year)	1			8
3. Profuse heavy bleeding during periods	1	2	4	8
4. Menstrual blood contains clots and tissue	1	2	4	8
5. Bleeding between periods can occur anytime	1	2	4	8
6. Menstrual bleeding at cycles greater than every 35 days	1			8
7. Intense upper stomach pain, lasting several hours at the time you ovulate (approximately day 14 of your cycle)	1	2	4	8
8. Bleeding occurs at ovulation (approximately day 14 of your cycle)	1	2	4	8
9. Monthly abdominal pain without bleeding	1	2	4	8
10. Abundant cervical mucous	1	2	4	8
11. Acne and/or oily skin	1	2	4	8
12. Overwhelming urges for sexual intercourse	1	2	4	8
13. Aggressive feelings	1	2	4	8
14. Increased growth of dark facial and/or body hair	1			8
15. Poor sense of smell	1			8
16. Voice is becoming deeper	1			8
17. Breasts seem to be getting smaller	1			8
18. Pain during periods is getting progressively worse	1			8

Total points ____

SECTION E

	Rarely	Occasionally	Often	Frequently
1. Urinary problems	1	2	4	8
2. Vaginal discharge	1	2	4	8
3. Vaginal secretions are watery and thin	1	2	4	8
4. Vaginal dryness	1	2	4	8
5. Sexual intercourse is uncomfortable	1	2	4	8

SECTION E *(cont.)*

	Rarely	Occasionally	Often	Frequently
6. Interest in having sex is low	1	2	4	8
7. Engorged breasts	1	2	4	8
8. Breast tenderness, soreness	1	2	4	8
9. Difficulty with orgasm	1	2	4	8
10. Vaginal bleeding after sexual intercourse	1	2	4	8
11. Occasionally skip periods	1	2	4	8
12. The length (number of days) of your period varies month to month, with the number of days of bleeding getting less	1			8

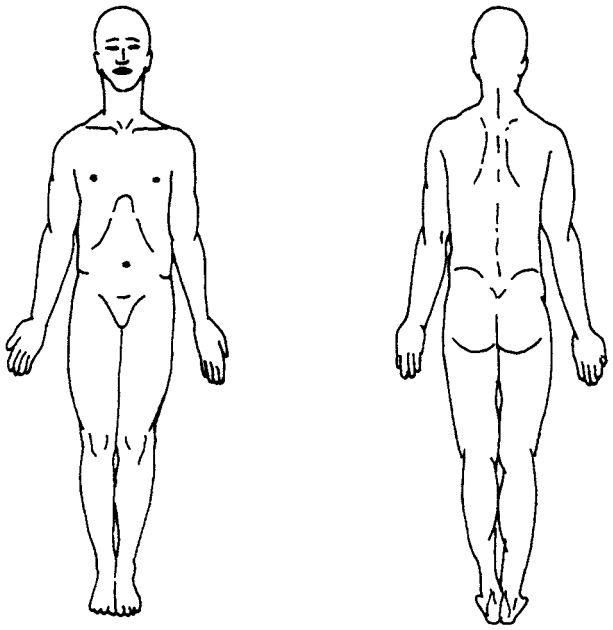
Total points ____

SECTION F

	Rarely	Occasionally	Often	Frequently
1. Sense of well-being fluctuates throughout the day for no apparent reason	1	2	4	8
2. Sudden hot flashes	1	2	4	8
3. Spontaneous sweating	1	2	4	8
4. Chills	1	2	4	8
5. Cold hands and feet	1	2	4	8
6. Heart beats rapidly or feels like it is fluttering	1	2	4	8
7. Numbness, tingling or prickling sensations	1	2	4	8
8. Dizziness	1	2	4	8
9. Mental fogginess, forgetful, distracted	1	2	4	8
10. Inability to concentrate	1	2	4	8
11. Depression, anxiety, nervousness and/or irritability	1	2	4	8
12. Difficulty sleeping	1	2	4	8
13. Conscious of new feelings of anger and frustration	1	2	4	8
14. Skin, hair, vagina and/or eyes feel dry	1	2	4	8
15. Stopped menstruating around six months ago, yet still experience some vaginal bleeding	1			8

Total points ____

Please mark an "X" to indicate areas where you feel pain, swelling or discomfort, or areas of your skin that have changed color or texture (e.g., moles, rashes, etc.). Describe what you feel or observe in your own words. Write anywhere in this area.



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Name: _____

DIET ACTIVITY REPORT

Please take the time to complete the following survey carefully and accurately. List in detail the quantity and the exact nature of all foods consumed (i.e. frozen, canned, etc.). Please mention how the foods were prepared (i.e. raw, baked, fried). Be sure to list all beverages, all fats or oils and any condiments used (i.e. mayonnaise, mustard, relish, etc.). Please complete the exercise activity portion at the bottom as well, listing the type of exercise, its duration and your pulse before and during exercising. Also record any periods of relaxation.

ACTIVITY	**DAY 1** **DATE** **WEEK:**
Morning Meal time:	
Snack	
Noon Meal time:	
Snack	
Evening Meal time:	
Snack	
Water (cups per day)	
Additional Beverages	
Fats/Oils	
Condiments (sugar/salt/ spices/herbs etc.)	
Exercise Type: Duration: Pulse before: Pulse During:	
Relaxation Type: Duration:	

ACTIVITY	DAY 2 DATE WEEK:	DAY 3 DATE WEEK:
Morning Meal time:		
Snack		
Noon Meal time:		
Snack		
Evening Meal time:		
Snack		
Water (cups per day)		
Additional Beverages		
Fats/Oils		
Condiments (sugar/salt/ spices/herbs etc.)		
Exercise Type: Duration: Pulse before: Pulse During:		
Relaxation Type: Duration:		

ACTIVITY	DAY 4 DATE WEEK:	DAY 5 DATE WEEK:
Morning Meal time:		
Snack		
Noon Meal time:		
Snack		
Evening Meal time:		
Snack		
Water (cups per day)		
Additional Beverages		
Fats/Oils		
Condiments (sugar/salt/ spices/herbs etc.)		
Exercise Type: Duration: Pulse before: Pulse During:		
Relaxation Type: Duration:		

ACTIVITY	DAY 6 DATE WEEK:	DAY 7 DATE WEEK:
Morning Meal time:		
Snack		
Noon Meal time:		
Snack		
Evening Meal time:		
Snack		
Water (cups per day)		
Additional Beverages		
Fats/Oils		
Condiments (sugar/salt/ spices/herbs etc.)		
Exercise Type: Duration: Pulse before: Pulse During:		
Relaxation Type: Duration:		

WOMEN HORMONE BALANCE TEST

Read carefully through the list of symptoms in each group, and put a check mark next to each symptom that you have. (If you cheek off the same symptom in more than one group, that's fine.)

SYMPTOMS GROUP 1	
☐ PMS	☐ Insomnia
☐ Early Miscarriage	☐ Painful and / or lumpy breasts
☐ Unexplained weight gain	☐ Cyclical Headaches
☐ Anxiety	☐ Infertility
	TOTAL BOXES CHECKED

SYMPTOMS GROUP 2	
☐ Vaginal Dryness	☐ Night Sweats
☐ Painful Intercourse	☐ Memory Problems
☐ Bladder Infections	☐ Lethargic Depression
☐ Hot Flashes	TOTAL BOXES CHECKED

SYMPTOMS GROUP 3	
☐ Puffiness and Bloating	☐ Cervical Dysplasia (abnormal pap smear)
☐ Rapid Weight Gain	☐ Breast Tenderness
☐ Mood Swings	☐ Heavy Bleeding
☐ Anxious Depression	☐ Migraine Headaches
☐ Insomnia	☐ Foggy Thinking
☐ Red flush on face	☐ Gallbladder Problems
☐ Weepiness	TOTAL BOXES CHECKED

SYMPTOMS GROUP 4	
☐ A combination of the symptoms in #1 and #3	TOTAL BOXES CHECKED

SYMPTOMS GROUP 5	
☐ Acne	☐ Polycystic Ovary Syndrome (PCOS)
☐ Excessive hair on the Face and Arms	☐ Dysglycemia and/or unstable Blood Sugar
☐ Thinning Hair on the Head	☐ Infertility
☐ Ovarian Cysts	☐ Mid-Cycle Pain
	TOTAL BOXES CHECKED

SYMPTOMS GROUP 6	
☐ Debilitating fatigue	☐ Unstable Blood Sugar
☐ Foggy Thinking	☐ Low Blood Pressure
☐ Thin and/or Dry Skin	☐ Intolerance to Exercise
☐ Brown Spots on Face	TOTAL BOXES CHECKED