Richard Grossman, L.Ac., O.M.D., Ph.D.

530 Wilshire Blvd., $206
Santa Monica, CA 90401
310.293.9475
e-mail: acudoc@acudoc.com
http://acudoc.com

Welcome,

As a doctor and healer, I have four basic concerns. First, how can I best help you find relief from your pain or illness. Second, what are the cause or causes of the problem for which you are seeking help. Third, how to correct the underlying imbalances that led to your being ill or in pain. Fourth, what are the practices and lifestyle changes I can coach you in that will maintain the good health you will have achieved through the care you are about to receive.

To assist me in this process, I use the forms that follow this note. They are:

1. Context of Care Overview,
2. A complete medical history, and
3. The Health Appraisal Questionnaire.

To make certain your answers are complete, accurate and thoughtful, you will need to set aside some time when you will not be disturbed. Be assured that there is not a single question on these forms that is not there for a specific reason serving a vital purpose. Upon completion, please mail the forms to my office.

I understand that filling out these forms is challenging. If you find yourself overwhelmed and unable to complete them, please contact me at the above number.

For our first meeting or telephone consultation together please bring (or mail to me at the above address) copies of any recent test results (ask your doctors for copies). Also, if you will be seeing me in the office, please bring any nutritional supplements, herbs, vitamins, or other medications you are currently taking. If you are having a telephone consultation with me, please also send me a recent Polaroid photo of yourself against a plain background.

I look forward to assisting you.

Sincerely yours,

Richard Grossman, L.Ac., O.M.D., Ph.D.

My highest professional value is contributing and assisting in the transformation of humanity into more conscious, healthy, compassionate, and whole beings.

To do this, I employ a threefold process in my medical practice:

- First. to remove pain and relieve symptoms.

- Second. to correct the underlying imbalances in a person, be they physical, chemical, nutritional, emotional, spiritual, or ethical.

- Third, to assist and educate a person in living their newfound life, maintaining their optimal level of health, and guiding them in a spirit of cooperation and wellness.

To achieve this, I maintain my own life with the highest degree of spiritual growth, integrity, love for and from both my blood family and my extended family of friends and patients. I recognize that I must practice what I teach, so I maintain myself at the top of my profession by continual study and learning, and by total pragmatism for the direction of health care my patients need.

The success of my patients, and the quality of service I provide them is of the utmost importance. I am here for the long haul for my patients.

Further, I am committed to creating an environment where people can come and find a moment of true sanity in an increasingly insane world, be that in my office, my home, or a place of spiritual and physical retreat.

COMPREHENSIVE NEW PATIENT INTAKE

Date: _____

Full name: _____

Social Security #: _____ Drivers Lic. _____

Home Address: _____ City: _____ State: _____ Zip: _____

Birth date: _____ Age: _____ Sex: _____ Marital status: _____

Occupation: _____ Employed by: _____

Business address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Business phone: _____ Ext. _____

Fax: _____ E-Mail Address _____

Name of spouse: _____ Employed by: _____

Address: _____ City: _____ State: _____ Zip: _____

Nearest relative not living with you: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Who may we thank for referring you to our office? _____

Person responsible for account: _____

Is your condition due to an accident or to an illness? _____ Date of onset: _____

If you had an accident, where and how did it occur? _____

Signature of patient or legal guardian: _____ Date: _____

Health insurance is a method of reimbursing the patient for fees paid to the doctor. It is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay for services when received. You will be given a receipt that you may submit directly to your insurance company. Your insurance company will then pay you for any amounts they cover. We are not able to bill the insurance companies for you.

Overview

1. Please tell me what is bothering you. If this involves a specific health condition or illness, please tell me about it in as much detail as possible. List the very first time that you noticed the condition and describe carefully any factors that you think may have played a role in its onset and progression. (Please attach a sheet if more space is required).

2. Is your health currently getting better, worse, or staying the same. How do you know?

3. What have you tried to do to improve your state of health (e.g. other doctors, treatments, etc)?

4. Please list the 5 most significant stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.

5. Please list any other health concerns/conditions, which you are aware of even if you think they may not be important.

CONTEXT OF CARE OVERVIEW

Why did you choose to see me?

For our time together to be a true win for you, what do you want to take place over the course of your care here?

How long do you feel this will take?

Do you think the pain and/or illness that you are experiencing could be purposeful? That is, could they be your body's wisdom saying, "I need some help... let's change some things here!"

Do you feel your pain and/or illness is a reflection of short-term superficial circumstances or longer term, potentially deeper seated challenges? (Please circle your inclination here.)

What are the areas of your lifestyle that you would like to improve:
(Circle, then prioritize # l, 2, 3, etc.)

My level of anxiety
My pace of living
Not enough quiet time and rest
My diet and nutrition program
My exercise program
Time spent in nature
My creative expression
My feelings around career
My social and family life
My communication skills

Please list any self-destructive lifestyle habits (e.g. smoking, lack of exercise, addictions, etc.)

What might it cost you if you don't significantly improve your lifestyle and any underlying contributors to compromised health? (e.g. Percentage of vitality and/or longevity, percentage of joy, happiness, peace of mind, future physical independence, current and/or future relationships, career effectiveness, etc.)

What is your present level of commitment to address any underlying causes of problem(s) which relate to your lifestyle? (Rate from 1 to 10, with 10 being 100**%** committed).

Reflect on your highest priorities in life and list the top 3 which come to your mind and speak to your heart. Where does your health and vitality factor in?

What potential obstacles do you foresee in changing the lifestyle factors that are undermining your health and in following the therapeutic protocols that we will be giving you?

Having a support team while undergoing lifestyle changes is important. Who do you know who would like to help you achieve your health goals?

HEALTH HISTORY

Please answer the questions below and use the back for more details if necessary.
All answers are absolutely confidential.

Present complaint: _____
When did you first notice your problem?_____
_____
No. of children:_____ages: _____
Occupation:_____
Religion (optional) _____
Are you exposed to toxic chemicals? _____
If yes, which ones?_____
_____
_____

Other health care providers you are seeing, and their specialty:_____
_____
_____
_____
_____
What diagnosis('s) were you given: _____
_____
_____
_____

Women only:

Age at onset of menstruation: _____ Number of children: _____
No. of miscarriages/c-sections: _____ Age at onset of menopause: _____

How was your health as a child? (circle one): excellent good fair poor

Were there any complications with your delivery? Please explain:_____

Were you breast fed?_____ How long? _____

Did you have any serious emotional or mental traumas as a child? Please explain:_____

Check diseases for which you have been immunized:

☐ measles ☐ mumps ☐ rubella ☐ small pox ☐ influenza ☐ tetanus ☐ diphtheria ☐other

What is your blood type? (circle one): **A B AB O don't know**

Serious Illnesses / Injuries / Surgeries	Date	Outcome

✓	Allergies / Sensitivities (Please Specify)	Typical Reaction
	Animal hair/dander:	
	Chemicals:	
	Drugs, medications:	
	Dust, molds:	
	Food:	
	Grasses, weeds, pollen:	
	Others:	

Tests History

Please list date of most recent procedures. Please circle any tests that were abnormal.

Test	Year	Test	Year	Test	Year	Test	Year
Chest x-ray		TB Test		Pap Smear		Others:	
Kidney x-ray		EKG		Mammogram			
G.I. Series		MRI		Sigmoidoscopy			
Colon x-ray		CAT Scan		Rectal Exam			
Spine x-ray		Cardiac Stress Test		PSA			
Blood Tests		Cholesterol		Complete Physical Exam			

Health Habits (Please print clearly)

Please list all supplements / herbs / homeopathics you are currently taking (attach a separate sheet or use the back if necessary):

Type (include brand name)	**Dosage**

Please circle any of the following medications you are currently taking or have recently taken.

Allergy medication
Antacids
Anti-inflammatory
Antibiotic /Anti-fungal
Antidepressants
Antidiabetic/insulin
Aspirin/Tylenol / Advil
Chemotherapy
Cortisone
Heart Medications
High Blood Pressure
Hormones
Laxatives
Lithium
Oral Contraceptives
Pain Medication
Radiation
"Recreational" Drugs
Relaxants
Sleeping Pills
Thyroid
Ulcer Medication
Other _____

_____

_____

Do you:
(Circle day or week, as appropriate)

Use tobacco _____cigarettes per day How Many Years?_____
Drink coffee _____cups per day
Drink black tea _____cups per day
Drink alcohol _____cups per day
Drink cola drinks _____cups per day
Use artificial sweeteners _____packets per day
Use margarine _____pats per day

How many times a week do you eat in a restaurant? Breakfast_____ Lunch_____ Dinner_____

What types of restaurants?_____

What are your favorite foods: _____

Do you crave sweets?_____ At what time?:_____ Do you salt your food at the table: _____

Are there other foods you crave? (Please Circle) Bread Pasta Dairy Meat Other: _____

What foods do you <u>really</u> dislike: _____

Are you on any specific diet? If so, please specify: _____

Would you like to increase or decrease your weight? If so, by how much: _____

When did you last have a significant (more than 10 pounds) change in weight? _____

What exercise do you do and how often: _____

How many hours of sleep do you get each night? _____ Do you wake rested? _____

Are you presently sexually active? _____ Any difficulties? _____ Method of birth control: _____

Rate your current stress level from 1-10: _____ How much does this affect you (1-10): _____

What are the major stress factors in your life now: _____

Please rate your current emotional health (please circle): excellent good fair poor unstable crisis

Are you currently in psychotherapy?_____ Do you have a good support network/team? _____

Does your home environment have a supportive effect on your health? _____

How many hours of free time (not including sleep) do you give yourself during the work week: _____

During weekends: _____ Favorite recreational activities:_____

When was your last eye exam?_____ Do you wear contacts?_____ Hard or soft? _____

Do you drink purified or bottled water? _____If so, what brand do you use? _____

Do you have an air purifier in the room you sleep in?_____ What brand?_____

Do you have amalgam (silver) fillings?_____ Any other dental problems? _____

Do you make an effort to eat organically grown foods?_____ What % of your diet? _____

Are you on a restricted diet do to religious or other beliefs (e.g. Halaal, Hindu, Kosher, Vegan, etc.?

Please explain: _____

Are you considering any elective surgery or medical procedures in the near future: _____

Family Health History

Relation	Age	State Of Health (if living)	Age At Death	Cause of Death	Check (✓) if your blood relatives have/had		
						Disease	Relationship
Father						Arthritis, gout	
Mother						Asthma, hay fever	
Brothers						Cancer	
						Chemical dependency	
						Diabetes	
						Heart disease, stroke	
Sisters						High blood pressure	
						Syphilis, gonorrhea	
						Tuberculosis	
						Other	

Diet Survey

Please list everything you eat and drink for 2-3 days.

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

Informed Consent For Acupuncture Treatment And Care
(The lawyers made me do it)

I hereby request and consent to the performance of acupuncture and/or other Oriental Medicine or nutritional procedures including various modes of physiotherapy on me (or on the patient named below, for whom I am legally responsible) by Richard Grossman, Lic.Ac., O.M.D., Ph.D. (hereafter known as "the doctor"). and/or other licensed acupuncturists or other therapists who now or in the future treat me while employed by, working or associated with or serving as a back-up for the doctor, including those working at this office/clinic or any other office or clinic.

I understand that methods of treatment may include, but are not limited to, acupuncture (the insertion of very fine, sterile needles into specific points on the body), moxibustion (the heating of specific points on the body with burning herbs), cupping (the application of vacuum devices to areas of the body), *Gwa Saa* (gently rubbing lubricated skin with a special implement) electrical stimulation, *Tui-Na* (a type of Chinese massage) *Shiatsu*, deep tissue massage, Chinese or Western herbal medicine, nutritional consulting, and/or life-style counseling.

I have had the opportunity to discuss with the doctor or his staff the nature and purpose of acupuncture treatments and other procedures that may be utilized in my treatment.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases, injury, or dysfunction of the body. I have been informed that acupuncture is a very safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that may last several days. There have been very rare instances reported of fainting, infections and scarring. There have been very rare instances of minor burns from moxibustion. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There will likely be temporary bruising or skin discoloration after cupping and *Gwa Saa*.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommenced are traditionally considered safe in the practice of natural medicine. I understand that some herbs may be inappropriate during pregnancy, and I will inform the acupuncturist if I am pregnant or am planning on getting pregnant in the near future. If I experience any gastro-intestinal upset or allergic reactions to the supplements I will immediately inform the doctor, or his employees.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I understand that in certain conditions the administration of diagnostic palpation and/or the above mentioned treatments may occur in areas of my body near to (but not directly on) sexual organs. I understand that the doctor will, upon my request, immediately have a staff member of my gender observe the treatment and/or diagnostic palpation.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released to anyone without my prior written consent.

I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient or by the patient's representative if the patient is a minor or is physically or legally incapacitated:

Name of Patient: _____

Patient's or Patient's representative signature: _____

Relationship of Representative:_____

Health Assessment Questionnaire Instructions

The following questionnaire is designed to give us a very thorough assessment of your nutritional strengths and weaknesses.

Please fill out the following questionnaire according to these instructions.

1. Carefully and completely fill in the circle which best fits the frequency of your symptoms.

2. Use a black non-bleeding marker. Do not use pencil. This may result in our computer inaccurately scoring your responses.

3. Fill only one circle per question. If you make a mistake either use white out, or let us know when you turn in your form. That way we can be sure your form will be scored correctly

4. If you have any comments about a question, please write them on a separate sheet of paper. Writing on the questionnaire will make it impossible for our computer to process it correctly.

5. Some questions are asked more than one time. This is done for a reason. Each section of the questionnaire is related to a different part of your body and any given symptom you have may show difficulties in more than one area of your body.

6. Please note. On Part 12 section B, answer questions with "0" being very dissatisfied and "10" being very satisfied.

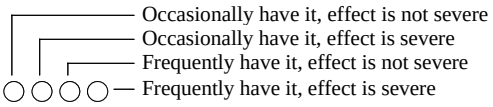
7. When you complete a section, please add up the total score and then mark it down next to the top of that section. Circle the number. Some sections are on more than one page.

8. If you are unsure how to answer a particular question please wait and ask for clarification. We will be happy to assist you.

9. If you do not have a particular symptom or condition, please leave that circle blank.

Patient Response Form

Health Assessment Questionnaire



Carefully and ***completely*** fill in the circle which best describes the ***frequency*** of your symptoms. If you are unsure, leave it blank.

Name: _____ **Date:** _____

Part 1

Section A

	1	2	3	4
1. Nausea or vomiting	○	○	○	○
2. Diarrhea	○	○	○	○
3. Constipation	○	○	○	○
4. Bloated Feeling	○	○	○	○
5. Belching, or passing gas	○	○	○	○
6. Heartburn	○	○	○	○

Section B

	1	2	3	4
1. Watery or itchy eyes	○	○	○	○
2. Swollen, reddened or sticky eyelids	○	○	○	○
3. Bags or dark circles under eyes	○	○	○	○
4. Blurred or tunnel vision (excluding near- or far-sightedness)	○	○	○	○
5. Headaches	○	○	○	○
6. Faintness	○	○	○	○
7. Dizziness	○	○	○	○
8. Insomnia	○	○	○	○
9. Itchy ears	○	○	○	○
10. Earaches, ear infections	○	○	○	○
11. Drainage from ear	○	○	○	○
12. Ringing in ears, hearing loss	○	○	○	○
13. Stuffy nose	○	○	○	○
14. Sinus problems	○	○	○	○
15. Hay fever	○	○	○	○
16. Sneezing attacks	○	○	○	○
17. Excessive mucus formation	○	○	○	○
18. Chronic coughing	○	○	○	○
19. Gagging, frequent need to clear throat	○	○	○	○
20. Sore throat, hoarseness, loss of voice	○	○	○	○
21. Swollen or discolored tongue, gums, lips	○	○	○	○
22. Canker sores	○	○	○	○

Section C

	1	2	3	4
1. Irregular or skipped heartbeat	○	○	○	○
2. Rapid or pounding heartbeat	○	○	○	○
3. Chest pain	○	○	○	○
4. Chest congestion	○	○	○	○
5. Asthma, bronchitis	○	○	○	○
6. Shortness of breath	○	○	○	○
7. Difficulty breathing	○	○	○	○

Section D

	1	2	3	4
1. Pain or aches in joints	○	○	○	○
2. Arthritis	○	○	○	○
3. Stiffness or limitation of movement	○	○	○	○
4. Pain or aches in muscles	○	○	○	○
5. Feeling of weakness or tiredness	○	○	○	○
6. Acne	○	○	○	○
7. Hives, rashes, or dry skin	○	○	○	○
8. Hair loss	○	○	○	○

Part 1

Section D

	1	2	3	4
9. Flushing or hot flashes	○	○	○	○
10. Excessive sweating	○	○	○	○

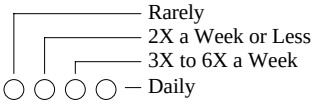
Section E

	1	2	3	4
1. Fatigue, sluggishness	○	○	○	○
2. Apathy, lethargy	○	○	○	○
3. Hyperactivity	○	○	○	○
4. Restlessness	○	○	○	○
5. Mood swings	○	○	○	○
6. Anxiety, fear or nervousness	○	○	○	○
7. Anger, irritability, or aggressiveness	○	○	○	○
8. Depression	○	○	○	○
9. Poor memory	○	○	○	○
10. Confusion, poor comprehension	○	○	○	○
11. Poor concentration	○	○	○	○
12. Poor physical condition	○	○	○	○
13. Difficulty making decisions	○	○	○	○
14. Stuttering or stammering	○	○	○	○
15. Slurred speech	○	○	○	○
16. Learning disabilities	○	○	○	○
17. Binge eating/drinking	○	○	○	○
18. Craving certain foods	○	○	○	○
19. Excessive weight	○	○	○	○
20. Compulsive eating	○	○	○	○
21. Water retention	○	○	○	○
22. Underweight	○	○	○	○

Section F

	1	2	3	4
1. Frequent illness	○	○	○	○
2. Frequent or urgent urination	○	○	○	○
3. Genital itch or discharge	○	○	○	○

Part 2



Section A

	0	1	2	3
1. Indigestion, "sour stomach"	○	○	○	○
2. Excessive belching/burping/bloating	○	○	○	○
3. Gas immediately following a meal	○	○	○	○
4. Sense of fullness during and after meals	○	○	○	○
5. Poor appetite, disinterest in food	○	○	○	○
6. Offensive breath	○	○	○	○
7. Bad taste in mouth	○	○	○	○
8. Partial loss of taste or smell	○	○	○	○
9. Difficult bowel movements	○	○	○	○

Rarely
2X a Week or Less
3X to 6X a Week
○ ○ ○ ○ — Daily

Name: _____ **Date:** _____

Part 2

Section A

	0	1	2	3
10. Difficulty swallowing	○	○	○	○
11. Unintentional weight loss			Yes ○	5
12. History of anemia, unresponsive to iron			Yes ○	5
13. Vegetarian (no eggs, dairy)			Yes ○	3
14. Picky eater			Yes ○	3
15. Spoon shaped nails			Yes ○	3
16. Sores in corner of mouth			Yes ○	3
17. Smooth tongue			Yes ○	3
18. Currently using digestive enzymes			Yes ○	10

Section B

	0	1	2	3
1. Indigestion and fullness lasts 2-4 hours after eating	○	○	○	○
2. Pain, tenderness, soreness on the left side under rib cage	○	○	○	○
3. Bloated	○	○	○	○
4. Excessive passage of gas	○	○	○	○
5. Abdominal cramps, aches	○	○	○	○
6. Nausea and/or vomiting	○	○	○	○
7. Dry, flaky skin, dry brittle hair	○	○	○	○
8. Difficulty gaining weight	○	○	○	○
9. Weakness and fatigue	○	○	○	○
10. Specific foods/beverages aggravate indigestion	○	○	○	○
11. Roughage and fiber cause constipation	○	○	○	○
12. Three or more large bowel movements daily	○	○	○	○
13. Alternating constipation and diarrhea	○	○	○	○
14. Stool poorly formed	○	○	○	○
15. Stool - undigested food	○	○	○	○
16. Stool - greasy, shiny	○	○	○	○
17. Stool yellowish, foul smelling	○	○	○	○
18. Mucus in stool	○	○	○	○
19. Black stool	○	○	○	○
20. Rectal spasms	○	○	○	○
21. Dark urine	○	○	○	○
22. Bone and back pain	○	○	○	○
23. Pounding heart	○	○	○	○
24. Iron deficiency anemia			Yes ○	3
25. Currently using digestive enzymes			Yes ○	10

Section C

	0	1	2	3
1. Stomach pain, burning, aching 1-4 hours after eating	○	○	○	○
2. Feel hungry 1 - 2 hours after eating	○	○	○	○
3. Strong emotions, thought, smell of food aggravates stomach	○	○	○	○
4. Heartburn, especially when lying down or bending forward	○	○	○	○
5. Heartburn due to spicy and fatty foods, chocolate, peppers, citrus, alcohol, caffeine	○	○	○	○
6. Difficulty or pain when swallowing	○	○	○	○

Part 2

Section C

	0	1	2	3
7. Chest pain, difficulty breathing, lung infections	○	○	○	○
8. Constipation, difficult bowel movements	○	○	○	○
9. Black, tarry stool	○	○	○	○
10. Unexplained weight gain			Yes ○	3
11. Temporary relief from antacids, carbonated beverages, cream/milk/food			Yes ○	5
12. Digestive problems subside with rest and relaxation			Yes ○	5
13. Currently using antacids or other stomach medication			Yes ○	10

Section D

	0	1	2	3
1. Lower abdominal pain, cramping and/or spasms	○	○	○	○
2. Lower abdominal pain relief by passing stool or gas	○	○	○	○
3. Raw fruits, vegetables and stress aggravate bowel pain	○	○	○	○
4. Diarrhea (loose watery stool)	○	○	○	○
5. More than three bowel movements daily	○	○	○	○
6. Excessive gas and bloating	○	○	○	○
7. Painful, difficult, straining during bowel movements	○	○	○	○
8. Hard, dry or small stool	○	○	○	○
9. Extremely narrow stools, thin stool	○	○	○	○
10. Alternating diarrhea/constipation	○	○	○	○
11. Mucus and pus in stool	○	○	○	○
12. Feel that bowels do not completely empty	○	○	○	○
13. Rectal pain or cramps	○	○	○	○
14. Bright red blood following bowel movement	○	○	○	○
15. Anal itching	○	○	○	○
16. Irritable, moody	○	○	○	○
17. Rash under breast, armpit, around naval or groin area			Yes ○	5
18. Feeling ill in damp, moldy setting or rainy weather			Yes ○	3
19. Currently on medication for IBS, Colitis, Crohn's or other bowel conditions			Yes ○	10

Part 3

Section A

	0	1	2	3
1. Moderate to severe pain under right side of rib cage	○	○	○	○
2. Abdominal pain worse with deep breathing	○	○	○	○
3. Bitter fluid repeats after eating	○	○	○	○
4. Bloated, full feeling	○	○	○	○

Rarely
2X a Week or Less
3X to 6X a Week
○ ○ ○ ○ — Daily

Name: _____ **Date:** _____

Part 3

Section A

	0	1	2	3
5. Belching, heartburn, gas	○	○	○	○
6. Fatty foods cause indigestion	○	○	○	○
7. Nausea and/or vomiting	○	○	○	○
8. Chronic fatigue	○	○	○	○
9. Unexplained itchy skin worse at night	○	○	○	○
10. Yellowing cast to skin, eyes	○	○	○	○
11. Stool color alternates from clay colored to normal brown	○	○	○	○
12. General feeling of poor health	○	○	○	○
13. Fatigue, weakness, exhaustion	○	○	○	○
14. Unable to concentrate, irritable, confused	○	○	○	○
15. Aching muscles	○	○	○	○
16. Trembling hands	○	○	○	○
17. Weight gain due to water retention	○	○	○	○
18. Swollen feet and/or legs	○	○	○	○
19. Bleeding tendencies in gums, nose	○	○	○	○
20. Loss of chest and armpit hair	○	○	○	○
21. Reddened skin, especially palms	○	○	○	○
22. Dark urine, diminished flow	○	○	○	○
23. Dry, flaky skin and/or hair			Yes ○	3
24. Loss of appetite and weight			Yes ○	3
25. Easy bruising			Yes ○	3
26. Thinning of pubic hair			Yes ○	3
27. Feeling of extreme dryness			Yes ○	3
28. Loss of skin elasticity			Yes ○	3
29. Recent tests show abnormal liver enzymes or gallbladder function			Yes ○	6

Section B

	0	1	2	3
1. Tired, sluggish	○	○	○	○
2. Feel cold - hands, feet, all over	○	○	○	○
3. Tight sensation in neck	○	○	○	○
4. Difficult, infrequent bowel movements	○	○	○	○
5. Dryness, discoloration skin, hair	○	○	○	○
6. Thick, brittle nails	○	○	○	○
7. Puffy face, hands and feet	○	○	○	○
8. Swollen upper eyelids	○	○	○	○
9. Eyeballs move involuntarily	○	○	○	○
10. Muscles weak, cramp and/or tremble	○	○	○	○
11. Slow mental processes, forgetfulness	○	○	○	○
12. Slow heart beats	○	○	○	○
13. Abdominal swelling	○	○	○	○
14. Unsteady gait, movements	○	○	○	○
15. Lack of interest in sex	○	○	○	○
16. Gain weight easily			Yes ○	5
17. Swelling of the neck			Yes ○	5
18. Outer third of eyebrow thins			Yes ○	3
19. Thinning hair on scalp, face and genitals			Yes ○	3
20. Loss of appetite			Yes ○	3
21. Premenstrual tension			Yes ○	3
22. Infertility			Yes ○	3
23. Excessive menstrual bleeding			Yes ○	3
24. Absence of periods			Yes ○	3

Part 3

Section B

	0	0	0	10
25. Axillary temp below 97.4 F or recent blood tests show low thyroid function			Yes ○	10

Part 4

Section A

	0	1	2	3
1. Progressive, mild fatigue after exertion or stress	○	○	○	○
2. General weakness	○	○	○	○
3. Blurred vision, dizzy when rising	○	○	○	○
4. Depression	○	○	○	○
5. Rapid mood swings	○	○	○	○
6. Irritable	○	○	○	○
7. Dark circles under the eyes	○	○	○	○
8. Abdominal pain, indigestion	○	○	○	○
9. Bouts of nausea, vomiting	○	○	○	○
10. Diarrhea or constipation	○	○	○	○
11. Blotchy skin (white patches)	○	○	○	○
12. Cravings for salty foods	○	○	○	○
13. Decreased appetite			Yes ○	3
14. Gradual weight loss			Yes ○	3
15. Tan skin, no sun			Yes ○	3
16. Gradual loss of body hair			Yes ○	3
17. Black freckles on upper forehead, face, neck			Yes ○	3
18. Sensitive to minor changes in weather and surroundings			Yes ○	5
19. Systolic blood pressure drops on standing			Yes ○	5

Section B

	0	1	2	3
1. Catch colds easily	○	○	○	○
2. Infections - eyes, ears, nose, throat, lungs, skin	○	○	○	○
3. Diarrhea	○	○	○	○
4. Puffy face	○	○	○	○
5. Dark areas on cheeks, under eyes	○	○	○	○
6. Difficulty seeing at night	○	○	○	○
7. Eyes tear, burn, discharge	○	○	○	○
8. Ears, continuously drain	○	○	○	○
9. Nasal congestion or discharge - thick, yellow, green	○	○	○	○
10. Sore throat or post-nasal drip	○	○	○	○
11. Cough with mucus	○	○	○	○
12. Inflamed or bleeding gums	○	○	○	○
13. Cold sores, fever blisters	○	○	○	○
14. Gums swelling, bleeding	○	○	○	○
15. Unexplained weight loss of 10 pounds in last three months			Yes ○	3
16. Lack of appetite			Yes ○	3
17. Nail discolorations			Yes ○	3
18. Bumpy skin on back of arms			Yes ○	3

Rarely
2X a Week or Less
3X to 6X a Week
Daily

Name: _____ **Date:** _____

Part 4

Section B

	0	0	0	3
19. Wounds heal slowly				Yes ○ 3
20. Hair is easily plucked out or falls out, grows slow				Yes ○ 3
21. Lips are red and swollen				Yes ○ 3
22. Tongue is red, swollen, raw looking				Yes ○ 3
23. Impaired taste and smell				Yes ○ 3
24. Neck, armpit, groin swelling				Yes ○ 5
25. Current infection of any kind				Yes ○ 10

Section C

	0	1	2	3
1. Muscles fatique quickly	○	○	○	○
2. Moody, irritable, tired	○	○	○	○
3. Severe fatigue	○	○	○	○
4. Severe joint pain, redness swelling	○	○	○	○
5. Chronic pain, stiffness throughout body	○	○	○	○
6. Migraine headaches	○	○	○	○
7. Specific food(s) worsen pain, inflammation, stiffness	○	○	○	○
8. Sensitive to light (skin or eyes)	○	○	○	○
9. Dark circles under eyes	○	○	○	○
10. Swollen-looking face or body	○	○	○	○
11. Localized or general itching - eyes, ears, throat, nose, skin	○	○	○	○
12. Clear, watery discharge from nose, eyes	○	○	○	○
13. Extreme dryness of eyes, nasal passages, mouth	○	○	○	○
14. Sneezing	○	○	○	○
15. Cough or wheezing	○	○	○	○
16. Moldy, damp environments trigger sickness	○	○	○	○
17. Post nasal drip with certain foods	○	○	○	○
18. Heart palpitations after eating certain foods	○	○	○	○
19. Weight loss, muscle weakness				Yes ○ 3
20. Scalp hair falls out easily, in clumps				Yes ○ 3
21. Hair loss, entire body				Yes ○ 5
22. Easy bruising				Yes ○ 3
23. Nails - loosened, pitted, discolored				Yes ○ 5
24. Current food or inhalant allergies				Yes ○ 10

Part 5

Section A

	0	1	2	3
1. Sense of being overly tired	○	○	○	○
2. Prolonged recovery after exercise	○	○	○	○
3. Coldness, especially in hands and feet	○	○	○	○
4. Difficulty breathing on exertion, palpitations	○	○	○	○
5. Headache, dizziness, spots before eyes	○	○	○	○
6. Irritable	○	○	○	○
7. Forgetful, poor concentration	○	○	○	○

Part 5

Section A

	0	1	2	3
8. Mild yellowing of eyes or skin	○	○	○	○
9. Ringing in ears	○	○	○	○
10. Susceptible to infections	○	○	○	○
11. Jaundice and dark urine	○	○	○	○
12. Black stool (no iron supplements)	○	○	○	○
13. Unusual cravings for clay, dirt, ice	○	○	○	○
14. Fingernails are flattened, spoonshaped brittle, thin				Yes ○ 5
15. White patches on skin				Yes ○ 3
16. Pale lips, gums, eyelids, nail beds				Yes ○ 3
17. Red, sore tongue				Yes ○ 3
18. Mouth, throat, rectum ulcers				Yes ○ 3
19. Unusual bruising				Yes ○ 3
20. Spontaneous bleeding - nose, mouth, gums, rectum or vagina				Yes ○ 3
21. Small red spots under the skin				Yes ○ 3
22. Sores in the corner of mouth				Yes ○ 3
23. Smooth tongue				Yes ○ 3
24. Diagnosis of chronic or recent anemia				Yes ○ 10

Section B

	0	1	2	3
1. Nosebleeds	○	○	○	○
2. Headache, typically in morning	○	○	○	○
3. Weakness, fatigue, nervous	○	○	○	○
4. Ringing in ears	○	○	○	○
5. Dizziness, drowsiness	○	○	○	○
6. Blushing - no apparent cause	○	○	○	○
7. Numbness, tingling in hand and feet	○	○	○	○
8. Blurred vision	○	○	○	○
9. High blood pressure (>140/90)				Yes ○ 10
10. Currently using blood pressure medication				Yes ○ 10

Section C

	0	1	2	3
1. Feel jittery	○	○	○	○
2. Heartburn that moves to neck, jaws, left shoulder and arm	○	○	○	○
3. First effort of the day causes chest pain	○	○	○	○
4. Dizziness	○	○	○	○
5. Choking, smothering sensation	○	○	○	○
6. Exhaust with minor exertion	○	○	○	○
7. Heart pounds easily	○	○	○	○
8. Heavy sweating (no exertion)	○	○	○	○
9. Mild or severe chest pain	○	○	○	○
10. Difficulty catching breath especially during exercise	○	○	○	○
11. Wheezing or dry cough	○	○	○	○
12. Slow, rapid or irregular heart beat	○	○	○	○
13. Swelling in feet, ankle, legs comes and goes	○	○	○	○
14. Veins on neck are prominent	○	○	○	○
15. Currently diagnosed with heart disease				Yes ○ 10

Rarely
2X a Week or Less
3X to 6X a Week
Daily

Name: _____ **Date:** _____

Part 5

Section D

	0	1	2	3
1. Fluid retention	○	○	○	○
2. Numbness, tingling, pricking sensation in hands, feet	○	○	○	○
3. Muscle pain in the calves or thighs when walking	○	○	○	○
4. Muscle pain at rest	○	○	○	○
5. Cold feet	○	○	○	○
6. Headaches	○	○	○	○
7. Dizziness, everything spins	○	○	○	○
8. Poor concentration	○	○	○	○
9. Slurred speech	○	○	○	○
10. Ringing in ears	○	○	○	○
11. Brief moments of hearing loss	○	○	○	○
12. Nausea comes and goes quickly	○	○	○	○
13. Falling without known cause	○	○	○	○
14. Brief difficulty swallowing	○	○	○	○
15. Brief difficulty speaking	○	○	○	○
16. Stammering or twitching of tongue	○	○	○	○
17. Double vision	○	○	○	○
18. Difficulty understanding spoken or written word	○	○	○	○
19. Brief loss of muscular coordination in legs, arms	○	○	○	○
20. Inability to recognize persons or things that pass very quickly	○	○	○	○
21. Loss of feeling, usually on one side, that quickly disappears	○	○	○	○
22. One leg or arm - shiny, hairless skin	Yes ○ 5			
23. Discolored or blue toes	Yes ○ 5			
24. Open sores on feet and legs	Yes ○ 5			
25. Fingers and toes numb in response to cold weather even when protected	Yes ○ 5			

Part 6

Section A

	0	1	2	3
1. Sudden anxiety associated with hunger	○	○	○	○
2. Tingling sensation in hands	○	○	○	○
3. Palpitations	○	○	○	○
4. Feel shaky, jittery, tremors	○	○	○	○
5. Weakness	○	○	○	○
6. Profuse perspiration, clammy	○	○	○	○
7. Nightmares	○	○	○	○
8. Awake from sleep restless	○	○	○	○
9. Agitated, easily upset, nervous	○	○	○	○
10. Poor memory, forgetful	○	○	○	○
11. Confusion, disoriented	○	○	○	○
12. Dizziness, feel faint	○	○	○	○
13. Feeling cold, numbness	○	○	○	○
14. Mild headaches	○	○	○	○
15. Blurred or double vision	○	○	○	○

Part 6

Section A

	0	1	2	3
16. Lack of coordination	○	○	○	○

Section B

	0	1	2	3
1. Excessive, frequent urination	○	○	○	○
2. Increased thirst and appetite	○	○	○	○
3. Blurred vision, failing eyesight	○	○	○	○
4. Fatigue, drowsiness	○	○	○	○
5. Crave sweets, but eating sweets does not relieve craving	○	○	○	○
6. Feel hungry for air (can't get enough)	○	○	○	○
7. Breath smells sweet	○	○	○	○
8. Depressed	○	○	○	○
9. Tingling, numbness, prickling sensation in extremities	○	○	○	○
10. Profuse sweating	○	○	○	○
11. Dribble after voiding	○	○	○	○
12. Impotency	○	○	○	○
13. Dizziness when standing quickly	○	○	○	○
14. Slurred speech	○	○	○	○
15. Unintentional weight loss	Yes ○ 3			
16. Reoccurring persistent infection bladder, skin or gums	Yes ○ 3			
17. Boils and leg sores	Yes ○ 3			
18. Very slow wound healing	Yes ○ 3			
19. Excessive weight gain	Yes ○ 3			
20. Currently have diabetes or elevated blood sugar	Yes ○ 10			

Part 7

Section A

	0	1	2	3
1. Weakness and fatigue	○	○	○	○
2. Chest discomfort, pain	○	○	○	○
3. Sudden breathing difficulty	○	○	○	○
4. Shortness of breath	○	○	○	○
5. Shallow breathing	○	○	○	○
6. Noisy/rattling sounds when breathing	○	○	○	○
7. Cough - dry or moist	○	○	○	○
8. Rapid heartbeats	○	○	○	○
9. Excessive perspiration	○	○	○	○
10. Anxiety, restlessness	○	○	○	○
11. Consistent low grade fever (100 - 101)	○	○	○	○
12. Bluish nails and lips	○	○	○	○
13. Post nasal drip	○	○	○	○
14. Sputum - thick, clear, yellow	○	○	○	○
15. Sputum - smells offensive	○	○	○	○
16. Bloody sputum	○	○	○	○
17. Bad breath	○	○	○	○
18. Wheezing	○	○	○	○
19. Loud snoring	○	○	○	○
20. Sleepy during day	○	○	○	○

Rarely
2X a Week or Less
3X to 6X a Week
○ ○ ○ ○ — Daily

Name: _____ **Date:** _____

Part 7

Section A

	0	1	2	3
21. Morning headache	○	○	○	○
22. Difficulty concentrating	○	○	○	○
23. Unexplained weight loss			Yes ○	3
24. Infections settle in lungs			Yes ○	3
25. Flu symptoms last longer than 5 days			Yes ○	3
26. Currently have lung/bronchial infection			Yes ○	10

Part 8

Section A

	0	1	2	3
1. Retain fluid throughout body	○	○	○	○
2. Mild lower back pain	○	○	○	○
3. Frequent urge to urinate, but only small amounts pass	○	○	○	○
4. Interruption of urine stream	○	○	○	○
5. Excessive urination	○	○	○	○
6. Excessive urination at night	○	○	○	○
7. Burning when urinating	○	○	○	○
8. Frequent urination with urgency	○	○	○	○
9. Rarely need to urinate	○	○	○	○
10. Difficulty passing urine	○	○	○	○
11. Dripping after urination	○	○	○	○
12. Can't hold urine	○	○	○	○
13. Bloody, cloudy and/or darkened urine	○	○	○	○
14. Strong smelling urine	○	○	○	○
15. Joint and muscle pain	○	○	○	○
16. Tingling in joints	○	○	○	○
17. Dark circles under eyes	○	○	○	○
18. Grey, blackish caste to skin	○	○	○	○
19. Back or leg pains associated with dripping after urination			Yes ○	5
20. Poor skin elasticity, dryness			Yes ○	3
21. Acute or chronic urinary tract infection			Yes ○	10

Part 9: Males Only

Section A

	0	1	2	3
1. Frequent or urgent need to urinate	○	○	○	○
2. Delayed, weak, or interrupted urinary stream	○	○	○	○
3. Pain or burning upon urination	○	○	○	○
4. Urge to urinate several times a night	○	○	○	○
5. Rose colored (bloody) urine	○	○	○	○
6. Difficulty urinating	○	○	○	○
7. A sense of bladder fullness	○	○	○	○
8. Ejaculation causes pain	○	○	○	○
9. Blood in the semen	○	○	○	○
10. Lack of sex drive	○	○	○	○
11. Impotency	○	○	○	○

Part 9: Males Only

Section A

	0	1	2	3
12. Pain or fatigue in the legs or back	○	○	○	○
13. Dripping after urination	○	○	○	○
14. Increased straining with small amounts of urine passed	○	○	○	○
15. Anemia			Yes ○	3
16. Current prostate enlargement or elevated PSA			Yes ○	10

Section B

	0	1	2	3
1. Itchy patches around inner thigh/groin	○	○	○	○
2. Itching at night	○	○	○	○
3. Painful testicles	○	○	○	○
4. Difficulty attaining and/or maintaining an erection	○	○	○	○
5. Low sexual drive	○	○	○	○
6. Premature ejaculation	○	○	○	○
7. Low energy level or stamina	○	○	○	○
8. Inflammation on the head of penis			Yes ○	5
9. Genital and/or rectal rash or irritation			Yes ○	5
10. Distorted nail growth			Yes ○	3
11. Loss of pubic or armpit hair			Yes ○	3
12. Infertile			Yes ○	3
13. Low sperm count, low sperm motility			Yes ○	3
14. Unexplained weight gain			Yes ○	3
15. Testicles appear smaller			Yes ○	3
16. Development of breasts or nipple tenderness			Yes ○	3
17. Feeling of heaviness or hardness in testicles			Yes ○	3
18. Sparse beard or slow hair growth			Yes ○	3
19. Decreased body hair			Yes ○	3
20. Fine wrinkling in corner of mouth/eyes			Yes ○	3
21. Current or recurrent epididimitis			Yes ○	10

Part 10: Females Only

Section A

	0	1	2	3
1. Insomnia	○	○	○	○
2. Abdominal bloating	○	○	○	○
3. Breast tenderness, swelling	○	○	○	○
4. Breast lumps appear	○	○	○	○
5. Heart palpitations	○	○	○	○
6. Sweating and flushing	○	○	○	○
7. Depressed, irritable, nervous	○	○	○	○
8. Easy to anger, resentful	○	○	○	○
9. Easily overwhelmed	○	○	○	○
10. Nausea and/or vomiting	○	○	○	○
11. Diarrhea or constipation	○	○	○	○
12. Headache	○	○	○	○
13. Food cravings, binge eating	○	○	○	○
14. Back pain	○	○	○	○

Rarely
2X a Week or Less
3X to 6X a Week
Daily

Name: _____ **Date:** _____

Part 10: Females Only

Section A

	0	1	2	3
15. Feel faint	○	○	○	○
16. Clumsiness	○	○	○	○
17. Forgetful	○	○	○	○
18. Weight gain - water			Yes ○	3
19. Suicidal			Yes ○	10

Section B

	0	1	2	3
1. Vaginal dryness, pain	○	○	○	○
2. Painful intercourse	○	○	○	○
3. Engorged breasts	○	○	○	○
4. Milk production (not nursing)	○	○	○	○
5. Disinterest in sex	○	○	○	○
6. Blurred vision	○	○	○	○
7. Headache	○	○	○	○
8. Acne and/or oily skin	○	○	○	○
9. Aggressive feelings	○	○	○	○
10. Overwhelming sexual urges	○	○	○	○
11. Absence of menstrual flow for six or more months			Yes ○	20
12. Occasionally skip periods			Yes ○	5
13. Menstruation began after 16 years old			Yes ○	3
14. Breasts shrinking			Yes ○	5
15. Thinning pubic and armpit hair			Yes ○	5
16. Unable to get pregnant			Yes ○	10
17. Miscarriage			Yes ○	3
18. Excess facial hair			Yes ○	5
19. Poor sense of smell			Yes ○	3
20. Monthly abdominal pain without bleeding			Yes ○	5

Section C

	0	1	2	3
1. Painful intercourse	○	○	○	○
2. Menstrual type pain between menses	○	○	○	○
3. Irregular time intervals between periods			Yes ○	5
4. Menstrual cycles greater than 32 days			Yes ○	10
5. Menstrual cycles less than 24 days			Yes ○	5
6. Vaginal bleeding between periods			Yes ○	10
7. Vaginal discharge between periods			Yes ○	5
8. Pain during periods is getting progressively worse			Yes ○	5
9. Pain, cramps	○	○	○	○
10. Unusual fatigue, can't work	○	○	○	○
11. Irritable and depressed	○	○	○	○
12. Constipation and/or diarrhea	○	○	○	○
13. Lower abdominal pain, bloating	○	○	○	○
14. Nausea and/or vomiting	○	○	○	○
15. Lower backache	○	○	○	○
16. Pelvic and/or rectal pressure	○	○	○	○
17. Urinary difficulties	○	○	○	○
18. Frequent urination			Yes ○	5
19. Scanty or heavy blood flow			Yes ○	3
20. Heavy blood flow			Yes ○	3

Part 10: Females Only

Section D

	0	1	2	3
1. Lumps are painful, tender	○	○	○	○
2. Clear, gray, or yellow vaginal discharge	○	○	○	○
3. Vaginal bleeding after sex or between periods	○	○	○	○
4. Burning or itching of external genitalia	○	○	○	○
5. Urgent, painful urination	○	○	○	○
6. Lower abdominal or back pain	○	○	○	○
7. Heavy, watery and bloody vaginal discharge	○	○	○	○
8. Heavy menstrual flow	○	○	○	○
9. Pelvic cramps	○	○	○	○
10. Thin, scant, white vaginal discharge	○	○	○	○
11. Greenish, yellow, or offensive discharge	○	○	○	○
12. Cheesy white discharge	○	○	○	○
13. Breast lumps or swelling			Yes ○	10
14. Lumps hurt just before period			Yes ○	5
15. Swelling under armpit			Yes ○	5
16. Change in breast size, shape			Yes ○	5
17. White or slightly bloody vaginal discharge, one week prior to period			Yes ○	10
18. Current diagnosis of Fibrocystic Breast Disease			Yes ○	10

Section E

	0	1	2	3
1. Irregular menstrual cycle	○	○	○	○
2. Dry skin, hair, vagina	○	○	○	○
3. Disinterest in sex	○	○	○	○
4. Mood swings, irritable	○	○	○	○
5. Depression, anxiety, nervousness	○	○	○	○
6. Craving for sweets, binge eating	○	○	○	○
7. Headaches or dizziness	○	○	○	○
8. Painful intercourse	○	○	○	○
9. Sudden hot flashes	○	○	○	○
10. Spontaneous sweating	○	○	○	○
11. Shortness of breath and/or heart palpitations	○	○	○	○
12. Unpredictable vaginal bleeding	○	○	○	○
13. Difficulty holding urine	○	○	○	○
14. Difficulty sleeping	○	○	○	○
15. Mental fogginess	○	○	○	○
16. Vaginal pain and/or itching	○	○	○	○
17. Thin, scant white vaginal discharge	○	○	○	○
18. Low back and/or hip pain	○	○	○	○
19. Breast tenderness, pain or tingling, pricking sensation	○	○	○	○
20. Easy bruising, loss of skin tone	○	○	○	○
21. Thinning armpit and pubic hair			Yes ○	5
22. Stopped menstruating			Yes ○	20
23. Breasts beginning to shrink, sag			Yes ○	10
24. Abnormal growth of hair above lip			Yes ○	3

Rarely
2X a Week or Less
3X to 6X a Week
○ ○ ○ ○ — Daily

Name: _____ **Date:** _____

Part 11

Section A

	0	1	2	3
1. Generalized bone tenderness and achiness	○	○	○	○
2. Localized bone pain	○	○	○	○
3. Bone deformity or swelling	○	○	○	○
4. Shins hurt during or after exercises	○	○	○	○
5. Low back or hip pain	○	○	○	○
6. Difficulty sitting straight	○	○	○	○
7. Limp, walking difficulties	○	○	○	○
8. Crunching or creaking sounds when move joints	○	○	○	○
9. Hands, feet, throat spasm or feel numb	○	○	○	○
10. Joint pain and stiffness - especially spine, hips, knees	○	○	○	○
11. Hearing loss, headaches, ringing in ears	○	○	○	○
12. Cavities	Yes ○ 5			
13. Tooth loss due to gum disease	Yes ○ 5			
14. Established bone loss	Yes ○ 10			
15. Calcium deposits	Yes ○ 5			
16. Spinal curvature	Yes ○ 10			
17. Recent loss of height	Yes ○ 10			
18. Bow legs	Yes ○ 5			
19. Stooped posture	Yes ○ 5			
20. Hump at base of neck	Yes ○ 5			
21. Irregular patches of increased pigmentation	Yes ○ 3			
22. Unexplained bone fracture	Yes ○ 10			
23. Osteoporosis diagnosed	Yes ○ 10			

Section B

	0	1	2	3
1. Muscle aches and pains	○	○	○	○
2. Muscle stiffness, tension	○	○	○	○
3. Specific points on body feel sore when pressed	○	○	○	○
4. Headaches	○	○	○	○
5. Fatigue, tired, sluggish	○	○	○	○
6. Difficulty sleeping	○	○	○	○
7. Feel unrefreshed upon awakening	○	○	○	○
8. Difficulty speaking/swallowing	○	○	○	○
9. Muscle cramps or spasm	○	○	○	○
10. Muscles twitch or tremble - eyelids, thumb, calf muscle	○	○	○	○
11. Irresistible urge to move legs	○	○	○	○
12. Legs move during sleep	○	○	○	○
13. Unpleasant crawling sensation inside the calves, while lying down	○	○	○	○
14. Numbing, tingling sensation	○	○	○	○
15. Excessive joint mobility	○	○	○	○
16. Unable to fully straighten or extend legs and/or arms	○	○	○	○
17. Upper or lower back pain	○	○	○	○
18. Loss of muscle strength	Yes ○ 3			
19. Muscle loss, wasting	Yes ○ 3			
20. Myositis or Fibromyalgia diagnosed	Yes ○ 10			

Part 11

Section B

	0	1	2	3
1. Joint stiffness, soreness, swelling	○	○	○	○

Section C

	0	1	2	3
2. Red, swollen painful joints	○	○	○	○
3. Joint stiffness improves when resting, worsens with movement	○	○	○	○
4. Dry mouth	○	○	○	○
5. Dry painful eyes	○	○	○	○
6. Joint stiffness worsens with rest, improves with movement	○	○	○	○
7. Cracking joints	○	○	○	○
8. Limp when walking	○	○	○	○
9. Shooting, aching, tingling pain down the back of leg	○	○	○	○
10. Joint pain involves one or a few joints	○	○	○	○
11. Joints hurt when moving or when carrying weight	○	○	○	○
12. Limited range of motions	○	○	○	○
13. Difficulty standing up	○	○	○	○
14. Walks slowly	○	○	○	○
15. Headache	○	○	○	○
16. Difficulty chewing or opening mouth	○	○	○	○
17. Intermittent pain, ache on one side of head spreading to cheek, temple, lower jaw, ear, neck and shoulder	○	○	○	○
18. Numbness, prickling, tingling sensation in the neck, shoulder and arms	○	○	○	○
19. Injure, strain, sprain easily	○	○	○	○
20. Discomfort or pain in neck, shoulder or arm	○	○	○	○
21. Involuntary muscle spasms	○	○	○	○
22. Difficulty controlling hand movements	○	○	○	○
23. Red painless skin lumps on elbows, knees, toes, ear, nose, back of scalp	Yes ○ 5			
24. Knobby overgrowths on the joints closest to the fingertips	Yes ○ 5			
25. Muscle loss around inflamed joint	Yes ○ 10			
26. Double jointed	Yes ○ 3			
27. One leg shorter than the other	Yes ○ 5			
28. Diagnosis of thinning cartilage, osteoarthritis, or degenerative joint disease	Yes ○ 10			

Section D

	0	1	2	3
1. Head feels heavy	○	○	○	○
2. Light headedness/fainting	○	○	○	○
3. Ringing/buzzing in ears	○	○	○	○
4. Trembling hands	○	○	○	○
5. Limbs feel too heavy to hold up	○	○	○	○
6. Loss of feeling in hands and/or feet (toes)	○	○	○	○
7. Tingling, followed by numbness or pain; begins in hands and feet, spreads toward center of body	○	○	○	○

Rarely
2X a Week or Less
3X to 6X a Week
Daily

Name: _____ **Date:** _____

Part 11

Section D

	0	1	2	3
8. Unsteady gait, lose balance	○	○	○	○
9. Muscles feel weak	○	○	○	○
10. Weak grip with spasm and arm weakness	○	○	○	○
11. Exhaustion on slightest effort	○	○	○	○
12. Need for 10-12 hours sleep	○	○	○	○
13. Muscular weakness begins in leg and moves upward	○	○	○	○
14. Difficulty walking, moving around, handling small objects	○	○	○	○
15. Nervous, anxious	○	○	○	○
16. Convulsions	○	○	○	○
17. Confused, forgetful	○	○	○	○
18. Slowed or slurred speech	○	○	○	○
19. Difficulty breathing	○	○	○	○
20. Blurred vision	○	○	○	○
21. Eyelids droop	○	○	○	○
22. Impaired hearing, eyesight, sense of touch, smell, taste	Yes ○ 10			
23. Accident prone: trip, stumble, feel clumsy.	Yes ○ 5			
24. Diagnosis of MS, Parkinson's or other neuromuscular degenerative disease	Yes ○ 10			

Part 12

Occasionally have it, effect is not severe
Occasionally have it, effect is severe
Frequently have it, effect is not severe
Frequently have it, effect is severe

Section A

	1	2	3	4
1. Experience indifference (don't care)	○	○	○	○
2. Lose your sense of humor/take life too seriously	○	○	○	○
3. Experience doubt or indecision	○	○	○	○
4. Experience worry or anxiety	○	○	○	○
5. Feel over cautious or pessimistic	○	○	○	○
6. Lack self confidence	○	○	○	○
7. Feeling stressed, nervous or tense	○	○	○	○
8. Feel irritable or oversensitive	○	○	○	○
9. Experience difficulty concentrating and loss of clear thought	○	○	○	○
10. Experience inadequate energy (fatigue)	○	○	○	○
11. Have coffee, tea, tobacco, sugar or other stimulants as a pick-me-up	○	○	○	○
12. Experience nervous indigestion	○	○	○	○
13. Experience loss of sex drive	○	○	○	○
14. Experience difficulty sleeping	○	○	○	○
15. Experience difficulty getting up in the morning	○	○	○	○
16. Feel run down	○	○	○	○

Part 12

Section A

	1	2	3	4
17. Feel depressed or feel like crying for no reason	○	○	○	○
18. Difficulty sitting quietly without fidgeting, talking, reading, watching TV, etc.	○	○	○	○
19. Find it difficult to express your feelings	○	○	○	○
20. Experience rapid heart beat or panic	○	○	○	○
21. Feel moody	○	○	○	○
22. Feel suicidal or wonder whether life is worth living	○	○	○	○
23. Have anxiety about not having enough money	○	○	○	○
24. Fear ill health	○	○	○	○
25. Fear criticism	○	○	○	○
26. Fear loss of love	○	○	○	○
27. Fear old age or death	○	○	○	○
28. Feel "something is the matter with me" but don't know what	○	○	○	○
29. Think you might be going crazy	○	○	○	○

Section B

Where 10 is totally satisfied, rate how you feel about ...

	0	2	4	6	8	10
1. The way my body looks	○	○	○	○	○	○
2. The way my body feels	○	○	○	○	○	○
3. My body fat	○	○	○	○	○	○
4. My lean muscle mass	○	○	○	○	○	○
5. My strength	○	○	○	○	○	○
6. My endurance	○	○	○	○	○	○
7. My flexibility	○	○	○	○	○	○
8. My attractiveness	○	○	○	○	○	○