New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

First Name | Last Name | Date | Email*

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address | City | State | Zip

Telephone (Work) | (home) | Referred By

Age | Birth Date | Social Security # | Number of Children

Occupation | Employer

Marital Status | Spouse's Name | Spouse's Occupation

Spouse's Employer | Spouse's Health Status

Emergency Contact | Phone

Current Complaints

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other

Please describe:

Date if Injury | Date symptoms appeared

Have you ever had same condition? ◯ No ◯ Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care? ◯ No ◯ Yes

If yes, please describe

Insurance Information

Name of party responsible for payment | Phone

Do you have health insurance? ◯ No ◯ Yes Name of company

*** If an auto accident, please provide:**

Insurance Company Name | Contact Person

Phone: | Claim #

Signatures

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

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Medical History

Have you been treated for any conditions in the last year? ◯ No ◯ Yes

If yes, please describe

Date of last physical exam Is there a chance that you are pregnant? ◯ No ◯ Yes

Have you had X-rays taken? ◯ No ◯ Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)I

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	◯	◯	
Been hospitalized?	◯	◯	
Been in an auto accident?	◯	◯	
Had Sprains/Strains?	◯	◯	
Been struck unconscious?	◯	◯	
Had surgery?	◯	◯	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	◯ No	◯ Yes
Do your symptoms interfere with daily life?	◯ No	◯ Yes
Does pain wake you up at night?	◯ No	◯ Yes
Are your symptoms worse during certain times of the day?	◯ No	◯ Yes
Do changes in weather affect your symptoms?	◯ No	◯ Yes
Do you wear orthotics?	◯ No	◯ Yes
Do you take vitamin supplements?	◯ No	◯ Yes

What activities aggravate your symptoms?

Habits	None	Light	Moderate	Heavy
Alcohol	◯	◯	◯	◯
Coffee	◯	◯	◯	◯
Tobacco	◯	◯	◯	◯
Drugs	◯	◯	◯	◯
Exercise	◯	◯	◯	◯
Sleep	◯	◯	◯	◯
Appetite	◯	◯	◯	◯
Soft Drinks	◯	◯	◯	◯
Water	◯	◯	◯	◯
Salty Foods	◯	◯	◯	◯
Sugary Foods	◯	◯	◯	◯
Artificial Sweeteners	◯	◯	◯	◯

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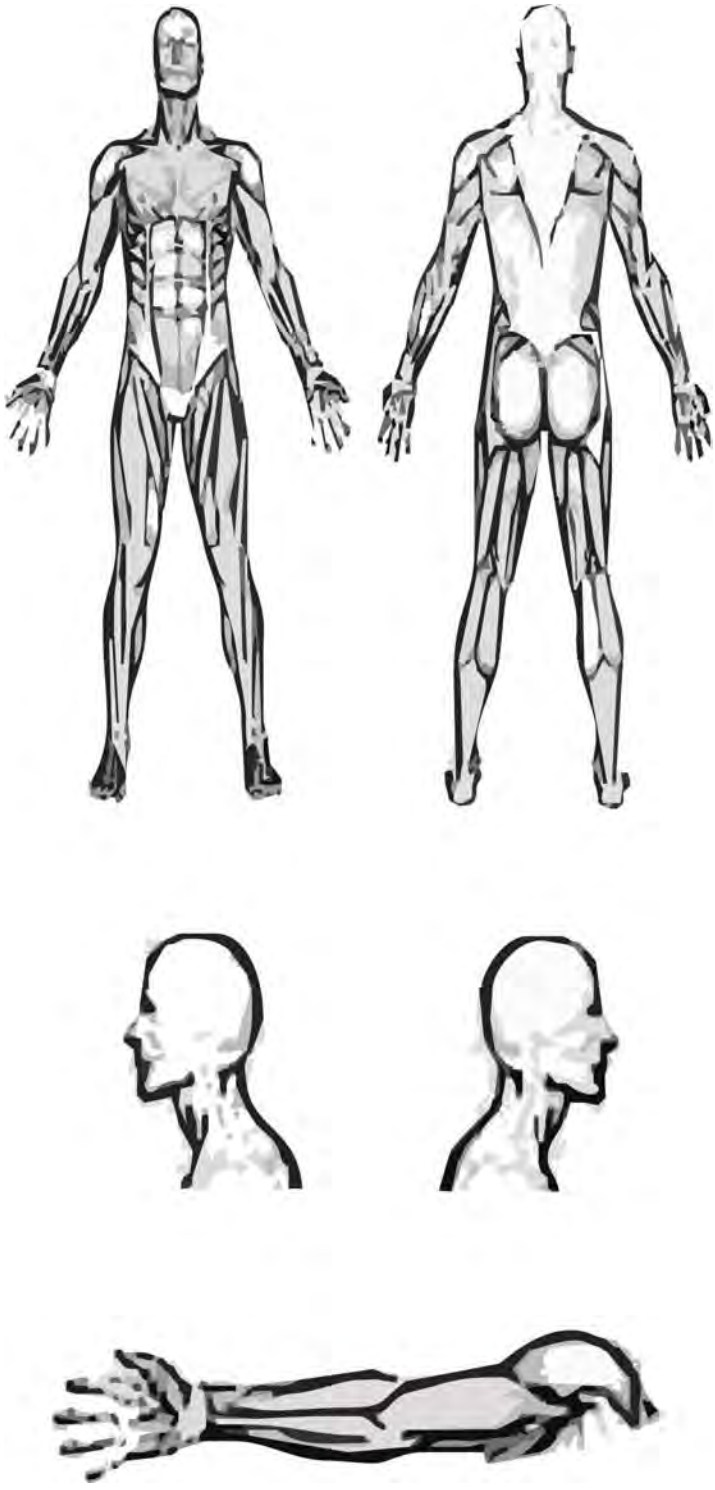
Have you ever suffered from:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing



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HEALTH APPRAISAL - COMPREHENSIVE

NAME_____ DATE_____

CIRCLE the number which best describes the ***frequency*** of your symptoms. If you do not know the answer to the question, leave it blank. When you are finished, please add the number of points in each section and enter the number in the **Total Points** box. The score for YES is the number inside the parenthesis ( ).

(0) never or rarely (1) twice a week or less (2) three to six times a week (3) daily

PART I

Section A

1. Indigestion, "sour stomach"	0	1	2	3
2. Excessive belching, burping and/or bloating	0	1	2	3
3. Gas immediately following a meal	0	1	2	3
4. Sense of fullness during and after meals	0	1	2	3
5. Poor appetite, disinterest in food	0	1	2	3
6. Offensive breath	0	1	2	3
7. Bad taste in mouth	0	1	2	3
8. Partial loss of taste or smell	0	1	2	3
9. Difficult bowel movements	0	1	2	3
10. Difficulty swallowing	0	1	2	3
11. Unintentional weight loss	N			Y (5)
12. History of anemia,unresponsive to iron	N			Y (5)
13. Vegetarian (no eggs, dairy)	N			Y (3)
14. Picky eater	N			Y (3)
15. Spoon shaped nails	N			Y (3)
16. Sores in corner of mouth	N			Y (3)
17. Smooth tongue	N			Y (3)

Total Points_____

Section B

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

Total Points_____

Section C

1. Stomach pain, burning, aching 1-4 hours after eating	0	1	2	3
2. Feeling hungry an hour or two after eating	0	1	2	3
3. Strong emotions, thought or smell of food aggravates stomach	0	1	2	3
4. Heartburn, especially when lying down or bending forward	0	1	2	3
5. Heartburn due to spicy and fatty foods, chocolate, peppers, citrus, alcohol, caffeine	0	1	2	3
6. Difficulty or pain when swallowing	0	1	2	3
7. Chest pain, difficulty breathing, lung infections	0	1	2	3
8. Constipation, difficult bowel movements	0	1	2	3
9. Black, tarry stool	0	1	2	3
10. Unexplained weight gain	N			Y (3)
11. Temporary relief from antacids, carbonated beverages, cream/milk/food	N			Y (5)
12. Digestive problems subside with rest and relaxation	N			Y (5)

Total Points_____

Section D

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

Total Points_____

PART II

Section A

1. Moderate to severe pain under right side of rib cage	0	1	2	3
2. Abdominal pain worse with deep breathing	0	1	2	3
3. Bitter fluid repeats after eating	0	1	2	3
4. Bloated, full feeling	0	1	2	3
5. Belching, heartburn, gas	0	1	2	3
6. Fatty foods cause indigestion	0	1	2	3
7. Nausea	0	1	2	3
8. Feel restless, agitated, angry	0	1	2	3

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PART II (continued)

Section A (continued)

9. Unexplained itchy skin worse at night	0	1	2	3
10. Yellowish cast to skin, eyes	0	1	2	3
11. Stool color alternates from clay colored to normal brown	0	1	2	3
12. General feeling of poor health	0	1	2	3
13. Fatigue, weakness, exhaustion	0	1	2	3
14. Unable to concentrate, irritable, confused	0	1	2	3
15. Aching muscles	0	1	2	3
16. Trembling hands	0	1	2	3
17. Weight gain due to water retention	0	1	2	3
18. Swollen feet and/or legs	0	1	2	3
19. Bleeding tendencies in gums, nose	0	1	2	3
20. Loss of chest and armpit hair	0	1	2	3
21. Reddened skin, especially palms	0	1	2	3
22. Dark urine, diminished flow	0	1	2	3
23. Dry, flaky skin and/or hair	N			Y (3)
24. Loss of appetite and weight	N			Y (3)
25. Easy bruising	N			Y (3)
26. Thinning of pubic hair	N			Y (3)
27. Feeling of extreme dryness	N			Y (3)
28. Loss of skin elasticity	N			Y (3)
29. Vomiting	N			Y (5)

Total Points_____

Section B

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

Total Points_____

PART III

Section A

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

Total Points_____

Section B

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

Section B (continued)

17. Nail discolorations	N		Y (3)
18. Bumpy skin on back of arms	N		Y (3)
19. Wounds heal slowly	N		Y (3)
20. Hair is easily plucked out, or falls out, grows slowly	N		Y (5)
21. Lips are red and swollen	N		Y (3)
22. Tongue is red, swollen, raw looking	N		Y (3)
23. Impaired taste and smell	N		Y (5)
24. Neck, armpit, groin swelling	N		Y (5)

Total Points_____

Section C

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

Total Points_____

PART IV

Section A

1. Sense of being overly tired	0	1	2	3
2. Prolonged recovery after exercise	0	1	2	3
3. Coldness, especially in hands and feet	0	1	2	3
4. Difficulty breathing on exertion, palpitations	0	1	2	3
5. Headache, dizziness, spots before eyes	0	1	2	3
6. Irritable	0	1	2	3
7. Forgetful, poor concentration	0	1	2	3
8. Ringing in ears	0	1	2	3
9. Jaundice and dark urine	0	1	2	3
10. Black stool (no iron supplements)	0	1	2	3
11. Unusual cravings for clay, dirt, ice	0	1	2	3
12. Fingernails are flattened, spoonshaped, brittle, thin	N			Y (5)
13. White patches on skin	N			Y (3)
14. Pale lips, gums, eyelids, nail beds	N			Y (3)
15. Red, sore tongue	N			Y (3)
16. Mouth, throat, rectum ulcers	N			Y (3)
17. Unusual bruising	N			Y (3)
18. Spontaneous bleeding - nose, mouth, gums, rectum or vagina	N			Y (3)
19. Small red dots under the skin	N			Y (3)
20. Sores in the corner of mouth	N			Y (3)
21. Smooth tongue	N			Y (3)
22. Mild yellowing of eyes or skin	N			Y (3)
23. Susceptible to infections	N			Y (3)

Total Points_____

Section B

1. Nosebleeds	0	1	2	3
2. Headache, typically in morning	0	1	2	3
3. Weakness, fatigue, nervous	0	1	2	3
4. Ringing in ears	0	1	2	3
5. Dizziness, drowsiness	0	1	2	3
6. Blushing - no apparent cause	0	1	2	3
7. Numbness, tingling in hands and feet	0	1	2	3
8. Blurred vision	0	1	2	3

Total Points_____

Section C

1. Feel jittery	0	1	2	3
2. Heartburn that moves to neck, jaws, left shoulder and arm	0	1	2	3
3. First effort of the day causes pain around chest	0	1	2	3
4. Dizziness	0	1	2	3
5. Choking, smothering sensation	0	1	2	3
6. Exhaustion with minor exertion	0	1	2	3

Section C (continued)

7. Heart pounds easily	0	1	2	3
8. Heavy sweating (no exertion)	0	1	2	3
9. Mild or severe chest pain	0	1	2	3
10. Difficulty catching breath especially during exercise	0	1	2	3
11. Wheezing or dry cough	0	1	2	3
12. Heart palpitations - slow, rapid or irregular	0	1	2	3
13. Swelling in feet, ankle, legs comes and goes	0	1	2	3
14. Veins on neck are prominent	0	1	2	3

Total Points_____

Section D

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

Total Points_____

PART V

Section A

Missing meals or fasting is associated with the following:

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

Section A (continued)

15. Blurred or double vision	0	1	2	3
16. Lack of coordination	0	1	2	3

Total Points_____

Section B

1. Excessive, frequent urination	0	1	2	3
2. Increased thirst and appetite	0	1	2	3
3. Blurred vision, failing eyesight	0	1	2	3
4. Fatigue, drowsiness	0	1	2	3
5. Crave sweets, but eating sweets does not relieve craving	0	1	2	3
6. Feel hungry for air (can't get enough)	0	1	2	3
7. Breath smells sweet	0	1	2	3
8. Depressed	0	1	2	3
9. Tingling, numbness, prickling sensation in extremities	0	1	2	3
10. Profuse sweating	0	1	2	3

PART X

Section A

1. Generalized bone tenderness and achiness	0	1	2	3
2. Localized bone pain	0	1	2	3
3. Bone deformity with or without swelling	0	1	2	3
4. Shins hurt during or after exercise	0	1	2	3
5. Low back or hip pain	0	1	2	3
6. Difficulty sitting straight	0	1	2	3
7. Limp, walking difficulties	0	1	2	3
8. Crunching or creaking sounds when move joints	0	1	2	3
9. Hands, feet, throat spasm or feel numb	0	1	2	3
10. Joint pain and stiffness - especially spine, hips, knees	0	1	2	3
11. Hearing loss, headaches, ringing in ears	0	1	2	3
12. Cavities within the last two years	N			Y (5)
13. Tooth loss due to gum disease	N			Y (5)
14. Established bone loss	N			Y (10)
15. Calcium deposits around joints	N			Y (5)
16. Spinal curvature	N			Y (10)
17. Recent loss of height	N			Y (10)
18. Bow legs	N			Y (5)
19. Stooped posture	N			Y (5)
20. Hump at base of neck	N			Y (5)
21. Irregular patches of increased pigmentation	N			Y (3)
22. Unexplained bone fracture	N			Y (10)

Total Points_____

Section B

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

Total Points_____

Section C

1. Joint stiffness, soreness, swelling	0	1	2	3
2. Red, swollen, painful joints	0	1	2	3
3. Joint stiffness improves when resting, worsens with movement	0	1	2	3
4. Dry mouth	0	1	2	3
5. Dry painful eyes	0	1	2	3
6. Joint stiffness worsens with rest, improves with movement	0	1	2	3
7. Cracking joints	0	1	2	3
8. Limp	0	1	2	3
9. Shooting, aching, tingling pain down the back of leg	0	1	2	3

Section C (continued)

10. Joint pain involves one or a few joints	0	1	2	3
11. Joints hurt when moving or when carrying weight	0	1	2	3
12. Difficulty standing up from sitting position	0	1	2	3
13. Headache	0	1	2	3
14. Difficulty chewing food or opening mouth	0	1	2	3
15. Intermittent pain, ache on one side of head spreading to cheek, temple, lower jaw, ear, neck and shoulder	0	1	2	3
16. Numbness, prickling, tingling sensation in the neck, shoulder and arms	0	1	2	3
17. Injure, strain, sprain easily	0	1	2	3
18. Discomfort or pain in neck, shoulder or arm	0	1	2	3
19. Involuntary muscle spasms	0	1	2	3
20. Deliberate movement with hands are difficult	0	1	2	3
21. Red, painless skin lumps on elbows, knees, toes, ear, nose, back of scalp	N			Y (5)
22. Knobby overgrowths on the joints closest to the fingertips	N			Y (5)
23. Muscle loss around inflamed joint	N			Y (10)
24. Double jointed	N			Y (3)
25. One leg shorter than the other	N			Y (5)
26. Walk slowly	N			Y (3)
27. Limited range of motion	N			Y (3)

Total Points_____

Section D

1. Head feels heavy	0	1	2	3
2. Light headedness/fainting	0	1	2	3
3. Ringing/buzzing in ears	0	1	2	3
4. Trembling hands	0	1	2	3
5. Limbs feel too heavy to hold up	0	1	2	3
6. Loss of feeling in hands and/or feet (toes)	0	1	2	3
7. Tingling sensation followed by numbness, or pain begins in hands and feet and spreads toward the center of your body	0	1	2	3
8. Unsteady gait, lose balance	0	1	2	3
9. Muscles feel weak	0	1	2	3
10. Weak grip with spasm and arm weakness	0	1	2	3
11. Exhaustion on slightest effort	0	1	2	3
12. Need for 10-12 hours sleep	0	1	2	3
13. Muscular weakness begins in leg and moves upward	0	1	2	3
14. Difficulty walking, moving around, handling small objects	0	1	2	3
15. Nervous, anxious	0	1	2	3
16. Confused, forgetful	0	1	2	3
17. Slowed or slurred speech	0	1	2	3
18. Difficulty breathing	0	1	2	3
19. Blurred vision	0	1	2	3
20. Eyelids droop	0	1	2	3
21. Accident prone - trip, stumble, feel clumsy	N			Y (5)
22. Impaired hearing, eyesight, sense of touch, smell, taste	N			Y (15)
23. Convulsions	N			Y (15)

Total Points_____

PART V Section B (continued)

11. Dribble after voiding	0	1	2	3
12. Impotency	0	1	2	3
13. Dizziness when standing from sitting position	0	1	2	3
14. Slurred speech	0	1	2	3
15. Unintentional weight loss	N			Y (3)
16. Reoccurring, persistent infection in bladder, skin or gums	N			Y (3)
17. Boils and leg sores	N			Y (3)
18. Very slow wound healing	N			Y (3)
19. Excessive weight gain	N			Y (3)

Total Points_____

PART VI

1. Weakness and fatigue	0	1	2	3
2. Chest discomfort, pain	0	1	2	3
3. Sudden breathing difficulty	0	1	2	3
4. Shortness of breath	0	1	2	3
5. Shallow breathing	0	1	2	3
6. Noisy rattling sounds when breathing in or out	0	1	2	3
7. Cough - dry or moist	0	1	2	3
8. Rapid heartbeats	0	1	2	3
9. Excessive perspiration	0	1	2	3
10. Anxiety, restlessness	0	1	2	3
11. Consistent low grade fever (100-101°)	0	1	2	3
12. Bluish nails and lips	0	1	2	3
13. Postnasal drip	0	1	2	3
14. Sputum - thick, clear, yellow	0	1	2	3
15. Sputum - smells offensive	0	1	2	3
16. Bloody sputum	0	1	2	3
17. Bad breath	0	1	2	3
18. Wheezing	0	1	2	3
19. Loud snoring	0	1	2	3
20. Sleepy during the day	0	1	2	3
21. Morning headache	0	1	2	3
22. Difficulty concentrating	0	1	2	3
23. Unexplained weight loss	N			Y (3)
24. Infections settle in lungs	N			Y (3)
25. Flu symptoms last longer than 5 days	N			Y (3)

Total Points_____

PART VII

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

Total Points_____

PART VIII (Men Only)

Section A

1. Frequent or urgent need to urinate	0	1	2	3
2. Delayed, weak, or interrupted urinary stream	0	1	2	3
3. Pain or burning upon urination	0	1	2	3
4. Urge to urinate several times a night	0	1	2	3
5. Rose colored (bloody) urine	0	1	2	3
6. Difficulty urinating	0	1	2	3
7. A sense of bladder fullness	0	1	2	3
8. Ejaculation causes pain	0	1	2	3
9. Blood in the semen	0	1	2	3
10. Lack of sex drive	0	1	2	3
11. Impotency	0	1	2	3
12. Pain or fatigue in the legs or back	0	1	2	3
13. Dripping after urination	0	1	2	3
14. Increased straining with small amounts of urine passed	0	1	2	3
15. Anemia	N			Y (3)

Total Points_____

Section B

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

Total Points_____

PART IX (Women Only)

Section A

Circle, if you experience any of these symptoms within 3 days to two weeks prior to menstruation (ovulation):

1. Insomnia	0	1	2	3
2. Abdominal bloating	0	1	2	3
3. Breast tenderness, swelling	0	1	2	3
4. Heart palpitations	0	1	2	3
5. Sweating and flushing	0	1	2	3
6. Depressed, irritable, nervous	0	1	2	3
7. Easy to anger, resentful	0	1	2	3
8. Easily overwhelmed	0	1	2	3
0. Nausea and/or vomiting	0	1	2	3
10. Diarrhea or constipation	0	1	2	3
11. Headache	0	1	2	3
12. Food cravings, binge eating	0	1	2	3
13. Back pain	0	1	2	3
14. Numbness, tingling in hands and feet	0	1	2	3
15. Clumsiness	0	1	2	3
16. Feeling hopeless, sad	0	1	2	3
17. Weight gain - water	N			Y (3)
18. Breast lumps appear	N			Y (3)
19. Suicidal	N			Y (10)

Total Points_____

Section B

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

Total Points_____

Section C

1. Painful intercourse	0	1	2	3
2. Menstrual type pain between menses	N			Y (3
3. Irregular time intervals between periods	N			Y (5)
4. Extended menses (greater than every 32 days)	N			Y (10)
5. Shortened menses (less than every 24 days)	N			Y (5)
6. Vaginal bleeding between periods	N			Y (10)
7. Vaginal discharge between periods	N			Y (5)
8. Pain during periods is getting progressively worse	N			Y (5)

Section C (continued)

Circle, if you experience any of these symptoms during your period:

9. Pain, cramps	0	1	2	3
10. Irritable and depressed	0	1	2	3
11. Constipation and/or diarrhea	0	1	2	3
12. Lower abdominal pain, bloating	0	1	2	3
13. Nausea and/or vomiting	0	1	2	3
14. Lower backache	0	1	2	3
15. Pelvic and/or rectal pressure	0	1	2	3
16. Urinary difficulties	0	1	2	3
17. Frequent urination	N			Y (5)
18. Unusual fatigue, can't work	N			Y (5)
19. Scanty blood flow	N			Y (3)
20. Heavy blood flow	N			Y (3)

Total Points_____

Section D

1. Clear, gray, or yellow vaginal discharge	0	1	2	3
2. Burning or itching of the external genitalia	0	1	2	3
3. Urgent, painful urination	0	1	2	3
4. Lower abdominal or back pain	0	1	2	3
5. Heavy, watery and bloody vaginal discharge	0	1	2	3
6. Pelvic cramps	0	1	2	3
7. Thin, scant, white vaginal discharge	0	1	2	3
8. Greenish, yellow, or offensive discharge	0	1	2	3
9. Cheesy white discharge	0	1	2	3
10. Breast lumps or swelling with or without pain or tenderness	N			Y (10)
11. Lumps hurt just before period	N			Y (5)
12. Swelling under armpit	N			Y (5)
13. Change in breast size, shape	N			Y (5)
14. White or slightly bloody vaginal discharge, one week prior to period	N			Y (10)
15. Heavy menstrual flow	N			Y (3)
16. Vaginal bleeding after sex or between periods	N			Y (5)

Total Points_____

Section E

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

Total Points_____