

CHIROPRACTIC
WELLNESS CENTER

Dear Nutritional Patient,

Please fill out the attached questionnaire and return it to our office at least 24 hours before your appointment. In addition, if you have had any blood tests done in the last 6 months, please include a copy of the results. If you are taking prescription medications, please provide a list of the drugs. If you are taking any nutritional supplements, please bring them with you for your appointment.

Summary of needed information:

- 24 hours prior to appointment:
- 1) Questionnaire
 - 2) Copy of any blood work done within the last 6 months
 - 3) List of prescription medications

Bring with you for the appointment: 1) All nutritional supplements you are taking

Dr. Campbell will reserve 1 ½ hours for your consultation. Should you have to cancel, please give us at least **24 hours notice**. If a **24 hour notice** is not received and we cannot fill the time slot reserved for you, then we will be forced to charge you for that time.

Thanks for your help,

Dr. Charles Campbell

1434 Kingwood Drive • Kingwood, Texas 77339
281-358-7777 • fax: 281-358-8780

PATIENT HISTORY

Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Phone _____ Date of Birth _____ Age _____ Sex: M F
 Social Security number _____ Marital Status: S M D W
 How Many Children _____ Spouse's Name _____
 Your Employer _____ Employer Phone _____
 Your Occupation _____
 Date when your symptoms started? _____
 Was this incident due to a recent motor vehicle accident? _____ Date of accident: _____
 Insured Name _____ Insured DOB _____
 Insured ID# _____ Insured SS # _____
 Insured Employer _____
 Insurance Company _____
 Group # _____ Insurance Company Phone # _____
 How did you hear about our Clinic: _____ Phone Book _____ Dr. Referral: Name _____
 _____ Patient Referral _____ Insurance Co. _____ Walk-In _____
 Please list your Primary Physician: _____
 E-Mail Address: _____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I also understand that if I suspend or terminate any treatment any fees for professional services rendered me will be immediately due and payable.

HABITS

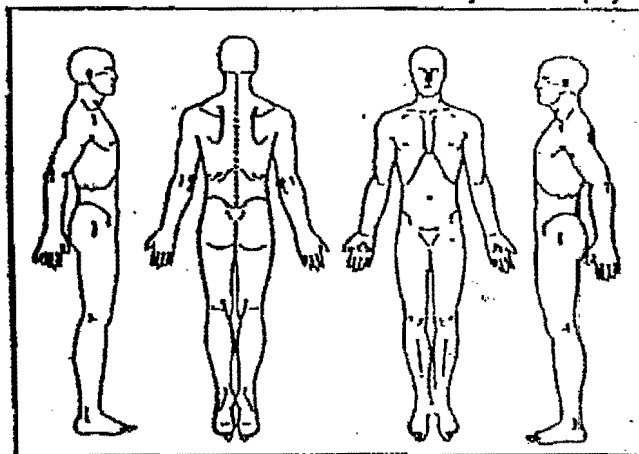
_____ Smoking Packs/Day _____
 _____ Drinking Alcohol _____
 _____ Coffee Cups/Day _____

EXERCISE

_____ None _____ Moderate _____ Daily

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____



INDICATE ON THE DIAGRAM THE AREAS YOU ARE PRESENTLY EXPERIENCING PAIN. CIRCLE YOUR PAIN LEVEL: 1 2 3 4 5 6 7 8 9 10

Women are you pregnant? _____ Yes _____ No

Have you had any of the following diseases?

_____ Appendicitis	_____ Anemia	_____ Gopher	_____ Lumbago	_____ Heart Disease
_____ Arthritis	_____ Influenza	_____ Eczema	_____ Pneumonia	_____ Measles
_____ Pleurisy	_____ Aids	_____ Mumps	_____ Polio	_____ Alcoholism
_____ Chicken Pox	_____ Diabetes	_____ Epilepsy	_____ Cancer	_____ Tuberculosis
_____ Rheumatic Fever		_____ Venereal Infection		_____ Whooping Cough
_____ Mental Disorder		List any Allergies _____		

Patient's/Guardian's Signature _____ Date _____

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 you keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

For each question, circle the number that best describes your symptoms:

- 0 = No or Rarely**—You have never experienced the symptom or the symptom is familiar to you but you perceive it as insignificant (monthly or less)
- 1 = Occasionally**—Symptom comes 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 questions require a YES or NO response: 0 = NO 8 = YES

PART I

SECTION A

- | | No/Rarely | Occasionally | Often | Frequently |
|--|-----------|--------------|-------|------------|
| 1. Indigestion, food repeats on you after you eat | 0 | 1 | 4 | 8 |
| 2. Excessive burping, belching and/or bloating following meals | 0 | 1 | 4 | 8 |
| 3. Stomach spasms and cramping during or after eating | 0 | 1 | 4 | 8 |
| 4. A sensation that food just sits in your stomach creating uncomfortable fullness, pressure and bloating during or after a meal | 0 | 1 | 4 | 8 |
| 5. Bad taste in your mouth | 0 | 1 | 4 | 8 |
| 6. Small amounts of food fill you up immediately | 0 | 1 | 4 | 8 |
| 7. Skip meals or eat erratically because you have no appetite | 0 | 1 | 4 | 8 |

Total points

SECTION B

- | | | | | |
|--|-------|---|--------|---|
| 1. Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt | 0 | 1 | 4 | 8 |
| 2. Feel hungry an hour or two after eating a good-sized meal | 0 | 1 | 4 | 8 |
| 3. Stomach pain, burning and/or aching over a period of 1-4 hours after eating | 0 | 1 | 4 | 8 |
| 4. Stomach pain, burning and/or aching relieved by eating food; drinking carbonated beverages, cream or milk; or taking antacids | 0 | 1 | 4 | 8 |
| 5. Burning sensation in the lower part of your chest, especially when lying down or bending forward | 0 | 1 | 4 | 8 |
| 6. Digestive problems that subside with rest and relaxation | (0)No | | (8)Yes | |
| 7. Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache | 0 | 1 | 4 | 8 |
| 8. Feel a sense of nausea when you eat | 0 | 1 | 4 | 8 |
| 9. Difficulty or pain when swallowing food or beverage | 0 | 1 | 4 | 8 |

Total points

SECTION C

- | | | | | |
|--|---|---|---|---|
| 1. When massaging under your rib cage on your left side, there is pain, tenderness or soreness | 0 | 1 | 4 | 8 |
| 2. Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal | 0 | 1 | 4 | 8 |
| 3. Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement | 0 | 1 | 4 | 8 |
| 4. Specific foods/beverages aggravate indigestion | 0 | 1 | 4 | 8 |
| 5. The consistency or form of your stool changes [e.g., from narrow to loose] within the course of a day | 0 | 1 | 4 | 8 |

SECTION C (cont.)

- | | | | | |
|---|---|---|---|---|
| 6. Stool odor is embarrassing | 0 | 1 | 4 | 8 |
| 7. Undigested food in your stool | 0 | 1 | 4 | 8 |
| 8. Three or more large bowel movements daily | 0 | 1 | 4 | 8 |
| 9. Diarrhea (frequent loose, watery stool) | 0 | 1 | 4 | 8 |
| 10. Bowel movement shortly after eating (within 1 hour) | 0 | 1 | 4 | 8 |

Total points

SECTION D

- | | | | | |
|--|-------|---|--------|---|
| 1. Discomfort, pain or cramps in your colon (lower abdominal area) | 0 | 1 | 4 | 8 |
| 2. Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas | 0 | 1 | 4 | 8 |
| 3. Generally constipated (or straining during bowel movements) | 0 | 1 | 4 | 8 |
| 4. Stool is small, hard and dry | 0 | 1 | 4 | 8 |
| 5. Pass mucus in your stool | 0 | 1 | 4 | 8 |
| 6. Alternate between constipation and diarrhea | 0 | 1 | 4 | 8 |
| 7. Rectal pain, itching or cramping | 0 | 1 | 4 | 8 |
| 8. No urge to have a bowel movement | (0)No | | (8)Yes | |
| 9. An almost continual need to have a bowel movement | (0)No | | (8)Yes | |

Total points

PART II

- | | | | | |
|---|---|---|---|---|
| 1. When massaging under your rib cage on your right side, there is pain, tenderness or soreness | 0 | 1 | 4 | 8 |
| 2. Abdominal pain worsens with deep breathing | 0 | 1 | 4 | 8 |
| 3. Pain at night that may move to your back or right shoulder | 0 | 1 | 4 | 8 |
| 4. Bitter fluid repeats after eating | 0 | 1 | 4 | 8 |
| 5. Feel abdominal discomfort or nausea when eating rich, fatty or fried foods | 0 | 1 | 4 | 8 |
| 6. Throbbing temples and/or dull pain in forehead associated with overeating | 0 | 1 | 4 | 8 |
| 7. Unexplained itchy skin that's worse at night | 0 | 1 | 4 | 8 |
| 8. Stool color alternates from clay colored to normal brown | 0 | 1 | 4 | 8 |
| 9. General feeling of poor health | 0 | 1 | 4 | 8 |

PART II

	No/Rarely	Occasionally	Often	Frequently
10. Aching muscles not due to exercise	0	1	4	8
11. Retain fluid and feel swollen around the abdominal area	0	1	4	8
12. Reddened skin, especially palms	0	1	4	8
13. Very strong body odor	0	1	4	8
14. Are you embarrassed by your breath?	0	1	4	8
15. Bruise easily	(0)No	(8)Yes		
16. Yellowish cast to eyes	(0)No	(8)Yes		
Total points <input type="text"/>				

PART III

SECTION A

1. Feel cold or chilled—hands, feet or all over—for no apparent reason	0	1	4	8
2. Your upper eyelids look swollen	0	1	4	8
3. Muscles are weak, cramp and/or tremble	0	1	4	8
4. Are you forgetful?	0	1	4	8
5. Do you feel like your heart beats slowly?	0	1	4	8
6. Reaction time seems slowed down	0	1	4	8
7. In general, are you disinterested in sex because your desire is low?	0	1	4	8
8. Feel slow-moving, sluggish	0	1	4	8
9. Constipation	0	1	4	8
10. Dryness, discoloration of skin and/or hair	(0)No	(8)Yes		
11. Have you noticed recently that your voice is deepening?	(0)No	(8)Yes		
12. Thick, brittle nails	(0)No	(8)Yes		
13. Weight gain for no apparent reason	(0)No	(8)Yes		
14. Outer third of your eyebrow is thinning or disappearing	(0)No	(8)Yes		
15. Swelling of the neck	(0)No	(8)Yes		
Total points <input type="text"/>				

SECTION B

1. Lingering mild fatigue after exertion or stress	0	1	4	8
2. Do you find that you get tired and exhaust easily?	0	1	4	8
3. Craving for salty foods	0	1	4	8
4. Sensitive to minor changes in weather and surroundings	0	1	4	8
5. Dizzy when rising or standing up from a kneeling position	0	1	4	8
6. Dark bluish or black circles under your eyes	0	1	4	8
7. Have bouts of nausea with or without vomiting	0	1	4	8
8. Catch colds or infections easily	(0)No	(8)Yes		
9. Wounds heal slowly	(0)No	(8)Yes		
10. Your body or parts of your body feel tender, sore, sensitive to the touch, hot and/or painful	0	1	4	8
11. Feel puffy and swollen all over your body	0	1	4	8
12. Skin is gradually tanning without exposure to sun or the ingestion of high levels of carotene-rich foods (e.g., daily carrot juice intake) or supplements	(0)No	(8)Yes		
Total points <input type="text"/>				

PART IV

	No/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	0	1	4	8
2. A sudden sense of anxiety when you get hungry	0	1	4	8
3. Tingling sensation in your hands	0	1	4	8
4. A sensation of your heart beating too quickly or forcefully	0	1	4	8
5. Shaky, jittery, hands trembling	0	1	4	8
6. Sudden profuse sweating and/or your skin feels clammy	0	1	4	8
7. Nightmares possibly associated with going to bed on an empty stomach	0	1	4	8
8. Wake up at night feeling restless	0	1	4	8
9. Agitation, easily upset, nervous	0	1	4	8
10. Poor memory, forgetful	0	1	4	8
11. Confused or disoriented	0	1	4	8
12. Dizzy, faint	0	1	4	8
13. Cold or numb	0	1	4	8
14. Mild headaches or head pounding	0	1	4	8
15. Blurred vision or double vision	0	1	4	8
16. Feel clumsy and uncoordinated	0	1	4	8
Total points <input type="text"/>				

SECTION B

1. Frequent urination during the day and night	0	1	4	8
2. Unusual thirst—feeling like you can't drink enough water	0	1	4	8
3. Unusual hunger—eating all the time	0	1	4	8
4. Vision blurs	0	1	4	8
5. Feel itchy all over	0	1	4	8
6. Tingling or numbness in your feet	0	1	4	8
7. Sense of drowsiness, lethargy during the day not associated with missing meals or not sleeping	0	1	4	8
8. Eating starchy foods, even if they are healthy and unprocessed (like rice, corn, beans, whole wheat or oats), causes you to gain weight or prevents you from losing weight	(0)No	(8)Yes		
9. Sores heal slowly	(0)No	(8)Yes		
10. Loss of hair on your legs	(0)No	(8)Yes		
Total points <input type="text"/>				

PART V

SECTION A

1. Feel jittery	0	1	4	8
2. First effort of the day causes pain, pressure, tightness or heaviness around the chest	0	1	4	8
3. Exhaustion with minor exertion	0	1	4	8
4. Heavy sweating (no exertion, no hot flashes)	0	1	4	8
5. Difficulty catching breath, especially during exercise	0	1	4	8
6. Heart pounding, sensation of heart beating too quickly, too slowly or irregularly	0	1	4	8
7. Swelling in feet, ankles and/or legs comes and goes for no apparent reason	0	1	4	8
Total points <input type="text"/>				

PART V (cont.)

SECTION B

	No/Rarely	Occasionally Often	Frequently
1. Muscle pain at rest	0	1 4	8
2. Cramp-like pains in your ankles, calves or legs	0	1 4	8
3. Numbness, tingling and prickling sensation in hands and feet	0	1 4	8
4. Cold feet and/or toes appear blue	0	1 4	8
5. Brief moments of hearing loss	0	1 4	8
6. Nausea comes and goes quickly (unrelated to eating)	0	1 4	8
7. Feel worse standing: legs get heavy and fatigued	0	1 4	8
8. Leg discomfort or fatigue relieved by elevating legs	0	1 4	8
9. Fingers and toes get numb in cold weather even when protected	0	1 4	8
10. Notice changes in your ability to feel pain or differentiate between sensations of hot or cold	(0)No	(8)Yes	
11. Body hair (on arms, hands, fingers, legs and toes) is thinning or has disappeared	(0)No	(8)Yes	
12. Do you notice a decline in your ability to make decisions, concentrate, focus attention or follow directions?	(0)No	(8)Yes	

Total points

SECTION B (cont.)

	No/Rarely	Occasionally Often	Frequently
12. Do you become suddenly scared for no reason?	0	1 4	8
13. Do you break out in a cold sweat?	0	1 4	8
14. "Butterflies in your stomach," nausea and/or diarrhea	0	1 4	8

Total points

SECTION C

	No/Rarely	Occasionally Often	Frequently
1. Do you feel pent up and ready to explode?	0	1 4	8
2. Are you prone to noisy and emotional outbursts?	0	1 4	8
3. Do you do things on impulse?	0	1 4	8
4. Are you easily upset or irritated?	0	1 4	8
5. Do you go to pieces if you don't control yourself?	0	1 4	8
6. Do little annoyances get on your nerves and make you angry?	0	1 4	8
7. Does it make you angry to have anyone tell you what to do?	0	1 4	8
8. Do you flare up in anger if you can't have what you want right away?	0	1 4	8

Total points

PART VI

SECTION A

	No/Rarely	Occasionally Often	Frequently
1. Family, friends, work, hobbies or activities you hold dear are no longer of interest	0	1 4	8
2. Do you cry?	0	1 4	8
3. Does life look entirely hopeless?	0	1 4	8
4. Would you describe yourself as feeling miserable and sad, unhappy or blue?	0	1 4	8
5. Do you find it hard to make the best of difficult situations?	0	1 4	8
6. Sleep problems—too much or too little sleep	0	1 4	8
7. Changes in your appetite and weight	(0)No	(8)Yes	
8. Lately you've noticed an inability to think clearly or concentrate	(0)No	(8)Yes	
9. Difficulty making decisions and/or clarifying and achieving your goals	(0)No	(8)Yes	

Total points

SECTION B

	No/Rarely	Occasionally Often	Frequently
1. Does worrying get you down?	0	1 4	8
2. Does every little thing get on your nerves and wear you out?	0	1 4	8
3. Would you consider yourself a nervous person?	0	1 4	8
4. Do you feel easily agitated?	0	1 4	8
5. Do you shake and tremble?	0	1 4	8
6. Are you keyed up and jittery?	0	1 4	8
7. Do you tremble or feel weak when someone shouts at you?	0	1 4	8
8. Do you become scared at sudden movements or noises at night?	0	1 4	8
9. Do you find yourself sighing a lot?	0	1 4	8
10. Are you awakened out of your sleep by frightening dreams?	0	1 4	8
11. Do frightening thoughts keep coming back in your mind?	0	1 4	8

PART VII

	No/Rarely	Occasionally Often	Frequently
1. Eyes water or tear	0	1 4	8
2. Mucus discharge from the eyes	0	1 4	8
3. Ears ache, itch, feel congested or sore	0	1 4	8
4. Discharge from ears	0	1 4	8
5. Is your nose continually congested?	0	1 4	8
6. Are you prone to loud snoring?	(0)No	(8)Yes	
7. Does your nose run?	0	1 4	8
8. Nosebleeds	(0)No	(8)Yes	
9. Hoarse voice	0	1 4	8
10. Do you have to clear your throat?	0	1 4	8
11. Do you feel a choking lump in your throat?	0	1 4	8
12. Do you suffer from severe colds?	(0)No	(8)Yes	
13. Do frequent colds keep you miserable all winter?	(0)No	(8)Yes	
14. Flu symptoms last longer than 5 days	(0)No	(8)Yes	
15. Do infections settle in your lungs?	(0)No	(8)Yes	
16. Chest discomfort or pain	0	1 4	8
17. Do you experience sudden breathing difficulties?	0	1 4	8
18. Do you struggle with shortness of breath?	0	1 4	8
19. Difficulty exhaling (breathing out)	0	1 4	8
20. Breathlessness followed by coughing during exertion, no matter how slight	0	1 4	8
21. Inability to breathe comfortably while lying down	0	1 4	8
22. Do you cough up lots of phlegm?	0	1 4	8
23. Can you hear noisy rattling sounds when breathing in and out?	0	1 4	8
24. Are you troubled with coughing?	0	1 4	8
25. Do you wheeze?	0	1 4	8
26. Do you have severe soaking sweats at night?	0	1 4	8
27. Do your lips and/or nails have a bluish hue?	0	1 4	8
28. Are you sleepy during the day?	0	1 4	8

PART VII (cont.)

	No/Rarely	Occasionally	Often	Frequently
29. Do you have difficulty concentrating?	0	1	4	8
30. Eyes, ears, nose, throat and lung symptoms seem associated with specific foods like dairy or wheat products	(0)No		(8)Yes	
31. Eyes, ears, nose, throat and lung symptoms are associated with seasonal changes	(0)No		(8)Yes	
Total points				<input type="text"/>

PART VIII

1. Involuntary loss of urine when you cough, lift something or strain during an activity	0	1	4	8
2. Mild lower back ache or pain	0	1	4	8
3. Abdominal achiness or pain	0	1	4	8
4. Pain or burning when urinating	0	1	4	8
5. Rarely feel the urge to urinate	0	1	4	8
6. Feel the need to urinate less than every two hours during the day or night	0	1	4	8
7. Strong smelling urine	0	1	4	8
8. Back or leg pains are associated with dripping after urination	0	1	4	8
9. Sore or painful genitals	0	1	4	8
10. Urine is a rose color	0	1	4	8
11. Sudden urge to void causes involuntary loss of urine	0	1	4	8
12. Generalized sense of water retention throughout your body	0	1	4	8
Total points				<input type="text"/>

PART IX

SECTION A

1. Bones throughout your entire body ache, feel tender or sore	0	1	4	8
2. Localized bone pain	0	1	4	8
3. Hands, feet or throat get tight, spasm or feel numb	0	1	4	8
4. Difficulty sitting straight	0	1	4	8
5. Upper back pain	0	1	4	8
6. Lower back pain	0	1	4	8
7. Pain when sitting down or walking	0	1	4	8
8. Find yourself limping or favoring one leg	0	1	4	8
9. Shins hurt during or after exercise	0	1	4	8
Total points				<input type="text"/>

SECTION B

1. Are you stiff in the morning when you wake up?	0	1	4	8
2. Difficulty bending down and picking up clothing or anything from the floor	0	1	4	8
3. Joint swelling, pain or stiffness involving one or more areas (fingers, hands, wrists, elbows, shoulders, toes, arches, feet, ankles, knees or ankles)	0	1	4	8
4. Joints hurt when moving or when carrying weight	0	1	4	8
5. A routine exercise program, like daily walking, causes your knees to swell or hurt	0	1	4	8
6. Difficulty opening jars that were previously easy to open	0	1	4	8
7. Discomfort, numbness, prickling or tingling sensation, or pain in neck, shoulder or arm	0	1	4	8

SECTION B (cont.)

	No/Rarely	Occasionally	Often	Frequently
8. Intermittent pain or ache on one side of head spreading to cheek, temple, lower jaw, ear, neck and shoulder	0	1	4	8
9. Difficulty chewing food or opening mouth	0	1	4	8
10. Difficulty standing up from a sitting position	0	1	4	8
11. Shooting, aching, tingling pain down the back of leg	0	1	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?	(0)No		(8)Yes	
13. Injure, strain or sprain easily	(0)No		(8)Yes	
Total points				<input type="text"/>

SECTION C

1. Muscles stiff, sore, tense and/or achy	0	1	4	8
2. Burning, throbbing, shooting or stabbing muscle pain	0	1	4	8
3. Muscle cramps or spasms (involuntary or after exertion/exercise)	0	1	4	8
4. Is muscle pain or stiffness greater in the morning than other times of the day?	0	1	4	8
5. Specific points on body feel sore when pressed	0	1	4	8
6. Feel unrefreshed upon awakening	0	1	4	8
7. Headaches	0	1	4	8
8. Pain at the sides of your head or in your face especially when awakening	0	1	4	8
9. Your jaw clicks or pops	0	1	4	8
10. Muscle twitch or tremor—eyelids, thumb, calf muscle	0	1	4	8
11. Irresistible urge to move legs	0	1	4	8
12. Legs move during sleep	0	1	4	8
13. Unpleasant crawling sensation inside calves when lying down	0	1	4	8
14. Hand and wrist numbness or pain (e.g., interferes with writing or with buttoning or unbuttoning your clothes)	0	1	4	8
15. Feeling of "pins and needles" in your thumb and first three fingers	0	1	4	8
16. Pain in forearm and sometimes in shoulder	0	1	4	8
Total points				<input type="text"/>

PART X

SECTION A

1. Head feels heavy	0	1	4	8
2. Dizziness	0	1	4	8
3. Difficulty bending over, standing up from sitting, rolling over in bed and/or turning your head from side to side	0	1	4	8
4. Your hands tremble, ever so slightly, for no apparent reason	0	1	4	8
5. You feel like you're wearing heavy weights on your feet when walking	0	1	4	8
6. Bump into things, trip, stumble and feel clumsy	0	1	4	8
7. Difficulty breathing	0	1	4	8
8. Difficulty swallowing	0	1	4	8
9. People tell you to speak up because they have trouble hearing you	0	1	4	8
10. Speaking and forming words does not feel automatic	0	1	4	8
11. Need 10-12 hours of sleep to feel rested	0	1	4	8

PART X (cont.)

No/Rarely
Occasionally
Often
Frequently

SECTION A (cont.)

- 12. Lack strength (your grip is weak, holding your head or picking your arms up takes effort) 0 1 4 8
- 13. Hands get tired when you write and your handwriting is less legible and smaller than it used to be (0)No (8)Yes
- 14. Muscles in arms and legs seem softer and smaller (0)No (8)Yes
- 15. Is your eyesight, sense of smell and taste or ability to hear not as sharp as it used to be? (0)No (8)Yes
- 16. Do you find yourself moving slower than you used to? (0)No (8)Yes

Total points

SECTION B

- 1. Difficulty absorbing new information 0 1 4 8
- 2. Tend to forget things 0 1 4 8
- 3. Trouble thinking or concentrating 0 1 4 8
- 4. Easily distracted 0 1 4 8
- 5. Do you have a tendency to become frustrated quickly? 0 1 4 8
- 6. Inability to sit still for any length of time, even at mealtime 0 1 4 8
- 7. Finishing tasks is easier said than done 0 1 4 8
- 8. Do you have more trouble solving problems or managing your time than usual? 0 1 4 8
- 9. Low tolerance for stress and otherwise ordinary problems 0 1 4 8

Total points

PART XI

Men Only

- 1. Sensation of not emptying your bladder completely 0 1 4 8
- 2. Need to urinate less than 2 hours after you have finished urinating 0 1 4 8
- 3. Find yourself needing to stop and start again several times while urinating 0 1 4 8
- 4. Find it difficult to postpone urination 0 1 4 8
- 5. Have a weak urinary stream 0 1 4 8
- 6. Need to push or strain to begin urinating 0 1 4 8
- 7. Dripping after urination 0 1 4 8
- 8. Urge to urinate several times a night 0 1 4 8

Total points

PART XII

Women Only

(Menopausal women should skip to Sections E and F)

SECTION A

Do you persistently experience any of these symptoms within three days to two weeks prior to menstruation?

[A]

- 1. Anxious, irritable or restless (0)No (8)Yes
- 2. Numbness, tingling in hands and feet (0)No (8)Yes
- 3. Easy to anger, resentful (0)No (8)Yes
- 4. Aggressive or hostile toward family/friends (0)No (8)Yes

Total points

SECTION A (cont.)

No/Rarely
Occasionally
Often
Frequently

[B]

- 5. Abdominal bloating, feeling swollen (e.g., feet) (0)No (8)Yes
- 6. Temporary weight gain (0)No (8)Yes
- 7. Breast tenderness, swelling (0)No (8)Yes
- 8. Appearance of breast lumps (0)No (8)Yes
- 9. Discharge from nipples (0)No (8)Yes
- 10. Nausea and/or vomiting (0)No (8)Yes
- 11. Diarrhea or constipation (0)No (8)Yes
- 12. Aches and pains (back, joints, etc.) (0)No (8)Yes

[C]

- 13. Craving for sweets (0)No (8)Yes
- 14. Increased appetite or binge eating (0)No (8)Yes
- 15. Headaches (0)No (8)Yes
- 16. Being easily overwhelmed, shaky or clumsy (0)No (8)Yes
- 17. Heart pounding (0)No (8)Yes
- 18. Dizziness or fainting (0)No (8)Yes

[D]

- 19. Confused and forgetful to the point that work suffers (0)No (8)Yes
- 20. Overwhelmed with feelings of sadness and worthlessness (0)No (8)Yes
- 21. Difficulty sleeping or falling asleep (0)No (8)Yes
- 22. Engaging in self-destructive behavior (0)No (8)Yes

Total points

SECTION B

Do you experience any of these symptoms during your period?

- 1. Cramping in lower abdomen or pelvic area (0)No (8)Yes
- 2. Lower abdominal pain is sharp and/or dull or intermittent (0)No (8)Yes
- 3. Bloating and sense of abdominal fullness (0)No (8)Yes
- 4. Diarrhea or constipation (0)No (8)Yes
- 5. Nausea and/or vomiting (0)No (8)Yes
- 6. Low back and/or legs ache (0)No (8)Yes
- 7. Headaches (0)No (8)Yes
- 8. Unusual fatigue (take naps) resulting in missed work (0)No (8)Yes
- 9. Painful and/or swollen breasts (0)No (8)Yes
- 10. Scanty blood flow (0)No (8)Yes

Total points

SECTION C

- 1. Painful or difficult sexual intercourse 0 1 4 8
- 2. Low abdominal, back and vaginal pain throughout the month 0 1 4 8
- 3. Pelvic pressure or pain while sitting down or standing up, relieved by lying down 0 1 4 8
- 4. Vaginal bleeding other than during your period 0 1 4 8
- 5. Painful bowel movements 0 1 4 8
- 6. Difficult (straining) urination 0 1 4 8
- 7. Abnormal vaginal discharge 0 1 4 8
- 8. Offensive vaginal discharge 0 1 4 8
- 9. Vaginal itching or burning with or without intercourse 0 1 4 8
- 10. Pain during periods is getting progressively worse (0)No (8)Yes
- 11. Profuse or prolonged menstrual bleeding (0)No (8)Yes
- 12. Unable to get pregnant (0)No (8)Yes

Total points

SECTION D

	No/Rarely	Occasionally	Often	Frequently
1. Absence of periods for six months or longer	(0)No	(8)Yes		
2. Periods occur irregularly (e.g., 3 to 6 times a year)	(0)No	(8)Yes		
3. Profuse heavy bleeding during periods	0	1	4	8
4. Menstrual blood contains clots and tissue	0	1	4	8
5. Bleeding between periods can occur anytime	0	1	4	8
6. Periods occur greater than every 35 days	(0)No	(8)Yes		
7. Intense upper stomach pain, lasting several hours at the time you ovulate (approximately day 14 of your cycle)	0	1	4	8
8. Bleeding occurs at ovulation (approximately day 14 of your cycle)	0	1	4	8
9. Monthly abdominal pain without bleeding	0	1	4	8
10. Abundant cervical mucus	0	1	4	8
11. Acne and/or oily skin	0	1	4	8
12. Overwhelming urges for sexual intercourse	0	1	4	8
13. Aggressive feelings	0	1	4	8
14. Increased growth of dark facial and/or body hair	(0)No	(8)Yes		
15. Poor sense of smell	(0)No	(8)Yes		
16. Voice is becoming deeper	(0)No	(8)Yes		
17. Breasts seem to be getting smaller	(0)No	(8)Yes		
18. Receding hairline	(0)No	(8)Yes		

Total points

SECTION E

1. Vaginal discharge	0	1	4	8
2. Vaginal secretions are watery and thin	0	1	4	8
3. Vaginal dryness	0	1	4	8
4. Sexual intercourse is uncomfortable	0	1	4	8

SECTION E (cont.)

	No/Rarely	Occasionally	Often	Frequently
5. Interest in having sex is low	0	1	4	8
6. Engorged breasts	0	1	4	8
7. Breast tenderness, soreness	0	1	4	8
8. Difficulty with orgasm	0	1	4	8
9. Vaginal bleeding after sexual intercourse	0	1	4	8
10. Do you skip periods?	(0)No	(8)Yes		
11. The length (number of days) of your period varies month to month, with the number of days of bleeding getting fewer	(0)No	(8)Yes		

Total points

SECTION F

1. Sense of well-being fluctuates throughout the day for no apparent reason	0	1	4	8
2. Sudden hot flashes	0	1	4	8
3. Spontaneous sweating	0	1	4	8
4. Chills	0	1	4	8
5. Cold hands and feet	0	1	4	8
6. Heart beats rapidly or feels like it is fluttering	0	1	4	8
7. Numbness, tingling or prickling sensations	0	1	4	8
8. Dizziness	0	1	4	8
9. Mental fogginess, forgetful or distracted	0	1	4	8
10. Inability to concentrate	0	1	4	8
11. Depression, anxiety, nervousness and/or irritability	0	1	4	8
12. Difficulty sleeping	0	1	4	8
13. Conscious of new feelings of anger and frustration	0	1	4	8
14. Skin, hair, vagina and/or eyes feel dry	0	1	4	8
15. Stopped menstruating around six months ago, yet still experience some vaginal bleeding	(0)No	(8)Yes		

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.

