Health Appraisal Questionnaire
Basic Form

PATIENT NUMBER _____

Name _____ Date ____/____/____

Part I

Circle any of the following medications you are taking:

- Antacids
- Antibiotic/Antifungal
- Antidepressants
- Anti Diabetic/Insulin
- Aspirin/Tylenol
- Chemotherapy
- Cortisone/Anti-inflammatories
- Heart Medications
- High Blood Pressure
- Hormones
- Laxatives
- Lithium
- Oral Contraceptives
- Radiation
- Recreational Drugs Specify _____
- Relaxants/Sleeping Pills
- Thyroid
- Ulcer Medications
- Other _____

Circle if you eat, drink or use:

- Alcohol
- Candy
- Carbonated beverages
- Cigarettes
- Coffee
- Distilled water
- Fast food, regularly
- Fried Foods
- Luncheon meats
- Margarine
- Vitamins and/or minerals (Please list)
- Refined sugars
- Saccharine (Sweet & Low)
- Chew Tobacco

Circle if you:

- Diet often
- Do not exercise regularly
- Salt food without tasting
- Are under excessive stress
- Are exposed to chemicals at work
- Are exposed to cigarette smoke

INSTRUCTIONS: Circle the number which best describes the intensity of your symptoms. If you do not know the answer to a question, leave it blank.
0= Symptom is not present 1 = Mild 2= Moderate 3= Severe

Part II

SECTION A:

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

SECTION B:

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

SECTION C:

1. Stomach pains	0	1	2	3
2. Stomach pains just before and/or after meals	0	1	2	3
3. Dependency on antacids	0	1	2	3
4. Chronic abdominal pain	0	1	2	3
5. Butterfly sensations in stomach	0	1	2	3
6. Difficulty belching	0	1	2	3
7. Stomach pain when emotionally upset	0	1	2	3
8. Sudden, acute indigestion	No			Yes
9. Relief of symptoms by carbonated beverages	No			Yes
10. Relief of stomach pain by drinking cream/milk	No			Yes
11. History of ulcer or gastritis	No			Yes
12. Current ulcer	No			Yes (10)
13. Black stool when not taking iron supplements	No			Yes (10)

SECTION D:

1. Seasonal diarrhea	0	1	2	3
2. Frequent and recurrent infections (colds)	0	1	2	3
3. Bladder and kidney infections	0	1	2	3
4. Vaginal yeast infection	0	1	2	3
5. Abdominal cramps	0	1	2	3
6. Toe and Fingernail Fungus	0	1	2	3
7. Alternating diarrhea/constipation	0	1	2	3
8. Constipation	0	1	2	3
9. History of antibiotic use	No			Yes
10. Meat eater	No			Yes
11. Rapidly Failing vision	No			Yes

Part III

SECTION A:

1. Intolerance to greasy foods	0	1	2	3
2. Headaches after eating	0	1	2	3
3. Light colored stool	0	1	2	3
4. Foul smelling stool	0	1	2	3
5. Less than one bowel movement daily	0	1	2	3
6. Constipation	0	1	2	3
7. Hard stool	0	1	2	3
8. Sour taste in mouth	0	1	2	3
9. Grey colored skin	0	1	2	3
10. Yellow in whites of eyes	0	1	2	3
11. Bad breath	0	1	2	3
12. Body odor	0	1	2	3
13. Fatigue and sleepiness after eating	0	1	2	3
14. Pain in right side under rib cage	0	1	2	3
15. Painful to pass stool	0	1	2	3
16. Retain water	0	1	2	3
17. Big toe painful	0	1	2	3
18. Pain radiates along outside of leg	0	1	2	3
19. Dry skin/hair	0	1	2	3
20. Red blood in stool	No			Yes (10)

Part III (continued)

Section A (continued)

21. Have had jaundice or hepatitis ..... No Yes
22. High blood cholesterol and low HDL cholesterol ..... No Unknown Yes
23. Is your cholesterol level above 200 ..... No Unknown Yes
24. Is your triglyceride level above 115 ..... No Unknown Yes

SECTION B:

1. Swollen eyes (bulging)	0	1	2	3
2. Strong smelling urine	0	1	2	3
3. Thick skin and finger nails	0	1	2	3
4. Dry skin	0	1	2	3
5. Sensitive to the cold	0	1	2	3
6. Cold hands and feet	0	1	2	3
7. Excessive menstrual bleeding	0	1	2	3
8. Chronic fatigue	0	1	2	3
9. Trouble waking up in the morning	0	1	2	3
10. Depressed, apathetic	0	1	2	3
11. Low sex drive	0	1	2	3
12. Puffy, wrinkly skin	0	1	2	3
13. Sugar causes irritability and mood swings	0	1	2	3
14. Premenstrual tension	0	1	2	3
15. Constipation	0	1	2	3

16. Thinning or loss of outside portion of eyebrow	No	Yes
17. Gain weight easily	No	Yes
18. Anemia unaffected by iron	No	Yes
19. Axiltary (armpit) temperature below 97.6°F	No	Yes
20. Slow reflexes	No	Yes
21. Infertility	No	Yes

	Part II Digestion				Part III Fat Metabolism	
	A. Hypoacidity	B. Small Intestine	C. Hyperacidity	D. Colon	A. Liver/Gallbladder	B. Thyroid
100	15+	15+	15+	15+	18+	25+
	13	13	13	13	15	20
	11	11	11	11	12	15
75					9	
	9	9	9	9	6	9
	7	7	7	7	5	7
50					4	
	5	5	5	5	3	5
	3	3	3	3	2	3
25					1	
	1	1	1	1		1
0						
SCORE						

HIGH PRIORITY

MODERATE PRIORITY

LOW PRIORITY

NAME _____ DATE _____

SUPPLEMENT RECOMMENDATIONS

Instructions

	Arise	Breakfast	Mid Morn	Lunch	Mid Noon	Dinner	Bed