# HEALTH APPRAISAL QUESTIONNAIRE

Name _____ Date _____

## Part I

### Circle any of the following medications you are taking:

Antacids
High Blood Pressure
Antibiotic/Antifungal
Antidepressants
Thyroid
Other _____

Antidiabetic/Insulin
Laxatives
Aspirin/Tylenol
Chemotherapy
Ulcer Medications

Cortisone/Anti-inflammatories
Radiation
Lithium
Heart Medications
Oral Contraceptives Specify _____

High Blood Pressure
Relaxants/Sleeping Pills
Recreational Drugs
Hormones

### Circle if you eat, drink or use:

Alcohol
Coffee
Luncheon meats
Chew Tobacco

Candy
Distilled water
Margarine
Vitamins and/or minerals (Please list) _____

Carbonated beverages
Eat at fast food restaurants regularly
Refined sugars

Cigarettes
Fried Foods
Saccharine

### Circle if you:

Diet often
Are exposed to chemicals at work

Do not exercise regularly
Are exposed to cigarette smoke

Salt food without tasting

Are under excessive stress

**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. Does your stomach bloat after meals | 0 | 1 | 2 | 3 |
| 2. Fullness for extended time after meals | 0 | 1 | 2 | 3 |
| 3. Do you burp frequently | 0 | 1 | 2 | 3 |
| 4. Does the above conditions alter your sleep | 0 | 1 | 2 | 3 |
| 5. Does your stomach upset easily | 0 | 1 | 2 | 3 |
| 6. Do you have a history of constipation | 0 | 1 | 2 | 3 |
| 7. Known food allergies | 0 | 1 | 2 | 3 |
| 8. Does fasting affect your stomach | 0 | 1 | 2 | 3 |

### Section B:

| | | | | |
|---|---|---|---|---|
| 1. Do you have lower bowel gas | 0 | 1 | 2 | 3 |
| 2. Is your stomach up set after eating | 0 | 1 | 2 | 3 |
| 3. Are your tired after eating | 0 | 1 | 2 | 3 |
| 4. Do you frequently have diarrhea | 0 | 1 | 2 | 3 |
| 5. Alternating constipation and diarrhea | 0 | 1 | 2 | 3 |
| 6. Do you have abdominal cramps | 0 | 1 | 2 | 3 |
| 7. Roughage and fiber causes constipation | 0 | 1 | 2 | 3 |
| 8. Does fiberous food irritate your diarrhea | 0 | 1 | 2 | 3 |
| 9. Are your stools poorly formed | 0 | 1 | 2 | 3 |
| 10. Do you have foul smelling stools | 0 | 1 | 2 | 3 |
| 11. Do you have frequently daily bowel movements | 0 | 1 | 2 | 3 |
| 12. Do you have shiny stools | 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. Do you have difficulty gaining weight | 0 | 1 | 2 | 3 |
| 18. Do you have mucous in your stools | 0 | 1 | 2 | 3 |
| 19. Has a Doctor told you that you have colitis | NO | YES | | |

### Section C:

| | | | | |
|---|---|---|---|---|
| 1. Do you depend on antacids | 0 | 1 | 2 | 3 |
| 2. Stomach pains just before and/or after meals | 0 | 1 | 2 | 3 |
| 3. Do you have stomach pain at any time | 0 | 1 | 2 | 3 |
| 4. Chronic abdominal pain | 0 | 1 | 2 | 3 |
| 5. Do you have butterfly sensations in stomach | 0 | 1 | 2 | 3 |
| 6. Do you have difficulty belching | 0 | 1 | 2 | 3 |
| 7. Stomach pain when emotionally upset | 0 | 1 | 2 | 3 |
| 8. Has a Doctor told you that you have ulcers | NO | YES | | |
| 9. Sudden, acute indigestion | NO | YES | | |
| 10. Is your condition worse at work | NO | YES | | |
| 11. Is your condition relieved by a vacation | NO | YES | | |
| 12. Relief of symptoms by carbonated beverages | NO | YES | | |
| 13. Relief of stomach pain by drinking cream/milk | NO | YES | | |
| 14. History of ulcer or gastritis | NO | YES(10) | | |
| 15. Does eating between meals help your stomach | NO | YES | | |
| 16. Do you have a current ulcer NO YES | | | | |
| 17. Black stool when not taking iron supplements | NO | YES(10) | | |

### Section D:

| | | | | |
|---|---|---|---|---|
| 1. Do you have stomach or abdominal cramps | 0 | 1 | 2 | 3 |
| 2. Frequent and recurrent infections (colds) | 0 | 1 | 2 | 3 |
| 3. Frequent bladder and kidney infections | 0 | 1 | 2 | 3 |
| 4. Do you have seasonal diarrhea | 0 | 1 | 2 | 3 |
| 5. Do you have frequent vaginal yeast infection | 0 | 1 | 2 | 3 |
| 6. Do you have vaginal or genital itching | 0 | 1 | 2 | 3 |
| 7. Toe and fingernail fungus | 0 | 1 | 2 | 3 |
| 8. Alternating diarrhea/constipation | 0 | 1 | 2 | 3 |
| 9. Constipation | 0 | 1 | 2 | 3 |
| 10. Do you have a history of antibiotic use | NO | YES | | |
| 11. Meat eater | NO | YES | | |
| 12. 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. Gray 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 (6) | | |
| 21. Have you 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 |

## Part III Continued

### 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, wrinkle 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. Axillary (armpit) temperature below 97.6F | NO | YES | | |
| 20. Slow reflexes | NO | YES | | |
| 21. Infertility | NO | YES | | |

## Part IV

### Section A:

| | | | | |
|---|---|---|---|---|
| 1. Sensitive to exhaust fumes, smoke, smog, petrochemicals | 0 | 1 | 2 | 3 |
| 2. Periodic constipation | 0 | 1 | 2 | 3 |
| 3. Cannot tolerate much exercise | 0 | 1 | 2 | 3 |
| 4. Depression or rapid mood swings | 0 | 1 | 2 | 3 |
| 5. Dark circles under the eyes | 0 | 1 | 2 | 3 |
| 6. Dizziness upon standing | 0 | 1 | 2 | 3 |
| 7. Lack of mental alertness | 0 | 1 | 2 | 3 |
| 8. Catch colds easily when weather changes | 0 | 1 | 2 | 3 |
| 9. Headaches | 0 | 1 | 2 | 3 |
| 10. Difficulty breathing | 0 | 1 | 2 | 3 |
| 11. Water retention | 0 | 1 | 2 | 3 |
| 12. Eyes sensitive to bright light | 0 | 1 | 2 | 3 |
| 13. Feel weak and shaky | 0 | 1 | 2 | 3 |

### Section B:

| | | | | |
|---|---|---|---|---|
| 1. Inflamed or bleeding gums | 0 | 1 | 2 | 3 |
| 2. Running nose | 0 | 1 | 2 | 3 |
| 3. Get boils or styes | 0 | 1 | 2 | 3 |
| 4. Nose bleeds | 0 | 1 | 2 | 3 |
| 5. Loss of smell | 0 | 1 | 2 | 3 |
| 6. Throat infections | 0 | 1 | 2 | 3 |
| 7. Cold sores, fever blisters | 0 | 1 | 2 | 3 |
| 8. Loss of taste | 0 | 1 | 2 | 3 |
| 9. Poor wound healing | 0 | 1 | 2 | 3 |
| 10. Hair falls out | 0 | 1 | 2 | 3 |
| 11. Swollen lymph glands | 0 | 1 | 2 | 3 |
| 12. Ear infection | 0 | 1 | 2 | 3 |
| 13. Hair grows slowly | 0 | 1 | 2 | 3 |
| 14. Slow to recover from cold or flu | 0 | 1 | 2 | 3 |
| 15. Catch colds or flu easily | 0 | 1 | 2 | 3 |
| 16. Bumpy skin on back of arms | 0 | 1 | 2 | 3 |

### Section C:

| | | | | |
|---|---|---|---|---|
| 1. Itching of nose or eyes | 0 | 1 | 2 | 3(5) |
| 2. Itching of roof of mouth or throat | 0 | 1 | 2 | 3(5) |
| 3. Migraine headaches | NO | YES(10) | | |
| 4. Entire body aches, painful to touch | 0 | 1 | 2 | 3 |
| 5. Swollen joints | 0 | 1 | 2 | 3 |
| 6. Food sensitivity or allergy | 0 | 1 | 2 | 3 |
| 7. Certain foods make you sick, depressed, jittery | 0 | 1 | 2 | 3 |
| 8. Chronic pain | 0 | 1 | 2 | 3 |
| 9. Painful stomach and/or intestine | 0 | 1 | 2 | 3 |
| 10. Alternating constipation and diarrhea | 0 | 1 | 2 | 3 |
| 11. Mucous in throat | 0 | 1 | 2 | 3 |
| 12. Post nasal drip | 0 | 1 | 2 | 3 |
| 13. Discharge from eyes | 0 | 1 | 2 | 3 |
| 14. Watery eyes | 0 | 1 | 2 | 3 |
| 15. Puffiness or dark circles under eyes | 0 | 1 | 2 | 3 |
| 16. Ear discharge or ears stuffed up | 0 | 1 | 2 | 3 |
| 17. Nasal congestion | 0 | 1 | 2 | 3 |
| 18. Running nose | 0 | 1 | 2 | 3 |
| 19. Breathe through mouth | 0 | 1 | 2 | 3 |
| 20. Swollen tongue | 0 | 1 | 2 | 3 |
| 21. Difficulty swallowing | 0 | 1 | 2 | 3 |
| 22. Bed wetting | N0 | YES (5) | | |
| 23. Hyperactivity | 0 | 1 | 2 | 3 |
| 24. Chronic lung congestion | 0 | 1 | 2 | 3 |
| 25. Use aspirin, Tylenol regularly | NO | YES | | |
| 26. Wheezing | 0 | 1 | 2 | 3 |
| 27. Skin rashes | 0 | 1 | 2 | 3 |
| 28. Sneezing | 0 | 1 | 2 | 3 |

## Part V

### Section A:

| | | | | |
|---|---|---|---|---|
| 1. Difficulty breathing at night | 0 | 1 | 2 | 3 |
| 2. Chest pain while walking | 0 | 1 | 2 | 3 |
| 3. Heaviness in legs | 0 | 1 | 2 | 3 |
| 4. Calf muscles cramp while walking | 0 | 1 | 2 | 3 |
| 5. Heart pounds easily | 0 | 1 | 2 | 3 |
| 6. Feel jittery | 0 | 1 | 2 | 3 |
| 7. Heart misses beats or has extra beats | 0 | 1 | 2 | 3 |
| 8. Swelling of feet and ankles | 0 | 1 | 2 | 3 |
| 9. Rapid beating heart | 0 | 1 | 2 | 3 |
| 10. Heartburn after eating | 0 | 1 | 2 | 3 |
| 11. Pain in left arm | 0 | 1 | 2 | 3 |
| 12. Exhaust with minor exertion | 0 | 1 | 2 | 3 |
| 13. Do you do aerobic exercise? | NO | YES | | |
| 14. Have you ever exercised regularly? | NO | YES | | |
| 15. Drink 5 or more cups of coffee daily | NO | YES | | |
| 16. Severe cough | NO | YES | | |
| 17. Has a doctor ever told you that you have heart trouble? | NO | YES | | |

### Section B:

| | | | | |
|---|---|---|---|---|
| 1. Cold hands and feet | 0 | 1 | 2 | 3 |
| 2. Slurred speech | 0 | 1 | 2 | 3 |
| 3. Calf muscles cramp while walking | 0 | 1 | 2 | 3 |
| 4. Headaches | 0 | 1 | 2 | 3 |
| 5. Numbness in extremities | 0 | 1 | 2 | 3 |
| 6. Poor concentration | 0 | 1 | 2 | 3 |
| 7. Ringing in ears | 0 | 1 | 2 | 3 |
| 8. Ear canal hair | NO | YES | | |
| 9. Tingling and/or burning in hands or feet | NO | YES | | |
| 10. Spider veins on nose and/or face | NO | YES | | |

### Section C:

| | | | | |
|---|---|---|---|---|
| 1. Pain when getting up in morning in back of head and neck | 0 | 1 | 2 | 3 |
| 2. Dizziness | 0 | 1 | 2 | 3 |
| 3. Vertigo | 0 | 1 | 2 | 3 |
| 4. Blushing with no apparent cause | 0 | 1 | 2 | 3 |
| 5. Is your blood pressure high? | NO | YES(10) | | |

## Part VI

### Section A:

1. Dizziness when standing suddenly 0 1 2 3
2. Loss of vision when standing suddenly 0 1 2 3
3. Crave sweets 0 1 2 3
4. Headaches relieved by eating sweets or alcohol 0 1 2 3
5. Feel shaky or jittery 0 1 2 3
6. Irritable if a meal is missed 0 1 2 3
7. Wake up in middle of night craving sweets 0 1 2 3
8. Feel tired or weak if a meal is missed 0 1 2 3
9. Heart palpitations after eating sweets 0 1 2 3
10. Need to drink coffee to get started 0 1 2 3
11. Impatient, moody, nervous 0 1 2 3
12. Feel tired 1 to 3 hours after eating 0 1 2 3
13. Poor memory 0 1 2 3
14. Feel faint 0 1 2 3
15. Poor concentration 0 1 2 3
16. Forgetful 0 1 2 3
17. Calmer after eating NO YES

### Section B:

1. Night sweats 0 1 2 3
2. Increased thirst 0 1 2 3
3. Lowered resistance to infection 0 1 2 3
4. Fatigue 0 1 2 3
5. Boils and leg sores 0 1 2 3
6. Lesions, cuts take a long time to heal 0 1 2 3
7. Overweight 0 1 2 3
8. Feel pick up from exercise 0 1 2 3
9. Failing eyesight 0 1 2 3
10. Crave sweets, but eating sweets does not relieve symptoms 0 1 2 3
11. Family history of diabetes 0 1 2 3
12. Sugar in urine NO YES

## Part VII

1. Chest pain 0 1 2 3
2. Chronic cough 0 1 2 3
3. Difficulty breathing 0 1 2 3
4. Coughing up blood 0 1 2 3
5. Coughing up phlegm 0 1 2 3
6. Pain around ribs 0 1 2 3
7. Shortness of breath 0 1 2 3
8. Rattling mucous when you breathe 0 1 2 3
9. Sensitive to smog 0 1 2 3
10. Infections settle in lungs 0 1 2 3
11. Live or work around people who smoke 0 1 2 3
12. Bronchitis NO YES(10)
13. Exposed to chemicals and radiation NO YES(6)
14. Smoker NO YES(6)

## Part VIII

1. Frequent urination 0 1 2 3
2. Frequent bladder infections 0 1 2 3
3. Rarely need to urinate 0 1 2 3
4. Urination when you cough or sneeze 0 1 2 3
5. Painful/burning when passing urine 0 1 2 3
6. Difficulty passing urine 0 1 2 3
7. Dripping after urination 0 1 2 3
8. Can't hold urine 0 1 2 3
9. Rose colored (bloody) urine 0 1 2 3
10. Cloudy urine 0 1 2 3
11. Strong smelling urine 0 1 2 3
12. Back or leg pains associated with dripping after urination 0 1 2 3
13. History of kidney or bladder infections NO YES
14. Have used antibiotics to control urinary tract infections NO YES
    If yes, when did you last use them _____
    Treatment duration _____
15. Back pain in the kidney area 0 1 2 3
16. General water retention 0 1 2 3

## Part IX (Males only)

### Section A:

1. Difficulty urinating 0 1 2 3
2. A sense of bladder fullness 0 1 2 3
3. Increased straining with smaller and smaller amounts of urine passed 0 1 2 3
4. Rose colored (bloody) urine 0 1 2 3
5. Pain or burning while urinating 0 1 2 3
6. Wake up to urinate at night 0 1 2 3
7. Dripping after urination 0 1 2 3
8. Pain or fatigue in the legs or back 0 1 2 3
9. Lack of sex drive 0 1 2 3
10. Ejaculation causes pain 0 1 2 3

### Section B:

1. Difficulty attaining and/or maintaining an erection 0 1 2 3
2. Low sexual drive 0 1 2 3
3. Premature ejaculation 0 1 2 3
4. Pain/coldness in genital area 0 1 2 3
5. Infertile NO YES(5)
6. Varicose veins on scrotum NO YES
7. Low sperm count NO YES (5)

### Section C:

1. Discharge from penis 0 1 2 3
2. Past or present rash on penis 0 1 2 3
3. Swollen genitals 0 1 2 3
4. Swelling in groin 0 1 2 3
5. Venereal disease (gonorrhea, syphilis, herpes or other) NO YES (9)
   Have V.D. now?_____ Had is past?_____

## Part X (Females only)

### Section A:

Circle if you experience any of these symptoms within approximately 2 weeks (ovulation) prior to menstruation.(Section A only)

1. Monthly weight gain 0 1 2 3
2. Depression 0 1 2 3
3. Moodiness/irritability 0 1 2 3
4. Bloating and swelling 0 1 2 3
5. Nausea and/or vomiting 0 1 2 3
6. Suicidal feeling NO YES(10)
7. Anxiety 0 1 2 3
8. Leg cramps and tenderness 0 1 2 3
9. Asthma attacks NO YES(10)
10. Headaches 0 1 2 3
11. Easily distracted 0 1 2 3
12. Anger 0 1 2 3
13. Tender breasts 0 1 2 3
14. Low backache 0 1 2 3
15. Other _____

### Section B:

1. Vaginal itching 0 1 2 3
2. Vaginal discharge 0 1 2 3
3. Low or no desire for sex 0 1 2 3
4. Dislike for intercourse 0 1 2 3
5. Missed periods NO YES
6. Over 15 years of age and have not begun menstruation NO YES
7. Unable to get pregnant NO YES
8. Miscarriages
   NO YES
   HOW MANY_____
9. Abortion
   NO YES
   HOW MANY?_____

## Part X (Females only) Continued

### Section C:

Check if you experience any of these symptoms during menstruation. (Section C only)

1. Low abdominal pain 0 1 2 3
2. Dull ache radiating to low back or legs 0 1 2 3
3. Increased urinary frequency 0 1 2 3
4. Pelvic soreness 0 1 2 3
5. Diarrhea 0 1 2 3
6. Headaches 0 1 2 3
7. Abdominal bloating 0 1 2 3
8. Menstrual pain 0 1 2 3
9. Nausea and/or vomiting 0 1 2 3
10. Have to lie down on first 1 or 2 days of period 0 1 2 3
11. Craving for sweets 0 1 2 3
12. Insomnia 0 1 2 3
13. Light scanty blood flow 0 1 2 3
14. Pain and cramps without blood flow 0 1 2 3
15. Heavy menstrual bleeding 0 1 2 3
16. Anxiety about menstrual cycle 0 1 2 3
17. Pain during period is progressively getting worse with time 0 1 2 3

### Section D:

1. Vaginal bumps and sores 0 1 2 3
2. Pubic area sore 0 1 2 3
3. Ovarian cysts NO YES(10)
4. Uterine cysts NO YES(10)
5. Pain in ovaries 0 1 2 3
6. Breast lumps NO YES(10)
7. Breasts sore to touch 0 1 2 3
8. Breasts painful 0 1 2 3
9. Water retention 0 1 2 3
10. Swollen feeling 0 1 2 3
11. Premenstrual breast pain or discomfort 0 1 2 3
12. Mother used D.E.S. (hormones) while pregnant NO YES
13. Recent pap smear positive NO YES(15)
14. Family history of breast cancer NO YES
15. Form of birth control: ___None ___Pill ___IUD ___Sponge ___Diaphragm ___Foam

Other _____

### Section E:

1. Hot flashes 0 1 2 3
2. Night sweats 0 1 2 3
3. Hysterectomy NO YES
4. Depression/mood swings 0 1 2 3
5. Insomnia 0 1 2 3
6. Craving for sweets 0 1 2 3
7. Heavy bleeding two weeks/month 0 1 2 3
8. Sweating throughout day 0 1 2 3
9. Dryness of skin, hair, and vagina 0 1 2 3
10. Painful intercourse 0 1 2 3
11. Vaginal pain 0 1 2 3
12. Vaginal itching 0 1 2 3
13. Osteoporosis (Bone loss) NO YES

## Part XI

### Section A:

1. Pain in fingers 0 1 2 3
2. Bones sore/painful 0 1 2 3
3. Eat meat 0 1 2 3
4. Cavities 0 1 2 3
5. Arthritis 0 1 2 3
6. Drink carbonated beverages/soda _____ oz. per week YES
7. Gum disease NO YES
8. Bone loss NO YES
9. Calcium deposits NO YES
10. Use antacids _____ # per week YES
11. Dentures NO YES
12. Bone deformity NO YES
13. Told you have osteoporosis/osteomalacia NO YES(5)
14. Recent bone fracture NO YES
15. Are you post menopausal NO YES

### Section B:

1. Muscle spasms 0 1 2 3
2. Tightness in shoulder muscles 0 1 2 3
3. Muscle cramps 0 1 2 3
4. Pain in arms, hands 0 1 2 3
5. Leg cramps at night 0 1 2 3
6. Stiff all over 0 1 2 3
7. Stiff in morning 0 1 2 3
8. Unable to sit straight 0 1 2 3
9. Pain in neck and/or shoulders 0 1 2 3
10. Back pain 0 1 2 3

### Section C:

1. Over flexible joints (double-jointed) 0 1 2 3
2. Back pain 0 1 2 3
3. Swollen knees/elbows 0 1 2 3
4. Athletic injury 0 1 2 3
5. Bursitis 0 1 2 3
6. Tendonitis 0 1 2 3
7. Joint pain 0 1 2 3
8. Slipped disc NO YES(5)
9. Herniated disc NO YES(10)
10. Loss in height NO YES
11. Injure easily NO YES

## Part XII

1. Head feels heavy 0 1 2 3
2. Light headedness/fainting 0 1 2 3
3. Loss of balance 0 1 2 3
4. Dizziness 0 1 2 3
5. Ringing/buzzing in ears 0 1 2 3
6. Trembling hands 0 1 2 3
7. Loss of feeling in hands and/or feet (toes) 0 1 2 3
8. Exhaustion on slightest effort 0 1 2 3
9. Limbs feel too heavy to hold up 0 1 2 3
10. Loss of grip strength 0 1 2 3
11. Tingling pain sensation 0 1 2 3
12. Convulsions NO YES(10)
13. Incoordination 0 1 2 3
14. Nervousness 0 1 2 3
15. Accident prone NO YES
16. Loss of muscle tone NO YES
17. Need for 10-12 hours sleep NO YES
18. Have had shingles NO YES

## Part XIII

1. Nightmares 0 1 2 3
2. Can't fall asleep 0 1 2 3
3. Intense dreams 0 1 2 3
4. Leg cramps/restless leg at night 0 1 2 3
5. Restless, uneasy sleeper 0 1 2 3
6. Awake frequently throughout night NO YES
7. Wake up in the middle of night, can't fall back to sleep NO YES
8. Sleep walk NO YES

Do you have any other symptoms that have not been covered in the questionnaire?

_____

_____

_____

_____

_____