

Health Appraisal Introduction

Name: _____ Date: _____

Nutritional supplements currently taking:

Type and brand	Amount per day	Type and brand	Amount per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications(including oral contraceptives and non prescription, i.e. Advil, Tylenol, Tagamet, Aspirin, Tums, etc.) List type and amount per day, week, or month: _____

Typical daily diet:

Breakfast _____
 Snack _____
 Lunch _____
 Snack _____
 Dinner _____
 Snack _____

Cups/day: Coffee _____ Tea/Iced tea _____ Soda _____ Milk _____ Water _____ Other? _____
 Alcoholic drinks/week _____ Cigarettes/day _____

CAAB-25

(Chronic Ailment Assessment Booklet)

Please complete this booklet based upon your health profile over the last 30 days. Upon completion, return to your practitioner for evaluation.

Thank you.



Name: _____

Phone # _____

Address: _____

Reassess Date: _____

MSQ - Medical Symptoms Questionnaire

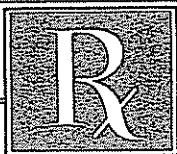
Rate each of the following symptoms based upon your typical health profile for the past 30 days.

Point Scale:

0 = Never or almost never have the symptom
 1 = Occasionally have it, effect is not severe

2 = Frequently have it, effect is not severe
 3 = Occasionally have it, effect is severe
 4 = Frequently have it, effect is severe

Digestive Tract	___ Nausea or vomiting	Total	Lungs	___ Chest Congestion	Total		
	___ Diarrhea			___ Asthma, bronchitis			
	___ Constipation			___ Shortness of breath			
	___ Bloating Feeling			___ Difficulty Breathing			
	___ Belching or passing gas			___ Heartburn			
Ears	___ Itchy Ears	Total	Mind	___ Poor memory	Total		
	___ Ear aches, ear infections			___ Confusion, poor comprehension			
	___ Drainage from ears			___ Difficulty in making decisions			
	___ Ringing in ears, hearing loss			___ Stuttering or stammering			
	___ Slurred speech			___ Learning disabilities			
Emotions	___ Mood swings	Total	Mouth/ Throat	___ Chronic coughing	Total		
	___ Anxiety, fear or nervousness			___ Gagging frequently; need to clear throat			
	___ Anger, irritability or aggressiveness			___ Sore throat, hoarseness, loss of voice			
	___ Depression			___ Swollen or discolored tongue, gums, lips			
	___ Canker sores						
Energy & Activity	___ Fatigue, sluggishness	Total	Nose	___ Stuffy nose	Total		
	___ Apathy, lethargy			___ Sinus problems			
	___ Hyperactivity			___ Hay fever			
	___ Restlessness			___ Sneezing attacks			
	___ Excessive mucus formation						
Eyes	___ Watery or itchy eyes	Total	Skin	___ Acne	Total		
	___ Swollen, reddened or sticky eyelids			___ Hives, rashes, or dry skin			
	___ Bags or dark circles under eyes			___ Hair loss			
	___ Blurred or tunnel vision			___ Flushing or hot flashes			
	(does not include near or far sightedness)			___ Excessive sweating			
Head	___ Headaches	Total	Weight	___ Binge eating	Total		
	___ Faintness			___ Craving certain foods			
	___ Dizziness			___ Excessive weight			
	___ Insomnia			___ Compulsive eating			
	___ Water retention			___ Underweight			
Heart	___ Irregular or skipped heartbeat	Total	Other	___ Frequent illness	Total		
	___ Rapid or pounding heartbeat			___ Frequent or urgent urination			
	___ Chest Pain			___ Genital itch or discharge			
	___ Pain or aches in joints			Total		<i>Grand Total</i>	___
	___ Arthritis						
___ Stiffness or limitation of movement							
___ Pain or aches in muscles							
___ Feeling of weakness or tiredness							



CAAB-25

Chronic Ailment Assessment Booklet

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 Point** box. The score for YES in the number inside the paranthesis ().

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

PART I Section A

- 1) Have you taken a broad spectrum antibiotic drug:
 - A) in the last 6 months N Y (10)
 - B) If the response to A is no, have you ever taken antibiotics? N Y (5)
- 2) Have you had recurrent infections requiring prolonged antibiotic use? N Y (20)
- 3) Have you taken birth control pills? N Y (5)
- 4) Have you taken prednisone? N Y (5)
- 5) Have you had athlete's foot, ringworm, jock itch, or other chronic fungus infections of the skin or nails? N Y (5)
- 6) Do you crave sugar? N Y (5)
- 7) Do you crave breads? N Y (5)
- 8) Do you crave alcoholic beverages? N Y (5)
- 9) Have you ever had candida/yeast? N Y (10)
- 10) Endometriosis or infertility N Y (5)
- 11) Symptoms worse on damp, muggy days or in moldy places 0 1 2 3
- 12) Fatigue or lethargy 0 1 2 3
- 13) Poor memory 0 1 2 3
- 14) Depression 0 1 2 3
- 15) Muscle and or joint aches or weakness 0 1 2 3
- 16) Abdominal pain 0 1 2 3
- 17) Constipation 0 1 2 3
- 18) Diarrhea 0 1 2 3
- 19) Bloating, belching, or intestinal gas 0 1 2 3
- 20) Vaginal burning, itching, or discharge 0 1 2 3
- 21) Premenstrual tension 0 1 2 3
- 22) Irritability 0 1 2 3
- 23) Inability to concentrate 0 1 2 3
- 24) Frequent mood swings 0 1 2 3
- 25) Recurrent rashes or itching 0 1 2 3
- 26) Rectal itching 0 1 2 3
- 27) Urgency or urinary frequency 0 1 2 3
- 28) Burning while urinating 0 1 2 3

Total Points _____

Section B

- 1) Have you traveled outside the USA? N Y (5)
- 2) Since traveling abroad, have you had an elevated white blood count, intestinal problems, night sweats, or unexplained fever? N Y (5)
- 3) Do you drink untested or unfiltered water? N Y (5)
- 4) Do you use a microwave oven for cooking (instead of reheating) beef, fish, or pork? N Y (5)
- 5) Do you prefer fish or meat that is undercooked, i.e., rare or medium rare? N Y (5)
- 6) At home, do you use the same cutting board for chicken, fish, and meat as you do for vegetables? N Y (5)
- 7) Have you lived with, or do you currently live with or handle pets? N Y (5)
- 8) Do you work or have children in a daycare center? N Y (5)
- 9) Do you garden or work in a yard to which cats and dogs have access? N Y (5)
- 10) Have you ever had parasites? N Y (10)
- 11) Red blood in stool 0 1 2 3
- 12) Abdominal pain and cramps 0 1 2 3
- 13) Lower back pain 0 1 2 3
- 14) Gas, bloating 0 1 2 3
- 15) Fever 0 1 2 3
- 16) Chronic Fatigue 0 1 2 3
- 17) Constipation 0 1 2 3
- 18) Diarrhea 0 1 2 3
- 19) Foul smelling stools 0 1 2 3
- 20) Anal itching 0 1 2 3
- 21) Bad breath 0 1 2 3
- 22) Grind teeth 0 1 2 3
- 23) Lethargic 0 1 2 3
- 24) Mucus in stool 0 1 2 3
- 25) Lack of stamina 0 1 2 3

Total Points _____

PART II

Section A

- 1) Indigestion 0 1 2 3
- 2) Belching, burping 0 1 2 3
- 3) Gas immediately following a meal 0 1 2 3
- 4) Sense of fullness during meals 0 1 2 3
- 5) Poor appetite, picky eater 0 1 2 3
- 6) Difficult bowel movements 0 1 2 3
- 7) Difficulty swallowing 0 1 2 3
- 8) History of anemia, unresponsive to iron 0 1 2 3
- 9) Vegetarian (no eggs, dairy) 0 1 2 3
- 10) Spoon shaped nails 0 1 2 3
- 11) Unintentional weight loss 0 1 2 3
- 12) Partial loss of taste or smell 0 1 2 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) Bloating 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) Specific foods/beverages aggravate indigestion 0 1 2 3
- 8) Roughage and fiber causes constipation 0 1 2 3
- 9) Three or more large bowel movements daily 0 1 2 3
- 10) Alternating constipation and diarrhea 0 1 2 3
- 11) Undigested food in stool 0 1 2 3
- 12) Mucus in stool 0 1 2 3
- 13) Dry, flaky skin, dry brittle hair 0 1 2 3
- 14) Difficulty gaining weight 0 1 2 3

Total Points _____

Section C

- 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 a day 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 stools 0 1 2 3
- 9) Alternating diarrhea/constipation 0 1 2 3
- 10) Mucus, pus in stool 0 1 2 3
- 11) Feeling that bowels do not empty completely 0 1 2 3
- 12) Bright red blood following bowel movement 0 1 2 3
- 13) Anal itching 0 1 2 3

Total Points _____

Section D

- 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) Stomach discomfort, pain in response to strong emotions, thoughts, smell of food 0 1 2 3
- 4) Heartburn, especially when lying down, 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 or infections, difficulty breathing 0 1 2 3
- 8) For relief from carbonated beverages, cream/milk/food 0 1 2 3
- 9) Constipation 0 1 2 3
- 10) Black, tarry stool 0 1 2 3

Total Points _____

PART III

Section A

- 1) Moderate to severe pain under right side of rib cage 0 1 2 3
- 2) Abdominal pain worsens with deep breathing 0 1 2 3
- 3) Regurgitate bitter fluid 0 1 2 3
- 4) Bloating, 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 or vomiting 0 1 2 3
- 8) Feel restless, agitated 0 1 2 3
- 9) Unexplained itchy skin worse at night 0 1 2 3
- 10) Stool color alternates from clay colored to normal brown 0 1 2 3

- 11) Feeling of poor health 0 1 2 3
- 12) Fatigue, weakness, exhaustion 0 1 2 3
- 13) Unable to concentrate, irritable, confused 0 1 2 3
- 14) Swollen feet and/or legs 0 1 2 3
- 15) Easy bruising 0 1 2 3
- 16) Feeling of extreme dryness 0 1 2 3
- 17) Reddened skin, especially palms 0 1 2 3
- 18) Dark urine, diminished flow 0 1 2 3
- 19) Dry, flaky skin, hair N Y (3)
- 20) Yellowish cast to skin, eyes N Y (3)

Total Points _____