Northwestern Memorial®
Physicians Group

INITIAL FUNCTIONAL NUTRITION CONSULTATION

Please print your name ______________________________

Thank you for making your appointment with the NMPG's Center for Integrative Medicine. Functional Nutrition appointments are very in-depth and personalized. For this reason we have prepared an extensive questionnaire for you to fill out. **Please read the following prior to filling out the questionnaire and send it in as soon as possible.**

We recommend that you take your time in filling out this questionnaire. For the food frequency part of the questionnaire, please pay close attention to the serving sizes listed. For instance, if the serving size for pasta is 1/2 cup and you eat 2 cups three times per week, you will need to enter 12 in the weekly column (only choose one column, the one that most closely matches your intake of the food). You don't need to be exact, but try to be as accurate as possible, so that the questionnaire will reflect an average of your daily intake. The more information you provide, the more assistance we will have to base your initial recommendations. If you consume any foods on a regular basis that you do not see listed, please add those at the end, i.e., pretzels, protein drinks, french fries, etc. Also note when a food is different from it's listing, i.e. fat free, low fat, etc.

Please bring to your visit:

- **A list of any medications and/or vitamin or herbal supplements that you currently take, even better—bring the actual bottles.**
- **A written sample of your "typical day" of eating/drinking-noting times of the day you eat as well.**
- If you are **not** seeing a doctor/practitioner at the Center for Integrative Medicine, please **obtain a copy of any recent blood work, labs, etc.** and bring them with you to the visit (or have them sent with your initial paperwork).

Since this appointment is very in-depth and personalized, we reserve the right to cancel or reschedule your appointment if we have not received this questionnaire either by mail or fax within 48 hours prior to your scheduled appointment.

Fax to: (312) 926-6285

Or send to: Northwestern Memorial Physicians Group
Center for Integrative Medicine and Wellness
Avenue Hotel Office Tower
150 East Huron Street, Suite 1100
Chicago, IL 60611

***Please allow enough mail time (1 week) for delivery.

You will also be assessed a fee for failing to keep this appointment without proper notification of cancellation within 24 hours. If you are having difficulty with the questionnaire, please do not hesitate to call (312) 926-DOCS (3627).

Please note: Insurance plans do not cover this service. You will be expected to pay at the time of your visit.

We look forward to working with you and helping you to reach optimal health.

Center for Integrative Medicine

HEALTH HISTORY

Name ______ Date of Birth ______ Today's Date ______

Occupation ______ Age ______ Height ______ Sex ______ Number of Children ____

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Are you recovering from a cold or flu? ____ Are you pregnant? ____ How did you hear about us? ______

Reason for office visit ______ Date began ______

Date of last physical exam ______ Practitioner name and phone number ______

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis) ______

Outcome ______

What types of therapy have you tried for this problem(s):

☐ diet modification ☐ fasting ☐ vitamin/mineral ☐ herbs ☐ homeopathy ☐ chiropractic ☐ acupuncture ☐ conventional drugs

☐ other ______

List current health problems for which you are being treated: ______

Current medications (prescription or over-the-counter): ______

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Operation, Illness, Injury	Outcome

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): ______

Do you consider yourself: ☐ underweight ☐ overweight ☐ just right Your weight today ______

☐ Unintentional weight loss or gain of 10 pounds or more in the last three months

Is your job related to potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner) ______

☐ Glasses ☐ Contacts ☐ Dentures ☐ Hearing aid ☐ Medical devices/prosthetics/implants, describe: ______

Recent changes in your ability to: ☐ see ☐ hear ☐ taste ☐ smell ☐ feel hot/cold sensations

☐ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Strong dislike for any one of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Do you: ☐ Prefer warmth (i.e., food, drinks, weather etc.) ☐ Prefer cold (i.e., food, drinks, weather etc.) ☐ No preference

Is your sleep disturbed at the same time each night? ______ If yes, what time? ______

Time of day you feel the most energy or the least symptoms:

☐ 7 a.m. - 9 a.m. ☐ 9 a.m. - 11 a.m. ☐ 11 a.m. - 1 p.m.
☐ 1 p.m. - 3 p.m. ☐ 3 p.m. - 5 p.m. ☐ 5 p.m. - 7 p.m.
☐ 7 p.m. - 9 p.m. ☐ 9 p.m. - 11 p.m. ☐ 11 p.m. - 1 a.m.
☐ 1 a.m. - 3 a.m. ☐ 3 a.m. - 5 a.m. ☐ 5 a.m. - 7 a.m.

Time of day you feel the worst or your symptoms are aggravated:

☐ 7 a.m. - 9 a.m. ☐ 9 a.m. - 11 a.m. ☐ 11 a.m. - 1 p.m.
☐ 1 p.m. - 3 p.m. ☐ 3 p.m. - 5 p.m. ☐ 5 p.m. - 7 p.m.
☐ 7 p.m. - 9 p.m. ☐ 9 p.m. - 11 p.m. ☐ 11 p.m. - 1 a.m.
☐ 1 a.m. - 3 a.m. ☐ 3 a.m. - 5 a.m. ☐ 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

☐ Debilitating fatigue ☐ Shortness of breath ☐ Insomnia ☐ Constipation ☐ Chronic pain/inflammation
☐ Depression ☐ Panic attacks ☐ Nausea ☐ Fecal incontinence ☐ Bleeding
☐ Disinterest in sex ☐ Headaches ☐ Vomiting ☐ Urinary incontinence ☐ Discharge
☐ Disinterest in eating ☐ Dizziness ☐ Diarrhea ☐ Low grade fever ☐ Itching/rash

Medical History
☐ Arthritis
☐ Allergies/hayfever
☐ Asthma
☐ Alcoholism
☐ Alzheimer's disease
☐ Autoimmune disease
☐ Blood pressure problems
☐ Bronchitis
☐ Cancer
☐ Chronic fatigue syndrome
☐ Carpal tunnel syndrome
☐ Cholesterol, elevated
☐ Circulatory problems
☐ Colitis
☐ Dental problems
☐ Depression
☐ Diabetes
☐ Diverticular disease
☐ Drug addiction
☐ Eating disorder
☐ Epilepsy
☐ Emphysema
☐ Eyes, ears, nose, throat problems
☐ Environmental sensitivities
☐ Fibromyalgia
☐ Food intolerance
☐ Gastroesophageal reflux disease
☐ Genetic disorder
☐ Glaucoma
☐ Gout
☐ Heart disease
☐ Infection, chronic
☐ Inflammatory bowel disease
☐ Irritable bowel syndrome
☐ Kidney or bladder disease
☐ Learning disabilities
☐ Liver or gallbladder disease (stones)
☐ Mental illness
☐ Mental retardation
☐ Migraine headaches
☐ Neurological problems (Parkinson's, paralysis)
☐ Sinus problems
☐ Stroke
☐ Thyroid trouble
☐ Obesity
☐ Osteoporosis
☐ Pneumonia
☐ Sexually transmitted disease
☐ Seasonal affective disorder
☐ Skin problems
☐ Tuberculosis
☐ Ulcer
☐ Urinary tract infection
☐ Varicose veins
Other ____________________
____

Medical (Men)
☐ BPH
☐ Prostate cancer
☐ Decreased sex drive
☐ Infertility
☐ STD
Other ____________________
____

Medical (Women)
☐ Menstrual irregularities
☐ Endometriosis
☐ Infertility
☐ Fibrocystic breasts
☐ Fibroids/ovarian cysts
☐ PMS
☐ Breast cancer
☐ Pelvic inflammatory disease
☐ Vaginal infections
☐ Decreased sex drive
☐ STD
Other ____________________
Age of first period ________
Date of last gynecological exam ____________
Mammogram ☐ + ☐ -
PAP ☐ + ☐ -
Form of birth control _______
# of children ____________
# of pregnancies ___________
☐ C-Section ____________
☐ Surgical menopause
☐ Menopause
Date of last menstrual cycle
____
Length of cycle _______ days
Interval of time between cycles ____________days
Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _______

Family Health History (parents and siblings)
☐ Arthritis, rheumatoid
☐ Asthma
☐ Alcoholism
☐ Alzheimer's disease
☐ Cancer
☐ Depression
☐ Diabetes
☐ Drug addiction
☐ Eating disorder
☐ Genetic disorder
☐ Glaucoma
☐ Heart disease
☐ Infertility
☐ Learning disabilities
☐ Mental illness
☐ Mental retardation
☐ Migraine headaches
☐ Neurological disorders (Parkinson's, paralysis)
☐ Obesity
☐ Osteoporosis
☐ Stroke
☐ Suicide
Other ____________________

Health Habits
☐ Tobacco:
Cigarettes: #/day __________
Cigars: #/day ____________
☐ Alcohol
Wine: #glasses/d or wk ______
Liquor: #ounces/d or wk _____
Beer: #glasses/d or wk ______
☐ Caffeine:
Coffee: #6 oz cups/d ________
Tea: #6 oz cups/d __________
Soda w/caffeine: #cans/d ____
Other sources ____________
☐ Water: #glasses/d ________

Exercise
☐ 5-7 days per week
☐ 3-4 days per week
☐ 1-2 days per week
☐ 45 minutes or more duration per workout
☐ 30-45 minutes duration per workout
☐ Less than 30 minutes
☐ Walk
☐ Run, jog, jump rope
☐ Weight lift
☐ Swim
☐ Box
☐ Yoga

Nutrition & Diet
☐ Mixed food diet (animal and vegetable sources)
☐ Vegetarian
☐ Vegan
☐ Salt restriction
☐ Fat restriction
☐ Starch/carbohydrate restriction
☐ The Zone Diet
☐ Total caloric restriction
Specific food restrictions:
☐ dairy ☐ wheat ☐ eggs
☐ soy ☐ corn ☐ all gluten
Other ____________________

Food Frequency
Servings per day:
Fruits (citrus, melons, etc.) ___
Dark green or deep yellow/ orange vegetables ________
Grains (unprocessed) _______
Beans, peas, legumes _______
Dairy, eggs ____________
Meat, poultry, fish ________

Eating Habits
☐ Skip breakfast
☐ Two meals/day
☐ One meal/day
☐ Graze (small frequent meals)
☐ Food rotation
☐ Eat constantly whether hungry or not
☐ Generally eat on the run
☐ Add salt to food

Current Supplements
☐ Multivitamin/mineral
☐ Vitamin C
☐ Vitamin E
☐ EPA/DHA
☐ Evening Primrose/GLA
☐ Calcium, source: _________
☐ Magnesium
☐ Zinc
☐ Minerals, describe ________
☐ Friendly flora (acidophilus)
☐ Digestive enzymes
☐ Amino acids
☐ CoQ10
☐ Antioxidants (e.g., lutein, resveritrol, etc.)
☐ Herbs - teas
☐ Herbs - extracts
☐ Chinese herbs
☐ Ayurvedic herbs
☐ Homeopathy
☐ Bach flowers
☐ Protein shakes
☐ Superfoods (e.g., bee pollen, phytonutrient blends)
☐ Liquid meals (e.g., Ensure)
Other ____________________

Would you like to:
☐ Have more energy
☐ Be stronger
☐ Have more endurance
☐ Increase your sex drive
☐ Be thinner
☐ Be more muscular
☐ Improve your complexion
☐ Have stronger nails
☐ Have healthier hair
☐ Be less moody
☐ Be less depressed
☐ Be less indecisive
☐ Feel more motivated
☐ Be more organized
☐ Think more clearly and be more focused
☐ Improve memory
☐ Do better on tests in school
☐ Not be dependent on over-the-counter medications like aspirin, Tylenol, Benadryl, sleeping aids, etc.
☐ Stop using laxatives or stool softeners
☐ Be free of pain
☐ Sleep better
☐ Have agreeable breath
☐ Have agreeable body odor
☐ Have stronger teeth
☐ Get less colds and flus
☐ Get rid of your allergies
☐ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

For each question, **circle** the response which best currently describes your usual behavior.

1.	How many days each week do you eat breakfast?	None	1-2 days	3-5 days	6-7 days
2.	How often do you eat between meals or after the evening meal?	Daily	Several times a week	Once a week or less	Seldom
3.	What is your usual pattern for the evening meal?	This is my biggest meal	Medium size meal	Light meal	Seldom eat in the evening
4.	Do the types of meals you usually eat include the following?	Red meats	Fish or chicken but no red meats	Vegetarian meals with dairy or eggs	Vegen-no animal foods
5.	How much water do you drink each day?	Rarely	1-2 cups	3-5 cups	$\geq$ 6 cups
6.	When salting your food, do you usually salt it:	Freely	Moderately	Sparingly	Never
7.	Do you use non fat or low fat products?	Never	Rarely	Sometimes	Regularly
8.	What kind of spread do you use most often?	Butter	Stick margarine	Soft tub margarine	None of these
9.	What other kinds of fat do you use most often?	Shortenings, lard and/or animal fat	Vegetable oils	Use all the above about the same	None of these
10.	Does your work or daily activity primarily involve the following?	Sitting	Standing	Walking or other active exercise	Heavy labor (eg. heavy lifting, etc.)
11.	Outside your normal work or daily activities, how often do you engage in exercise of 20 minutes or more which markedly increases your breathing (such as vigorous walking, cycling, running, swimming)?	"Seldom or never" "Less than once a week"	1-2 times per week	3-5 times per week	6 or more times per week
12.	Do you currently take a multi-vitamin?	Never	Rarely	Sometimes	Regularly
13.	Do you take any other vitamin or mineral supplement?	Antioxidant	Calcium	Iron	Other: (please specify) ________
14.	Do you take any nutritional supplements?	Never	Rarely	Sometimes	Regularly

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PART II - FOOD QUESTIONNAIRE:

This questionnaire asks about your eating patterns during the past year. For each food item listed, respond by indicating your usual food intake of that food per day, week, or month. For example: Eggs. If you eat 2 eggs every day, respond 2 daily. If you think you average 2 eggs per week over the year, respond 2 weekly. Check the never column if you don't eat the food or if you have it once or twice a year. This questionnaire will take about 20 minutes to complete. The accuracy of your nutrition report depends on the accuracy of your answers.

For example, if you eat 2 eggs per week, you would write 2 under the week column.

Indicate Servings Per:

Serving Size	Food Name / Description	Day	Week	Month	Never
1 item	Whole egg		2		

****

Breads, Cereals, Grain Products — Indicate Servings Per:

Serving Size	Food Name / Description	Day	Week	Month	Never
1 slice	Whole grain breads (whole wheat, rye, pumpernickel)				
1 serving	White breads (hamburger or hot dog bun- 1/2 item, french bread- 1 slice)				
1/2 item	English muffin, bagel, pita bread				
1 serving	Whole grain crackers: Triscuits, Wheat Thins (4-6 each)				
1 serving	Other Crackers: Saltines, Ritz (4-6 each)				
1 item	Tortilla, corn, 6" diameter (medium)				
1 item	Muffins				
1 serving	Pancakes (2); waffles (1- 7" diameter)				
1/2 cup	Whole grain hot cereal: rolled oats, rolled wheat, Roman Meal				
1/2 cup	Instant quick hot cereal: cream of wheat, cream of rice				
3/4 cup	Cold cereals: shredded wheat, raisin bran, bran flakes				
3/4 cup	Cold cereals: Frosted Flakes, Sugar Smacks, etc.				
1/2 cup	Rice, cooked				
1/2 cup	Pasta, cooked				

Fruits and Juices — Servings Per:

Serving Size	Food Name / Description	Day	Week	Month	Never
1 item	Apple or pear, fresh, medium				
1 item	Banana medium				
1 serving	Orange (1 item) or grapefruit (1/2 item)				
1 serving	Peaches (1 item), nectarines (1/2 item), apricots (2 items)				
3/4 cup	Berries (in season)				
1/4 item	Cantaloupe, medium (in season)				
1 cup	Other melon (watermelon, honeydew, casaba)				
1/2 cup	Pineapple, fresh				
1/4 cup	Dried Fruits: raisins (2 Tbsp), dates (2), prunes (2), dried apricots (4)				
1/2 cup	Canned or frozen fruit				
1/2 cup	Orange juice or grapefruit juice				
1/2 cup	Tomato juice or vegetable juice				
1/2 cup	Other juices: apple, grape, pineapple or cranberry				
1/2 cup	Fruit Drinks: Lemonade, punch, Koolaid				

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Center for Integrative Medicine

Indicate Servings Per:

Serving Size	Food Name / Description	Day	Week	Month	Never
1 Tbsp	Vegetable oils; corn, safflower, soy, etc.				
1 Tbsp	Olive oil				
1 Tbsp	Shortenings, vegetable				
1 Tbsp	Lard				
1 tsp	Margarine				
1 tsp	Butter				
1 Tbsp	Mayonnaise				
1 Tbsp	Regular salad dressing				
1 Tbsp	Low calorie dressing				
1 Tbsp	Sour cream				
1 Tbsp	Cream cheese				
1 Tbsp	Half & Half, table cream				

Milk, Yogurt and Cheeses

Servings Per:

Serving Size	Food Name / Description	Day	Week	Month	Never
1 cup	Skim milk, low fat milk				
1 cup	Whole milk				
1 cup	Chocolate milk				
1 cup	Yogurt				
1 ounce	Cheese: cheddar, colby, american, monterey jack, etc.				
1 ounce	Other cheeses: swiss, mozzarella, ricotta, string, etc.				
1/2 cup	Cottage cheese				

Vegetables

Servings Per:

Serving Size	Food Name / Description	Day	Week	Month	Never
1 cup	Salads: lettuce, celery, green peppers, onions				
1/2 cup	Dark green leafy vegetables, raw or cooked				
1/2 cup	Carrots, raw or cooked				
1 item	Tomatoes, fresh medium				
1/2 cup	Starchy vegetables, cooked: corn, peas, mixed vegetables				
1/2 cup	Other vegetables, cooked: green beans, beets, zucchini				
1/2 cup	Cauliflower, broccoli, brussel sprouts, cabbage				
1/2 cup	Winter squash, cooked: acorn, butternut, hubbard				
1 item	White potato, baked, boiled, or mashed				
1/2 cup	Sweet potatoes or yams, cooked				

Beverages

Servings Per:

Serving Size	Food Name / Description	Day	Week	Month	Never
12 fl. oz.	Cola drinks (1 can = 12 fl. oz.)				
12 fl. oz.	Diet cola drinks (1 can = 12 fl. oz.)				
12 fl. oz.	Non-cola drinks: 7-up, Sprite, Slice, etc. (1 can = 12 fl. oz.)				
12 fl. oz.	Diet non-cola drinks (1 can = 12 fl. oz.)				
8 fl. oz.	Coffee or tea (1 cup = 8 fl. oz.)				
8 fl. oz.	Decaffeinated coffee or teas: Sanka, herbal tea, etc.				
1 cup	Hot chocolate or cocoa				
12 fl. oz.	Beer (1 can = 12 fl. oz.)				
4 fl. oz.	Wine, dry or table (red, white or blush)				
1.5 fl. oz.	Liquor: vodka, whiskey, gin, rum, etc.				

Indicate Servings Per:

Serving Size	Food Name / Description	Day	Week	Month	Never
1 cup	Legumes: lentils, pinto beans, navy beans, cooked				
1/4 cup	Nuts and seeds: peanuts, almonds, sunflower seeds, etc.				
1 Tbsp	Peanut butter, nut butters				
3 ounces	Tofu or other meat substitutes				
3 ounces	Beef: rib roast, steak, pot roast, veal, etc.				
3 ounces	Beef, ground, cooked				
3 ounces	Pork: chops, roast, ham				
3 ounces	Lamb: chops, roast				
3 ounces	Poultry: chicken, turkey, duck				
3 ounces	Fish, canned with oil: tuna, sardines				
3 ounces	Tuna, water pack				
3 ounces	Fish, fresh or frozen, no breading: trout, halibut, sole, etc.				
3 ounces	Shellfish: shrimp, scallops, lobster, clams				
1 item	Eggs, whole, large				
1/4 cup	Egg substitutes or egg whites				
1 ounce	Lunch meats: bologna, salami, etc.				
1 item	Frankfurters or sausage links (4" x 1 1/8")				

Desserts and Sweets — Servings Per:

Serving Size	Food Name / Description	Day	Week	Month	Never
2 items	Cookies: chocolate chip, oatmeal, peanut butter, etc.				
1 item	Brownies, 2" x 2" inch				
1 item	Doughnut or sweet roll				
1 slice	Cake, 1/12 of 9 inch				
1 item	Granola bars (1 item) or granola (1/2 cup)				
1 slice	Pie, 1/8 of whole pie				
1/2 cup	Gelatin, flavored				
1/2 cup	Pudding or custard				
1/2 cup	Ice cream				
1/2 cup	Ice milk				
1/2 cup	Sherbet				
1 item	Candy bar, chocolate bar (1 bar), M&M's (1 pkg)				
1 item	Hard candy, gum drops, Lifesavers				

Miscellaneous — Servings Per:

Serving Size	Food Name / Description	Day	Week	Month	Never
1 slice	Fast food - pizza				
1 item	Fast food - hamburger or cheeseburger				
1 item	Fast food - burrito or taco				
2 slices	Bacon				
2 cups	Popcorn, popped				
1 ounce	Potato chips, corn chips, tortilla chips (10 to 15 each)				
1 Tbsp	Catsup or chili sauce				
1/2 cup	Tomato based sauce (spaghetti sauce)				
1 slice/Tbsp	Pickles, or pickle relish (1 Tbsp)				
5 items	Olive				
1/8 item	Avocado (1/8 item)				
1 Tbsp	Sauces: soy sauce, steak sauce, barbecue sauce				
1/4 cup	Brown gravy, giblet gravy, white sauce				
1 cup	Soups, vegetable or noodle type				
1 cup	Soups, cream				
1 piece	Chewing gum				
1 Tbsp	Sugar, honey, jam, jelly, syrups				

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 to 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.

Please circle the number that best describes your symptoms. PLEASE LEAVE THE QUESTION BLANK if you never experience the symptom.

- 1 = **Rarely** - symptom is familiar to you but you but you perceive it as insignificant (monthly or less)
- 2 = **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 symptoms require a YES or a NO response. 1 = NO 8 = YES

PART I

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

SECTION B	Rarely	Occasionally	Often	Frequently
1. Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt	1	2	4	8
2. Feel hungry an hour or two after eating a good-sized meal	1	2	4	8
3. Stomach pain, burning and/or aching over a period of 1-4 hours after eating	1	2	4	8
4. Stomach pain, burning and/or aching relieved by eating food, drinking carbonated beverage, cream or milk, or taking antacids	1	2	4	8
5. Burning sensation in the lower part of your chest, especially when lying down or bending forward	1	2	4	8
6. Painful indigestion even when relaxed or on vacation	1	2	4	8
7. Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache	1	2	4	8
8. Feel a sense of nausea when you eat	1	2	4	8
9. Difficulty or pain when swallowing food or beverage	1	2	4	8
Total points				

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

SECTION C (cont)	Rarely	Occasionally	Often	Frequently
6. Stool odor is embarrassing	1	2	4	8
7. Undigested food in your stool	1	2	4	8
8. Three or more large bowel movements daily	1	2	4	8
9. Diarrhea (frequent loose, watery stool)	1	2	4	8
10. Bowel movement shortly after eating (within 1 hour)	1	2	4	8
Total points				

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

PART II

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

PART II

	Rarely	Occasionally	Often	Frequently
10. Aching muscles not due to exercise	1	2	4	8
11. Retain fluid and feel swollen around the abdominal area	1	2	4	8
12. Reddened skin, especially palms	1	2	4	8
13. Very strong body odor	1	2	4	8
14. Are you embarrassed by your breath?	1	2	4	8
15. Bruise easily	1			8
16. Yellowish cast to eyes	1			8

Total points ______

PART III

SECTION A

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

Total points ______

SECTION B

	Rarely	Occasionally	Often	Frequently
1. Lingering mild fatigue after exertion or stress	1	2	4	8
2. Do you feel that you get tired and exhaust very easily?	1	2	4	8
3. Craving for salty foods	1	2	4	8
4. Sensitive to minor changes in weather and surroundings	1	2	4	8
5. Dizzy when rising or standing up from a kneeling position	1	2	4	8
6. Dark bluish or black circles under your eyes	1	2	4	8
7. Have bouts of nausea with or without vomiting	1	2	4	8
8. Catch colds or infections easily	1	2	4	8
9. Wounds heal slowly	1	2	4	8
10. Your body or parts of your body feel tender, sore, sensitive to the touch, hot and/or painful	1	2	4	8
11. Feel puffy and swollen all over your body	1	2	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	1			8

Total points ______

PART IV

SECTION A

When you miss meals or go without food for extended periods of time do you experience any of the following symptoms?

	Rarely	Occasionally	Often	Frequently
1. A sense of weakness	1	2	4	8
2. A sudden sense of anxiety when you get hungry	1	2	4	8
3. Tingling sensation in your hands	1	2	4	8
4. A sensation of your heart beating too quickly or forcefully	1	2	4	8
5. Shaky, jittery, hands trembling	1	2	4	8
6. Sudden profuse sweating and/or your skin feels clammy	1	2	4	8
7. Nightmares possibly associated with going to bed on an empty stomach	1	2	4	8
8. Wake up at night feeling restless	1	2	4	8
9. Agitation, easily upset, nervous	1	2	4	8
10. Poor memory, forgetful	1	2	4	8
11. Confused or disoriented	1	2	4	8
12. Dizzy, faint	1	2	4	8
13. Cold or numb	1	2	4	8
14. Mild headaches or head pounding	1	2	4	8
15. Blurred vision or double vision	1	2	4	8
16. Feel clumsy and uncoordinated	1	2	4	8

Total points ______

SECTION B

	Rarely	Occasionally	Often	Frequently
1. Frequent urination day and night	1	2	4	8
2. Unusual thirst - feeling like you can't drink enough water	1	2	4	8
3. Unusual hunger - eating all the time	1	2	4	8
4. Vision blurs	1	2	4	8
5. Feel itchy all over	1	2	4	8
6. Tingling or numbness in your feet	1	2	4	8
7. Sores heal slowly	1	2	4	8
8. Sense of drowsiness, lethargy during the day not associated with missing meals or not sleeping	1	2	4	8
9. 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	1			8
10. Loss of hair on your legs	1			8

Total points ______

PART V

SECTION A

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

Total points ______

PART V

SECTION B	Rarely	Occasionally	Often	Frequently
1. Muscle pain at rest	1	2	4	8
2. Cramp-like pains in your ankles, calves or legs	1	2	4	8
3. Cold feet and/or toes appear blue	1	2	4	8
4. Brief moments of hearing loss	1	2	4	8
5. Nausea comes and goes quickly unrelated to eating	1	2	4	8
6. Feel worse standing: legs get heavy and fatigued	1	2	4	8
7. Leg discomfort or fatigue relieved by elevating legs	1	2	4	8
8. Fingers and toes numb in cold weather even when protected	1	2	4	8
9. Notice changes in your ability to feel pain or discriminate sensations of hot or cold	1			8
10. Body hair (on arms, hands, fingers, legs and toes) is thinning or has disappeared	1			8
11. Not as coordinated as you used to be	1			8
12. Do you notice a decline in your ability to make decisions, concentrate, focus attention or follow directions?	1			8
Total points				

PART VI

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

SECTION B	Rarely	Occasionally	Often	Frequently
1. Does worrying get you down?	1	2	4	8
2. Does every little thing get on your nerves and wear you out?	1	2	4	8
3. Would you consider yourself a nervous person?	1	2	4	8
4. Do you feel easily agitated?	1	2	4	8
5. Do you shake and tremble?	1	2	4	8
6. Are you keyed up and jittery?	1	2	4	8
7. Do you tremble or feel weak when someone shouts at you?	1	2	4	8
8. Do you become scared at sudden movements or noises at night?	1	2	4	8
9. Do you find yourself sighing alot?	1	2	4	8
10. Are you awakened out of your sleep by frightening dreams?	1	2	4	8
11. Do frightening thoughts keep coming back in your mind?	1	2	4	8
12. Do you become suddenly scared for no good reason?	1	2	4	8
13. Do you break out in a cold sweat?	1	2	4	8
14. "Butterflies in your stomach", nausea and/or diarrhea	1	2	4	8
Total points				

SECTION C	Rarely	Occasionally	Often	Frequently
1. Do you feel pent up and ready to explode?	1	2	4	8
2. Are you prone to noisy and emotional outbursts?	1	2	4	8
3. Do you do things on impulse?	1	2	4	8
4. Are you easily upset or irritated?	1	2	4	8
5. Do you go to pieces if you don't control yourself?	1	2	4	8
6. Do little annoyances get on your nerves and make you angry?	1	2	4	8
7. Does it make you angry to have anyone tell you what to do?	1	2	4	8
8. Do you flare up in anger if you can't have what you want right away?	1	2	4	8
Total points				

PART VII

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

PART VIII

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

Total points ______

PART IX

SECTION A

	Rarely	Occasionally	Often	Frequently
1. Bones throughout your entire body ache, feel tender or sore	1	2	4	8
2. Localized bone pain	1	2	4	8
3. Hands, feet or throat get tight, spasm or feel numb	1	2	4	8
4. Difficulty sitting straight	1	2	4	8
5. Upper back pain	1	2	4	8
6. Lower back pain	1	2	4	8
7. Pain when sitting down or walking	1	2	4	8
8. Find yourself limping or favoring one leg	1	2	4	8
9. Shins hurt during or after exercise	1	2	4	8

Total points ______

SECTION B

	Rarely	Occasionally	Often	Frequently
1. Are you stiff in the morning when you wake up?	1	2	4	8
2. Difficulty bending down and picking up clothing or anything from the floor	1	2	4	8
3. Joint swelling, pain or stiffness involving one or more areas (fingers, hands, wrists, elbows, shoulders, toes, arches, feet, ankles, knees)	1	2	4	8
4. Joints hurt when moving or when carrying weight	1	2	4	8
5. A routine exercise program, like daily walking, causes your knees to swell or hurt	1	2	4	8
6. Difficulty opening jars that were previously easy to open	1	2	4	8
7. Discomfort, numbness, prickling or tingling sensation, or pain in neck, shoulder or arm	1	2	4	8
8. Intermittent pain or ache on one side of head spreading to cheek, temple, lower jaw, ear, neck and shoulder	1	2	4	8
9. Difficulty chewing food or opening mouth	1	2	4	8
10. Difficulty standing up from a sitting position	1	2	4	8
11. Shooting, aching, tingling pain down the back of leg	1	2	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?	1			8
13. Injure, strain or sprain easily	1			8

Total points ______

SECTION C

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

Total points ______

PART X

SECTION A

	Rarely	Occasionally	Often	Frequently
1. Head feels heavy	1	2	4	8
2. Dizziness	1	2	4	8
3. Difficulty bending over, standing up from sitting, rolling over in bed and/or turning your head from side to side	1	2	4	8
4. Your hands tremble, ever so slightly, for no apparent reason	1	2	4	8
5. When walking you feel like you're wearing heavy weights on your feet	1	2	4	8
6. Bump into things, trip, stumble and feel clumsy	1	2	4	8
7. Difficulty breathing	1	2	4	8
8. Difficulty swallowing	1	2	4	8
9. People tell you to speak up because they have trouble hearing you	1	2	4	8
10. Speaking and forming words does not feel automatic	1	2	4	8
11. Need 10-12 hours of sleep to feel rested	1	2	4	8
12. Lack of strength (your grip is weak, holding your head or picking your arms up takes effort)	1	2	4	8
13. Hands get tired when you write and your handwriting is less legible and smaller than it used to be	1			8
14. Muscles in arms and legs seem softer and smaller	1			8
15. Is your eyesight, sense of smell and taste or ability to hear not as sharp as it used to be?	1			8
16. Do you find yourself moving slower than you used to?	1			8

Total points ______

PART X

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

PART XI

Men Only

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

PART XII

Women Only

(Menopausal women should skip to sections E and F)

SECTION A

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

	Rarely	Occasionally	Often	Frequently
[A]				
1. Anxious, irritable or restless	1	2	4	8
2. Numbness, tingling in hands and feet	1	2	4	8
3. Easy to anger, resentful	1	2	4	8
4. Aggressive or hostile toward family/friends	1	2	4	8
[B]				
5. Abdominal bloating, feeling swollen (e.g., feet)	1	2	4	8
6. Temporary weight gain	1	2	4	8
7. Breast tenderness, swelling	1	2	4	8
8. Appearance of breast lumps	1	2	4	8
9. Discharge from nipples	1	2	4	8
10. Nausea and/or vomiting	1	2	4	8
11. Diarrhea or constipation	1	2	4	8
12. Aches and pains (back, joints, etc.)	1	2	4	8

SECTION A (cont)	Rarely	Occasionally	Often	Frequently
[C]				
13. Craving for sweets	1	2	4	8
14. Increased appetite or binge eating	1	2	4	8
15. Headaches	1	2	4	8
16. Being easily overwhelmed, shaky or clumsy	1	2	4	8
17. Heart pounding	1	2	4	8
18. Dizziness or fainting	1	2	4	8
[D]				
19. Confused and forgetful to the point that work suffers	1	2	4	8
20. Overwhelmed with feelings of sadness and worthlessness	1	2	4	8
21. Difficulty sleeping or falling asleep	1	2	4	8
22. Engaging in self destructive behavior	1	2	4	8
Total points				

SECTION B

Do you experience any of these symptoms *during your period*?

	Rarely	Occasionally	Often	Frequently
1. Cramping in lower abdomen or pelvic area	1	2	4	8
2. Pain is sharp and/or dull or intermittent	1	2	4	8
3. Bloating and sense of abdominal fullness	1	2	4	8
4. Diarrhea or constipation	1	2	4	8
5. Nausea and/or vomiting	1	2	4	8
6. Low back and/or legs ache	1	2	4	8
7. Headaches	1	2	4	8
8. Unusual fatigue (take naps) resulting in missed work	1	2	4	8
9. Painful and/or swollen breasts	1	2	4	8
10. Scanty blood flow	1	2	4	8
Total points				

SECTION C	Rarely	Occasionally	Often	Frequently
1. Painful or difficult sexual intercourse	1	2	4	8
2. Low abdominal pain throughout the month	1	2	4	8
3. Low back ache or pain throughout the month	1	2	4	8
4. Pelvic pressure or pain while sitting down or standing up, relieved by lying down	1	2	4	8
5. Painful bowel movements	1	2	4	8
6. Constipated or difficult bowel movements	1	2	4	8
7. Rectal pain	1	2	4	8
8. Painful or difficult (straining) urination	1	2	4	8
9. Abnormal vaginal discharge	1	2	4	8
10. Offensive vaginal discharge	1	2	4	8
11. Vaginal itching or burning with or without intercourse	1	2	4	8
12. Pain during periods is getting progressively worse	1			8
Total points				

SECTION D	Rarely	Occasionally	Often	Frequently
1. Absence of periods for six months or longer	1			8
2. Periods occur irregularly (e.g., 3 to 6 times a year)	1			8
3. Profuse heavy bleeding during periods	1	2	4	8
4. Menstrual blood contains clots and tissue	1	2	4	8
5. Bleeding between periods can occur any time	1	2	4	8
6. Menstrual bleeding at cycles greater than every 35 days	1			8
7. Intense upper stomach pain, lasting several hours at the time you ovulate (approximately day 14 of your cycle)	1	2	4	8

PART XII

SECTION D (cont)	Rarely	Occasionally	Often	Frequently
8. Bleeding occurs at ovulation (approximately day 14 of your cycle)	1	2	4	8
9. Monthly abdominal pain without bleeding	1	2	4	8
10. Abundant cervical mucous	1	2	4	8
11. Acne and/or oily skin	1	2	4	8
12. Overwhelming urges for sexual intercourse	1	2	4	8
13. Aggressive feelings	1	2	4	8
14. Increased growth of dark facial and/or body hair	1			8
15. Poor sense of smell	1			8
16. Voice is becoming deeper	1			8
17. Breasts seem to be getting smaller	1			8
18. Pain during periods is getting progressively worse	1			8
Total points				

SECTION E	Rarely	Occasionally	Often	Frequently
1. Urinary problems	1	2	4	8
2. Vaginal discharge	1	2	4	8
3. Vaginal secretions are watery and thin	1	2	4	8
4. Vaginal dryness	1	2	4	8
5. Sexual intercourse is uncomfortable	1	2	4	8
6. Interest in having sex is low	1	2	4	8
7. Engorged breasts	1	2	4	8
8. Breast tenderness, soreness	1	2	4	8
9. Difficulty with orgasm	1	2	4	8
10. Vaginal bleeding after sexual intercourse	1	2	4	8

SECTION E (cont)	Rarely	Occasionally	Often	Frequently
11. Occasionally skip periods	1	2	4	8
12. The length (number of days) of your period varies month to month, with the number of days of bleeding getting less	1			8
Total points				

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