HEALTH APPRAISAL QUESTIONNAIRE

Name_____ Week_____ Date _____/_____/_____

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 1 DIGESTION

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. Pour 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. Mucus in stools..... 0 1 2 3
9. Stool poorly formed..... 0 1 2 3
10. Shiney stool..... 0 1 2 3
11. Three or more large bowl 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

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 the 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 symptoms by drinking cream/milk..... NO YES
11. History of ulcers or gastritis..... NO YES
12. Current ulcer..... NO YES (10)
13. Black stool when not taking iron supplements NO YES

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 II: LIVER/GALLBLADDER

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 the 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 had jaundice or hepatitis..... NO YES
22. High blood cholesterol and low HDL level.. NO YES (10)
23. Is your cholesterol level above 260..... NO YES
24. Is your triglyceride level above 115 NO YES

SECTION B: THYROID 0 1 2 3

1. Swollen eyes (bulging)..... 0 1 2 3
2. Thick skin and finger nails..... 0 1 2 3
3. Dry skin..... 0 1 2 3
4. Sensitive to the cold..... 0 1 2 3
5. Cold hands and feet..... 0 1 2 3
6. Excessive or clotting menstrual bleeding..... 0 1 2 3
7. Tired, sluggish..... 0 1 2 3
8. Fatigued..... 0 1 2 **3**
9. Trouble waking up in the morning..... 0 1 2 3
10. Apathetic..... 0 1 2 3
11. Gravelly or tired voice..... 0 1 2 3
12. Hard to swallow pills..... 0 1 2 3
13. Thyroid problems in family..... 0 1 2 3
14. Hair loss..... 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. Oral temperature under 98.6°..... NO YES
20. Low blood pressure..... NO YES
21. Infertility..... NO YES

Part III: IMMUNE FUNCTION

SECTION A: HYPO ADRENAL

1. Sensitive or exposed 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. Difficulty breathing..... 0 ◯ 1 ◯ 2 ◯ 3 ◯
10. Water retention..... 0 ◯ 1 ◯ 2 ◯ 3 ◯
11. Eyes sensitive to bright light..... 0 ◯ 1 ◯ 2 ◯ 3 ◯
12. Feel weak and shakey..... 0 ◯ 1 ◯ 2 ◯ 3 ◯

SECTION B: HYPO IMMUNE

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: HYPER IMMUNE

1. Eczema and psoriasis..... NO ◯ YES (10) ◯
2. Asthma/bronchitis..... NO ◯ YES (10) ◯
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. Eyes itch..... 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. Sinusitis/Rhinitis..... NO ◯ 1 2 YES (5) ◯
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. Bedwetting..... NO ◯ YES (5) ◯
23. Hyperactivity..... 0 ◯ 1 ◯ 2 ◯ 3 ◯
24. Chronic lung congestion..... 0 ◯ 1 ◯ 2 ◯ 3 ◯
25. Use aspirin, Tylenol regularly..... NO ◯ YES ◯
26. Use Cortisone, Prednisone..... NO ◯ YES ◯
27. Total body hair loss (Alopecia)..... NO ◯ YES ◯

Part IV: CARDIOVASCULAR

SECTION A: HEART

1. Shortness of breath..... 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?..... YES ◯ NO ◯
14. Have you ever exercised regularly?..... YES ◯ NO ◯
15. Bright red nose..... NO ◯ YES ◯
16. At rest, heart beats per minute..... 80-90 ◯ 90+ ◯ (under 80 leave blank)

SECTION B: CIRCULATION

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 the ears..... 0 ◯ 1 ◯ 2 ◯ 3 ◯
8. Ear canal hair..... NO ◯ YES ◯
9. Heart attack..... NO ◯ YES(10) ◯
10. Stroke..... NO ◯ YES(10) ◯
11. Vertical wrinkle in lover ear lobe..... NO ◯ YES ◯

SECTION C: HYPERTENSION

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. Fatigue easily..... 0 ◯ 1 ◯ 2 ◯ 3 ◯
5. Blushing with no apparent cause..... 0 ◯ 1 ◯ 2 ◯ 3 ◯
6. Is your blood pressure high?..... NO ◯ YES(10) ◯

Part V: SUGAR TOLERANCE

SECTION A: HYPOGLYCEMIA

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 when eating sweets or alcohol..... 0 ◯ 1 ◯ 2 ◯ 3 ◯
5. Feel shakey..... 0 ◯ 1 ◯ 2 ◯ 3 ◯
6. Irritable if a meal is missed..... 0 ◯ 1 ◯ 2 ◯ 3 ◯
7. Wake up in the middle of the 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. Poor concentration..... 0 ◯ 1 ◯ 2 ◯ 3 ◯
15. Forgetful..... 0 ◯ 1 ◯ 2 ◯ 3 ◯
16. Calmer after eating..... NO ◯ YES ◯

SECTION B : HYPERGLYCEMIA

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. Craves 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 VI: LUNG

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. Asthmatic..... 0 1 2 3
10. Sensitive to smog..... 0 1 2 3
11. Infections settle in lungs..... 0 1 2 3
12. Work around people who smoke..... 0 1 2 3
13. Bronchitis..... NO YES (10)
14. Exposed to chemicals and radiation..... NO YES (6)
15. Smoker..... NO YES (6)

What did you smoke?_____ # per day _____

Part VII: UROLOGICAL

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 bladder infections..... NO YES
14. Have you used antibiotics to control urinary tract infections..... NO YES

IF YES, WHEN DID YOU LAST USE THEM?_____

TREATMENT DURATION_____

Part VIII: (Male only)

SECTION A: MALE

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. Anxiety or fear of sexual intimacy with women 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 VD now?_____ Had in the past? _____

Part IX FEMALE PMS

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..... O 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: AMENORRHEA

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____
10. Abortions..... NO YES HOW MANY____

SECTION C: DYSMENORRHEA

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

Part IX SECTION C continued

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 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: FIBROCYSTIC

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: MENOPAUSE 0 1 2 3

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 X MUSCULOSKELETAL

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 drinks..... YES ☐ oz. per week____
7. Gum disease..... NO YES
8. Bone loss..... NO YES
9. Calcium deposits..... NO YES
10. Use antacids..... YES ☐ # per week_____
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 the 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

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 disk..... NO YES(5)
9. Herniated disk..... NO YES(10)
10. Loss in height..... NO YES
11. Injure easily..... NO YES

Part XI: NEUROLOGICAL

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 XI: SLEEP PATTERNS

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 the night, can't fall back to sleep..... NO YES
8. Sleep walk..... NO YES