NAQ

Name:		Date:	
Gender:		Date of Birth:	

TOP 5 HEALTH CONCERNS

1:
2:
3:
4:
5:

Directions: Please read the following questions and circle the number that applies. Unless otherwise noted, use the default scale shown at the top of each section or page. Trust your instincts and choose quickly without overthinking.

Part 1

DIET

Section Subtotal **/ 58**

0: Never Consume | 1: Consume 1-2x/month | 2: Consume Weekly | 3: Consume Daily

#					Item
1.	0	1	2	3	Alcohol
2.	0	1	2	3	Artificial Sweeteners
3.	0	1	2	3	Candy, Desserts, Sugar
4.	0	1	2	3	Carbonated Beverages
5.	0	1	2	3	Chewing Tobacco
6.	0	1	2	3	Cigarettes
7.	0	1	2	3	Cigars or Pipes
8.	0	1	2	3	Caffeinated Beverages
9.	0	1	2	3	Fast Food
10.	0	1	2	3	Fried Foods
11.	0	1	2	3	Processed Lunch Meats
12.	0	1	2	3	Margarine
13.	0	1	2	3	Milk Products
14.	0	1			Radiation Exposure (0=No, 1=Yes)
15.	0	1	2	3	Refined Flour & Baked Goods
16.	0	1	2	3	Vitamins & Minerals
17.	0	1	2	3	Distilled Water
18.	0	1	2	3	Tap Water
19.	0	1	2	3	Well Water
20.	0	1	2	3	Restrict Calories for Weight Control

LIFESTYLE

Section Subtotal **/ 12**

See each question below for the rating key.

#					Item	Rating key
21.	0	1	2	3	Exercise Sessions Per Week	0 = 2+ times/week; 1 = 1 time/week; 2 = 1-2 times/week; 3 = < 1 time/month
22.	0	1	2	3	Changed Jobs	0 = over 12 mo. ago; 1 = last 12 mo.; 2 = last 6 mo.; 3 = last 2 mo.
23.	0	1	2	3	Divorced	0 = never or over 2 years ago; 1 = last 2 years.; 2 = last year; 3 = last 6 mo.
24.	0	1	2	3	Work 60+ Hours Per Week	0 = never; 1 = occasionally; 2 = usually; 3 = always

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MEDICATIONS

Section Subtotal / 27

0: No (Not Taking or Have Not Taken in the Last Month) 1: Yes (Currently Taking or Have Taken in the Last Month)

#			Medication
25.	0	1	Antacids
26.	0	1	Antianxiety Medications
27.	0	1	Antibiotics
28.	0	1	Anticonvulsants
29.	0	1	Antidepressants
30.	0	1	Antifungals
31.	0	1	Aspirin/Ibuprofen
32.	0	1	Asthma Inhalers
33.	0	1	Beta Blockers
34.	0	1	Birth Control Pill/Implant
35.	0	1	Chemotherapy
36.	0	1	Cholesterol Lowering Medications
37.	0	1	Cortisone/Steroids
38.	0	1	Diabetic Medications/Insulin
39.	0	1	Diuretics
40.	0	1	Estrogen or Progesterone (Prescript.)
41.	0	1	Estrogen or Progesterone (Natural)
42.	0	1	Heart Medications
43.	0	1	High Blood Pressure Medications
44.	0	1	Laxatives
45.	0	1	Recreational Drugs
46.	0	1	Relaxants/Sleeping Pills
47.	0	1	Testosterone (Prescript. or Natural)
48.	0	1	Thyroid Medication
49.	0	1	Acetaminophen (Tylenol®)
50.	0	1	Ulcer Medications
51.	0	1	Sildenafil Citrate (Viagra®)

Part 2

SECTION 1

Section Subtotal / 55

0: Never Occurs 1: Minor; Rarely Occurs (1x/month) 2: Moderate; Occasional (Weekly) 3: Severe; Frequent (Daily)

#					Symptom
52.	0	1	2	3	Belching/Gas Within 1 Hour of Eating
53.	0	1	2	3	Heartburn or Acid Reflux
54.	0	1	2	3	Bloating Within 1 Hour of Eating
55.	0	1			Vegan Diet [1]
56.	0	1	2	3	Bad Breath (Halitosis)
57.	0	1	2	3	Loss of Taste for Meat
58.	0	1	2	3	Strong Smelling Sweat
59.	0	1	2	3	Stomach Upset by Taking Vitamins
60.	0	1	2	3	Sense of Excess Fullness After Meals
61.	0	1	2	3	Feel Like Skipping Breakfast
62.	0	1	2	3	Feel Better if You Don’t Eat
63.	0	1	2	3	Sleepy After Meals
64.	0	1	2	3	Fingernails Chip, Peal or Break Easily
65.	0	1	2	3	Anemia Unresponsive to Iron
66.	0	1	2	3	Stomach Pains or Cramps
67.	0	1	2	3	Chronic Diarrhea
68.	0	1	2	3	Diarrhea Shortly After Meals
69.	0	1	2	3	Black or Tarry Colored Stools
70.	0	1	2	3	Undigested Food in Stool

[1] 0 = No 1 = Yes No animal products (meat, fish, eggs, dairy, etc.)

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NAQ

0: Never Occurs   1: Minor; Rarely Occurs (1x/month)   2: Moderate; Occasional (Weekly)   3: Severe; Frequent (Daily)

SECTION 2

Section Subtotal **/ 64**

No.	Rating	Item
71.	0 1 2 3	Pain Between Shoulder Blades
72.	0 1 2 3	Stomach Upset by Greasy Foods
73.	0 1 2 3	Greasy or Shiny Stools
74.	0 1	Nausea [1]
75.	0 1 2 3	Motion Sickness (Sea, Car, Airplane)
76.	0 1	History of Morning Sickness [1]
77.	0 1 2 3	Light or Clay Colored Stools
78.	0 1 2 3	Dry Skin, Itchy or Peeling Feet
79.	0 1 2 3	Headache Over Eyes
80.	0 1 2 3	Gallbladder Attacks [2]
81.	0 1	Gallbladder Removed [1]
82.	0 1 2 3	Bitter Taste in Mouth, Especially After Meals
83.	0 1	Become Sick When Drinking Wine [1]
84.	0 1	Easily Intoxicated from Wine [1]
85.	0 1	Easily Hungover from Wine [1]
86.	0 1 2 3	Alcoholic Beverages Per Week [3]
87.	0 1	Recovering Alcoholic [1]
88.	0 1	History of Drug Abuse [1]
89.	0 1	History of Hepatitis [1]
90.	0 1	Long-term Use of Prescript./Rec. Drugs [1]
91.	0 1 2 3	Sensitive to Chemicals (e.g. Perfume, Cleaning Agents, etc.)
92.	0 1 2 3	Sensitive to Tobacco Smoke
93.	0 1 2 3	Exposure to Diesel Fumes
94.	0 1 2 3	Pain Under Right Side of Rib Cage
95.	0 1 2 3	Hemorrhoids or Varicose Veins
96.	0 1 2 3	Consume NutraSweet® (Aspartame)
97.	0 1 2 3	Sensitive to Aspartame
98.	0 1 2 3	Chronic Fatigue or Fibromyalgia

[1] 0 = No 1 = Yes   [2] 0 = Never 1 = Years Ago 2 = Within Last Year 3 = Within Past 3 Months   [3] 0 = < 3 1 = < 7 2 = < 14 3 = > 14

SECTION 3

Section Subtotal **/ 47**

No.	Rating	Item
99.	0 1 2 3	Food Allergies
100.	0 1 2 3	Abdominal Bloating 1-2 Hours After Meal
101.	0 1	Specific Foods Make You Tired / Bloated [1]
102.	0 1 2 3	Pulse Speeds After Eating
103.	0 1 2 3	Airborne Allergies
104.	0 1 2 3	Experience Hives
105.	0 1 2 3	Sinus Congestion, “Stuffy Head”
106.	0 1 2 3	Crave Bread or Noodles
107.	0 1 2 3	Alternating Constipation/Diarrhea
108.	0 1 2 3	Crohn’s Disease [2]
109.	0 1 2 3	Wheat or Grain Sensitivity
110.	0 1 2 3	Dairy Sensitivity
111.	0 1	Are There Any Foods You Can’t Give Up? [1]
112.	0 1 2 3	Asthma, Sinus Infections, Stuffy Nose
113.	0 1 2 3	Bizarre, Vivid Dreams; Nightmares
114.	0 1 2 3	Use Over-the-Counter Pain Meds
115.	0 1 2 3	Feel Spacey or Unreal

[1] 0 = No 1 = Yes   [2] 0 = No 1 = Yes in the Past 2 = Currently Mild 3 = Currently Severe

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NAQ

0: Never Occurs 1: Minor; Rarely Occurs (1x/month) 2: Moderate; Occasional (Weekly) 3: Severe; Frequent (Daily)

SECTION 4

Section Subtotal / 58

#					Symptom	#					Symptom
116.	0	1	2	3	Anus Itches	126.	0	1	2	3	Stools Have Corners/Edges, are Flat, or Ribbon Shaped
117.	0	1	2	3	Coated Tongue	127.	0	1	2	3	Stools are Not Well Formed (Loose)
118.	0	1	2	3	Feel Worse in Moldy/Musty Places	128.	0	1	2	3	Irritable Bowel or Mucus Colitis
119.	0	1	2	3	Total Antibiotic Use [2]	129.	0	1	2	3	Blood in Stool
120.	0	1	2	3	Fungal or Yeast Infections	130.	0	1	2	3	Mucus in Stool
121.	0	1	2	3	Ring Worm, Jock Itch, Athletes Foot, Nail Fungus	131.	0	1	2	3	Excessive, Foul Smelling Flatulence
122.	0	1	2	3	Yeast Symptoms Increase with Sugar, Starch, or Alcohol Consumption	132.	0	1	2	3	Bad Breath or Strong Body Odors
123.	0	1	2	3	Hard or Difficult to Pass Stool	133.	0	1	2	3	Painful to Press Along Outer Thighs (Iliotibial Bands)
124.	0	1			History of Parasites [1]	134.	0	1	2	3	Cramps in Lower Abdominal Region
125.	0	1	2	3	Less Than 1 Bowel Movement/Day	135.	0	1	2	3	Dark Circles Under Eyes

[1] 0 = No 1 = Yes [2] 0 = Never 1 = Less than 1 Month 2 = Less than 3 Months 3 = More than 3 Months

SECTION 5

Section Subtotal / 75

#					Symptom	#					Symptom
136.	0	1			History of Carpal Tunnel Syndrome [1]	151.	0	1	2	3	Morning Stiffness
137.	0	1			History of Lower Right Abdominal Pains or Ileocecal Valve Problems [1]	152.	0	1	2	3	Nausea with Vomiting
138.	0	1			History of Stress Fracture [1]	153.	0	1	2	3	Crave Chocolate
139.	0	1	2	3	Bone Loss (Reduced Density on Bone Scan)	154.	0	1	2	3	Feet Have a Strong Odor
140.	0	1			Are You Shorter Than You Used to Be? [1]	155.	0	1	2	3	History of Anemia
141.	0	1	2	3	Calf, Foot, or Toe Cramps at Rest	156.	0	1	2	3	Whites of Eyes (Sclera) are Blue Tinted
142.	0	1	2	3	Cold Sores, Fever Blisters, or Herpes Lesions	157.	0	1	2	3	Hoarseness
143.	0	1	2	3	Frequent Fevers	158.	0	1	2	3	Difficulty Swallowing
144.	0	1	2	3	Frequent Skin Rashes or Hives	159.	0	1	2	3	Lump in Throat
145.	0	1			Herniated Disc [1]	160.	0	1	2	3	Dry Mouth, Eyes, or Nose
146.	0	1	2	3	Excessively Flexible Joints / “Double Jointed”	161.	0	1	2	3	Gag Easily
147.	0	1	2	3	Joints Pop or Click	162.	0	1	2	3	White Spots on Fingernails
148.	0	1	2	3	Pain or Swelling in Joints	163.	0	1	2	3	Cuts Heal Slowly and/or Scar Easily
149.	0	1	2	3	Bursitis or Tendonitis	164.	0	1	2	3	Decreased Sense of Taste or Smell
150.	0	1			History of Bone Spurs [1]						

[1] 0 = No 1 = Yes

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NAQ

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SECTION 6

Section Subtotal **/ 22**

#					Item
165.	0	1			Experience Pain Relief with Aspirin [1]
166.	0	1	2	3	Crave Fatty or Greasy Foods
167.	0	1	2	3	Low-Fat or Reduced-Fat Diet [2]
168.	0	1	2	3	Tension Headaches at Base of Skull
169.	0	1	2	3	Headaches When Out in the Hot Sun
170.	0	1	2	3	Sunburn Easily or Get "Sun Poisoning"
171.	0	1	2	3	Muscles Easily Fatigued
172.	0	1	2	3	Dry, Flaky Skin or Dandruff

[1] 0 = No 1 = Yes [2] 0 = Never 1 = Years Ago 2 = Within Past Year 3 = Currently

SECTION 7

Section Subtotal **/ 39**

#					Item
173.	0	1	2	3	Awaken a Few Hours After Falling Asleep & Have Difficulty Falling Back to Sleep
174.	0	1	2	3	Crave Sweets
175.	0	1	2	3	Binging or Uncontrolled Eating
176.	0	1	2	3	Excessive Appetite
177.	0	1	2	3	Crave Coffee or Sugar in the Afternoon
178.	0	1	2	3	Sleep in the Afternoon
179.	0	1	2	3	Fatigue that is Relieved by Eating
180.	0	1	2	3	Headache if Meals are Skipped / Delayed
181.	0	1	2	3	Irritable Before Meals
182.	0	1	2	3	Shaky if Meals are Delayed
183.	0	1	2	3	Family Members with Diabetes [1]
184.	0	1	2	3	Frequent Thirst
185.	0	1	2	3	Frequent Urination

[1] 0 = None 1 = 1-2 People 2 = 3-4 People 3 = > 4 People

SECTION 8

Section Subtotal **/ 79**

#					Item
186.	0	1	2	3	Muscles Become Easily Fatigued
187.	0	1	2	3	Feel Exhausted or Sore After Moderate Exercise
188.	0	1	2	3	Vulnerable to Insect Bites
189.	0	1	2	3	Loss of Muscle Tone, Heaviness in Arms/Legs
190.	0	1	2	3	Enlarged Heart or Congestive Heart Failure
191.	0	1			Pulse Below 65 Beats Per Minute [1]
192.	0	1	2	3	Ringing in the Ears (Tinnitus)
193.	0	1	2	3	Numbness, Tingling, or Itching in Hands & Feet
194.	0	1	2	3	Depressed
195.	0	1	2	3	Fear of Impending Doom
196.	0	1	2	3	Worrier, Apprehensive, Anxious
197.	0	1	2	3	Nervous or Agitated
198.	0	1	2	3	Feelings of Insecurity
199.	0	1	2	3	Heart Races
200.	0	1	2	3	Can Hear Heartbeat on Pillow at Night
201.	0	1	2	3	Whole Body or Limb Jerk as Falling Asleep
202.	0	1	2	3	Night Sweats
203.	0	1	2	3	Restless Leg Syndrome
204.	0	1	2	3	Cracks at Corner of Mouth (Cheilosis)
205.	0	1	2	3	Fragile, Easily Chaffed Skin (e.g. When Shaving)
206.	0	1	2	3	Polyps or Warts
207.	0	1	2	3	MSG Sensitivity
208.	0	1	2	3	Wake Up Without Remembering Dreams
209.	0	1	2	3	Small Bumps on Back of Arms
210.	0	1	2	3	Strong Light at Night Irritates Eyes
211.	0	1	2	3	Nose Bleeds and/or Tends to Bruise Easily
212.	0	1	2	3	Bleeding Gums, Especially When Brushing

[1] 0 = No 1 = Yes

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NAQ

0: Never Occurs 1: Minor; Rarely Occurs (1x/month) 2: Moderate; Occasional (Weekly) 3: Severe; Frequent (Daily)

SECTION 9

Section Subtotal **/ 78**

#					Item	#					Item
213.	0	1	2	3	Tend to be a "Night Person"	226.	0	1	2	3	Arthritic Tendencies
214.	0	1	2	3	Difficulty Falling Asleep	227.	0	1	2	3	Crave Salty Foods
215.	0	1	2	3	Slow Starter in the Morning	228.	0	1	2	3	Salt Foods Before Tasting
216.	0	1	2	3	Tend to be "Keyed Up", Trouble Calming Down	229.	0	1	2	3	Perspire Easily
217.	0	1	2	3	Blood Pressure Above 120/80	230.	0	1	2	3	Chronic Fatigue or Get Drowsy Often
218.	0	1	2	3	Headache After Exercising	231.	0	1	2	3	Afternoon Yawning
219.	0	1	2	3	Feeling Wired or Jittery After Drinking Coffee	232.	0	1	2	3	Afternoon Headache
220.	0	1	2	3	Clench or Grind Teeth	233.	0	1	2	3	Asthma, Wheezing, or Difficulty Breathing
221.	0	1	2	3	Calm on the Outside, Troubled on the Inside	234.	0	1	2	3	Pain on the Medial or Inner Side of Knee
222.	0	1	2	3	Chronic Lower Back Pain, Worse with Fatigue	235.	0	1	2	3	Tendency to Sprain Ankles or Get "Shin Splints"
223.	0	1	2	3	Become Dizzy When Standing Up Quickly	236.	0	1	2	3	Tendency to Need Sunglasses
224.	0	1	2	3	Difficulty Maintaining Manipulative Correction	237.	0	1	2	3	Allergies and/or Hives
225.	0	1	2	3	Pain After Manipulative Correction	238.	0	1	2	3	Weakness, Dizziness

SECTION 10

Section Subtotal **/ 29**

#					Item	#					Item
239.	0	1			Height Over 6' 6" [1]	246.	0	1	2	3	Decreased Libido
240.	0	1			Early Sexual Development [1] (Before Age 10)	247.	0	1	2	3	Excessive Thirst
241.	0	1	2	3	Increased Libido	248.	0	1	2	3	Weight Gain Around Hips or Waist
242.	0	1	2	3	Splitting Type Headache	249.	0	1	2	3	Menstrual Disorders
243.	0	1	2	3	Memory Failing	250.	0	1			Delayed Sexual Development [1] (After Age 13)
244.	0	1			Tolerate / Feel Fine When Eating Sugar [1]	251.	0	1	2	3	Tendency to Ulcers or Colitis
245.	0	1			Height Under 4' 10" [1]						

[1] 0 = No 1 = Yes

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NAQ

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SECTION 11 **Section Subtotal / 48**

#	Score	Symptom
252.	0 1 2 3	Sensitive/Allergic to Iodine
253.	0 1 2 3	Difficulty Gaining Weight (Even With Large Appetite)
254.	0 1 2 3	Nervous or Emotional (Can't Work Under Pressure)
255.	0 1 2 3	Inward Trembling
256.	0 1 2 3	Flush Easily
257.	0 1 2 3	Fast Pulse at Rest
258.	0 1 2 3	Intolerance to High Temperatures
259.	0 1 2 3	Difficulty Losing Weight
260.	0 1 2 3	Mentally Sluggish / Reduced Initiative
261.	0 1 2 3	Easily Fatigued / Sleepy During the Day
262.	0 1 2 3	Sensitive to Cold / Poor Circulation (Cold Hands & Feet)
263.	0 1 2 3	Chronic Constipation
264.	0 1 2 3	Excessive Hair Loss and/or Course Hair
265.	0 1 2 3	Morning Headaches (Wear Off During the Day)
266.	0 1 2 3	Loss of Lateral (Outside) ⅓ of Eyebrow
267.	0 1 2 3	Seasonal Sadness

SECTION 12: MEN ONLY **Section Subtotal / 27**

#	Score	Symptom
268.	0 1 2 3	Prostate Problems
269.	0 1 2 3	Difficulty with Urination / Dribbling
270.	0 1 2 3	Difficult to Start & Stop Urine Stream
271.	0 1 2 3	Pain or Burning During Urination
272.	0 1 2 3	Waking to Urinate at Night
273.	0 1 2 3	Interruption of Stream During Urination
274.	0 1 2 3	Pain on Inside of Legs or Heels
275.	0 1 2 3	Feeling of Incomplete Bowel Evacuation
276.	0 1 2 3	Decreased Sexual Function*

* Dysfunction related to prostate issues only.

SECTION 13: WOMEN ONLY **Section Subtotal / 60**

If you are in menopause or no longer menstruating, please indicate the average symptoms that occurred when you were last menstruating.

#	Score	Symptom
277.	0 1 2 3	Depression During Periods
278.	0 1 2 3	Mood Swings Associated with Periods (Premenstrual Syndrome)
279.	0 1 2 3	Crave Chocolate Around Periods
280.	0 1 2 3	Breast Tenderness Associated with Cycle
281.	0 1 2 3	Excessive Menstrual Flow
282.	0 1 2 3	Scanty Blood Flow During Periods
283.	0 1 2 3	Occasional Skipped Periods
284.	0 1 2 3	Variations in Menstrual Cycles
285.	0 1 2 3	Endometriosis
286.	0 1 2 3	Uterine Fibroids
287.	0 1 2 3	Breast Fibroids / Benign Masses
288.	0 1 2 3	Painful Intercourse (Dyspareunia)
289.	0 1 2 3	Vaginal Discharge
290.	0 1 2 3	Vaginal Dryness
291.	0 1 2 3	Vaginal Itchiness
292.	0 1 2 3	Gain Weight Around Hips, Thighs & Buttocks
293.	0 1 2 3	Excess Facial or Body Hair
294.	0 1 2 3	Hot Flashes
295.	0 1 2 3	Night Sweats (in Menopausal Women)
296.	0 1 2 3	Thinning Skin

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NAQ

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SECTION 14

Section Subtotal / 30

#					Symptom
297.	0	1	2	3	Aware of Heavy or Irregular Breathing
298.	0	1	2	3	Discomfort at High Altitudes
299.	0	1	2	3	"Air Hunger" or Sigh Frequently
300.	0	1	2	3	Compelled to Open Windows in a Closed Room
301.	0	1	2	3	Shortness of Breath with Moderate Exertion
302.	0	1	2	3	Ankles Swell, Especially at End of Day
303.	0	1	2	3	Cough at Night
304.	0	1	2	3	Blush / Face Turns Red for No Reason
305.	0	1	2	3	Dull Pain or Tightness in Chest and/or Radiating Into Right Arm (Worse with Exertion)
306.	0	1	2	3	Muscle Cramps with Exertion

SECTION 15

Section Subtotal / 13

#					Symptom
307.	0	1	2	3	Pain in Mid-Back Region
308.	0	1	2	3	Puffy / Dark Circles Around the Eyes
309.	0	1			History of Kidney Stones [1]
310.	0	1	2	3	Cloudy, Bloody, or Darkened Urine
311.	0	1	2	3	Urine Has a Strong Odor

[1] 0 = No 1 = Yes

SECTION 16

Section Subtotal / 30

#					Symptom
312.	0	1	2	3	Runny or Drippy Nose
313.	0	1	2	3	Catch Colds at the Beginning of Winter
314.	0	1	2	3	Mucus Producing Cough
315.	0	1	2	3	Frequent Colds of Flu[1]
316.	0	1	2	3	Other Infections[1] (e.g. Sinus, Ear, Lung, Skin, Bladder, Kidney, etc.)
317.	0	1	2	3	Never Get Sick[2]
318.	0	1	2	3	Adult Acne
319.	0	1	2	3	Itchy Skin (Dermatitis)
320.	0	1	2	3	Cysts, Boils, or Rashes
321.	0	1	2	3	History of Chronic Viral Condition[3] (e.g. Mono, Epstein Bar, Herpes, Shingles, Chronic Fatigue Syndrome)

[1] 0 = 1 or Less Per Year 1 = 2 to 3 per Year 2 = 4 to 5 Per Year 3 = 6 or More Per Year

[2] 0 = Sick Only 1 or 2 Times in Last 2 Years 1 = Not Sick in Last 2 Years 2 = Not Sick in Last 4 Years 3 = Not Sick in Last 7 Years

[3] 0 = No 1 = Yes in the Past 2 = Currently Mild Condition 3 = Severe