# HOLISTIC CLINICAL APPROACHES QUESTIONNAIRE

NAME______________________________________ DATE_____________ PHONE __________________ EMAIL:________________

CIRCLE the number on the blank which best describes the **frequency**, or **severity** of your symptoms. If you do not know the answer to the question, or if the question does not apply, leave it blank. When you are finished, please add the number of points and write on the **Part Score Line**. The score for YES is 3 and the score for NO is 0.

**(0) never or rarely (1) twice a week or less (mild) (2) three to six times a week (moderate) (3) daily (severe)**

## SECTION 1

### Part 1-A

| Question | Score |
|---|---|
| Indigestion — food repeats on you after you eat? | 0 1 2 3 |
| Excessive burping, belching and / or bloating following meals? | 0 1 2 3 |
| Stomach spasms and cramping during or after eating? | 0 1 2 3 |
| A sensation that food sits in your stomach after eating? | 0 1 2 3 |
| Abdominal pain on right side, underneath rib cage? | 0 1 2 3 |
| Offensive breath? | 0 1 2 3 |
| Diarrhea? | 0 1 2 3 |
| Constipation? | 0 1 2 3 |
| Alternating Diarrhea and constipation? | 0 1 2 3 |
| Belching / Burping? | 0 1 2 3 |
| Excessive bloating or passing of gas? | 0 1 2 3 |
| Stomach Pains? | 0 1 2 3 |
| Acid or spicy foods upset stomach or digestion? | 0 1 2 3 |
| Sour stomach frequently? | 0 1 2 3 |
| Indigestion soon after meals? | 0 1 2 3 |
| Stomach pains before, and, or after meals? | 0 1 2 3 |
| Black stools even though not taking iron supplements or bismuth (Pepto Bismal)? | 0 1 2 3 |
| Roughage and fiber causes constipation or indigestion? | 0 1 2 3 |
| Poorly formed stools? | 0 1 2 3 |
| Stools float? | 0 1 2 3 |
| Pain on left side of abdomen, underneath rib cage? | 0 1 2 3 |
| Stool - greasy, shiny? | 0 1 2 3 |
| Stool yellowish, foul smelling? | 0 1 2 3 |
| Undigested food in your stool? | 0 1 2 3 |
| Vitamin deficiency? | 0 1 2 3 |
| Dependency on antacids? | N(0) Y(3) |
| **Part 1-A Score:** | _________ |

### Part 1-B

| Question | Score |
|---|---|
| Discomfort, pain or cramps in your lower abdominal area? | 0 1 2 3 |
| Anal itching? | 0 1 2 3 |
| Stool is small, hard and dry? | 0 1 2 3 |
| Pass mucus in stool? | 0 1 2 3 |
| Rectal pain or cramping? | 0 1 2 3 |
| No urge to have a bowel movement? | 0 1 2 3 |
| Almost continual need to have a bowel movement? | 0 1 2 3 |
| Alternating constipation / diarrhea? | 0 1 2 3 |
| Prone to vaginal yeast infections? | 0 1 2 3 |
| Stomach pain, burning and, or, aching over a period of 1-4 hours after eating ? | 0 1 2 3 |
| Stomach pain, burning/aching relieved by eating food or drinking beverages? | 0 1 2 3 |
| Burning sensation in the lower part of your chest, especially when lying down or bending forward? | 0 1 2 3 |
| Feel a sense of nausea or desire to vomit when you eat? | 0 1 2 3 |
| Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal? | 0 1 2 3 |
| Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement? | 0 1 2 3 |
| Stool odor is embarrassing? | 0 1 2 3 |
| Black, tarry stools? | 0 1 2 3 |
| Bloated? | 0 1 2 3 |
| Extremely narrow or thin stools? | 0 1 2 3 |
| Dark circles underneath eyes? | 0 1 2 3 |
| Three or more large bowel movements daily? | 0 1 2 3 |
| Bowel movement shortly after eating (within 1 hour)? | 0 1 2 3 |
| History of antibiotic use? | N(0) Y(3) |
| **Part 1-B Score:** | _________ |

### Part 1-C

| Question | Score |
|---|---|
| Inflamed corners of mouth? | 0 1 2 3 |
| Thirsty, often? | 0 1 2 3 |
| Feel thirsty, even after drinking water? | 0 1 2 3 |
| Weird / Strange cravings? | 0 1 2 3 |
| Sense of taste seems reduced? | 0 1 2 3 |
| Sense of smell seems reduced? | 0 1 2 3 |
| How often do you not eat 5 servings of fruits & veges per day? | 0 1 2 3 |
| Cuts heal slowly? | 0 1 2 3 |
| Feel depleted, exhausted? | 0 1 2 3 |
| Dry skin or scalp? | 0 1 2 3 |
| General feeling of poor health? | 0 1 2 3 |
| Do you not consume fermented foods more than 1-2 x's week? | N(0) Y(3) |
| Vegetarian (no eggs, dairy)? | N(0) Y(3) |
| Picky eater? | N(0) Y(3) |
| Don't take a multi-mineral, and, or multi-vitamin? | N(0) Y(3) |
| Spots on nails? | N(0) Y(3) |
| Thick, coarse hairs on body? | N(0) Y(3) |
| Consume lots of sweets? | N(0) Y(3) |
| Thinning eyebrows? | N(0) Y(3) |
| Most foods you eat come in a box or can? | N(0) Y(3) |
| Diet is low in fiber ( < 30 grams/day)? | N(0) Y(3) |
| Eat fish less than 3 times per week? | N(0) Y(3) |
| **Part 1-C Score:** | _________ |

## SECTION 2

### Part 2-A

| Question | Score |
|---|---|
| When massaging under your rib cage on your right side, there is pain, tenderness and soreness? | 0 1 2 3 |
| Flushing, or "hot flashes", shortly after you eat? | 0 1 2 3 |
| How often do you experience right shoulder / neck pain? | 0 1 2 3 |
| Feel like you have the "flu"? | 0 1 2 3 |
| Belch up bitter fluid after eating? | 0 1 2 3 |
| Feel abdominal discomfort or nausea when eating fatty or fried foods? | 0 1 2 3 |
| Unexplained itchy skin, that may be worse at night? | 0 1 2 3 |
| Stool color alternatives from clay colored to normal brown? | 0 1 2 3 |
| General feeling of poor health? | 0 1 2 3 |
| Easily bruise? | 0 1 2 3 |
| More than 10 beers, or 10 ounces of alcohol, per week? | 0 1 2 3 |
| Drink caffeine or caffeinated beverages? | 0 1 2 3 |
| Sensitive to even small amounts of alcohol? | 0 1 2 3 |
| Personal or family history of cancer? | 0 1 2 3 |
| Sensitive to fragrances, exhaust fumes, or strong odors? | 0 1 2 3 |
| Often feel angry or like you have a short fuse? | 0 1 2 3 |

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| Question | Score |
|---|---|
| Use artificial sweeteners regularly? | 0 1 2 3 |
| Exposed to chemicals or radiation at work or in home? | 0 1 2 3 |
| How often do you use cosmetics / make-up? | 0 1 2 3 |
| How often do you experience fatigue or sluggishness? | 0 1 2 3 |
| How often do you experience apathy or fatigue? | 0 1 2 3 |
| How often do you experience hyperactive or racing thoughts? | 0 1 2 3 |
| How often do you experience restlessness? | 0 1 2 3 |
| How often do you experience headaches or migraines? | 0 1 2 3 |
| How often do you experience poor memory? | 0 1 2 3 |
| How often do you experience confusion? | 0 1 2 3 |
| How often do you experience poor concentration, and, or coordination? | 0 1 2 3 |
| Have you ever been diagnosed with multiple chemical sensitivity? | N(0) Y(3) |
| Have you ever been diagnosed with Fibromyalgia, Chronic Fatigue, or Gulf War Syndrome? | N(0) Y(3) |
| Yellowish tint to white part of eyes? | N(0) Y(3) |
| Yellowish tint to skin? | N(0) Y(3) |
| Personal or family history of Parkinson's, Alzheimer's or other neurological diseases? | N(0) Y(3) |
| Personal or family history of Lupus, Rheumatoid Arthritis, Multiple Sclerosis, Ankylosing Spondylitis or other autoimmune disease? | N(0) Y(3) |
| Do you feel poorly after consuming grapefruit / grapefruit juice? | N(0) Y(3) |
| **Part 2-A Score:** | _________ |

**Part 2-B**

| Question | Score |
|---|---|
| Exposed to chemicals, and, or radiation at work? | 0 1 2 3 |
| How often do you not eat 5 servings of fruits & veges per day? | 0 1 2 3 |
| Sensitive to smog / air pollution? | 0 1 2 3 |
| Age or "sun" spots on skin? | 0 1 2 3 |
| Use cell-phone more than 30 minutes per day? | 0 1 2 3 |
| Work with computers for more than 2 hours per day? | 0 1 2 3 |
| Driving causes fatigue? | 0 1 2 3 |
| Travel more than 75 miles per day on average? | 0 1 2 3 |
| Feel tired, depleted? | 0 1 2 3 |
| Any, or all, of the following: Ringing in ears, dizziness, knee pain, low back pain? | 0 1 2 3 |
| Exposure to high amounts of radiation? | 0 1 2 3 |
| Diagnosis or symptoms of hypothyroidism? | 0 1 2 3 |
| Lack of exposure to natural, full-spectrum natural light ? on a daily basis for at least 15 minutes? | 0 1 2 3 |
| Metallic taste in mouth? | 0 1 2 3 |
| Cook with a microwave more than 2 x's week? | N(0) Y(3) |
| Have amalgam fillings? | N(0) Y(3) |
| Work or live around power lines? | N(0) Y(3) |
| "Frequent flyer"? | N(0) Y(3) |
| Work or live in buildings with poor ventilation? | N(0) Y(3) |
| Smoker? | N(0) Y(3) |
| **Part 2-B Score:** | _________ |

**SECTION 3**

**Part 3-A**

| Question | Score |
|---|---|
| Far sightedness (can't see things up close)? | 0 1 2 3 |
| Chronic phlegm or respiratory mucus? | 0 1 2 3 |
| Incontinence (involuntary urination)? | 0 1 2 3 |
| More than 3 bowel movements per day? | 0 1 2 3 |
| Slow heart beat? | 0 1 2 3 |
| Spasm of eye, with decreased visual ability? | 0 1 2 3 |
| Diarrhea? | 0 1 2 3 |
| Profuse sweating? | 0 1 2 3 |
| Urinary urgency? | 0 1 2 3 |
| Motion sickness? | 0 1 2 3 |
| Fatigue / drowsiness? | 0 1 2 3 |
| Dizziness when standing up from sitting or lying position? | 0 1 2 3 |
| Vertigo / dizziness? | 0 1 2 3 |
| Sexual dysfunction? | 0 1 2 3 |
| Pupils seem constricted (pin point), often? | N(0) Y(3) |
| Possible Pesticide or Insecticide exposure at home, and, or work? | N(0) Y(3) |
| Low blood pressure, often? | N(0) Y(3) |
| Do not like vegetables? | N(0) Y(3) |
| Eat non-organic foods? | N(0) Y(3) |
| Use tranquilizer prescription medication? | N(0) Y(3) |
| **Part 3-A Score:** | _________ |

**Part 3-B**

| Question | Score |
|---|---|
| Rapid heart rate? | 0 1 2 3 |
| Feelings of restlessness, anxiety, or feel jittery? | 0 1 2 3 |
| Difficulty getting or maintaining an erection? | 0 1 2 3 |
| Constipation? | 0 1 2 3 |
| Uterine prolapse? | 0 1 2 3 |
| Pulsing in arteries? | 0 1 2 3 |
| Blurred Vision? | 0 1 2 3 |
| Confusion? | 0 1 2 3 |
| Urinary retention / difficulty urinating? | 0 1 2 3 |
| Mouth feels dry? | 0 1 2 3 |
| Difficulty remembering things? | 0 1 2 3 |
| Muscle spasms, especially of face, and, or fingers? | 0 1 2 3 |
| Cardiac arrhythmia (skipping of heart beat)? | 0 1 2 3 |
| Headaches? | 0 1 2 3 |
| Hyperactivity? | 0 1 2 3 |
| Insomnia (inability or difficulty falling asleep)? | 0 1 2 3 |
| Nausea? | 0 1 2 3 |
| Tremors? | 0 1 2 3 |
| Hypertension / high blood pressure? | N(0) Y(3) |
| Pupils seem dilated, often? | N(0) Y(3) |
| Suffer from premature ejaculation? | N(0) Y(3) |
| Use or exposed to insecticides at home, and, or work? | N(0) Y(3) |
| **Part 3-B Score:** | _________ |

**Part 3-C**

| Question | Score |
|---|---|
| Need 10-12 hours of sleep to feel rested? | 0 1 2 3 |
| Hands get tired when you write and your handwriting is less legible and smaller than it used to be? | 0 1 2 3 |
| Decreased ability to remember things? | 0 1 2 3 |
| Accident prone – trip, stumble, feel clumsy? | 0 1 2 3 |
| Blurred vision? | 0 1 2 3 |

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**(0) never or rarely (1) twice a week or less (mild) (2) three to six times a week (moderate) (3) daily (severe)**

| | |
|---|---|
| Limbs feel too heavy to hold up? | 0 1 2 3 |
| Head feel too heavy to hold up? | 0 1 2 3 |
| Trembling hands? | 0 1 2 3 |
| Slowed or slurred speech? | 0 1 2 3 |
| Confused, forgetful? | 0 1 2 3 |
| Nervous, anxious? | 0 1 2 3 |
| Difficulty walking, moving around, handling small objects? | 0 1 2 3 |
| Depression? | 0 1 2 3 |
| Foggy? | 0 1 2 3 |
| Weird cravings? | 0 1 2 3 |
| Speaking and forming words does not feel automatic? | 0 1 2 3 |
| Difficulty absorbing new information? | 0 1 2 3 |
| Tend to forget things? | 0 1 2 3 |
| Trouble thinking or concentrating? | 0 1 2 3 |
| Easily distracted? | 0 1 2 3 |
| Finishing tasks is easier said than done? | 0 1 2 3 |
| Experience convulsions or seizure? | N(0) Y(3) |
| **Part 3-C Score:** | _________ |

**Part 3-D**

| | |
|---|---|
| Tremors or trembling hands? | 0 1 2 3 |
| Twitching in muscles, arms, hands, legs or feet? | 0 1 2 3 |
| Tingling and, or, burning in hands or feet? | 0 1 2 3 |
| Reduced vibratory sense? | 0 1 2 3 |
| Shooting or stabbing like pains? | 0 1 2 3 |
| Unsteady gait, easily lose balance? | 0 1 2 3 |
| Tingling sensation followed by numbness, or pain in hands and feet that moves towards the center of your body? | 0 1 2 3 |
| Loss of feeling in hands and/or feet (toes)? | 0 1 2 3 |
| Numbing or tingling in body parts? | 0 1 2 3 |
| Sense of taste seems reduced? | 0 1 2 3 |
| Sense of smell seems reduced? | 0 1 2 3 |
| Use artificial sweeteners regularly? | 0 1 2 3 |
| Diagnosis of Multiple Sclerosis? | N(0) Y(3) |
| **Part 3-D Score:** | _________ |

**Part 3-E**

| | |
|---|---|
| Family, friends, work, hobbies or activities you hold dear are no longer of interest? | 0 1 2 3 |
| Do you cry frequently? | 0 1 2 3 |
| Life seems / feels entirely hopeless? | 0 1 2 3 |
| Feeling sad, unhappy or blue? | 0 1 2 3 |
| Does every little thing get on your nerves and wear your out? | 0 1 2 3 |
| Do you feel easily agitated? | 0 1 2 3 |
| Are you keyed up and jittery? | 0 1 2 3 |
| Do you tremble or feel weak when someone shouts at you? | 0 1 2 3 |
| Do you become scared at sudden movements or noises at night? | 0 1 2 3 |
| Are you awakened out of your sleep by frightening dreams? | 0 1 2 3 |
| Do you feel pent up and ready to explode? | 0 1 2 3 |
| Are you prone to noisy and, or, emotional outbursts? | 0 1 2 3 |
| Easily upset or irritated? | 0 1 2 3 |
| Do little annoyances get on your nerves and make you angry? | 0 1 2 3 |
| Feeling that your life is out of control? | 0 1 2 3 |
| Feel helpless or trapped? | 0 1 2 3 |
| **Part 3-E Score:** | _________ |

**SECTION 4**

**Part 4-A**

| | |
|---|---|
| Upper eyelids look swollen? | 0 1 2 3 |
| Feel chilled? | 0 1 2 3 |
| Have difficulty getting “going” in the morning? | 0 1 2 3 |
| Hands and feet feel cold? | 0 1 2 3 |
| Slow, sluggish speech ? | 0 1 2 3 |
| Voice gets coarse or horse? | 0 1 2 3 |
| Swelling, or dark circles, around eyes? | 0 1 2 3 |
| Constipation? | 0 1 2 3 |
| High cholesterol or blood lipids? | 0 1 2 3 |
| Periods that are irregular (too heavy or too light)? | 0 1 2 3 |
| Breast pain, and, or fibrocystic breast disease? | 0 1 2 3 |
| Feel fatigued, exhausted? | 0 1 2 3 |
| Weight gain or difficulty loosing weight? | 0 1 2 3 |
| Water retention? | 0 1 2 3 |
| Frequent infections? | 0 1 2 3 |
| Muscle weakness, cramps or pains? | 0 1 2 3 |
| Ligaments are lax? | 0 1 2 3 |
| Slow, weak heart rate? | 0 1 2 3 |
| Congestive heart failure? | 0 1 2 3 |
| Skin, and, or hair dry / coarse? | 0 1 2 3 |
| Slow wound healing? | 0 1 2 3 |
| Thick, brittle nails with ridges? | N(0) Y(3) |
| Hair loss? | N(0) Y(3) |
| Loss of eyebrow hair? | N(0) Y(3) |
| History of multiple miscarriages? | N(0) Y(3) |
| Infertility? | N(0) Y(3) |
| PMS type symptoms? | N(0) Y(3) |
| Menstrual cramps? | N(0) Y(3) |
| Tongue is thick with ridges? | N(0) Y(3) |
| Carpal tunnel syndrome or other nerve compression? | N(0) Y(3) |
| **Part 4-A Score:** | _________ |

**Part 4-B**

| | |
|---|---|
| Racing heart rate or pulse? | 0 1 2 3 |
| Experience low blood sugar (hypoglycaemia)? | 0 1 2 3 |
| Nervousness? | 0 1 2 3 |
| Muscle weakness? | 0 1 2 3 |
| Increased appetite? | 0 1 2 3 |
| Diarrhea? | 0 1 2 3 |
| Intolerance to heat? | 0 1 2 3 |
| Excessive perspiration? | 0 1 2 3 |
| Tremor of the hand? | 0 1 2 3 |
| Warm, flushed skin? | 0 1 2 3 |
| Heart palpitations? | 0 1 2 3 |
| Bulging eyes? | 0 1 2 3 |
| Osteoporosis or decreased bone density? | N(0) Y(3) |
| Weight loss? | N(0) Y(3) |
| **Part 4-B Score:** | _________ |

**Part 4-C**

| | |
|---|---|
| Wounds heal slowly? | 0 1 2 3 |
| Your body — or parts of your body — feel tender, sore, sensitive to the touch, hot and/or painful? | 0 1 2 3 |

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**(0) never or rarely (1) twice a week or less (mild) (2) three to six times a week (moderate) (3) daily (severe)**

| Question | Score |
|---|---|
| Brown spots on face? | 0 1 2 3 |
| Lack of exposure to full-spectrum natural light on a daily basis for at least 15 minutes? | 0 1 2 3 |
| Thin, and, or dry skin? | 0 1 2 3 |
| Unstable blood sugar? | 0 1 2 3 |
| Physical intolerance to exercise? | 0 1 2 3 |
| Feelings of greying out or blacking out? | 0 1 2 3 |
| Chronic fatigue; not relieved by sleep? | 0 1 2 3 |
| Feelings of heart racing when rising rapidly from a sitting or lying position? | 0 1 2 3 |
| Difficulty getting up in the morning (don't really wake up until about 10:00 am)? | 0 1 2 3 |
| Experience chronic fatigue? | 0 1 2 3 |
| Tenderness in my back near my spine at the bottom of my rib cage, when pressed? | 0 1 2 3 |
| Need coffee or some other stimulant to get going in the morning? | 0 1 2 3 |
| Crave salt and / or foods high in salt? | 0 1 2 3 |
| Crave high protein foods (meats, cheeses, etc. .)? | 0 1 2 3 |
| Feel better if I lie down? | 0 1 2 3 |
| Experience light, non-restful sleep? | 0 1 2 3 |
| Feel anxiety? | 0 1 2 3 |
| Pre-mature greying of hair? | 0 1 2 3 |
| Best, most refreshing sleep often comes between 7:00-9:00 am? | N(0) Y(3) |
| Low blood pressure? | N(0) Y(3) |
| Spinal curvature, and, or scoliosis? | N(0) Y(3) |
| Overwork with little play or relaxation for extended periods? | N(0) Y(3) |
| Tend to gain weight, especially around the middle (spare tire)? | N(0) Y(3) |
| Get light-headed or dizzy when rising rapidly from a sitting or lying position? | N(0) Y(3) |
| Experience constant stress in my life or work? | N(0) Y(3) |
| I suffer, or have suffered, from nervous breakdowns? | N(0) Y(3) |
| My relationships at work and / or home are unhappy? | N(0) Y(3) |
| Type A personality? | N(0) Y(3) |
| My best work is late at night (or early morning hours) | N(0) Y(3) |
| **Part 4-C Score:** | _________ |

**Part 4-D**

| Question | Score |
|---|---|
| Experience intense / vivid dreaming? | 0 1 2 3 |
| Experience daytime grogginess / sleepiness? | 0 1 2 3 |
| Experience depression? | 0 1 2 3 |
| Feel "hung over" when you wake up, even when not consuming alcohol the night before? | N(0) Y(3) |
| **Part 4-D Score:** | _________ |

**Part 4-E**

| Question | Score |
|---|---|
| Hot flashes? | 0 1 2 3 |
| Cold hands and feet? | 0 1 2 3 |
| Dryness of skin, hair and vagina? | 0 1 2 3 |
| Intercourse ("sex") is painful? | 0 1 2 3 |
| Experience night sweats? | 0 1 2 3 |
| Thinking feels foggy? | 0 1 2 3 |
| Memory lapses? | 0 1 2 3 |
| Decreased sex drive? | 0 1 2 3 |
| Constant abdominal pain past menstruation? | 0 1 2 3 |
| Headaches before menstruation? | 0 1 2 3 |
| Lack of deep sleep or feeling rested? | 0 1 2 3 |
| Breast, ovary, or uterus cysts? | 0 1 2 3 |
| Depressed mood? | 0 1 2 3 |
| Anxiety? | 0 1 2 3 |
| Sleep disturbances? | 0 1 2 3 |
| Vaginal dryness? | 0 1 2 3 |
| Early miscarriage? | N(0) Y(3) |
| History of tubal ligation? | N(0) Y(3) |
| Bone loss (Osteopenia or Osteoporosis)? | N(0) Y(3) |
| History of endometrial and, or, uterine, and, or breast cancer in self or immediate family? (Women only) | N(0) Y(3) |
| Excess menstruation? | N(0) Y(3) |
| Bruise easily? | N(0) Y(3) |
| Unexplained weight gain? | N(0) Y(3) |
| Infertility? (Women only) | N(0) Y(3) |
| Heavy bleeding, fibroid or endometriosis? (Women only) | N(0) Y(3) |
| **Part 4-E Score:** | _________ |

**Part 4-F**

| Question | Score |
|---|---|
| Sleepiness? | 0 1 2 3 |
| Breast or chest tenderness? | 0 1 2 3 |
| Breast Swelling? (Women only) | 0 1 2 3 |
| Slowed digestion, and, or constipation? | 0 1 2 3 |
| Depressed mood? | 0 1 2 3 |
| **Part 4F Score:** | _________ |

**Part 4-G**

| Question | Score |
|---|---|
| Weight loss? | 0 1 2 3 |
| Loss of, or decrease in, sex drive? | 0 1 2 3 |
| Enlarged breasts? | 0 1 2 3 |
| Lower stamina, endurance? | 0 1 2 3 |
| Softer erections? (Men only) | 0 1 2 3 |
| Gallbladder problems? | 0 1 2 3 |
| Fatigue, which worsens with physical activity? | 0 1 2 3 |
| Muscle weakness, and, or shrinkage? | 0 1 2 3 |
| Suffer from lack of self-confidence? | 0 1 2 3 |
| Lack of initiative? | 0 1 2 3 |
| Experience decreased or poor memory? | 0 1 2 3 |
| Decreased or poor muscle tone? | 0 1 2 3 |
| Decrease in sex drive? | 0 1 2 3 |
| Feel hypersensitive or hyperemotional? | 0 1 2 3 |
| Anxious, and, or irritable? | 0 1 2 3 |
| Agitated, light sleep? | 0 1 2 3 |
| Depression? | 0 1 2 3 |
| Bone loss or Osteoporosis? | N(0) Y(3) |
| Cardiovascular problems? | N(0) Y(3) |
| **Part 4-G Score:** | _________ |

**Part 4-H**

| Question | Score |
|---|---|
| Acne? | 0 1 2 3 |
| Hypoglycemia or unstable blood sugar? | 0 1 2 3 |
| Irritability? | 0 1 2 3 |
| Sterility? | 0 1 2 3 |
| Elevated liver enzymes? | 0 1 2 3 |

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| | |
|---|---|
| Enlarged heart, especially left ventricle? | 0 1 2 3 |
| Gynecomastia (enlarged breasts on men)? (Men only) | 0 1 2 3 |
| Testicular shrinkage? (Men only) | 0 1 2 3 |
| Mid-Cycle pain? (Women only) | 0 1 2 3 |
| Ovarian cysts? (Women only) | 0 1 2 3 |
| Polycystic ovary syndrome? (Women only) | 0 1 2 3 |
| Urinary retention? (Women only) | 0 1 2 3 |
| Infertility? (Women only) | N(0) Y(3) |
| Excessive hair on the face and arms? | N(0) Y(3) |
| Thinning hair on head? | N(0) Y(3) |
| **Part 4-H Score:** | _________ |

**Part 4-I**

| | |
|---|---|
| Joint pain? | 0 1 2 3 |
| Loss of libido (sex drive)? | 0 1 2 3 |
| Painful intercourse? | 0 1 2 3 |
| Memory lapses? | 0 1 2 3 |
| Foggy thinking? | 0 1 2 3 |
| Bruise easily? | 0 1 2 3 |
| Lethargic depression? | 0 1 2 3 |
| Bone loss (Osteopenia or Osteoporosis)? | 0 1 2 3 |
| Migraine headaches? | 0 1 2 3 |
| Anxiety? | 0 1 2 3 |
| Nervousness? | 0 1 2 3 |
| Irritability? | 0 1 2 3 |
| Hot flashes? | 0 1 2 3 |
| Night sweats? | 0 1 2 3 |
| Weight gain? | 0 1 2 3 |
| Cyclical headaches? | 0 1 2 3 |
| Incontinence? (Women only) | 0 1 2 3 |
| Bladder infections? (Women only) | 0 1 2 3 |
| Vaginal dryness? (Women only) | 0 1 2 3 |
| Vaginal secretions are watery and thin? (Women only) | 0 1 2 3 |
| Bleeding changes? (Women only) | 0 1 2 3 |
| Dryness, thinning of vagina? (Women only) | 0 1 2 3 |
| Rapid weight gain? | N(0) Y(3) |
| **Part 4-I Score:** | _________ |

**Part 4-J**

| | |
|---|---|
| History of fatty tumors? | 0 1 2 3 |
| Water retention? | 0 1 2 3 |
| Puffiness and bloating? | 0 1 2 3 |
| Mood swings? | 0 1 2 3 |
| Red flush on face? | 0 1 2 3 |
| Weepiness? | 0 1 2 3 |
| Gallbladder problems? | 0 1 2 3 |
| Migraine headaches? | 0 1 2 3 |
| Heavy bleeding? | 0 1 2 3 |
| Sleep disturbances? | 0 1 2 3 |
| Cervical dysplasia (abnormal pap smear)? (Women only) | 0 1 2 3 |
| Breast tenderness, swelling or pain? (Women only) | 0 1 2 3 |
| Fibrocystic breast disease? (Women only) | 0 1 2 3 |
| PMS type symptoms? (Women only) | 0 1 2 3 |
| Low fiber diet? | N(0) Y(3) |

*(Continue. . .)*

| | |
|---|---|
| Don't eat vegetables? | N(0) Y(3) |
| **Part 4-J Score:** | _________ |

**Part 4-K**

| | |
|---|---|
| Dry eyes and skin? | 0 1 2 3 |
| Decreased pubic and arm pit hair? | 0 1 2 3 |
| Decreased fat in pubic area? | 0 1 2 3 |
| Inflammation of tissue underneath skin (cellulites)? | 0 1 2 3 |
| Anxious? | 0 1 2 3 |
| Dehydration / Increased thirst? | 0 1 2 3 |
| Low blood sugar (hypoglycaemia)? | 0 1 2 3 |
| Noise makes you feel intolerant, anxious or irritated? | 0 1 2 3 |
| Decreased energy, fatigue? | 0 1 2 3 |
| Muscle weakness? | 0 1 2 3 |
| **Part 4-K Score:** | _________ |

**Part 4-L**

| | |
|---|---|
| Acne? | 0 1 2 3 |
| Greasy hair and skin? | 0 1 2 3 |
| Hair overgrowth on face and body? | 0 1 2 3 |
| Excess body odor? | 0 1 2 3 |
| Edema, swelling? | 0 1 2 3 |
| Hypertension? | 0 1 2 3 |
| Weakness? | 0 1 2 3 |
| **Part 4-L Score:** | _________ |

**Part 4-M**

| | |
|---|---|
| Decrease or loss of muscle tone? | 0 1 2 3 |
| High cholesterol or triglycerides? | 0 1 2 3 |
| Bone loss (Osteopenia or Osteoporosis)? | 0 1 2 3 |
| Loss of hair? | 0 1 2 3 |
| Sagging skin, loss of skin elasticity? | 0 1 2 3 |
| Feel pessimistic, like things won't or don't go right? | 0 1 2 3 |
| Wounds heals slowly? | 0 1 2 3 |
| Weak immune system, frequent infections? | 0 1 2 3 |
| Decreased sexual function, ability or desire? | 0 1 2 3 |
| Excess abdominal fat ("spare tire")? | 0 1 2 3 |
| Decreased energy, especially in the morning? | 0 1 2 3 |
| Depression, especially in the morning? | 0 1 2 3 |
| Poor metabolism, weight gain? | N(0) Y(3) |
| **Part 4-M Score:** | _________ |

**Part 4-N**

| | |
|---|---|
| Swelling, water retention (edema)? | 0 1 2 3 |
| Hypertension / High Blood Pressure? | N(0) Y(3) |
| Carpal tunnel syndrome, or other nerve compression syndromes? | N(0) Y(3) |
| **Part 4-N Score:** | _________ |

**Part 4-O**

| | |
|---|---|
| Increased thirst? | 0 1 2 3 |
| Nightmares, possibly associated with going to bed on an empty stomach? | 0 1 2 3 |
| Unusual thirst – feeling like you can't drink enough water? | 0 1 2 3 |
| Polycystic ovary syndrome? (Women only) | 0 1 2 3 |
| Headaches that are relieved by eating sweets or alcohol? | 0 1 2 3 |
| Irritable if meals missed? | 0 1 2 3 |
| Crave sweets, often? | 0 1 2 3 |
| Hungry, even shortly after you eat? | 0 1 2 3 |

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# HOLISTIC CLINICAL APPROACHES QUESTIONNAIRE

NAME________________________________________ DATE_____________ PHONE __________________ EMAIL:________________

CIRCLE the number on the blank which best describes the **frequency**, or **severity** of your symptoms. If you do not know the answer to the question, or if the question does not apply, leave it blank. When you are finished, please add the number of points and write on the **Part Score Line**. The score for YES is 3 and the score for NO is 0.

**(0) never or rarely (1) twice a week or less (mild) (2) three to six times a week (moderate) (3) daily (severe)**

| Question | Score |
|---|---|
| Suffer from poor memory or concentration when skip meals? | 0 1 2 3 |
| Feel tired, or hungry, an hour or so after eating? | 0 1 2 3 |
| Feel shaky when miss meals? | 0 1 2 3 |
| Afternoon fatigue? | 0 1 2 3 |
| Suffer from mood swings, and or depression, when meals are missed? | 0 1 2 3 |
| Anxious if meals skipped? | 0 1 2 3 |
| Body fat percentage more than 20%? | 0 1 2 3 |
| Desire to loose weight? | 0 1 2 3 |
| Clothes don’t fit anymore? | N(0) Y(3) |
| Have diabetes? | N(0) Y(3) |
| Midnight Snacker? | N(0) Y(3) |
| Family history of diabetes? | N(0) Y(3) |
| Tend to gain weight around middle, “Spare tire”? | N(0) Y(3) |
| Overweight? | N(0) Y(3) |
| Weight gain? | N(0) Y(3) |
| **Part 4-O Score:** | _________ |

**SECTION 5**

**Part 5-A (Men Only)**

| Question | Score |
|---|---|
| Dripping after urination? | 0 1 2 3 |
| Sensation of not emptying your bladder completely? | 0 1 2 3 |
| Need to urinate less than 2 hours after you have finished urinating? | 0 1 2 3 |
| Find yourself needing to stop and start again several times while urinating? | 0 1 2 3 |
| Have a weak urinary stream or “flow”? | 0 1 2 3 |
| Need to push or strain to begin urinating? | 0 1 2 3 |
| Back pain associated with urination? | 0 1 2 3 |
| Difficulty urinating? | 0 1 2 3 |
| Frequently feel have to urinate? | 0 1 2 3 |
| When you feel you have to urinate, the need is urgent? | 0 1 2 3 |
| Ejaculation causes pain? | 0 1 2 3 |
| Urge to urinate several times at night? | 0 1 2 3 |
| **Part 5-A Score:** | _________ |

**Part 5-B (Women Only)**

| Question | Score |
|---|---|
| Diet low in vegetables? | 0 1 2 3 |
| Diet low in fiber? | 0 1 2 3 |
| Little to no physical activity? | 0 1 2 3 |
| Family history of breast disease, and, or cancer? | 0 1 2 3 |
| Suffer depression or low mood? | 0 1 2 3 |
| History of neurotube defects in siblings or offspring? | 0 1 2 3 |
| Cardiac (heart) problems? | 0 1 2 3 |
| Painful breasts? | 0 1 2 3 |
| Discharge from breasts not related to breastfeeding? | 0 1 2 3 |
| Gastrointestinal problems? | 0 1 2 3 |
| Clots are expelled during menstruation? | 0 1 2 3 |
| Painful or difficult sexual intercourse? | 0 1 2 3 |
| Abnormal vaginal discharge? | 0 1 2 3 |
| Offensive vaginal odor? | 0 1 2 3 |
| Vaginal bleeding other than during your period? | 0 1 2 3 |
| **Part 5-B Score:** | _________ |

**Part 5-C**

| Question | Score |
|---|---|
| To what extent have you felt a lack of sex drive to be a problem? | 0 1 2 3 |
| How would you rate your level of desire for sexual activity? | 0 1 2 3 |
| How often have you felt sexually aroused when sexually? stimulated in any way? | 0 1 2 3 |
| How would you rate your level of sexual arousal when? sexually stimulated in any way? | 0 1 2 3 |
| How difficult was it to become erect or “hard” when sexually stimulated? | 0 1 2 3 |
| How often did you reach orgasm during sexual activity? | 0 1 2 3 |
| How difficult was it for you to reach orgasm? | 0 1 2 3 |
| How often did you experience pain or discomfort during sexual activity? | 0 1 2 3 |
| How would you rate your level of pain or discomfort during sexual activity? | 0 1 2 3 |
| Painful testicles? (Men only) | 0 1 2 3 |
| Difficulty attaining and / or maintaining an erection? (Men only) | 0 1 2 3 |
| Premature ejaculation? (Men only) | 0 1 2 3 |
| Inflammation on the head of penis? (Men only) | 0 1 2 3 |
| Genital and/or rectal rash or irritation? (Men only) | 0 1 2 3 |
| Low sperm count, low sperm motility? (Men only) | 0 1 2 3 |
| Feeling of heaviness or hardness in testicle? (Men only) | 0 1 2 3 |
| Impotent? (Men Only) | 0 1 2 3 |
| How difficult was it to become lubricated or “wet” when sexually stimulated? (Women only) | 0 1 2 3 |
| Vagina itchiness or discharge? (Women only) | 0 1 2 3 |
| Foul feminine odor? (Women only) | 0 1 2 3 |
| Development of breasts or nipple tenderness? (Women only) | 0 1 2 3 |
| Unable to get pregnant? (Women only) | 0 1 2 3 |
| **Part 5-C Score:** | _________ |

**SECTION 6**

**Part 6-A**

| Question | Score |
|---|---|
| Prone to lots of phlegm or mucus associated with seasonal changes? | 0 1 2 3 |
| Puffiness, and, or dark circles under eyes? | 0 1 2 3 |
| Migraine headaches? | 0 1 2 3 |
| Hyperactivity? | 0 1 2 3 |
| Chinese food causes anxiety, irregular heart beat or fatigue? | 0 1 2 3 |
| Sneeze more than 3 times after meals or drinks? | 0 1 2 3 |
| Pulse “speeds” after meals? | 0 1 2 3 |
| Prone to lots of phlegm or mucus associated with certain foods? | 0 1 2 3 |
| Puffiness, and, or dark circles under eyes? | 0 1 2 3 |
| Joint, and, or muscle pain, stiffness or achyness? | 0 1 2 3 |
| Stomach, and, or intestinal disturbances? | N(0) Y(3) |
| **Part 6-A Score:** | _________ |

**Part 6-B**

| Question | Score |
|---|---|
| Slow to recovery from cold or flu? | 0 1 2 3 |
| Consistent low grade fever (100°–101°)? | 0 1 2 3 |
| Nail infection(s)? | 0 1 2 3 |
| Vaginal / Yeast infections? | 0 1 2 3 |
| Dark circles under eyes? | 0 1 2 3 |
| Allergies? | 0 1 2 3 |

# HOLISTIC CLINICAL APPROACHES QUESTIONNAIRE

NAME_________________________________ DATE____________ PHONE ________________ EMAIL:_______________

CIRCLE the number on the blank which best describes the **frequency**, or **severity** of your symptoms. If you do not know the answer to the question, or if the question does not apply, leave it blank. When you are finished, please add the number of points and write on the **Part Score Line**. The score for YES is 3 and the score for NO is 0.

**(0) never or rarely (1) twice a week or less (mild) (2) three to six times a week (moderate) (3) daily (severe)**

| | |
|---|---|
| Chronic inflammation, and, or pain? | 0 1 2 3 |
| Intestinal gas, bloating, and, or cramping? | 0 1 2 3 |
| Fungal infections? | N(0) Y(3) |
| Autoimmune disease? | N(0) Y(3) |
| Cancer or history of cancer? | N(0) Y(3) |
| **Part 6-B Score:** | ________ |

**SECTION 7**

**Part 7-A**

| | |
|---|---|
| Poor wound healing? | 0 1 2 3 |
| Fatigue? | 0 1 2 3 |
| Blood sugar imbalances / hypoglycaemia? | 0 1 2 3 |
| Tendency towards, or presence of, anaemia? | 0 1 2 3 |
| Feel tired, fatigued? | 0 1 2 3 |
| Shortness of breath? | 0 1 2 3 |
| Feels like heart races? | 0 1 2 3 |
| Depression? | 0 1 2 3 |
| Skin ulcers of the legs or feet? | 0 1 2 3 |
| Varicose or “spider” veins? | 0 1 2 3 |
| Nose bleeds frequent? | 0 1 2 3 |
| Bruise easily, “black / blue” spots? | 0 1 2 3 |
| Noises in head or “ringing in ears”? | 0 1 2 3 |
| One leg or arm – shiny, hairless skin? | 0 1 2 3 |
| Vegetarian? | N(0) Y(3) |
| **Part 7-A Score:** | ________ |

**Part 7-B**

| | |
|---|---|
| Pain in big toe? | 0 1 2 3 |
| Pain in joints? | 0 1 2 3 |
| Stiffness in joints lasting more than 30 minutes on arising in mornings? | 0 1 2 3 |
| Stiffness in joints lasting more than 30 minutes after prolonged activity? | 0 1 2 3 |
| Deformation in joints? | 0 1 2 3 |
| Knobby overgrowths on the joints closest to the fingertips? | 0 1 2 3 |
| One leg shorter than the other? | 0 1 2 3 |
| Joint(s) lock with movement? | 0 1 2 3 |
| Crunching or creaking sounds when move joints? | 0 1 2 3 |
| Redness, and, or heat in joints? | 0 1 2 3 |
| **Part 7-B Score:** | ________ |

**Part 7-C**

| | |
|---|---|
| Bones throughout your entire body ache, feel tender or sore? | 0 1 2 3 |
| Hearing loss, headaches, ringing in ears? | 0 1 2 3 |
| Calcium deposits around joints or in muscles? | 0 1 2 3 |
| Localized bone pain? | 0 1 2 3 |
| Difficulty sitting straight? | 0 1 2 3 |
| Shins hurt during or after exercise? | 0 1 2 3 |
| Lack of exercise, sedentary lifestyle? | 0 1 2 3 |
| Ingest caffeine, such as coffee, and, or colas (including diet)? | 0 1 2 3 |
| Deep pain in bones, especially hip or lower back? | 0 1 2 3 |
| Tendency to cramp in legs, feet or toes, especially at night? | 0 1 2 3 |
| Unusually lean, low body fat? | 0 1 2 3 |
| Excessive or very strenuous exercise, such as endurance running? | 0 1 2 3 |
| Over 50 year of age? | 0 1 2 3 |
| Stooped posture, forward bending of spine? | 0 1 2 3 |
| Fractures, especially vertebral? | 0 1 2 3 |
| Radiation or heavy metal exposure? | 0 1 2 3 |
| Smoker? | 0 1 2 3 |
| High protein diet? | N(0) Y(3) |
| Receding gums? | N(0) Y(3) |
| Periodontal disease? | N(0) Y(3) |
| Teeth loosening in sockets of jawbone? | N(0) Y(3) |
| Shifting dental plates? | N(0) Y(3) |
| Loss of height, more than one inch? | N(0) Y(3) |
| Chronic renal (kidney) disease, including kidney stones? | N(0) Y(3) |
| Hysterectomy? | N(0) Y(3) |
| Hyperparathyroidsim? | N(0) Y(3) |
| History of Corticosteroid use? | N(0) Y(3) |
| Hyperthyroidism? | N(0) Y(3) |
| Long-term Use of any of the following medications? (anticonvulsants, corticosteroids, non-steroidal anti-inflammatory, diuretics, anticoagulatants, antibiotics, antacids, lithium, cancer medications)? | N(0) Y(3) |
| Spinal curvature, and, or scoliosis? | N(0) Y(3) |
| Unexplained bone fracture? | N(0) Y(3) |
| **Part 7-C Score:** | ________ |

**Part 7-D**

| | |
|---|---|
| Recent injury? | 0 1 2 3 |
| Chronic pain or stiffness? | 0 1 2 3 |
| Red or swollen joints or muscles? | 0 1 2 3 |
| Pain in muscles? | 0 1 2 3 |
| Pain around joints? | 0 1 2 3 |
| Stomach or intestinal disturbances? | N(0) Y(3) |
| **Part 7-D Score:** | ________ |

**Part 7-E**

| | |
|---|---|
| Injure, strain or sprain easily? | 0 1 2 3 |
| Intermittent pain, ache on one side of head spreading to cheek, temple, lower jaw, ear, neck and shoulder? | 0 1 2 3 |
| Burning, throbbing shooting or stabbing muscle pain? | 0 1 2 3 |
| Stiffness in muscles when you wake up? | 0 1 2 3 |
| Difficulty bending down and picking up clothing or anything from the floor? | 0 1 2 3 |
| Difficulty opening jars that were previously easy to open? | 0 1 2 3 |
| Muscles have shrunken or become flabby? | 0 1 2 3 |
| Muscle cramps or spasms? | 0 1 2 3 |
| Muscle twitch or tremor – eyelids, thumb, calf-muscle? | 0 1 2 3 |
| Irresistible urge to move legs often? | 0 1 2 3 |
| Legs move during sleep? | 0 1 2 3 |
| Upper or lower back pain? | 0 1 2 3 |
| Shooting, aching, tingling pain down the back of leg? | 0 1 2 3 |
| Headaches on one side or both sides of head, without sensitivity to light? | 0 1 2 3 |
| Muscles stiff, sore, tense and, or, ache? | 0 1 2 3 |
| Feel “tense” in body? | 0 1 2 3 |
| Specific points on body feel sore when pressed? | 0 1 2 3 |
| Feel un-refreshed upon awakening? | 0 1 2 3 |
| **Part 7-E Score:** | ________ |

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NAME______________________________________ DATE_____________ PHONE __________________ EMAIL:________________

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**(0) never or rarely (1) twice a week or less (mild) (2) three to six times a week (moderate) (3) daily (severe)**

**Part 7-F**

| Question | Score |
|---|---|
| Dry, flaky skin? | 0 1 2 3 |
| Rashes? | 0 1 2 3 |
| Acne? | 0 1 2 3 |
| Scaly, fish like plaques on skin? | 0 1 2 3 |
| Large pores? | 0 1 2 3 |
| Skin itches? | 0 1 2 3 |
| Loss of skin elasticity? | 0 1 2 3 |
| Hard, leathery skin? | 0 1 2 3 |
| Photosensitivity, and, or "allergic" skin? | 0 1 2 3 |
| Dandruff? | 0 1 2 3 |
| Dry, flaky skin around nose? | 0 1 2 3 |
| **Part 7-F Score:** | _________ |

**SECTION 8**

**Part 8-A**

| Question | Score |
|---|---|
| Elevated blood cholesterol? | N(0) Y(3) |
| High triglyceride levels? | N(0) Y(3) |
| Low HDL levels? | N(0) Y(3) |
| Overweight? | N(0) Y(3) |
| Lack of social support or fulfilment? | N(0) Y(3) |
| History of diabetes? | N(0) Y(3) |
| **Part 8-A Score:** | _________ |

**Part 8-B**

| Question | Score |
|---|---|
| Exhaustion with minor exertion? | 0 1 2 3 |
| Difficulty catching breath, especially during exercise? | 0 1 2 3 |
| Cold feet and, or toes appear blue? | 0 1 2 3 |
| When standing legs get heavy and fatigued? | 0 1 2 3 |
| Leg discomfort or fatigue relieved by elevating legs? | 0 1 2 3 |
| Swollen ankles, worse at night? | 0 1 2 3 |
| Temper — "fuse" — short? | 0 1 2 3 |
| Dull pain in chest or radiating into left arm, worse with activity or excitement? | 0 1 2 3 |
| Smoker? | N(0) Y(3) |
| Overweight? | N(0) Y(3) |
| Type A personality? | N(0) Y(3) |
| High blood pressure (Hypertension)? | N(0) Y(3) |
| **Part 8-B Score:** | _________ |

**Part 8-C**

| Question | Score |
|---|---|
| Wheezing? | 0 1 2 3 |
| Asthma or bronchitis? | 0 1 2 3 |
| Shortness of breath? | 0 1 2 3 |
| Difficulty breathing? | 0 1 2 3 |
| Sigh frequently, "air hunger" ? | 0 1 2 3 |
| Aware of "breathing heavily"? | 0 1 2 3 |
| Cough up phlegm or sputum that smells offensive? | 0 1 2 3 |
| Cough up phlegm or sputum that is thick, clear, yellow? | 0 1 2 3 |
| Shallow breathing? | 0 1 2 3 |
| Noisy rattling sounds when breathing in or out? | 0 1 2 3 |
| Cough – dry or moist? | 0 1 2 3 |
| Shortness of breath on exertion? | 0 1 2 3 |
| Bluish nails and lips? | N(0) Y(3) |
| High altitude discomfort? | N(0) Y(3) |
| Smoker? | N(0) Y(3) |
| Lungs make crackling sounds when you breath? | N(0) Y(3) |
| **Part 8-C Score:** | _________ |

**SECTION 9**

**Part 9-A**

| Question | Score |
|---|---|
| Ears itch? | 0 1 2 3 |
| Pain in ears? | 0 1 2 3 |
| Ear Infections? | 0 1 2 3 |
| Drainage from ears? | 0 1 2 3 |
| Ringing in ears? | 0 1 2 3 |
| Hearing Loss? | 0 1 2 3 |
| How often do you experience excessive ear wax? | 0 1 2 3 |
| **Part 9-A Score:** | _________ |

**Part 9-B**

| Question | Score |
|---|---|
| See spots, stars, or floaters? | 0 1 2 3 |
| Night blindness? | 0 1 2 3 |
| Have you had LASIK surgery? | N(0) Y(3) |
| Decreased ability to read things close up (far sighted)? | N(0) Y(3) |
| Decreased ability to see things far away (near sighted)? | N(0) Y(3) |
| Need glasses, contacts or bifocals? | N(0) Y(3) |
| Cataracts? | N(0) Y(3) |
| **Part 9-B Score:** | _________ |

**Part 9-C**

| Question | Score |
|---|---|
| Are you prone to snoring? | 0 1 2 3 |
| Is your nose continuously congested? | 0 1 2 3 |
| Post nasal drip? | 0 1 2 3 |
| Stuffy nose? | 0 1 2 3 |
| Sinus problems? | 0 1 2 3 |
| Hay fever? | 0 1 2 3 |
| Sneezing attacks? | 0 1 2 3 |
| Excessive mucous, and, or congestion? | 0 1 2 3 |
| **Part 9-C Score:** | _________ |

**SECTION 10**

**Part 10-A**

| Question | Score |
|---|---|
| Blood in urine or cloudy urine? | 0 1 2 3 |
| Strong, foul smelling urine? | 0 1 2 3 |
| Pain in back, at base of ribcage (one or both sides)? | 0 1 2 3 |
| Feel like you have the "flu"? | 0 1 2 3 |
| Pain or burning during urination? | 0 1 2 3 |
| Cloudy urine? | 0 1 2 3 |
| Dark urine? | 0 1 2 3 |
| Kidney Stones? | N(0) Y(3) |
| **Part 10-A Score:** | _________ |

**Part 10-B**

| Question | Score |
|---|---|
| Involuntary loss of urine when you cough, lift something or strain during an activity? | 0 1 2 3 |
| Involuntary loss of urine when excited or stressed? | 0 1 2 3 |
| Need to urinate more than every 2 hours? | 0 1 2 3 |
| Prone to urinary tract infections? | N(0) Y(3) |
| **Part 10-B Score:** | _________ |

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