Naturopathic Adult Health Assessment

Patient Name: _____ Date of birth: _____ Sex: M F Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Occupation: _____ Employer: _____

Please check any medical treatments you have received:

❑ Acupuncture ❑ Chiropractic ❑ Herbal Medicine ❑ Mind/Body Therapy ❑ Physical Therapy

❑ Biofeedback ❑ Counseling ❑ Homeopathy ❑ Naturopathic Medicine ❑ Therapeutic Massage

❑ Other treatments: _____

Living Situation: Married Single Divorced Widowed Children (number): ____ Children's Ages: _____

PRIMARY HEALTH CONCERNS:

In your opinion, what are your most important health concerns?

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

What are your current health goals? _____

_____

_____

_____

_____

On a scale of 1 – 10, how would you rate your current overall state of health? _____

Over the past year has your state of health: ❑ Improved ❑ Worsened ❑ Stayed the Same

Blood Type: A B AB O (+) (-) Unsure?

Ht: _____ Wt: _____ Wt at 20 yr: _____

Over the past year have you gained weight: ❑ Yes (amount): _____ ❑ No

Is there any condition, trauma, or incident after which you have never been totally well again? _____

_____

_____

_____

Have you ever been exposed to toxic chemicals, solvents or other possible toxins? ❑ Yes ❑ No If Yes, please explain:

_____

_____

HEALTH HISTORY – ADULTHOOD:

Please indicate whether you or an immediate relative has ever had the following diseases or conditions:

Disease	Self	Age at onset	Which Relative?
Angina/MI/Heart Attack			
High Blood Pressure			
Stroke			
Blood Clot			
High Cholesterol			
Obesity			
Thyroid Disease			
Diabetes			
Ulcer, GI Bleeding			
Irritable Bowel Syndrome			
Inflammatory Bowel Disease			
Celiac Disease			
Heartburn/Reflux			
Asthma			
Hay Fever/Allergies			
Tuberculosis			
Pneumonia			
Psoriasis			
Eczema			
Liver disease/hepatitis			

Disease	Self	Age at onset	Which Relative?
Substance addiction			
Epilepsy/Seizures			
Alzheimer's Disease			
Parkinson's			
Headache			
Anemia			
Mononucleosis			
Depression			
Chronic Fatigue			
Fibromyalgia			
Nervous Exhaustion			
Glaucoma			
Macular Degeneration			
Arthritis/Rheumatism			
Cancer Specify:_____			
Kidney, bladder			
Osteoporosis			
Gout			
Venereal Disease (STDs) Specify _____			
HIV/AIDS			

CURRENT MEDICATIONS AND DOSE

CURRENT SUPPLEMENTS AND DOSE

HEALTH MAINTENANCE: Please list any significant findings and the date of your last visit for the following exams:

	Significant Findings	**Date of Last Visit**
Routine Exam		
Pap/Pelvic		
Breast/Mammogram		
Prostate Exam		
Hemoccult		
Flexible Sigmoidoscopy		
Retinal Eye Exam		

Describe any dental work done: _____

HEALTH HISTORY – CHILDHOOD (check all that apply):

- ❑ Measles ❑ Whooping Cough ❑ Diabetes ❑ Mumps ❑ Strep/Tonsillitis
- ❑ Chicken Pox ❑ Polio ❑ Appendicitis ❑ Rubella ❑ Diphtheria
- ❑ Other: _____

At the time of your birth, did you experience any unusual birth trauma: ❑ Yes ❑ No

PSYCHOLOGICAL:

How would you rate your overall level of stress (with 1 being No Stress, and 10 being Unbearable Stress)?

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

What types of things cause you stress? _____

_____

What symptoms of stress have you experienced? _____

_____

Please list any significant stressors you have experienced (e.g., accidents, divorce, death, or change/loss of job):

Type of stressor: Month/Year:

_____ _____

_____ _____

_____ _____

Do you follow any spiritual practices? ❑ Yes ❑ No If Yes, what are they? _____

Do you practice any form of meditation or relaxation techniques? ❑ Yes ❑ No If Yes, what types and how often? _____

_____

How would you describe your sleep patterns?

❑ Normal ❑ Irregular ❑ Heavy ❑ Light ❑ Dream-filled

How do you characterize your relationships (spouses/partners, family, friends, co-workers, etc)? _____

_____

_____

_____

Have you ever been diagnosed with a psychiatric condition? ❑ Yes ❑ No If Yes, when and how were you treated?

_____

_____

Name: _____ **Dates:** _____

Food Plan Instructions:

- Please record, in honesty, what you eat for a few days. It will benefit you more to be real and not ideal!
- Include condiments, drinks, snacks, supplements (vitamins/minerals/herbs/homeopathic remedies).
- Include any comments, symptoms (emotional/mental/physical), energy levels, etc at the end of each column for each day.
- Be specific in your recordings by including what type of food was eaten ("white bread" or "whole wheat bread"), the quantity (cups, tsp, oz, etc), how it was prepared (baked, boiled, deep fried, etc) and the time of day it was eaten.

	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						

How many meals do you generally eat each day? ❑One ❑Two ❑Three ❑More than three

How often do you skip meals? ❑Never ❑Once or twice a month ❑Once a week ❑More than once a week

Where do you usually buy your food? _____

_____

Who cooks the food you eat? _____

_____

List the foods you exclude from your diet and why: _____

_____

_____

List any foods you crave, regardless of their nutritional value: _____

_____

_____

List any foods to which you are allergic to or have a bad reaction to and how you react: _____

_____

_____

Are you thirsty? ❑ No ❑ Yes Amount of plain water you drink each day _____

_____

What type of water do you drink? ❑Distilled water ❑Filtered ❑Spring ❑Well ❑Deionized ❑Tap

At what temperature do you prefer to drink liquids? ❑ Hot ❑ Cold ❑ Room temp

Health Appraisal Questionnaire

Instructions: Circle the number which best describes the intensity of your symptoms. If you do not know the answer, leave it blank.

0 = Symptom is not present 1 = Mild 2 = Moderate 3 = Severe

PART 1

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. Poor appetite 0 1 2 3
5. Stomach 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. Mucous in stools 0 1 2 3
9. Stool poorly formed 0 1 2 3
10. Shiny stool 0 1 2 3
11. Three or more large bowel movements daily 0 1 2 3
12. Foul smelling stool 0 1 2 3
13. Dry, flaky skin and/or 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
17. Difficulty gaining weight 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 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 stomach pain by drinking cream/milk NO YES
11. History of ulcer or gastritis NO YES
12. Current ulcer NO YES (10)
13. Black stool when not taking iron supplements NO YES (10)

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 NO YES
10. Meat eater NO YES
11. Rapidly failing vision NO YES

PART 2

SECTION A:

1. Difficulty breathing at night 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 as 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. Exhaustion with minor exertion 0 1 2 3
13. Do you do aerobic exercise YES NO
14. Have you ever exercised regularly YES NO
15. Drink 5 or more cups of coffee daily NO YES
16. Severe cough NO YES
17. Has a doctor ever told you that you have heart trouble NO YES(6)

SECTION B:

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 ears 0 1 2 3
8. Ear canal hair 0 1 2 3
9. Tingling and/or burning in hands or feet 0 1 2 3
10. Spider veins on nose and/or face 0 1 2 3

SECTION C:

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

PART 3

SECTION A:

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 by eating sweets or alcohol 0 1 2 3
5. Feel shaky or jittery 0 1 2 3
6. Irritable if a meal is missed 0 1 2 3
7. Wake up in middle of night craving sweets 0 1 2 3
8. Feel tired or weak if a meal is missed 0 1 2 3
9. Hear 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. Feel faint 0 1 2 3
15. Poor concentration 0 1 2 3
16. Forgetful 0 1 2 3
17. Calmer after eating 0 1 2 3

SECTION B:

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. Crave 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 0 1 2 3

PART 4

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 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 0 1 2 3
22. High blood cholesterol level and low HDL cholesterol 0 1 2 3
23. Is your cholesterol level above 200 ..... NO UNKNOWN YES
24. Is you triglyceride level above 115 ..... NO UNKNOWN YES

SECTION B:

1. Swollen eyes (bulging) 0 1 2 3
2. Strong smelling urine 0 1 2 3
3. Thick skin and finger nails 0 1 2 3
4. Dry skin 0 1 2 3
5. Sensitive to the cold 0 1 2 3
6. Cold hands and feet 0 1 2 3
7. Excessive menstrual bleeding 0 1 2 3
8. Chronic fatigue 0 1 2 3
9. Trouble waking up in the morning 0 1 2 3
10. Depressed, apathetic 0 1 2 3
11. Low sex drive 0 1 2 3
12. Puffy, wrinkly skin 0 1 2 3
13. Sugar causes irritability and mood swings 0 1 2 3
14. Premenstrual tension 0 1 2 3
15. Constipation 0 1 2 3
16. Thinning or loss of outside portion of eyebrow 0 1 2 3
17. Gain weight easily 0 1 2 3
18. Anemia unaffected by iron 0 1 2 3
19. Axillary (armpit) temperature below 97.6°F 0 1 2 3
20. Slow reflexes 0 1 2 3
21. Infertility 0 1 2 3

PART 5

SECTION A:

1. Sensitive to exhaust fumes, smoke, smog, petrochemicals 0 1 2 3
2. Periodic constipation 0 1 2 3
3. Cannot tolerate 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. Headaches 0 1 2 3
10. Difficulty breathing 0 1 2 3
11. Water retention 0 1 2 3
12. Eyes sensitive to bright light 0 1 2 3
13. Feel weak and shaky 0 1 2 3

SECTION B:

1. Inflamed and 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:

1. Itching of nose or eyes ..... 0 1 2 3(5)
2. Itching of roof of mouth or throat ..... 0 1 2 3(5)
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. Watery eyes 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. Nasal congestion 0 1 2 3
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 of aspirin, tylenol regularly ..... NO YES
26. Wheezing 0 1 2 3
27. Skin rashes 0 1 2 3
28. Sneezing 0 1 2 3

PART 6

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. Sensitive to smog 0 1 2 3
10. Infections settle in lungs 0 1 2 3
11. Live or work around people who smoke 0 1 2 3
12. Bronchitis 0 1 2 3
13. Exposed to chemicals and radiation 0 1 2 3
14. Smoker 0 1 2 3

PART 7

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 kidney or bladder infections 0 1 2 3
14. Have used antibiotics to control urinary tract infections ..... YES NO
    IF YES, WHEN DID YOU LAST USE THEM? _____
    TREATMENT DURATION _____
15. Back pain in the kidney area 0 1 2 3
16. General water retention 0 1 2 3

PART 8 (Males Only)

SECTION A:

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. Low sexual drive 0 1 2 3
3. Premature ejaculation 0 1 2 3
4. Pain/coldness in genital area 0 1 2 3
5. Infertile 0 1 2 3
6. Varicose veins on scrotum 0 1 2 3
7. Low sperm count 0 1 2 3

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
   Have V.D. now?_____ Had in past?_____

PART 9 (Females Only)

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 0 1 2 3
5. Nausea and/or vomiting 0 1 2 3
6. Suicidal feeling 0 1 2 3
7. Anxiety 0 1 2 3
8. Leg cramps and tenderness 0 1 2 3
9. Asthma attacks 0 1 2 3
10. Headaches 0 1 2 3
11. Easily distracted 0 1 2 3
12. Anger 0 1 2 3
13. Tender breast 0 1 2 3
14. Low backache 0 1 2 3
15. Other_____ 0 1 2 3
16. Age of onset of menses_____
17. Date of last menses_____

SECTION B:

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? ____
9. Abortion ..... NO YES HOW MANY? ____

SECTION C: 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
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 and/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:

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
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:

1. Hot flashes 0 1 2 3
2. Night sweats 0 1 2 3
3. Hysterectomy 0 1 2 3
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) 0 1 2 3

PART 10

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 nights	0	1	2	3
6. Stiff all over	0	1	2	3
7. Stiff in 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
10. Back pain	0	1	2	3
11. Joint pain	0	1	2	3

PART 11

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. Uncoordination	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 12

SECTION A: Over the last year, I have experienced:

1. Becoming forgetful	0	1	2	3
2. Lapses in memory	0	1	2	3
3. Becoming less attentive	0	1	2	3
4. Less interest in normal activities	0	1	2	3
5. Feeling less sharp	0	1	2	3
6. Difficulty remembering people's names	0	1	2	3
7. Difficulty making decisions	0	1	2	3
8. Problems finding the right words to communicate	0	1	2	3
9. Difficulty solving routine problems	0	1	2	3
10. Difficulty learning new things	0	1	2	3
11. Problems writing, reading, or organizing thoughts	0	1	2	3
12. Difficulty following instructions	0	1	2	3

SECTION B: I experience:

1. Lack of interest in normal activities	0	1	2	3
2. Loss of energy	0	1	2	3
3. Oversleeping or sleepiness	0	1	2	3
4. Sense of sadness for no apparent reason	0	1	2	3
5. Increased appetite, especially for carbohydrates	0	1	2	3
6. Fatigue	0	1	2	3
7. Symptoms that usually get worse in the winter	0	1	2	3
8. Weight gain or weight loss	0	1	2	3
9. Difficulty concentrating and processing Information, especially in the afternoon	0	1	2	3
10. Diminished sexual desire	0	1	2	3

SECTION C: I frequently

1. Feel tense and have trouble relaxing	0	1	2	3
2. Have headaches and other aches and pains	0	1	2	3
3. Get crabby or grouchy	0	1	2	3
4. Have trouble falling asleep or staying asleep	0	1	2	3
5. Sweat and have hot flashes in anticipation of events	0	1	2	3
6. Feel irritable or short tempered	0	1	2	3
7. Have trouble letting go of things	0	1	2	3
8. Get angry for no apparent reason	0	1	2	3
9. Women only: Get worse symptoms prior to getting my period	0	1	2	3

SECTION D: I often:

1. Feel overly active and compelled to do things, like being driven by a motor	0	1	2	3
2. Have difficulty relaxing and unwinding when I have time to myself	0	1	2	3
3. Misplace and have difficulty finding things	0	1	2	3
4. Crave caffeine and stimulants to keep me going	0	1	2	3
5. Delay getting started when I have a task or work that requires a lot of thought	0	1	2	3
6. Get easily distracted by activity or noise around me	0	1	2	3
7. Have difficulty keeping my attention when doing boring and repetitive work	0	1	2	3
8. Fidget or squirm with my hands and feet when I have to sit down for a long time	0	1	2	3
9. Leave my seat in meetings or other situations in which I am expected to remain seated	0	1	2	3
10. Have problems remembering appointments or obligations	0	1	2	3
11. Have difficulty concentrating on what people say to me, even when they are speaking directly to me	0	1	2	3
12. Move around and kick in my sleep	0	1	2	3

SECTION E: I experience:

1. Waking up frequently during the night with difficulty returning to sleep	0	1	2	3
2. Looking forward to catching up on my sleep on the weekends	0	1	2	3
3. Taking more than 30 minutes to fall asleep at night	0	1	2	3
4. Stomach problems or nausea	0	1	2	3
5. Waking up repeatedly throughout the night	0	1	2	3
6. Waking up groggy and not well rested	0	1	2	3
7. Preferring to go to sleep later than midnight and waking up late, after 10:00 a.m.	0	1	2	3
8. Preferring an early bedtime – going to sleep between 7 p.m. and 9 p.m. and waking up early, around 5:00 a.m.	0	1	2	3
9. Jet lag	0	1	2	3
10. Difficulty turning off my thoughts when I lay down to sleep	0	1	2	3