

Name _____ Date _____

Confidential Patient Case History

Please complete this questionnaire making sure your name and the date is at the top of each page. This confidential patient case history will become part of your permanent records. Thank you.

Your demographic information

Last Name _____	First Name _____	M.I. _____
Street _____		
City _____ State _____		
Zipcode _____		
Email _____		
Home _____	Work _____	
Cell _____	Fax _____	
Date of Birth _____		
Sex: F M		
Social Security Number _____		
Emergency Contact _____		
Home Phone _____		
Cell Phone _____		
Occupation _____		
Employer _____		
Marital Status: M S D W		
Children (Ages) _____		
Spouses name _____		

Information about your journey to our office

Who referred you to us? _____
How else did you hear about us? _____
Were you given accurate directions to find UHI? Yes No
How did you travel here? car, bus, train, cab, bicycle, walk
Did you find parking? Yes No
Where? Circle: Street Meter Parking Garage (location) _____

Information about your experience with natural health care

Have you seen a chiropractor before? Yes No
If yes, who is the doctor? _____
Where is the doctor's office? _____
If yes, what was your experience; if no, what have you heard about chiropractic?

Have you used natural health care before? Yes No If yes, what kind of natural health care?

Name _____

Date _____

In this box, describe your main problem only

If we could help you with **one** health **problem**, what would it be? Write you main problem/complaint here: _____

Answer the 10 most important questions about your problem here:

1. How many days out of the week or month do you find yourself suffering from this problem? Be specific, please. Circle one, if it applies to your problem:
Every day. Every other day. Several (2,3,4,5,6) days per week/month.
2. How long will it last on a bad day? _____
3. How long have you been suffering with this problem/complaint? (Since what year/month) Be specific, please. _____
4. Have you had this or a similar condition in the past? Yes No
If Yes, describe it here _____
5. Has the problem been getting worse over time? Yes No
6. When the problem is at its worst, exactly what does it feel like?

7. On a scale of 1-10, with 10 being the worst, how do you rate this pain right now?
Rate the pain right now: 1 2 3 4 5 6 7 8 9 10
8. On a scale of 1-10, with 10 being the worst, how do you rate this pain in the last week? Rate the pain in the last week: 1 2 3 4 5 6 7 8 9 10
9. What do you do that makes this problem worse?

10. Many people tell us that their condition makes them feel older than they are. Have you experienced this? Yes No How does it make you feel? _____

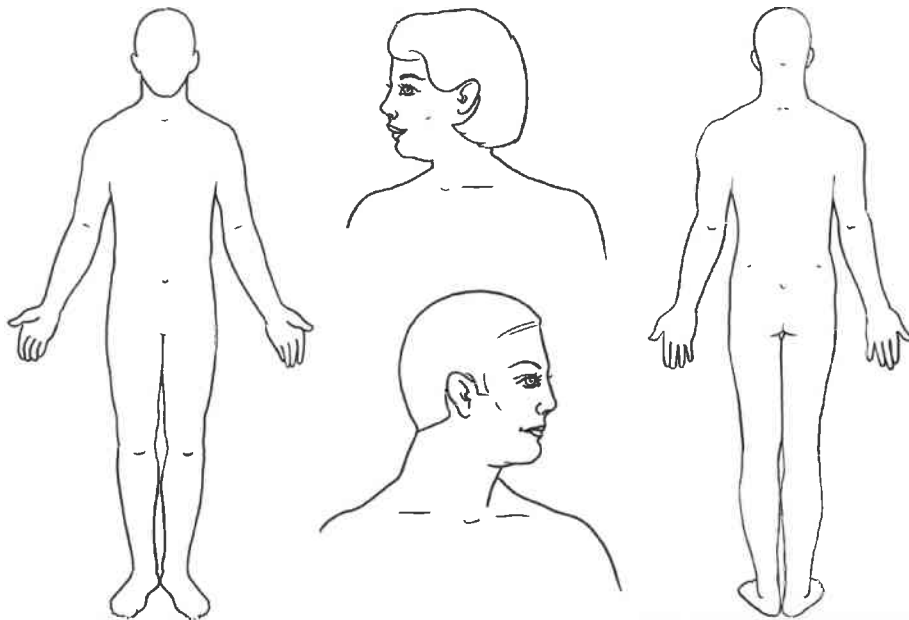
Mark the areas of your symptoms on the figures to the right. Use the following symbols to describe them:

Aches + + + + +

Numbness * * * *

Pins/Needles - - - - -

Stabbing // // // //



Describe what caused your problem.

Do think that a specific accident/injury/trauma caused this problem? Yes No
If yes, what was the event? _____

Have you had any falls or accidents in the past that may have caused injury to your neck and spine, even as a child? Yes No _____

Name _____

Date _____

In this box, describe how you have tried to manage this problem

Since the time you began suffering from this problem, what, if anything, have you tried as a remedy or cure that did not work? Please circle all that apply to your main problem:

Ice, heat, rest, over-the-counter drugs, physical therapy, exercise, stretching, massage, prescription drugs, doctor advice, ignoring it, waiting, change in diet, change in habits, staying away from activities, prayer, meditation, wishing, concentrating, acupuncture, changing activities, limiting activities, sleep, nutrition.

Anything else that you have tried to do to help your problem? _____

Anything that has given you relief? Yes No If yes, what was it that gave you the most relief?

Even if you have experienced temporary relief, has anything you have tried thus far fixed your problem yet? Yes No What was it? _____

In this box, describe how this problem is affecting you

Answer the following 10 important questions about your problem:

1. What activity does this problem prevent you from doing either partially or totally, that you would really like to be doing again if you didn't have this condition? _____

2. How does this problem prevent you from doing that? _____

3. What areas of your life is it most affecting?

Circle any that apply: My Work. My Hobbies. My Social Activities. My Sports.

My Ability to Rest. My Family Life. My Attitude. My Financial Plan.

My Personal Life. My Productivity. My Appetite. My interest in Others.

My Personal Hygiene. My enthusiasm. My Ability to Concentrate. My mental state.

4. How else is it affecting you? _____

5. Has this problem affected your sleep patterns?

Trouble falling asleep because you are uncomfortable? Yes No

Not enough restful sleep? Yes No

Awakening in the middle of the night? Yes No

Waking you earlier than you would normally awake? Yes No

6. Have you become discouraged about this? Yes No

7. If you are not discouraged, does it concern you that your problem persists? Yes No

Why does it concern you? _____

8. Are you concerned that it will not go away or get worse in the future? Yes No

9. How often are you able to keep a positive attitude?

Circle: Most of the time Some of the time Not very often Hardly at all

10. If you don't get this problem taken care of where do you think you will be in 5 years?

Are you ready to take care of this problem?

Taking into consideration what you have described so far, so you feel you need to change the way you have been dealing with this problem? Yes No

On a scale of 1 – 10, ten being the highest, how would you rate your commitment to getting rid of this problem? 1 2 3 4 5 6 7 8 9 10

Is there anything preventing you from getting this problem taken care of? Please specify your concerns: _____

Name _____

Date _____

Other health problems you have that have bothered you in last 6 months

If you have any other problems/complaints, please list them here:

- #1 _____
- #2 _____
- #3 _____
- #4 _____

When was the last time you experienced the problems listed above?

- #1 _____
- #2 _____
- #3 _____
- #4 _____

Do you take any medications? Yes No

What is it?

How long have you taken this medication?

- 1. _____
- 2. _____
- 3. _____
- 4. _____

General Information

Your current weight _____ Height _____

Have you lost or gained weight in the last 6 months to 1 year? Yes No

If yes, how much? _____

Did you lose it intentionally? Yes No

Your work load is (circle):

Mental work	Heavy	Moderate	Light	_____	hours/day
Physical work	Heavy	Moderate	Light	_____	hours/day
Exercise	Heavy	Moderate	Light	_____	hours/day

Your habits (circle):

Cigarette smoking	Current	Yes	No	_____	packs/day, _____	years
	Past	Yes	No	_____	packs/day, _____	years
Alcohol use	Beer/week	_____	for	_____	years	
	Wine/week	_____	for	_____	years	
	Liquor/week	_____	for	_____	years	
Caffeine use	Coffee/day	_____	for	_____	years	
	Tea/day	_____	for	_____	years	
Aspirin use	Aspirin/day	_____	for	_____	years	

Doctor Visits

Do you have a family physician? Yes No

What is the name of your doctor? _____

Address of this doctor: _____

Do you see this doctor each year? Yes No

When is the last time you saw this doctor? _____

Are you satisfied with the care you receive from this doctor? Yes No

Do you see any specialists? Yes No

What are their names and specialties?

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Name _____

Date _____

Women doctor visits

Do you have a gynecologist? Yes No
 What is the name of this doctor? _____
 Address of this doctor: _____
 Do you see this doctor each year? Yes No
 When is the last time you saw this doctor? _____
 Are you satisfied with the care you receive from this doctor? Yes No

Family History

List anything that you know about the sickness, disease or death of the following relatives:

	Age if living	State of health	Age at death	Cause of death
Father				
Mother				
Sister(s)				
Brother(s)				
Grandmothers				
Grandfathers				

Past Diagnoses

Have you ever been diagnosed as having a disease? Yes No
 What is it? _____
 Have you ever been diagnosed with Cancer? Yes No
 High or Low Blood Pressure? Yes No
 Stroke? Yes No
 Have you ever suffered from: Alcoholism? Yes No Drug Addiction? Yes No

Trauma History

Any trauma your body suffered in the past is important to helping us help you. A trauma may be obvious or non-obvious. A trauma to your body could have happened last week, ten years ago, when you were three years old or during the birth process. *Please note that body trauma is most often related to a physical event, but may also be related to a chemical event or a mental event.* This list may help you to remember (please check any that apply):

Obvious Body Trauma

- Car accident
- Bike accident
- Ski accident
- A bad sprain
- Sports injury or accident
- Roller-blading accident
- A fall
- Being struck with an object
- Something that made you bleed
- Recreational injury
- A violent birth process
- A childhood injury or accident
- A time when someone thought you were 'really hurt'
- Surgery, any type
- Injury while moving (home/work)

Non-Obvious Body Trauma

- Always sleeping in a strained position
- Sitting at a bad work-station
- Repetitive movements related to work such as mouse use, hanging head over a desk or shoulder-held phone
- Repetitive movements related to sports like tennis, golf, baseball
- Movements related to playing an instrument
- Years of small falls related to youth sports
- Repeated carrying of a heavy bag
- Long term period of being over-weight
- Pregnancy or pregnancies too close together
- Birth process with forceps or difficult birth process
- Use of a drug that caused a reaction
- Mental trauma due to death of a loved one, divorce, money, drug addiction, bankruptcy, miscarriage

Please list dates (years will suffice) of trauma to your body and include a brief description of each event.

Universal Health Institute

Are you a doer, a hider? Are you beating yourself up? Are you a 'label'? Stress Strategies Screening Questionnaire

This questionnaire is used to identify the strategies you use to handle stressful challenges in your life. Why? If you are like most patients who come to UHI, you want to get better as quickly and as thoroughly as possible - and you are interested in doing it without a lot of drugs or surgery. Recognizing how you deal with stress is a fascinating process that helps you heal because once you know the strategies you use, you are in control of them, rather than vice versa. It's empowering.

Strategies for handling stress change over time, and though you use strategies habitually, you are probably blind to many of them. Once a strategy is put in front of you, you can choose whether it is really working for you, or whether it is working against you. If a strategy is working against you, it not only increases your stress, it complicates and interferes with the healing process.

Follow these instructions to complete the survey:

You might use the statements below to describe yourself or your situation. Read each one and determine if it describes you or fits your experience, and to what degree, during the past year. **Score the accuracy of the sentence is (using the Answers Table below)**. Score the sentence based on your emotional experience, *not using judgment*. Just refer to your emotional experience!

Some of the sentences refer to relationships. Relationships may include close friends, your parents or a romantic relationship. Look at each statement and score it based on the first person who comes to mind.

- If you are not currently in a romantic relationship, you can score the statement based on your most recent significant relationship.
- If your parent is no longer living, you can score the sentence based on your experience of the relationship when she or he was alive.
- If you are currently distant from your close friends, you may score the sentence based on your relationship with them, even though they are far away geographically.

Answers Table

1 = Completely untrue of me	4 = Moderately true of me
2 = Mostly untrue of me	5 = Mostly true of me
3 = Slightly more true than untrue	6 = Describes me perfectly

Using the Table, above, fill in the blank with the score that most properly reflects how accurately the statement describes you:

1. _____ I really missed having someone relate to me with warmth and affection, or who really understands me.

Answers Table

1 = Completely untrue of me	4 = Moderately true of me
2 = Mostly untrue of me	5 = Mostly true of me
3 = Slightly more true than untrue	6 = Describes me perfectly

2. _____ I feel like I really need people to be close to me, but I fear I will lose them, so I often cling to them.
3. _____ Its hard for me to feel like I can let my guard down with people. My sense is people often betray others.
4. _____ I often feel as though I'm really different from other people and don't really fit in.
5. _____ If someone really knew the inner me (or truth about me), they wouldn't like me .
6. _____ Other people are much better at handling most tasks in life than I am.
7. _____ I need help from others to manage most things in life.
8. _____ I am worried that some type of problem: financial, medical – even becoming a victim of crime - will happen to me.
9. _____ I often feel as though my life is so involved with others, I don't have a life of my own.
10. _____ If I don't do what others want of me, there will be negative results.
11. _____ Most of the time my life is focused on other people and their needs.
12. _____ I feel as though I must control my feelings; most people don't know how I feel about things.
13. _____ I really feel I have to be the best; its hard for me to make mistakes or just be "good enough"
14. _____ I feel that most rules are meant for others, I hate to be kept from doing what I want.
15. _____ If a goal isn't interesting or a task enjoyable, I lose interest easily or just don't do it.
16. _____ I feel most worthwhile when others notice my accomplishments.
17. _____ If something positive occurs, its only natural to think that something negative will happen soon.
18. _____ If something goes wrong and its my fault, I should suffer the consequences.

Name: _____

PATIENT CONSENT

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Universal Health Institute to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 312-266-9090. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and / or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

X _____
Patient's Signature

X _____
Witness

Universal Health Institute Financial Policy

We will verify your insurance benefits as a courtesy to you. Your insurance will provide a quote of benefits, not a guarantee of payment. Your insurance company retains the right to deny service payments and/or pay at a different percentage than quoted. Your insurance contract is between you, your employer, and your insurance company. We are not a party to that contract. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered.____(initial).

Please note that the out-of-network benefits may apply if we are not contracted with your insurance company____(initial).

We do not accept or bill secondary insurance carriers.If you have Medicare and you have supplemental insurance, Medicare will send the claim to your secondary insurance on your behalf. ____ (initial).

If referrals or prescriptions are required by your insurance company, you are solely responsible for obtaining and keeping track of them.____(initial).

If your insurance company has not paid a claim within ninety (90) days of submission, you accept full responsibility for payment in full of any outstanding balance ____ (initial).

Your copayment, coinsurance and deductible must be paid at the time of service.____ (initial).

All services must be paid in full if you are satisfying a deductible set by your insurance copay. Any credits to your account will be applied to future visits____(initial).

If you discontinue care for any reason other than discharge by the doctor, all patient balances become immediately due and payable in full by you and you authorize us to use your credit card to collect full payment.____(initial).

In the case that an account becomes delinquent (90 days past due) and we are unable to charge your credit card for the balance due, your account will be turned over to a third-party collection agency. If this occurs, our staff will no longer handle the account and all correspondence and phone calls will be directed to our agency Keynote Consulting.____(initial).

All patients are required to maintain a valid credit card number on file with us. If you choose not to provide this information, we will not bill your insurance and you must pay cash for all service provided to you____(initial).

Cancellations:

Scheduled visits are available for all services at UHI. If you are unable to make your appointment, 24 hour notice must be given. If you make an appointment on another patient's behalf, you assume all financial responsibility for that appointment in the event of a cancellation or missed appointment. Any missed appointment carry a charge of \$50.00 (except for chiropractic adjustments). This fee are not covered by insurance and must be paid before scheduling another appointment.

This financial policy supercedes any and all previous financial policies, contracts, and agreements issued by Universal Health Institute.____(initial).

Card # _____ Expiration Date _____

CVV Code (3 digit number on the back of your card) _____

Printed Name as Appears on Card: _____

Signature: _____ Date: _____

Witness: _____ Date: _____



Relieve your pain and
revitalize your life...
naturally

ELIMINATION ASSESSMENT

Bowels

1. My bowels move ____ x day or ____ x week
2. Laxative use: Circle one: Daily Weekly Occasionally Never
3. My stools are:
 - ____ Large (2-3 fingers wide and 6"plus in length)
 - ____ Medium (1-2 fingers wide and <6" in length)
 - ____ Small and hard
 - ____ Soft but not watery
 - ____ Watery and loose (diarrhea)
 - ____ Alternates between hard and watery
 - ____ Mucous or blood is present
 - ____ Undigested food is present

Stool odor:

- ____ Offensive usually
- ____ Offensive occasionally
- ____ Little to no odor

Stool color is:

- Medium brown
- Dark brown
- Tan, yellowish, gold or clay colored
- Greenish

Intestinal gas:

- Daily
- Occasionally
- Excessive
- Foul smelling
- Little odor

Do you have abdominal bloating: never sometimes always
Does any abdominal discomfort accompany bowel movements?

Have you or do you have hemorrhoids varicose veins?

Water:

- Amount daily
- Tap
- Bottled
- Filtered

What brands or filtering system?

Urination

Do you have any burning or irritation during or after urination?

Do you have any difficulty starting or stopping urination?

Does your urine have a strong odor?

Is it usually:

- Clear
- Dark Yellow
- Cloudy
- Bright Yellow

Do you get recurrent bladder or kidney infections?

Do you get unexplained back pain just below your ribs? Explain

Exercise

Do you perspire with exercise?

____ Lightly ____ Moderately ____ Heavily

Do you perspire easily?

Do you perspire other than when exercising?

Foods

Do you avoid any foods? Details.

Do you have any food allergies?

Do you have an adverse reaction to:

____ MSG ____ Dried fruit ____ Wine ____ Salad bar
____ Caffeine ____ Chocolate ____ Onions vegetables

Are you or have you been on any special diets?

Environment

Are you sensitive to:

Fragrances Exhaust Smoke
 Perfumes Strong odors

What is your blood type?

A
 B

O
 AB

Do your work or have hobbies that involve toxic fumes or chemicals? Details.

PART II

	No/Rarely	Occasionally	Often	Frequently
10. Aching muscles not due to exercise	0	1	4	8
11. Retain fluid and feel swollen around the abdominal area	0	1	4	8
12. Reddened skin, especially palms	0	1	4	8
13. Very strong body odor	0	1	4	8
14. Are you embarrassed by your breath?	0	1	4	8
15. Bruise easily	(0)No	(8)Yes		
16. Yellowish cast to eyes	(0)No	(8)Yes		

Total points

PART III

SECTION A

1. Feel cold or chilled—hands, feet or all over—for no apparent reason	0	1	4	8
2. Your upper eyelids look swollen	0	1	4	8
3. Muscles are weak, cramp and/or tremble	0	1	4	8
4. Are you forgetful?	0	1	4	8
5. Do you feel like your heart beats slowly?	0	1	4	8
6. Reaction time seems slowed down	0	1	4	8
7. In general, are you disinterested in sex because your desire is low?	0	1	4	8
8. Feel slow-moving, sluggish	0	1	4	8
9. Constipation	0	1	4	8
10. Dryness, discoloration of skin and/or hair	(0)No	(8)Yes		
11. Have you noticed recently that your voice is deepening?	(0)No	(8)Yes		
12. Thick, brittle nails	(0)No	(8)Yes		
13. Weight gain for no apparent reason	(0)No	(8)Yes		
14. Outer third of your eyebrow is thinning or disappearing	(0)No	(8)Yes		
15. Swelling of the neck	(0)No	(8)Yes		

Total points

SECTION B

1. Lingering mild fatigue after exertion or stress	0	1	4	8
2. Do you find that you get tired and exhaust easily?	0	1	4	8
3. Craving for salty foods	0	1	4	8
4. Sensitive to minor changes in weather and surroundings	0	1	4	8
5. Dizzy when rising or standing up from a kneeling position	0	1	4	8
6. Dark bluish or black circles under your eyes	0	1	4	8
7. Have bouts of nausea with or without vomiting	0	1	4	8
8. Catch colds or infections easily	(0)No	(8)Yes		
9. Wounds heal slowly	(0)No	(8)Yes		
10. Your body or parts of your body feel tender, sore, sensitive to the touch, hot and/or painful	0	1	4	8
11. Feel puffy and swollen all over your body	0	1	4	8
12. Skin is gradually tanning without exposure to sun or the ingestion of high levels of carotene-rich foods (e.g., daily carrot juice intake) or supplements	(0)No	(8)Yes		

Total points

PART IV

SECTION A

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

	No/Rarely	Occasionally	Often	Frequently
1. A sense of weakness	0	1	4	8
2. A sudden sense of anxiety when you get hungry	0	1	4	8
3. Tingling sensation in your hands	0	1	4	8
4. A sensation of your heart beating too quickly or forcefully	0	1	4	8
5. Shaky, jittery, hands trembling	0	1	4	8
6. Sudden profuse sweating and/or your skin feels clammy	0	1	4	8
7. Nightmares possibly associated with going to bed on an empty stomach	0	1	4	8
8. Wake up at night feeling restless	0	1	4	8
9. Agitation, easily upset, nervous	0	1	4	8
10. Poor memory, forgetful	0	1	4	8
11. Confused or disoriented	0	1	4	8
12. Dizzy, faint	0	1	4	8
13. Cold or numb	0	1	4	8
14. Mild headaches or head pounding	0	1	4	8
15. Blurred vision or double vision	0	1	4	8
16. Feel clumsy and uncoordinated	0	1	4	8

Total points

SECTION B

1. Frequent urination during the day and night	0	1	4	8
2. Unusual thirst—feeling like you can't drink enough water	0	1	4	8
3. Unusual hunger—eating all the time	0	1	4	8
4. Vision blurs	0	1	4	8
5. Feel itchy all over	0	1	4	8
6. Tingling or numbness in your feet	0	1	4	8
7. Sense of drowsiness, lethargy during the day not associated with missing meals or not sleeping	0	1	4	8
8. Eating starchy foods, even if they are healthy and unprocessed (like rice, corn, beans, whole wheat or oats), causes you to gain weight or prevents you from losing weight	(0)No	(8)Yes		
9. Sores heal slowly	(0)No	(8)Yes		
10. Loss of hair on your legs	(0)No	(8)Yes		

Total points

PART V

SECTION A

1. Feel jittery	0	1	4	8
2. First effort of the day causes pain, pressure, tightness or heaviness around the chest	0	1	4	8
3. Exhaustion with minor exertion	0	1	4	8
4. Heavy sweating (no exertion, no hot flashes)	0	1	4	8
5. Difficulty catching breath, especially during exercise	0	1	4	8
6. Heart pounding, sensation of heart beating too quickly, too slowly or irregularly	0	1	4	8
7. Swelling in feet, ankles and/or legs comes and goes for no apparent reason	0	1	4	8

Total points

PART V

SECTION B

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

Total points

PART VI

SECTION A

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

Total points

SECTION B

1. Does worrying get you down?	1	2	4	8
2. Does every little thing get on your nerves and wear you out?	1	2	4	8
3. Would you consider yourself a nervous person?	1	2	4	8
4. Do you feel easily agitated?	1	2	4	8
5. Do you shake and tremble?	1	2	4	8
6. Are you keyed up and jittery?	1	2	4	8
7. Do you tremble or feel weak when someone shouts at you?	1	2	4	8
8. Do you become scared at sudden movements or noises at night?	1	2	4	8
9. Do you find yourself sighing a lot?	1	2	4	8
10. Are you awakened out of your sleep by frightening dreams?	1	2	4	8
11. Do frightening thoughts keep coming back in your mind?	1	2	4	8

Rarely
Occasionally
Often
Frequently

SECTION B (cont.)

12. Do you become suddenly scared for no good reason?	1	2	4	8
13. Do you break out in a cold sweat?	1	2	4	8
14. "Butterflies in your stomach", nausea and/or diarrhea	1	2	4	8

Total points

SECTION C

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

Total points

PART VII

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

PART VII (cont.)

	No/Rarely	Occasionally	Often	Frequently
29. Do you have difficulty concentrating?	0	1	4	8
30. Eyes, ears, nose, throat and lung symptoms seem associated with specific foods like dairy or wheat products	(0)No		(8)Yes	
31. Eyes, ears, nose, throat and lung symptoms are associated with seasonal changes	(0)No		(8)Yes	
Total points				

PART VIII

1. Involuntary loss of urine when you cough, lift something or strain during an activity	0	1	4	8
2. Mild lower back ache or pain	0	1	4	8
3. Abdominal achiness or pain	0	1	4	8
4. Pain or burning when urinating	0	1	4	8
5. Rarely feel the urge to urinate	0	1	4	8
6. Feel the need to urinate less than every two hours during the day or night	0	1	4	8
7. Strong smelling urine	0	1	4	8
8. Back or leg pains are associated with dripping after urination	0	1	4	8
9. Sore or painful genitals	0	1	4	8
10. Urine is a rose color	0	1	4	8
11. Sudden urge to void causes involuntary loss of urine	0	1	4	8
12. Generalized sense of water retention throughout your body	0	1	4	8
Total points				

PART IX

SECTION A

1. Bones throughout your entire body ache, feel tender or sore	0	1	4	8
2. Localized bone pain	0	1	4	8
3. Hands, feet or throat get tight, spasm or feel numb	0	1	4	8
4. Difficulty sitting straight	0	1	4	8
5. Upper back pain	0	1	4	8
6. Lower back pain	0	1	4	8
7. Pain when sitting down or walking	0	1	4	8
8. Find yourself limping or favoring one leg	0	1	4	8
9. Shins hurt during or after exercise	0	1	4	8
Total points				

SECTION B

1. Are you stiff in the morning when you wake up?	0	1	4	8
2. Difficulty bending down and picking up clothing or anything from the floor	0	1	4	8
3. Joint swelling, pain or stiffness involving one or more areas (fingers, hands, wrists, elbows, shoulders, toes, arches, feet, ankles, knees or ankles)	0	1	4	8
4. Joints hurt when moving or when carrying weight	0	1	4	8
5. A routine exercise program, like daily walking, causes your knees to swell or hurt	0	1	4	8
6. Difficulty opening jars that were previously easy to open	0	1	4	8
7. Discomfort, numbness, prickling or tingling sensation, or pain in neck, shoulder or arm	0	1	4	8

SECTION B (cont.)

	No/Rarely	Occasionally	Often	Frequently
8. Intermittent pain or ache on one side of head spreading to cheek, temple, lower jaw, ear, neck and shoulder	0	1	4	8
9. Difficulty chewing food or opening mouth	0	1	4	8
10. Difficulty standing up from a sitting position	0	1	4	8
11. Shooting, aching, tingling pain down the back of leg	0	1	4	8
12. Is it difficult to reach up and get a 5-pound object like a bag of flour from just above your head?	(0)No		(8)Yes	
13. Injure, strain or sprain easily	(0)No		(8)Yes	
Total points				

SECTION C

1. Muscles stiff, sore, tense and/or achy	0	1	4	8
2. Burning, throbbing, shooting or stabbing muscle pain	0	1	4	8
3. Muscle cramps or spasms (involuntary or after exertion/exercise)	0	1	4	8
4. Is muscle pain or stiffness greater in the morning than other times of the day?	0	1	4	8
5. Specific points on body feel sore when pressed	0	1	4	8
6. Feel unrefreshed upon awakening	0	1	4	8
7. Headaches	0	1	4	8
8. Pain at the sides of your head or in your face especially when awakening	0	1	4	8
9. Your jaw clicks or pops	0	1	4	8
10. Muscle twitch or tremor—eyelids, thumb, calf muscle	0	1	4	8
11. Irresistible urge to move legs	0	1	4	8
12. Legs move during sleep	0	1	4	8
13. Unpleasant crawling sensation inside calves when lying down	0	1	4	8
14. Hand and wrist numbness or pain (e.g., interferes with writing or with buttoning or unbuttoning your clothes)	0	1	4	8
15. Feeling of "pins and needles" in your thumb and first three fingers	0	1	4	8
16. Pain in forearm and sometimes in shoulder	0	1	4	8
Total points				

PART X

SECTION A

1. Head feels heavy	0	1	4	8
2. Dizziness	0	1	4	8
3. Difficulty bending over, standing up from sitting, rolling over in bed and/or turning your head from side to side	0	1	4	8
4. Your hands tremble, ever so slightly, for no apparent reason	0	1	4	8
5. You feel like you're wearing heavy weights on your feet when walking	0	1	4	8
6. Bump into things, trip, stumble and feel clumsy	0	1	4	8
7. Difficulty breathing	0	1	4	8
8. Difficulty swallowing	0	1	4	8
9. People tell you to speak up because they have trouble hearing you	0	1	4	8
10. Speaking and forming words does not feel automatic	0	1	4	8
11. Need 10-12 hours of sleep to feel rested	0	1	4	8

PART X (cont.)

SECTION A (cont.)

- | | No/Rarely | Occasionally | Often | Frequently |
|--|-----------|--------------|-------|------------|
| 12. Lack strength (your grip is weak, holding your head or picking your arms up takes effort) | 0 | 1 | 4 | 8 |
| 13. Hands get tired when you write and your handwriting is less legible and smaller than it used to be | (0)No | (8)Yes | | |
| 14. Muscles in arms and legs seem softer and smaller | (0)No | (8)Yes | | |
| 15. Is your eyesight, sense of smell and taste or ability to hear not as sharp as it used to be? | (0)No | (8)Yes | | |
| 16. Do you find yourself moving slower than you used to? | (0)No | (8)Yes | | |

Total points

SECTION B

- | | | | | |
|--|---|---|---|---|
| 1. Difficulty absorbing new information | 0 | 1 | 4 | 8 |
| 2. Tend to forget things | 0 | 1 | 4 | 8 |
| 3. Trouble thinking or concentrating | 0 | 1 | 4 | 8 |
| 4. Easily distracted | 0 | 1 | 4 | 8 |
| 5. Do you have a tendency to become frustrated quickly? | 0 | 1 | 4 | 8 |
| 6. Inability to sit still for any length of time, even at mealtime | 0 | 1 | 4 | 8 |
| 7. Finishing tasks is easier said than done | 0 | 1 | 4 | 8 |
| 8. Do you have more trouble solving problems or managing your time than usual? | 0 | 1 | 4 | 8 |
| 9. Low tolerance for stress and otherwise ordinary problems | 0 | 1 | 4 | 8 |

Total points

PART XI

Men Only

- | | | | | |
|--|---|---|---|---|
| 1. Sensation of not emptying your bladder completely | 0 | 1 | 4 | 8 |
| 2. Need to urinate less than 2 hours after you have finished urinating | 0 | 1 | 4 | 8 |
| 3. Find yourself needing to stop and start again several times while urinating | 0 | 1 | 4 | 8 |
| 4. Find it difficult to postpone urination | 0 | 1 | 4 | 8 |
| 5. Have a weak urinary stream | 0 | 1 | 4 | 8 |
| 6. Need to push or strain to begin urinating | 0 | 1 | 4 | 8 |
| 7. Dripping after urination | 0 | 1 | 4 | 8 |
| 8. Urge to urinate several times a night | 0 | 1 | 4 | 8 |

Total points

PART XII

Women Only

(Menopausal women should skip to Sections E and F)

SECTION A

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

[A]

- | | | | | |
|--|-------|--------|--|--|
| 1. Anxious, irritable or restless | (0)No | (8)Yes | | |
| 2. Numbness, tingling in hands and feet | (0)No | (8)Yes | | |
| 3. Easy to anger, resentful | (0)No | (8)Yes | | |
| 4. Aggressive or hostile toward family/friends | (0)No | (8)Yes | | |

Total points

SECTION A (cont.)

[B]

- | | | | | |
|---|-------|--------|--|--|
| 5. Abdominal bloating, feeling swollen (e.g., feet) | (0)No | (8)Yes | | |
| 6. Temporary weight gain | (0)No | (8)Yes | | |
| 7. Breast tenderness, swelling | (0)No | (8)Yes | | |
| 8. Appearance of breast lumps | (0)No | (8)Yes | | |
| 9. Discharge from nipples | (0)No | (8)Yes | | |
| 10. Nausea and/or vomiting | (0)No | (8)Yes | | |
| 11. Diarrhea or constipation | (0)No | (8)Yes | | |
| 12. Aches and pains (back, joints, etc.) | (0)No | (8)Yes | | |

[C]

- | | | | | |
|---|-------|--------|--|--|
| 13. Craving for sweets | (0)No | (8)Yes | | |
| 14. Increased appetite or binge eating | (0)No | (8)Yes | | |
| 15. Headaches | (0)No | (8)Yes | | |
| 16. Being easily overwhelmed, shaky or clumsy | (0)No | (8)Yes | | |
| 17. Heart pounding | (0)No | (8)Yes | | |
| 18. Dizziness or fainting | (0)No | (8)Yes | | |

[D]

- | | | | | |
|--|-------|--------|--|--|
| 19. Confused and forgetful to the point that work suffers | (0)No | (8)Yes | | |
| 20. Overwhelmed with feelings of sadness and worthlessness | (0)No | (8)Yes | | |
| 21. Difficulty sleeping or falling asleep | (0)No | (8)Yes | | |
| 22. Engaging in self-destructive behavior | (0)No | (8)Yes | | |

Total points

SECTION B

Do you experience any of these symptoms during your period?

- | | | | | |
|--|-------|--------|--|--|
| 1. Cramping in lower abdomen or pelvic area | (0)No | (8)Yes | | |
| 2. Lower abdominal pain is sharp and/or dull or intermittent | (0)No | (8)Yes | | |
| 3. Bloating and sense of abdominal fullness | (0)No | (8)Yes | | |
| 4. Diarrhea or constipation | (0)No | (8)Yes | | |
| 5. Nausea and/or vomiting | (0)No | (8)Yes | | |
| 6. Low back and/or legs ache | (0)No | (8)Yes | | |
| 7. Headaches | (0)No | (8)Yes | | |
| 8. Unusual fatigue (take naps) resulting in missed work | (0)No | (8)Yes | | |
| 9. Painful and/or swollen breasts | (0)No | (8)Yes | | |
| 10. Scanty blood flow | (0)No | (8)Yes | | |

Total points

SECTION C

- | | | | | |
|--|-------|--------|---|---|
| 1. Painful or difficult sexual intercourse | 0 | 1 | 4 | 8 |
| 2. Low abdominal, back and vaginal pain throughout the month | 0 | 1 | 4 | 8 |
| 3. Pelvic pressure or pain while sitting down or standing up, relieved by lying down | 0 | 1 | 4 | 8 |
| 4. Vaginal bleeding other than during your period | 0 | 1 | 4 | 8 |
| 5. Painful bowel movements | 0 | 1 | 4 | 8 |
| 6. Difficult (straining) urination | 0 | 1 | 4 | 8 |
| 7. Abnormal vaginal discharge | 0 | 1 | 4 | 8 |
| 8. Offensive vaginal discharge | 0 | 1 | 4 | 8 |
| 9. Vaginal itching or burning with or without intercourse | 0 | 1 | 4 | 8 |
| 10. Pain during periods is getting progressively worse | (0)No | (8)Yes | | |
| 11. Profuse or prolonged menstrual bleeding | (0)No | (8)Yes | | |
| 12. Unable to get pregnant | (0)No | (8)Yes | | |

Total points

PART XII (cont.)

SECTION D

	No/Rarely	Occasionally	Often	Frequently
1. Absence of periods for six months or longer	(0)No			(8)Yes
2. Periods occur irregularly (e.g., 3 to 6 times a year)	(0)No			(8)Yes
3. Profuse heavy bleeding during periods	0	1	4	8
4. Menstrual blood contains clots and tissue	0	1	4	8
5. Bleeding between periods can occur anytime	0	1	4	8
6. Periods occur greater than every 35 days	(0)No			(8)Yes
7. Intense upper stomach pain, lasting several hours at the time you ovulate (approximately day 14 of your cycle)	0	1	4	8
8. Bleeding occurs at ovulation (approximately day 14 of your cycle)	0	1	4	8
9. Monthly abdominal pain without bleeding	0	1	4	8
10. Abundant cervical mucus	0	1	4	8
11. Acne and/or oily skin	0	1	4	8
12. Overwhelming urges for sexual intercourse	0	1	4	8
13. Aggressive feelings	0	1	4	8
14. Increased growth of dark facial and/or body hair	(0)No			(8)Yes
15. Poor sense of smell	(0)No			(8)Yes
16. Voice is becoming deeper	(0)No			(8)Yes
17. Breasts seem to be getting smaller	(0)No			(8)Yes
18. Receding hairline	(0)No			(8)Yes

Total points

SECTION E

1. Vaginal discharge	0	1	4	8
2. Vaginal secretions are watery and thin	0	1	4	8
3. Vaginal dryness	0	1	4	8
4. Sexual intercourse is uncomfortable	0	1	4	8

SECTION E (cont.)

	No/Rarely	Occasionally	Often	Frequently
5. Interest in having sex is low	0	1	4	8
6. Engorged breasts	0	1	4	8
7. Breast tenderness, soreness	0	1	4	8
8. Difficulty with orgasm	0	1	4	8
9. Vaginal bleeding after sexual intercourse	0	1	4	8
10. Do you skip periods?	(0)No			(8)Yes
11. The length (number of days) of your period varies month to month, with the number of days of bleeding getting fewer	(0)No			(8)Yes

Total points

SECTION F

1. Sense of well-being fluctuates throughout the day for no apparent reason	0	1	4	8
2. Sudden hot flashes	0	1	4	8
3. Spontaneous sweating	0	1	4	8
4. Chills	0	1	4	8
5. Cold hands and feet	0	1	4	8
6. Heart beats rapidly or feels like it is fluttering	0	1	4	8
7. Numbness, tingling or prickling sensations	0	1	4	8
8. Dizziness	0	1	4	8
9. Mental foginess, forgetful or distracted	0	1	4	8
10. Inability to concentrate	0	1	4	8
11. Depression, anxiety, nervousness and/or irritability	0	1	4	8
12. Difficulty sleeping	0	1	4	8
13. Conscious of new feelings of anger and frustration	0	1	4	8
14. Skin, hair, vagina and/or eyes feel dry	0	1	4	8
15. Stopped menstruating around six months ago, yet still experience some vaginal bleeding	(0)No			(8)Yes

Total points