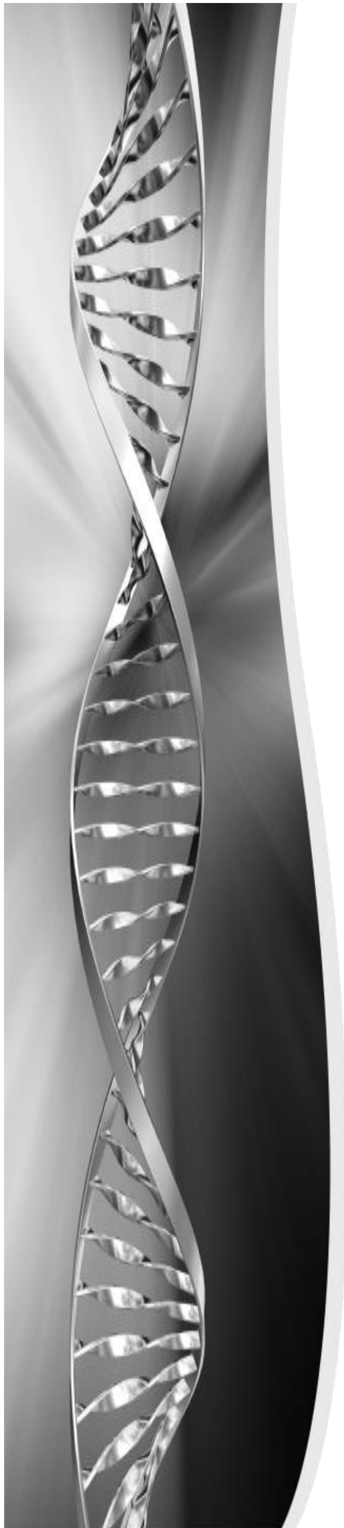
TNHC - FUNCTIONAL MEDICINE HAQ

2448 E 81st. St. Ste. 5125
Tulsa, OK 74137

(HAQ) Health Appraisal Questionnaire



CONNECTING SCIENCE, EVIDENCE AND CLINICAL INSIGHT

In your own words and in chronological order describe your health history from childhood to where you are today. Example, when I was a child I had a lot of ear infections, or asthma etc.

Or what happened that you feel caused your health to decline. For example, I had the flu 5 years ago and after that I have never felt the same, or after my 3rd child my health began to deteriorate, etc.

Health Appraisal Questionnaire

Date: ________________________ Age ________________________ DOB ____________ SS# ________________

Name:________________________ Weight ____________________ Height ________________________

Address ________________________ City ________________________ State ________________________ Zip ____________

Home Phone Business Cell e-mail
____

What is the purpose of your visit and what are your health goals

Circle and list any of the following medications (and doses) you are taking:

- Antacids
- Diabetic medication/Insulin, Metformin
- Anti-inflammatory medication
- High blood pressure medication
- Laxatives
- Tranquilizers/Sleep medication
- Chemotherapy
- Antibiotic/Antifungal
- Aspirin/Tylenol/other
- Lithium
- Recreational drugs
- Stomach medication/Ulcer
- Oral Contraceptive/Patch
- Thyroid
- Hormone replacement
- What is your blood pressure
- Who referred you to our clinic

3 Health Appraisal Questionnaire

Circle if you eat, drink or use the following. If yes, please give details

Alcohol

- Cigarettes/Cigars/Other forms of tobacco
- Coffee/Tea, if yes how many cups or glasses daily
- Cola Drinks/Energy drinks/How many
- Luncheon meats
- Refined sugar/Candy
- Drink tap water
- Margarine or trans fats
- Artificial sweeteners
- Eat at fast food restaurants
- Eat fried foods

Do you diet often / list diets you have been on or are on now

LIST ANY HOBBIES YOU HAVE:

• **Circle if these apply to you.** Salt food without tasting • Are under excessive stress • Do not exercise • Exercise (describe)

• Are you now or have you been exposed to chemicals at home or work • Are you now, or have you been exposed to second hand smoke

List all dental procedures and/or surgeries: indicate year. Have you been diagnosed with a medical condition, e.g. diabetes, high BP ect.?

4 Health Appraisal Questionnaire

INSTRUCTIONS: Circle the number which best describes the intensity of your symptoms. If you don't know the answer to a question, leave it blank.

0 = symptom not present 1 = Mild 2 = Moderate 3 = Severe

Part 2
Section A: ___________

1. Burping	0 1 2 3
2. Stomach upsets easily	0 1 2 3
3. Feel full for extended time after a meal	0 1 2 3
4. Bloating	0 1 2 3
5. History of constipation	0 1 2 3
6. Poor appetite	0 1 2 3
7. Known food allergies	0 1 2 3

Part 2 Section B: ___________

1. Abdominal cramps	0 1 2 3
2. Indigestion occurring 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. Mucous in stools	0 1 2 3
8. Roughage & fiber causes constipation	0 1 2 3
9. Stool poorly formed	0 1 2 3
10. Three or more large bowel movements daily	0 1 2 3
11. Shiny stool	0 1 2 3
12. Foul smelling stool	0 1 2 3
13. Dry flaky skin and /or dry brittle hair	0 1 2 3
14. Left sided pain 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 right after and/or before 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 or stressed	0 1 2 3
8. Sudden, acute indigestion	0 1 2 3
9. Relief of stomach pain by drinking cream or milk	0 1 2 3
10. History of ulcers or gastritis	0 1 2 3
11. Currently have an ulcer	0 1 2 3
12. Black stool when not taking iron supplements	0 1 2 3

Part 2 Section D: ___________

1. Seasonal diarrhea	0 1 2 3
2. Frequent & recurrent infections (cold, flue, etc.)	0 1 2 3
3. Vaginal yeast infection	0 1 2 3
4. Bladder and kidney infections	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 or steroid use	0 1 2 3
10. Eat red meat	0 1 2 3
11. Rapidly failing vision	0 1 2 3

5 Health Appraisal Questionnaire

Part 3
SECTION A: ___________

Item	Score
1. Cannot tolerate greasy food	0 1 2 3
2. Get headaches after eating	0 1 2 3
3. Light colored stool	0 1 2 3
4. Have less than one bowel movement daily	0 1 2 3
5. Constipation	0 1 2 3
6. Have hard stool	0 1 2 3
7. Foul smelling stool	0 1 2 3
8. Sour taste in mouth	0 1 2 3
9. Gray 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. Get tired or sleepy after meals	0 1 2 3
14. Pain in right side under rib cage	0 1 2 3
15. Difficulty or experience pain when passing stool	0 1 2 3
16. Retain water (fluid)	0 1 2 3
17. Big toe is painful	0 1 2 3
18. Have pain that radiates along outside of leg (s)	0 1 2 3
19. Dry skin/hair	0 1 2 3
20. Bright red or dark blood in stool	No Yes (10)
21. Have had jaundice or hepatitis (A-B-C)	No Yes
22. High cholesterol-Elevated LDL	No Unknown Yes (10)
23. Elevated triglycerides	No Unknown Yes (10)

Part 3 SECTION B: ___________

Item	Score
1. Swollen bulging eyes	0 1 2 3
2. Strong smelling urine	0 1 2 3
3. Thick skin and or 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 or feet	0 1 2 3
7. Excessive menstrual bleeding	0 1 2 3
8. Chronic fatigue	0 1 2 3
9. Difficulty waking in the mornings	0 1 2 3
10. Fell depressed or apathetic	0 1 2 3
11. Low or decreased sex drive	0 1 2 3
12. Puffy, wrinkly skin	0 1 2 3
13. Eating sugar causes irritability or mood swings	0 1 2 3
14. PMS	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 taking iron	0 1 2 3
19. Axillary (underarm temp below 97.6 for 7-10 days)	0 1 2 3
20. Slow reflexes	0 1 2 3
21. Infertility	0 1 2 3

Part 4 SECTION A: ___________

Item	Score
1. Sensitive to exhaust fumes, smoke, smog, petrochemicals	0 1 2 3
2. Periodic constipation	0 1 2 3
3. Cannot tolerate much exercise	0 1 2 3
4. Depression or rapid mood swings	0 1 2 3
5. Dark circles under the eyes	0 1 2 3
6. Experience dizziness when standing or standing quickly	0 1 2 3
7. Get colds easily with weather changes	0 1 2 3
8. Headaches	0 1 2 3
9. Exercise makes you feel worse	0 1 2 3

Part 4 SECTION A continued

9. Difficulty breathing 0 1 2 3
10. Water (fluid) retention 0 1 2 3
11. Eyes are sensitive to the sun or bright lights 0 1 2 3
12. Occasionally feel weak or shaky 0 1 2 3

SECTION B: ___________

1. Inflamed or bleeding gums 0 1 2 3
2. Running nose 0 1 2 3
3. Get boils or styes 0 1 2 3
4. Nose bleeds 0 1 2 3
5. Throat infections 0 1 2 3
6. Cold sores, fever blisters 0 1 2 3
7. Loss of smell 0 1 2 3
8. Loss of taste 0 1 2 3
9. Wounds, cuts heal slowly 0 1 2 3
10. Hair falls out 0 1 2 3
11. Swollen lymph glands 0 1 2 3
12. Ear infections 0 1 2 3
13. Hair grows slowly 0 1 2 3
14. Slow to recover from colds or flu 0 1 2 3
15. Catch colds or flu easily 0 1 2 3

SECTION C: ___________

1. Itching of nose or eyes 0 1 2 3
2. Itching of roof of mouth or throat 0 1 2 3
3. Migraine headaches 0 1 2 3
4. Entire body aches, painful to touch 0 1 2 3
5. Swollen joints 0 1 2 3
6. Food sensitivity or allergies 0 1 2 3
7. Certain foods make you feel sick, depressed or jittery 0 1 2 3
8. Chronic pain 0 1 2 3
9. Painful stomach or intestines 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 the eyes 0 1 2 3
16. Ears discharge or ears stuffed up 0 1 2 3
17. Nasal congestion 0 1 2 3
18. Runny nose 0 1 2 3
19. Breathe through mouth 0 1 2 3
20. Wheezing 0 1 2 3
21. Difficulty swallowing 0 1 2 3
22. Sneezing 0 1 2 3
23. Hyperactivity 0 1 2 3
24. Chronic lung congestion 0 1 2 3
25. Use aspirin, Tylenol, ibuprofen regularly 0 1 2 3
26. Skin rashes 0 1 2 3

Part 5 SECTION A: ___________

1. Difficulty breathing 0 1 2 3
2. Chest pain while walking 0 1 2 3
3. Heaviness in legs 0 1 2 3
4. Calf muscles cramp while walking 0 1 2 3
5. Heart pounds easily 0 1 2 3
6. Feel jittery 0 1 2 3
7. Heart misses beats or has extra beats 0 1 2 3

Part 5 SECTION A continued

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. Exhausted with minor exertion 0 1 2 3
13. Do you drink more than 5 cups of coffee daily Yes No
14. Have you ever been diagnosed with heart trouble Yes No

Part 5 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. Hair in ear canal 0 1 2 3
9. Tingling or burning in hands or feet 0 1 2 3
10. Spider vein on nose and or face 0 1 2 3

Part 5 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. Blushing with no apparent cause 0 1 2 3
4. High blood pressure 0 1 2 3

Part 6 SECTION A: ___________

1. Experience dizziness when standing quickly 0 1 2 3
2. Loss of vision when standing quickly 0 1 2 3
3. Crave sweets 0 1 2 3
4. Headaches relieved by eating sweets or consuming 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. Heart palpitations after eating sweets 0 1 2 3
10. Need to drink coffee or tea to get started 0 1 2 3
11. Impatient, moody or 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. Feel calmer after eating a meal 0 1 2 3

Part 6 SECTION B: ___________

1. Night sweats 0 1 2 3
2. Lowered resistance to infection 0 1 2 3
3. Increased thirst 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 better after 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
13. Skin tags 0 1 2 3

Part 7 ___________

1. Chest pain 0 1 2 3
2. Chronic cough 0 1 2 3
3. Difficult breathing 0 1 2 3
4. Coughing up blood 0 1 2 3
5. Pain around ribs 0 1 2 3
6. Shortness of breath 0 1 2 3
7. Coughing up phlegm 0 1 2 3
8. Rattling mucous when you breathe 0 1 2 3
9. Sensitive to smog 0 1 2 3
10. Infection settles in lung 0 1 2 3
11. Live or work around people who smoke 0 1 2 3
12. Bronchitis No Yes (10)
13. Exposed to chemicals and radiation No Yes (6)
14. Smoker or ex-smoker No Yes (6)

Part 8 ___________

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 urine (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 infection 0 1 2 3
14. Have you used antibiotics for urinary tract infections? 0 1 2 3
15. Back pain in the kidney region? 0 1 2 3
16. General water retention 0 1 2 3

Part 9 (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 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. Decrease 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 sex drive 0 1 2 3
3. Premature ejaculation 0 1 2 3
4. Pain/coldness in genital areas 0 1 2 3
5. Infertile No Yes (6)
6. Varicose vein on scrotum 0 1 2 3
7. Low sperm count No Yes (6)

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 No Yes (9)

Part 10 (Females - only if menstruating) SECTION A

1. Monthly weight gain 0 1 2 3
2. Depression 0 1 2 3
3. Moodiness/irritability 0 1 2 3
4. Bloating and/or vomiting 0 1 2 3
5. Nausea and/or vomiting 0 1 2 3
6. Suicidal feeling No Yes (10)
7. Anxiety 0 1 2 3
8. Leg cramps and tenderness 0 1 2 3
9. Asthma attacks 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 breasts 0 1 2 3
14. Low backache 0 1 2 3
15. Other ______________________________________

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 0 1 2 3
6. Over 15 years of age and have not begun menstruation 0 1 2 3

Part 10 SECTION B Cont. (FEMALES ONLY)

7. Unable to get pregnant No Yes
8. Miscarriages No Yes
   How many __________
9. Abortion No Yes
   How many __________

Part 10 SECTION C: __________

Check if you experience any of these symptoms *DURING MENSTRUATION*.

1. Low abdominal pain 0 1 2 3
2. Dull ache radiating to low back or leg 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 or 2 day 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

Part 10 SECTION D: __________

1. Vaginal bumps and sores 0 1 2 3
2. Pubic area sore 0 1 2 3
3. Ovarian cysts 0 1 2 3
4. Uterine cysts 0 1 2 3
5. Pain in ovaries 0 1 2 3
6. Breast lumps 0 1 2 3
7. Breast sore to touch 0 1 2 3

Part 10 SECTION D: continued

8. Breast 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. Abnormal PAP smear No Yes (15)
14. Family history of breast cancer No Yes (10)
15. Form of birth control ________________________________

Part 10 SECTION E: __________

1. Hot flashes 0 1 2 3
2. Night sweats 0 1 2 3
3. Hysterectomy No Yes
4. Depression/mood swings 0 1 2 3
5. Insomnia 0 1 2 3
6. Craving for sweets 0 1 2 3
7. Heavy bleeding two weeks/month 0 1 2 3
8. Sweating throughout the 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 0 1 2 3

Part 10 SECTION F: HORMONE BALANCE TEST

SYMPTOM GROUP 1

- ☐ PMS
- ☐ Early miscarriage
- ☐ Unexplained weight gain
- ☐ Anxiety
- ☐ Insomnia
- ☐ Painful and or lumpy breasts
- ☐ Cyclical headaches
- ☐ Infertility

Total boxes checked ☐

If you have checked 2 or more boxes in this group, turn to answers to find out what type of hormonal imbalance you may have

SYMPTOM GROUP 2

- ☐ Vaginal dryness
- ☐ Painful intercourse
- ☐ Bladder infections
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Memory problems
- ☐ Lethargic depression

Total boxes checked ☐

If you have checked two or more boxes in this group, turn to answers to find out what type of hormonal imbalance you may have.

SYMPTOM GROUP 3

- ☐ Rapid weight gain
- ☐ Mood swings
- ☐ Anxious, depression
- ☐ Red flush on face
- ☐ Weepiness (crying)
- ☐ Cervical dysplasia (abnormal pap smear)
- ☐ Breast tenderness
- ☐ Heavy bleeding
- ☐ Migraine headaches
- ☐ Foggy thinking
- ☐ Gallbladder problems

Total boxes checked ☐

If you have checked two or more boxes in this group, turn to answers to find out what type of hormonal imbalance you may have.

SYMPTOM GROUP 4

A combination of the symptoms in #1 and #3

Total boxes checked ☐

SYMPTOM GROUP 5

- ☐ Acne
- ☐ Excessive facial and arm hair
- ☐ Thinning hair on head
- ☐ Ovarian cysts
- ☐ Polycystic ovary syndrome (PCOS)
- ☐ Hypoglycemia and/or unstable blood sugar
- ☐ Infertility problems
- ☐ Mid-cycle pain

Total boxes checked ☐

If you have checked two or more boxes in this group, turn to answers to find out what type of hormonal imbalance you may have.

SYMPTOM GROUP 6

- ☐ Debilitating fatigue
- ☐ Foggy thinking
- ☐ Thin and/or dry skin
- ☐ Brown spots on face
- ☐ Unstable blood sugar
- ☐ Low blood pressure
- ☐ Intolerance to exercise

Total boxes checked ☐

If you have checked two or more boxes in this group, turn to answers to find out what type of hormonal imbalance you may have.

ANSWERS TO HORMONE TEST

1. SYMPTOM GROUP 1

Progesterone deficiency: This is the most common hormone imbalance among women of all ages. You may need to change your diet, ask your doctor about getting off of synthetic hormones and you may need to use some progesterone cream.

2. SYMPTOM GROUP 2

Estrogen deficiency: This hormone imbalance is most common in menopausal women; especially if you are petite and/or slim. You may need to make some special changes to your diet; take some women's herbs; and some women may even need natural estrogen.

3. SYMPTOM GROUP 3

Excess estrogen: In women, this is most often solved by getting off of the conventional hormones (with your primary care physician's approval) most often prescribed by doctors for menopausal women.

4. SYMPTOM GROUP 4

Estrogen dominance: This is caused when you don't have enough progesterone to balance the effects of estrogen. Thus, you can have low estrogen, but if you have even lower progesterone you may experience symptoms of estrogen dominance. Many women between the ages of 40 and 50 suffer from estrogen dominance.

5. SYMPTOM GROUP 5

Excess androgens (male hormones): This is most often caused by too much sugar and simple carbohydrates in the diet and is often found in women who have polycystic ovary syndrome (PCOS)

6. SYMPTOM GROUP 6

Cortisol deficiency: this is caused by tired adrenals, which is usually caused by chronic stress or chronic inflammation.

Our Recommending Adrenal Function Test: BH #205 – Functional Adrenal Stress Profile plus V

This profile is used to evaluate the adrenal glands and hormone balance. In the event of adrenal exhaustion and imbalances in the reported hormones, underlying causes must be determined through additional lab testing and investigation into environmental and lifestyle factors; while also supporting the endocrine system with therapies and lifestyle modifications.

Reference Material
Salivary Hormone Study References

Chronic Stress Response Chart (PDF)
Comparison of Specimens for Hormone Testing (PDF)
Steroidal Hormone Principle Pathways (PDF)
HPA-HPT Axes (PDF)
Major Pathways of Steroid Hormone Synthesis (PDF)
Physiological Aspects of Cortisol and DHEA (PDF)

When the body is under chronic stress, pregnenolone, the precursor to all other steroidal hormones, is diverted to produce cortisol (known as pregnenelone steal or cortisol escape – see Steroidal Hormone Principle Pathways).

This is to the detriment of all other steroidal hormones (such as DHEA and its metabolites, including progesterone, testosterone, and the estrogens). As pregnenolone is diverted to cortisol, DHEA depletion begins. The result is an elevated cortisol to DHEA ratio.

A normal ratio is approximately 5:1 to 6:1.
Profile #205 includes additional hormones for a more complete view into the impacts of chronic stress on the individual's core body systems. A vast amount of information can be gathered through this profile.

Part 11 SECTION A:

1. Painful fingers ___________ 0 1 2 3
2. Bones sore/painful 0 1 2 3
3. Eat red meat 0 1 2 3
4. Cavities 0 1 2 3
5. Arthritis 0 1 2 3
6. Drink carbonated beverages/soda_________cans per week Yes
7. Gum disease 0 1 2 3
8. Bone loss 0 1 2 3
9. Calcium deposits 0 1 2 3
10. Use antacids 0 1 2 3
11. Dentures 0 1 2 3
12. Bone deformity 0 1 2 3
13. Have you been diagnosed with osteoporosis or other bone Diseases. 0 1 2 3
14. Recent bone fracture or break 0 1 2 3
15. Postmenopausal 0 1 2 3

Part 11 SECTION B: ___________

1. Muscle spasms 0 1 2 3
2. Tightness in shoulder muscles 0 1 2 3
3. Muscle cramps 0 1 2 3
4. Pain in arms, hands 0 1 2 3
5. Leg cramps at night 0 1 2 3
6. Stiff all over 0 1 2 3
7. Stiff in the morning 0 1 2 3
8. Unable to sit up straight 0 1 2 3
9. Pain in neck and or shoulders 0 1 2 3
10. Back pain 0 1 2 3

Part 11 SECTION C ___________

1. Over flexible joints (double jointed) 0 1 2 3
2. Back pain 0 1 2 3
3. Swollen knees 0 1 2 3
4. Athletic injury 0 1 2 3
5. Bursitis 0 1 2 3
6. Tendonitis 0 1 2 3
7. Joint pain 0 1 2 3
8. Slipped disc No Yes (5)
9. Herniated disc No Yes (10)
10. Loss in height No Yes
11. Injure easily No Yes

Health Appraisal Questionnaire

Part 12

Item	Rating
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	0 1 2 3
13. Incoordination	0 1 2 3
14. Nervousness	0 1 2 3
15. Accident prone	0 1 2 3
16. Loss of muscle tone	0 1 2 3
17. Need for 10-12 hours of sleep	0 1 2 3
18. Have had shingles	0 1 2 3

Part 13 ___________

Item	Rating
1. Nightmares	0 1 2 3
2. Can't fall asleep	0 1 2 3
3. Intense dreams	0 1 2 3
4. Leg cramps/restless legs	0 1 2 3
5. Restless, uneasy sleeper	0 1 2 3
6. Wake frequently through night	No Yes
7. Wake up in the middle of night, can't fall back to sleep	No Yes
8. Sleep walk	No Yes

Part 13B (Sleep Apnea)

Sleep apnea is a common disorder. Experts say it affects about eighteen million Americans. People with sleep apnea stop breathing for brief periods while they sleep. They may awaken for a few seconds as they struggle to breathe. The next day, the sleeper may not remember what happened. Signs of the disorder include sleepiness during the day and restless sleep. Some people make rough sounds while they sleep. More men have sleep apnea than women do. It is also common in older adults and in persons who are heavy.

Circle the numbers of the comments that apply to you.

1. I have been told that I snore.
2. I sometimes suffer from daytime sleepiness.
3. I have dozed off in church on occasion.
4. If I doze off, I sometimes wake up with a "snort."
5. I have been told that I hold my breath or stop breathing in my sleep.
6. I have high blood pressure.
7. I toss and turn a lot in my sleep.
8. I get up to visit the bathroom more than once a night.
9. I often feel sleepy and struggle to stay alert, especially during the afternoon
10. I sometimes fall asleep while watching TV.
11. I have fallen asleep at a stop light or stop sign.
12. I have actually fallen asleep while driving.
13. I wish I had more energy and less fatigue.
14. My neck measures over 17 inches (males) or over 16 inches (females)
15. I am more than 15 pounds overweight.
16. I seem to be losing my sex drive, or my ability to perform in bed.
17. I sometimes get heartburn in the middle of the night.
18. I frequently wake with a bad taste in my mouth, or a dry mouth and throat.
19. I often get morning headaches.
20. When I cannot wake up from a nightmare, I feel paralyzed and I panic.

21. I suddenly wake up gasping for breath.

22. I sometimes wake up with a pounding or irregular heartbeat.

23. I frequently feel depressed.

24. I feel as if I'm getting old too fast.

25. My friends and family say I'm sometimes grumpy and irritable.

26. I have short term memory problems.

27. I don't feel rested or refreshed, even after 8 or 10 hours of sleep.

28. I sometimes perspire a lot, especially at night.

29. I'm tired all the time.

30. I have great difficulty concentrating.

If you circled 5 or more symptoms, you could have OSA (obstructive sleep apnea). The risks of OSA include heart attacks, strokes, impotence, irregular heartbeat, high blood pressure and heart disease.

Take this form to your doctor. Treatments are available to eliminate sleep apnea and snoring without surgery or drugs, but you must visit a sleep center or clinic to be tested.

Part 14 (Acid/base imbalance)

1. Fatigue	0 1 2 3
2. Cold hands and feet	0 1 2 3
3. Headaches	0 1 2 3
4. Allergies	0 1 2 3
5. Acne	0 1 2 3
6. Bloating	0 1 2 3
7. Rapid breathing	0 1 2 3
8. Irritability	0 1 2 3
9. Candida or fungal infections	0 1 2 3
10. Depression and anxiety	0 1 2 3
11. Cold sores	0 1 2 3
12. Urinary tract infections	0 1 2 3
13. Arthritis	0 1 2 3
14. Excess stress	0 1 2 3
15. Difficult weight loss	0 1 2 3
16. Constipation	0 1 2 3
17. Rheumatic conditions	0 1 2 3
18. Insomnia	0 1 2 3
19. Gastric and stomach problems	0 1 2 3
20. Water retention	0 1 2 3

1-5 low 6-9 moderate 10-15 high

Part 15 DENTAL RECORD & METAL ALLERGIES

This extensive Q&A gives us a preliminary indication of whether you may suffer with a metal allergy.

1. YOUR DENTAL RECORD

Dental restorations are the most common cause of metal allergy; the more intimate exposure to metals such as mercury and gold, the greater the chance of becoming sensitized. **NOTE: If you don't know the answer to a specific question, place a question mark.**

1.1 CURRENT DENTAL FILLINGS (if you're not sure, please ignore)

Dental Material	Year of placement:	Number of fillings:
Amalgam		
Gold		
Titanium		
Composites		
Metal-bound ceramic		
Cobalt-crown		
Non-metallic ceramic		

1.2 ROOT FILLINGS

Amalgam ______

Gutta Percha ______

Calcium hydroxide ______

Other ______

TULSA NATURAL HEALTH CLINIC

CitiPlex Towers

2448 E 81st. St., Ste. 5125

Tulsa, OK 74137

918-551-6600