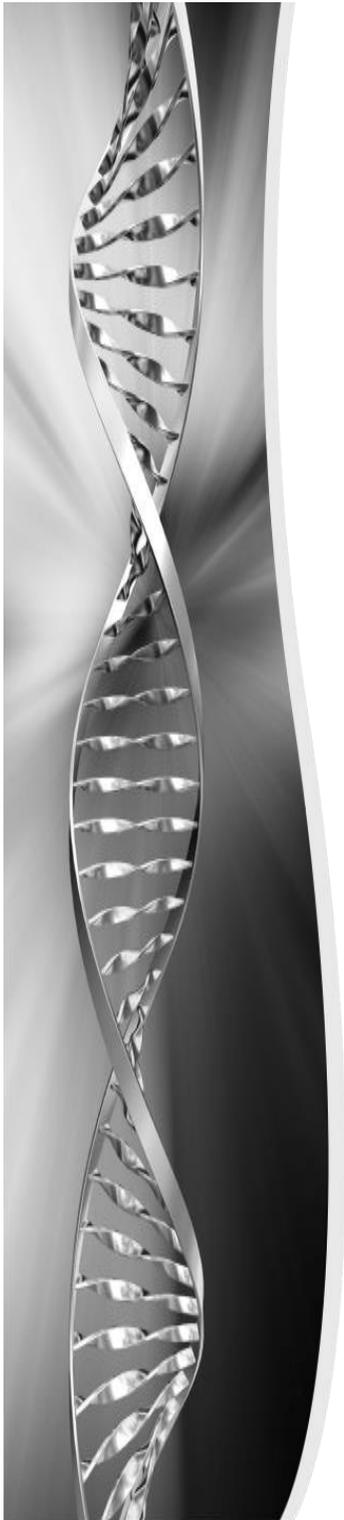




TNHC – Health Appraisal Questionnaire
2448 E 81st. St. Ste. 5125
Tulsa, OK 74137





CONNECTING SCIENCE, EVIDENCE AND CLINICAL INSIGHT

PLEASE NOTE:

If you score 7 or greater on Part 4B and 4C, complete the Part 16 HAQ Autoimmune addendum at the end of this questionnaire.

If you score 7 or greater on Part 4, complete the Part 17 Expanded Adrenal Questionnaire at the end of this questionnaire.

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, NSAID etc.

• High blood pressure medication

• Laxatives

• Tranquilizers/Sleep medication

• Chemotherapy

• Antibiotic/Antifungal

• Aspirin/Tylenol/other

• Lithium

• Recreational drugs

• Stomach medication/Ulcer

• Oral Contraceptive/Patch

• Thyroid (Synthroid, Armour, Naturthroid, other)

• 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. Frequent 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. Abdominal bloating 0 1 2 3
- 5. Frequent constipation 0 1 2 3
- 6. Poor appetite 0 1 2 3
- 7. Food allergies/sensitivities/intolerance (lactose) 0 1 2 3

Section C _____

- 1. Stomach pains 0 1 2 3
- 2. Stomach pains immediately after/or before meals 0 1 2 3
- 3. Dependency on antacids 0 1 2 3
- 4. Chronic stomach pain 0 1 2 3
- 5. Butterfly sensations in stomach 0 1 2 3
- 6. Difficulty belching 0 1 2 3
- 7. Stomach hurts when emotionally upset or stressed 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. Feel tired after eating a meal 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. Eating high fiber foods 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. Bad smelling stool 0 1 2 3
- 13. Dry flaky skin and /or dry brittle hair 0 1 2 3
- 14. Pain under left rib cage 0 1 2 3
- 15. Acne 0 1 2 3
- 16. Food allergies/sensitivities/intolerance (lactose) 0 1 2 3
- 17. Cannot gain weight 0 1 2 3

- 8. Sudden, acute indigestion 0 1 2 3
- 9. Stomach pain relieved by drinking cream or milk 0 1 2 3
- 10. History of ulcers or gastritis 0 1 2 3
- 11. Currently have an ulcer or gastritis 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/or kidney infections 0 1 2 3
- 5. Abdominal cramps 0 1 2 3
- 6. Toe and/or 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. Vision is getting worse 0 1 2 3

Part 3**SECTION A:** _____

1. Greasy food makes me sick or bloated	0 1 2 3	5. Don't like cold weather, sensitive to the cold	0 1 2 3
2. Get headaches after eating	0 1 2 3	6. Cold hands or feet	0 1 2 3
3. Light colored stool	0 1 2 3	7. Excessive menstrual bleeding	0 1 2 3
4. Have less than one bowel movement daily	0 1 2 3	8. Chronic fatigue	0 1 2 3
5. Constipation	0 1 2 3	9. Experience difficulty waking in the morning	0 1 2 3
6. Have hard stool	0 1 2 3	10. Fell depressed or apathetic	0 1 2 3
7. Bad smelling stool	0 1 2 3	11. Low or decreased sex drive	0 1 2 3
8. Sour taste in mouth	0 1 2 3	12. Puffy, wrinkly skin	0 1 2 3
9. Gray colored skin	0 1 2 3	13. Eating sugar causes irritability or mood swings	0 1 2 3
10. Yellow in whites of eyes	0 1 2 3	14. PMS	0 1 2 3
11. Bad breath	0 1 2 3	15. Constipation	0 1 2 3
12. Body odor or smelly feet	0 1 2 3	16. Thinning or loss of outside portion of eyebrow	0 1 2 3
13. Get tired or sleepy after meals	0 1 2 3	17. Gain weight easily	0 1 2 3
14. Pain in right side under rib cage	0 1 2 3	18. Anemia unaffected by taking iron	0 1 2 3
15. Experience pain and/or strain when passing stool	0 1 2 3	19. Axillary (underarm temp below 97.6 for 7-10 days)	0 1 2 3
16. Experience fluid retention	0 1 2 3	20. Slow reflexes	0 1 2 3
17. Occasional pain in big toe	0 1 2 3	21. Infertility	0 1 2 3
18. Have pain that radiates along outside of leg (s)	0 1 2 3	Part 4 SECTION A: _____	
19. Dry skin/hair	0 1 2 3	1. Sensitive to exhaust fumes, smoke, smog, petrochemicals	0 1 2 3
20. Bright red or dark blood in stool	No Yes (10)	2. Periodic constipation	0 1 2 3
21. Have had jaundice or hepatitis (A-B-C)	No Yes	3. Cannot tolerate much exercise/makes you very tired	0 1 2 3
22. High cholesterol-elevated LDL	No Unknown Yes (10)	4. Depression or rapid mood swings	0 1 2 3
23. Elevated triglycerides	No Unknown Yes (10)	5. Dark circles under the eyes	0 1 2 3

Part 3 SECTION B: _____

1. Swollen bulging eyes	0 1 2 3	6. Experience dizziness when standing quickly	0 1 2 3
2. Strong smelling urine	0 1 2 3	7. Get colds easily with weather changes	0 1 2 3
3. Thick skin and or finger nails	0 1 2 3	8. Headaches	0 1 2 3
4. Dry skin	0 1 2 3	9. Exercise makes you feel worse	0 1 2 3

6 Health Appraisal Questionnaire

Part 4 SECTION A continued

9. Difficulty breathing	0 1 2 3	8. Chronic pain	0 1 2 3
10. Fluid retention	0 1 2 3	9. Painful stomach or intestines	0 1 2 3
11. Eyes are sensitive to the sun/ bright lights/need sunglasses	0 1 2 3	10. Alternating constipation and diarrhea	0 1 2 3
12. Occasionally feel weak or shaky	0 1 2 3	11. Mucous in nose or throat	0 1 2 3

SECTION B: _____

1. Inflamed or bleeding gums, esp after brushing teeth	0 1 2 3	12. Post nasal drip	0 1 2 3
2. Runny nose	0 1 2 3	13. Discharge from eyes	0 1 2 3
3. Get boils or styes	0 1 2 3	14. Watery eyes	0 1 2 3
4. Nose bleeds	0 1 2 3	15. Puffiness or dark circles under the eyes	0 1 2 3
5. Throat infections	0 1 2 3	16. Ears discharge or ears stuffed up	0 1 2 3
6. Cold sores, fever blisters	0 1 2 3	17. Nasal congestion	0 1 2 3
7. Loss of smell	0 1 2 3	18. Runny nose	0 1 2 3
8. Loss of taste	0 1 2 3	19. Breathe through mouth	0 1 2 3
9. Wounds, cuts heal slowly	0 1 2 3	20. Wheezing	0 1 2 3
10. Hair falls out and/or thinning	0 1 2 3	21. Difficulty swallowing	0 1 2 3
11. Swollen lymph glands	0 1 2 3	22. Sneezing	0 1 2 3
12. Ear infections	0 1 2 3	23. Hyperactivity	0 1 2 3
13. Hair grows slowly	0 1 2 3	24. Chronic lung congestion	0 1 2 3
14. Takes long time to get over flu or colds	0 1 2 3	25. Use aspirin, Tylenol, ibuprofen regularly	0 1 2 3
15. Catch colds or flu easily	0 1 2 3	26. Skin rashes	0 1 2 3

SECTION C: _____

1. Nose and eyes frequently itch	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 and/or painful 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

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

7 Health Appraisal Questionnaire

Part 5 SECTION A continued

8. Swelling of feet and ankles	0 1 2 3	6. Irritable if a meal is missed	0 1 2 3
9. Rapid beating heart	0 1 2 3	7. Wake up in middle of night craving sweets	0 1 2 3
10. Heartburn after eating	0 1 2 3	8. Feel tired or weak if a meal is missed	0 1 2 3
11. Pain in left arm	0 1 2 3	9. Heart palpitations after eating sweets or high carb foods	0 1 2 3
12. Experience fatigue with minor exertion	0 1 2 3	10. Need to drink coffee or tea to get started	0 1 2 3
13. Drink more than 5 cups of coffee daily	Yes No	11. Impatient, moody or nervous	0 1 2 3
14. Have been diagnosed with heart problems	Yes No	12. Feel tired 1 to 3 hours after eating	0 1 2 3

Part 5 SECTION B _____

1. Cold hands and feet	0 1 2 3	13. Poor memory	0 1 2 3
2. Slurred speech	0 1 2 3	14. Feel faint	0 1 2 3
3. Calf muscles cramp while walking	0 1 2 3	15. Experience difficulty concentrating	0 1 2 3
4. Headaches	0 1 2 3	16. Forgetful	0 1 2 3
5. Numbness in extremities	0 1 2 3	17. Feel calmer/better after eating a meal	0 1 2 3

Part 6 SECTION B: _____

7. Ringing in ears	0 1 2 3	1. Night sweats	0 1 2 3
8. Hair in ear canal	0 1 2 3	2. Lowered resistance to infection/get sick easy	0 1 2 3
9. Tingling or burning in hands or feet	0 1 2 3	3. Increased thirst	0 1 2 3
10. Spider vein on nose and or face	0 1 2 3	4. Fatigue	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	5. Boils and leg sores	0 1 2 3
2. Dizziness	0 1 2 3	6. Sores and cuts take a long time to heal	0 1 2 3
3. Blushing with no apparent cause	0 1 2 3	7. Overweight	0 1 2 3
4. High blood pressure	0 1 2 3	8. Feel better after exercise	0 1 2 3

Part 6 SECTION A: _____

1. Experience dizziness when standing quickly	0 1 2 3	9. Vision getting weaker	0 1 2 3
2. Loss of vision when standing quickly	0 1 2 3	10. Crave sweets, but eating sweets does not relieve symptoms	0 1 2 3
3. Crave sweets	0 1 2 3	11. Family history of diabetes	0 1 2 3
4. Headaches relieved by eating sweets or consuming alcohol	0 1 2 3	12. Sugar in urine	0 1 2 3
5. Feel shaky or jittery	0 1 2 3	13. Skin tags on neck or other body parts	0 1 2 3

8 Health Appraisal Questionnaire

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/or radiation No Yes (6)
14. Smoker or ex-smoker No Yes (6)

Part 8 _____

1. Urinate frequently 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 frequently 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. Decreased/low 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. Infertile 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.

11 Health Appraisal Questionnaire

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 pregnenolone 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

Part 12

- 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 _____

- 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	_____

PART 16

AUTOIMMUNE QUESTIONNAIRE ADDENDUM

Place check mark in the box associated with your symptoms

AUTOIMMUNE: *This is a partial checklist of frequently noticed symptoms that are common to autoimmune issues*

Fever/Body Temperature

- Recurrent fever, high body temperature (3)
- Night sweats (1)

Hair

- Alopecia (loss of hair on the front and top of head) (1)
- Loss of hair in outer eyebrow (4)

Skin

- Hyperpigmentation, or dark tanning in skin (3)
- Easy bruising (1)
- Skin rashes of unknown cause (4)
- Extra sensitive to the sun (2)
- Skin ulcers on fingers or toes (2)

Eyes

- Dry eyes, little tear production (2)
- Eye discomfort or pain (1)

Throat/Neck/Voice/Mouth

- Dry mouth (1)
- Hoarseness, husky, gravelly voice (1)
- Difficulty swallowing (1)
- Mouth and nose sores (1)

Fatigue and Sleep

- Lack of energy (1)
- Exhausted after minimal effort or exercise (1)

Muscles/Joints/Tendons

- Pain and tenderness throughout the body (3)
- Loss of muscle control (4)
- Muscle weakness (1)
- Joint stiffness ((1)
- Bone, joint, and muscle aches, inflammation and pain (4)
- Backaches, unexplained rib & spinal column fractures (1)
- Carpal tunnel syndrome/tendonitis (1)

Hands and Feet

- Raynaud's phenomenon (extreme sensitivity to cold in the hands or feet) (4)
- Swelling in hands and feet (1)

Digestion/Gastrointestinal

- Recurring abdominal bloating and pain (1)
- Pale, foul-smelling stool (1)
- Constipation (1)

Mood and Thinking

- Irritability, anxiety, and depression (1)
- Brain Fog, difficulty concentrating, forgetfulness (1)

Balance, Coordination and Neurological Symptoms

- Dizziness (1)
- Vertigo (room spins) (2)
- Loss of balance (4)

Blood Changes

- Unexplained anemia (3)
- Elevated cholesterol levels (1)

Part 17: EXPANDED ADRENAL SYMPTOMS QUESTIONNAIRE

The answers to the questions help determine whether the adrenal glands are likely implicated as a factor in a person's health concerns. The results of the questionnaire will create a picture of how the adrenal glands are functioning in terms of their response to stress. This questionnaire will aid me in determining your adrenal status.

SEVERITY of SYMPTOMS RANKING

This questionnaire is easy to complete. Simply read each statement, decide its degree of severity, and then place the appropriate number beside each statement based on the severity ranking below.

Please rank your symptom according to the categories below and enter a number from 0-3 for each question.

0=Never

1=Occasionally (1-4 times per month)

2=Moderate in severity and occurs moderately in frequency (1-4 times per week)

3=Intense in severity and occurs frequently (more than 4 times per week)

KEY SIGNS AND SYMPTOMS

1. () I get dizzy or see spots when standing up quickly from a sitting or lying position.
2. () I urinate more frequently than others and have to get up frequently at night to urinate.
3. () I feel as though I might faint or black out.
4. () I have chronic fatigue
5. () I have mitral valve prolapse and/or get heart palpitations
6. () I often have to force myself to keep going.
7. () It is difficult getting up in the morning despite adequate sleep.
8. () I experience low energy before the noon meal (11:00 a.m.)
9. () I have low energy late afternoon (3:00 – 5:00 p.m.)
10. () I usually feel better after 6 p.m.
11. () I often feel the best late at night because I get a 'second wind.'
12. () I have trouble getting to sleep.
13. () I tend to wake during early morning (3:00 - 5:00a.m.) and have difficulty getting back to sleep.
14. () I experience feelings of being unwell for no apparent reason

15. () I experience edema (swelling) in my extremities, such as ankles.
16. () I require rest after experiencing mental, physical or emotional stress.
17. () I experience more fatigue after physical exertion/exercise either soon after or the next day.
18. () My muscles feel weak and heavy more than I think they should.
19. () I have chronic tenderness in my back near the bottom of my rib cage.
20. () I have a weak back and/or weak knees.
21. () I have restless extremities/legs.
22. () I am allergic to many things, such as food, animals, molds-pollens, perfumes.
23. () My allergies are getting worse.
24. () I have bags and/or dark circles under my eyes – worse in the morning.
25. () I have multiple chemical sensitivities.
26. () I have asthma or get regular bouts of bronchitis, pneumonia, or other upper respiratory infections.
27. () I have dermatographism (a white line appears on my skin if I run my fingernail over it and lasts for one minute).
28. () I have an area of pale skin around my lips.
29. () The skin on the palms of my hands and soles of my feet tends to be red/orange in color.
30. () I tend to have dry skin.
31. () I tend to get headaches and a sore neck.
32. () I am sensitive to bright lights and/or have to wear sunglasses.
33. () I frequently feel colder than others around me.
34. () I have a decreased tolerance for cold.
35. () I have Raynaud's syndrome (extremely cold hands/feet).
36. () My temperature tends to be below normal when measured with a thermometer.
37. () My temperature tends to fluctuate through the day.
38. () I have low blood pressure.
39. () I become hungry, confused, or shaky if I miss a meal.

40. () I crave sugar, sweets, or desserts.
41. () I have to use stimulants such as tea or coffee to get started in the morning.
42. () I crave high fat foods. High fat foods make me feel better.
43. () I need caffeine to get me through the day.
44. () I often crave salt and/or salty foods such as potato chips.
45. () I feel worse if I eat carbs and no protein for breakfast.
46. () I tend to skip meals.
47. () I eat fast food often.
48. () I am sensitive to pharmaceutical or nutritional supplements.
49. () I have taken steroid medications for a long term or at high doses.
50. () Some of my symptoms improve after I eat.
51. () I have feelings of hopelessness and despair or have been diagnosed with depression.
52. () I lack motivation because I do not feel I have the energy to get things done.
53. () I have decreased tolerance towards other people and tend to get irritated by them.
54. () I get more than 2 colds or flues per year.
55. () It takes me a long time to recover from illness.
56. () I get rashes, dermatitis, eczema, psoriasis, or other chronic skin conditions.
57. () I have one or more autoimmune diseases.
58. () I have been diagnosed with fibromyalgia.
59. () I have had Mono or have been diagnosed with EBV.
60. () I do not exercise regularly.
61. () I have a history of excess/chronic stress in my life.
62. () I tend to be a perfectionist.
63. () My health is negatively affected by stress.
64. () I tend to avoid stressful situations for the sake of my health.

65. () I am less productive at work than I used to be.
66. () My ability to focus mentally is generally impaired.
67. () Stressful situations hinder my ability to focus.
68. () Stress causes me to become overly anxious.
69. () I startle easily.
70. () It can take me days or weeks to recover from a stressful event.
71. () I tend to get digestive disturbances when tense.
72. () I tend to get unexplained fears and phobias.
73. () My sex drive is very low or non-existent.
74. () My relationships at work and/or home tend to be strained.
75. () My life contains insufficient time for fun and enjoyable activities.
76. () I have little control over my life and I feel "stuck."
77. () I tend to get addicted easily to drugs, alcohol or food.
78. () I suffer from post-traumatic stress disorder.
79. () I have or have had an eating disorder.
80. () I have gum disease and/or tooth infections or abscesses.

Questions 81 & 82 for women only

81. () I have PMS symptoms.
82. () My periods are irregular and/or affected by stress.

_____ **Total Score**

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Additional Notes of Comments, write below: