Sacramento Naturopathic Medical Center

Dear New Patient;

We congratulate you on making the decision to start or continue your journey revitalizing your health, and we thank you for having confidence in Sacramento Naturopathic Medical Center in serving your health care needs. We feel honored and privileged to serve you, and we will do everything possible to help you on that journey!

To help Dr. Godby to use your time and financial resources, as effectively and efficiently as possible, it is essential that you complete all the enclosed paperwork, prior to your first appointment, and bring it with you on the day of your appointment It would be wise to allow at least l.5 hours for filling out the attached intake forms, so that you don't have to rush through. Answering the symptoms on the "Health Appraisal Questionnaire, " as accurately as possible, is extremely important in providing important clues for helping Dr. Godby to find the cause(s) of your dis-ease/dysfunction! You can also mail your intake forms back to us so that Dr. Godby can review it before your appointment, however, please do not fax the intake forms prior to the appointment!

The first appointment will last about 75 minutes. It would be extremely beneficial to bring: copies of your most recent laboratory exams, a list of your current medications and nutritional supplements (if any). If you have no recent lab results, labs are available through our Center very inexpensively - about 5 times less than the going rate. We look forward to serving you and optimizing your health! As with almost anything in life, the more that you commit to the program, the greater results you can expect.

Because at Sacramento Naturopathic Medical Center we believe that building a partnership between practitioner and patient and effective communication are critical to health and healing, we encourage you to e-mail (DrGodby@SacND.com), or call Dr. Godby, or Wilma, the office manager at **916-446-2591**, if you need clarification of the treatment program. Because your message is so important to us, we will respond to your phone/email message, ASAP - usually the same day.

To your health and happiness,
Sacramento Naturopathic Medical Center

New Patient Packet

For patients under 18 years old - please fill out pages 1-9.

CONTEXT OF CARE OVERVIEW

Thank you for choosing Sacramento Naturopathic Medical Center as your health care provider. Whether you were referred by another practitioner for a one-time visit, or are looking for a longer-term comprehensive health solution, we look forward to our role in your care. Below are a few questions that really assist us in understanding "where you're coming from" and how we can best support your health.

1) How did you discover our clinic and how did you decide to see us now?

2) A. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle?(Please rate from 0 to 10, with 10 being 100% committed)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

B. If you answered less than "10", what stands between your current commitment and 100%?

3) A. What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)

B. What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (Please list)

4) What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

5) What are your top three expectations of us?

6) A. What are the best ways to communicate with you? (Please circle)

Email Voicemail Home Work Fax Other

B. Is there any place you would rather we don't try to reach/leave you a message?

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NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices

This Notice explains how our office may use and disclose your protected health information and your rights regarding how we protect your health information. "Protected Health Information, " including demographics, can be reasonably used to identify you, relates to your past, present or future physical or mental health condition, the provision of care to you, or the payment for that care. We reserve the right to change the terms of this Notice and our privacy policy at any time. Any changes will apply to all protected health information that we maintain effective the date of a new Notice. New Notices will be posted at Sacramento Naturopathic Medical Center and you may obtain one at any time. This notice goes into effect April 14, 2005.

Uses and Disclosures

We may use and disclose your health information for different reasons. **Treatment:** To assist in your diagnosis and treatment **Payment:** In order to bill and collect payment for services provided. For example, to claims processing companies, others that participate in the claims payment process, and your health insurance plan to get reimbursed for services. **Health Care Operations:** For activities necessary such as quality management, utilization review, antifraud and claims payment, provider credentialing activities, and as required by industry or government regulators such as state licensing boards, insurance regulatory agencies, and the sponsor of your health plan.

Our office may not use or disclose any more of your protected health information than is necessary to accomplish the purpose of the use or disclosure, except for treatment purposes.

We must disclose, when required by law, for the following examples:

- Avoid threat to health or safety. To law enforcement personnel or persons able to prevent or lessen a serious threat to public safety.
- Coroners, Funeral Directors, Organ Donation. To said professionals such that they can carry out their duties.
- Health oversight activities. To assist the government agencies, such as when it conducts an investigation or inspection of a health care organization.
- Health-related benefits or services. For appointment reminders or give you information about treatment alternatives or services that may be of interest to you.
- Law Enforcement, judicial and administrative proceedings. In response to a subpoena, discovery request, in response to a warrant, to identify or locate a suspect, to provide information about a victim of a crime, or other lawful process.
- National security and intelligence. As required by military officials for security and military purposes.
- Public health activities. To public health agencies for reasons such as preventing or controlling disease, injury or disability.
- Research. For medical research- Such circumstances include taking steps to protect your privacy.
- Victims of abuse, neglect or domestic violence. To government agencies and law enforcement personnel as required by law.
- Workers' compensation. In compliance with workers' compensation laws.

Authorization

Any uses or disclosures other than those described above will be made only with your prior written authorization, unless otherwise permitted or required by law. In the event that you authorize us to use your protected health information for other uses, you have the right to revoke any authorization by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage.

Patient Rights

Right to request restrictions on uses and disclosures: To request a restriction, please write a request to Sacramento Naturopathic Medical Center. Upon receiving your request, we will put the limits and terms in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.

Right to receive confidential communications: This includes the right to direct where communications are sent. For example, you may request that information be sent to our work address rather than your home address or via Email than by regular mail. To verify or modify where or how you would like communication sent, contact Sacramento Naturopathic Medical Center. Unless requested otherwise, we will direct mailings and telephone messages to the address/telephone number we have on record.

Right to inspect and copy: Includes the right to see and get copies of your information that we maintain. Submit your request in writing to Sacramento Naturopathic Medical Center and we will respond to you within 30 days of receipt of your written request. We will charge you a reasonable copying fee for each page and mailing costs but will inform you of that fee in advance.

Right to amend: If you believe there is a mistake or missing information, you have the right to request that we correct or add to your file. You must provide the request in writing to Sacramento Naturopathic Medical Center. We will respond within 60 days of receipt of your written request. We may deny your request in writing if your information is 1) correct and complete, 2) not created by us, 3) not allowed to be disclosed, 4) not part of our records. Upon approval, we will make the changes, inform you when the changes are complete, and inform others that need to know about the changes in a timely manner. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. You also have the right to request that copies of your initial request and our denial to be attached to all future disclosures of your information.

Right to receive an accounting of disclosures: This will not include uses or disclosures made for treatment, payment or health care operations, disclosures made directly to you, those you have already authorized, those made for national security reasons or to law enforcement that has lawful custody over you. We will respond within 60 days of receiving written request. Please include the time period for which you want the accounting (can be no longer than 6 years and may not include dates before April 14, 2003). The accounting will include the date of the disclosure, to whom information was sent, a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting at no charge. For additional accountings, we may charge you a fee but will inform you of that fee in advance.

Right to get a paper copy of this Notice: At any time even if you previously agreed to receive an electronic copy. Right to file a complaint: If you believe your health information has been improperly used or disclosed, or that your privacy rights have been violated, you may file a privacy complaint with us. Contact Sacramento Naturopathic Medical Center. You also have the right to file a complaint with the Secretary of the US Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint.

I acknowledge having carefully read this copy of the Notice of Privacy Practices:

Patient Name (Please Print) _____

Patient/GuardianSignature_____Date _____

Relationship to Patient (if other than self): _____

Note: If this acknowledgement is being signed by a legal representative, you must provide a copy of the power of attorney or other relevant document (s) designating you as the legal representative.

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INFORMED CONSENT

YOUR RIGHT TO MEDICAL PRIVACY Initials:_____ Date:_____

The privacy of your medical information is important to us. We understand that your medical records are personal, and we are committed to protecting them. Be confident that, while we create a record of the services you receive at our office in order to provide you with quality care, we are required by law to protect the privacy of your medical information.

INFORMED CONSENT

The purpose of this form is to present benefits and risks of the therapies offered in the Center. Please initial before treatment is rendered. Ask Dr. Dennis Godby about any questions or concerns at any time.

Naturopathic Medicine Initials:_____ Date:_____

Naturopathy combines safe and effective traditional therapies with the most current advances in modern medicine by attempting to find the underlying cause rather that focusing on symptomatic treatment. Dr. Godby treats a variety of conditions including hormone imbalance, diabetes, stress, pain, organ dysfunction, infections, and many more. There is risk of pharmaceutical/supplement interaction, so inform Dr. Godby of current medications. He may suggest hydrotherapy, which encourages circulation, enhanced immune function and relaxation. Side effects are minimal, but may include, dizziness, fatigue, detoxification reactions and irritated skin.

Supplements, Herbals, Homeopathic Initials:_____ Date:_____

There are products that can aid in healing by nutritional, energetic, and mechanical support. They can be effective for many conditions. Be sure to inform Dr. Godby about all medications you currently take to minimize drug/supplement interactions. Some side effects may be gas, bloating, and less commonly allergic reaction.

Referrals Initials:_____ Date:_____

Further lab work (X-rays, MRI, Blood work, Urine analysis, etc.) may be necessary. When co-management or referral is indicated, a prompt referral to another specialist for evaluation or alternative therapy will be suggested. The following are examples: medical management, physical therapy, vestibular testing, psychological evaluation, injection therapy, surgery, naturopathic, chiropractic, acupuncture, massage, etc.

Please inform Dr. Godby of any changes such as pregnancy, symptoms, medications and diagnoses by other doctors as soon as possible.

I have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments initialed above.

Patient Name (Please print): _____

Signature (Patient or Guardian if minor) _____ Date_____

CONFIDENTIAL PERSONAL INFORMATION

Full Legal Name:_____/ _____/ _____
(Last Name) (First Name) (Middle Initial)

Preferred Name:_____ Age:_____ Date of Birth:_____

Telephone #: ( )_____/ ( )_____/ ( )_____
(Home) (Cell) (Work)

E-mail address: _____

Address: _____City _____State_____ Zip _____

Gender: female _____male_____

Live with: Alone_____ Spouse_____ Partner_____ Family_____ Housemate_____Other____

Occupation: _____(circle) Full time Part time Student Retired

Employer/School: _____

Emergency Contact: _____
(Name) (Relationship)

( )_____( )_____
(Day Phone) (Evening Phone)

Do you have a family member/friend who is a patient of this center?____Name?_____

How did you hear about this center? _____

May we contact you regarding health-related events at SNMC? ❑ Yes ❑ No

FINANCIAL POLICIES

We are fully committed to providing you with excellent and affordable health care and with the very best service humanly possible. We will not rest until we do so. The following financial policy is designed to help us continue doing so.

- **Charges are to be paid at the time of the visit unless arrangements have been made PRIOR to the visit.**
- **If you miss an appointment or cancel less than 24 hours, you will be billed for half of the consultation fee for each occurrence.**

As the patient, you are responsible for the total charges incurred for each visit. We accept cash, checks, Visa, Master and American Express cards. There will be a charge of $25 for a returned check. I have read and understand the above-stated policies and I agree to these conditions. I sign below to also agree that in order to ensure the highest quality of health care, SacND physicians may discuss my case with other practitioners.

Signature (Patient or Guardian if minor) _____ Date_____

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Allergies, Prescription Medicine, and Nutritional Supplement Intake Form

To better assess your needs and philosophy toward nutritional supplements, please briefly answer the following questions.

Name:_____

Are you currently taking ANY prescription medicine? Yes_____ No_____
Are you currently taking ANY nutritional supplements (including multivitamins)? Yes_____ No_____

If yes, please list all supplements you are currently taking:

Prescription Medicines	Conditions/ Reasons
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Nutritional Supplements	Conditions/ Reasons
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Are the supplements you are now taking recommended by a health professional? Yes_____ No_____

Do you have any allergies? (Food, medication, or environmental) Yes_____ No_____

If yes, please list all current allergies:

Allergies	Reaction/ Symptoms
1.	
2.	
3.	
4.	

Signature (Patient or Guardian if minor) _____ Date_____

HEALTH HISTORY

Name_____ Date of birth _____ Date _____

Address_____ City _____ State _____ Zip Code _____

Phone _____ E-mail _____

Occupation_____ Age _____ Height_____ Sex____ Number of Children_____

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: Date began:

_____ _____

_____ _____

_____ _____

Date of last physical exam _____ Practitioner name and phone number _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

Outcome _____

What types of therapy have you tried for this problem(s):

☐ diet modification ☐ fasting ☐ vitamins/minerals ☐ herbs ☐ homeopathy ☐ chiropractic ☐ acupuncture ☐ conventional drugs

☐ other _____

List current health problems for which you are being treated:_____

_____

_____

Current medications (prescription or over-the-counter):_____

_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ☐ underweight ☐ overweight ☐ just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)?

_____

☐ Corrective lenses ☐ Dentures ☐ Hearing aid ☐ Medical devices/prosthetics/implants, describe: _____

Recent changes in your ability to: ☐ see ☐ hear ☐ taste ☐ smell ☐ feel hot/cold sensations

☐ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Strong dislike for any one of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Do you: ☐ Prefer warmth (i.e., food, drinks, weather, etc.) ☐ Prefer cold (i.e., food, drinks, weather, etc.) ☐ No preference

Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

Time of day you feel the worst or your symptoms are aggravated:

☐ 7 a.m. - 9 a.m.	☐ 9 a.m. - 11 a.m.	☐ 11 a.m. - 1 p.m.
☐ 1 p.m. - 3 p.m.	☐ 3 p.m. - 5 p.m.	☐ 5 p.m. - 7 p.m.
☐ 7 p.m. - 9 p.m.	☐ 9 p.m. - 11 p.m.	☐ 11 p.m. - 1 a.m.
☐ 1 a.m. - 3 a.m.	☐ 3 a.m. - 5 a.m.	☐ 5 a.m. - 7 a.m.

Time of day you feel the most energy or the least symptoms are aggravated

☐ 7 a.m. - 9 a.m.	☐ 9 a.m. - 11 a.m.	☐ 11 a.m. - 1 p.m.
☐ 1 p.m. - 3 p.m.	☐ 3 p.m. - 5 p.m.	☐ 5 p.m. - 7 p.m.
☐ 7 p.m. - 9 p.m.	☐ 9 p.m. - 11 p.m.	☐ 11 p.m. - 1 a.m.
☐ 1 a.m. - 3 a.m.	☐ 3 a.m. - 5 a.m.	☐ 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

☐ Debilitating fatigue	☐ Shortness of breath	☐ Insomnia	☐ Constipation	☐ Chronic pain/inflammation
☐ Depression	☐ Panic attacks	☐ Nausea	☐ Fecal incontinence	☐ Bleeding
☐ Disinterest in sex	☐ Headaches	☐ Vomiting	☐ Urinary incontinence	☐ Discharge
☐ Disinterest in eating	☐ Dizziness	☐ Diarrhea	☐ Low grade fever	☐ Itching/rash

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Medical History

☐ Arthritis
☐ Allergies/hay fever
☐ Asthma
☐ Alcoholism
☐ Alzheimer's disease
☐ Autoimmune disease
☐ Blood pressure problems
☐ Bronchitis
☐ Cancer
☐ Chronic fatigue syndrome
☐ Carpal tunnel syndrome
☐ Cholesterol, elevated
☐ Circulatory problems
☐ Colitis
☐ Dental problems
☐ Depression
☐ Diabetes
☐ Diverticular disease
☐ Drug addiction
☐ Eating disorder
☐ Epilepsy
☐ Emphysema
☐ Eyes, ears, nose, throat problems
☐ Environmental sensitivities
☐ Fibromyalgia
☐ Food intolerance
☐ Gastroesophageal reflux disease
☐ Genetic disorder
☐ Glaucoma
☐ Gout
☐ Heart disease
☐ Infection, chronic
☐ Inflammatory bowel disease
☐ Irritable bowel syndrome
☐ Kidney or bladder disease
☐ Learning disabilities
☐ Liver or gallbladder disease (stones)
☐ Mental illness
☐ Mental retardation
☐ Migraine headaches
☐ Neurological problems (Parkinson's, paralysis)
☐ Sinus problems
☐ Stroke
☐ Thyroid trouble
☐ Obesity
☐ Osteoporosis
☐ Pneumonia
☐ Sexually transmitted disease
☐ Seasonal affective disorder
☐ Skin problems
☐ Tuberculosis
☐ Ulcer
☐ Urinary tract infection
☐ Varicose veins
Other _____
_____

Medical (Men)

☐ Benign prostatic hyperplasia (BPH)
☐ Prostate cancer
☐ Decreased sex drive
☐ Infertility
☐ Sexually transmitted disease
Other _____
_____

Medical (Women)

☐ Menstrual irregularities
☐ Endometriosis
☐ Infertility
☐ Fibrocystic breasts
☐ Fibroids/ovarian cysts
☐ Premenstrual syndrome (PMS)
☐ Breast cancer
☐ Pelvic inflammatory disease
☐ Vaginal infections
☐ Decreased sex drive
☐ Sexually transmitted disease
Other _____
Age of first period _____
Date of last gynecological exam _____
Mammogram ☐ + ☐ –
PAP ☐ + ☐ –
Form of birth control _____
# of children _____
# of pregnancies _____
☐ C-section _____
☐ Surgical menopause
☐ Menopause
Date - last menstrual cycle _____
Length of cycle _____ days
Interval of time between cycles _____ days
Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)

Family Health History (Parents and Siblings)

☐ Arthritis
☐ Asthma
☐ Alcoholism
☐ Alzheimer's disease
☐ Cancer
☐ Depression
☐ Diabetes
☐ Drug addiction
☐ Eating disorder
☐ Genetic disorder
☐ Glaucoma
☐ Heart disease
☐ Infertility
☐ Learning disabilities
☐ Mental illness
☐ Mental retardation
☐ Migraine headaches
☐ Neurological disorders (Parkinson's, paralysis)
☐ Obesity
☐ Osteoporosis
☐ Stroke
☐ Suicide
Other _____

Health Habits

☐ Tobacco:
Cigarettes: #/day _____
Cigars: #/day _____
☐ Alcohol:
Wine: #glasses/d or wk _____
Liquor: #ounces/d or wk _____
Beer: #glasses/d or wk _____
☐ Caffeine:
Coffee: #6 oz cups/d _____
Tea: #6 oz cups/d _____
Soda w/caffeine: #cans/d _____
Other sources _____
☐ Water: #glasses/d _____

Exercise

☐ 5-7 days per week
☐ 3-4 days per week
☐ 1-2 days per week
☐ 45 minutes or more duration per workout
☐ 30-45 minutes duration per workout
☐ Less than 30 minutes
☐ Walk
☐ Run, jog, jump rope
☐ Weight lift
☐ Swim
☐ Box
☐ Yoga

Nutrition & Diet

☐ Mixed food diet (animal and vegetable sources)
☐ Vegetarian
☐ Vegan
☐ Salt restriction
☐ Fat restriction
☐ Starch/carbohydrate restriction
☐ The Zone Diet
☐ Total calorie restriction
Specific food restrictions:
☐ dairy ☐ wheat ☐ eggs
☐ soy ☐ corn ☐ all gluten
Other _____

Food Frequency

Number of servings per day:
Fruits (citrus, melons, etc.) _____
Dark green or deep yellow/orange vegetables _____
Grains (unprocessed) _____
Beans, peas, legumes _____
Dairy, eggs _____
Meat, poultry, fish _____

Eating Habits

☐ Skip breakfast
☐ Two meals/day
☐ One meal/day
☐ Graze (small frequent meals)
☐ Food rotation
☐ Eat constantly whether hungry or not
☐ Generally eat on the run
☐ Add salt to food

Current Supplements

☐ Multivitamin/mineral
☐ Vitamin C
☐ Vitamin E
☐ EPA/DHA
☐ Evening Primrose/GLA
☐ Calcium, source _____
☐ Magnesium
☐ Zinc
☐ Minerals, describe _____
☐ Friendly flora (acidophilus)
☐ Digestive enzymes
☐ Amino acids
☐ CoQ10
☐ Antioxidants (e.g., lutein, resveratrol, etc.)
☐ Herbs - teas
☐ Herbs - extracts
☐ Chinese herbs
☐ Ayurvedic herbs
☐ Homeopathy
☐ Bach flowers
☐ Protein shakes
☐ Superfoods (e.g., bee pollen, phytonutrient blends)
☐ Liquid meals
Other _____

Would you like to:

☐ Have more energy
☐ Be stronger
☐ Have more endurance
☐ Increase your sex drive
☐ Be thinner
☐ Be more muscular
☐ Improve your complexion
☐ Have stronger nails
☐ Have healthier hair
☐ Be less moody
☐ Be less depressed
☐ Be less indecisive
☐ Feel more motivated
☐ Be more organized
☐ Think more clearly and be more focused
☐ Improve memory
☐ Do better on tests in school
☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
☐ Stop using laxatives or stool softeners
☐ Be free of pain
☐ Sleep better
☐ Have agreeable breath
☐ Have agreeable body odor
☐ Have stronger teeth
☐ Get less colds and flus
☐ Get rid of your allergies
☐ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

HEALTH APPRAISAL QUESTIONNAIRE

Name _____ **Date** _____

DIRECTIONS

This questionnaire asks you to assess how you have been feeling **during the last four months**. This information will help you keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

For each question, circle the number that best describes your symptoms:

0 = No or Rarely—You have never experienced the symptom or the symptom is familiar to you but you perceive it as insignificant (monthly or less)

1 = Occasionally—Symptom comes and goes and is linked in your mind to stress, diet, fatigue or some identifiable trigger

4 = Often—Symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it

8 = Frequently—Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis

Some questions require a YES or NO response: 0 = NO 8 = YES

PART I

	No/Rarely	Occasionally	Often	Frequently
SECTION A				
1. Indigestion, food repeats on you after you eat	0	1	4	8
2. Excessive burping, belching and/or bloating following meals	0	1	4	8
3. Stomach spasms and cramping during or after eating	0	1	4	8
4. A sensation that food just sits in your stomach creating uncomfortable fullness, pressure and bloating during or after a meal	0	1	4	8
5. Bad taste in your mouth	0	1	4	8
6. Small amounts of food fill you up immediately	0	1	4	8
7. Skip meals or eat erratically because you have no appetite	0	1	4	8
Total points				
SECTION B				
1. Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt	0	1	4	8
2. Feel hungry an hour or two after eating a good-sized meal	0	1	4	8
3. Stomach pain, burning and/or aching over a period of 1-4 hours after eating	0	1	4	8
4. Stomach pain, burning and/or aching relieved by eating food; drinking carbonated beverages, cream or milk; or taking antacids	0	1	4	8
5. Burning sensation in the lower part of your chest, especially when lying down or bending forward	0	1	4	8
6. Digestive problems that subside with rest and relaxation	(0)No			(8)Yes
7. Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache	0	1	4	8
8. Feel a sense of nausea when you eat	0	1	4	8
9. Difficulty or pain when swallowing food or beverage	0	1	4	8
Total points				
SECTION C				
1. When massaging under your rib cage *on your left side*, there is pain, tenderness or soreness	0	1	4	8
2. Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal	0	1	4	8
3. Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement	0	1	4	8
4. Specific foods/beverages aggravate indigestion	0	1	4	8
5. The consistency or form of your stool changes (e.g., from narrow to loose) within the course of a day	0	1	4	8

	No/Rarely	Occasionally	Often	Frequently
SECTION C *(cont.)*				
6. Stool odor is embarrassing	0	1	4	8
7. Undigested food in your stool	0	1	4	8
8. Three or more large bowel movements daily	0	1	4	8
9. Diarrhea (frequent loose, watery stool)	0	1	4	8
10. Bowel movement shortly after eating (within 1 hour)	0	1	4	8
Total points				
SECTION D				
1. Discomfort, pain or cramps in your colon (lower abdominal area)	0	1	4	8
2. Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas	0	1	4	8
3. Generally constipated (or straining during bowel movements)	0	1	4	8
4. Stool is small, hard and dry	0	1	4	8
5. Pass mucus in your stool	0	1	4	8
6. Alternate between constipation and diarrhea	0	1	4	8
7. Rectal pain, itching or cramping	0	1	4	8
8. No urge to have a bowel movement	(0)No			(8)Yes
9. An almost continual need to have a bowel movement	(0)No			(8)Yes
Total points				

PART II

1. When massaging under your rib cage *on your right side*, there is pain, tenderness or soreness	0	1	4	8
2. Abdominal pain worsens with deep breathing	0	1	4	8
3. Pain at night that may move to your back or right shoulder	0	1	4	8
4. Bitter fluid repeats after eating	0	1	4	8
5. Feel abdominal discomfort or nausea when eating rich, fatty or fried foods	0	1	4	8
6. Throbbing temples and/or dull pain in forehead associated with overeating	0	1	4	8
7. Unexplained itchy skin that's worse at night	0	1	4	8
8. Stool color alternates from clay colored to normal brown	0	1	4	8
9. General feeling of poor health	0	1	4	8

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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

	No/Rarely	Occasionally	Often	Frequently

SECTION A

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

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 (cont.)

	No/Rarely	Occasionally	Often	Frequently
SECTION B				
1. Muscle pain at rest	0	1	4	8
2. Cramp-like pains in your ankles, calves or legs	0	1	4	8
3. Numbness, tingling and prickling sensation in hands and feet	0	1	4	8
4. Cold feet and/or toes appear blue	0	1	4	8
5. Brief moments of hearing loss	0	1	4	8
6. Nausea comes and goes quickly (unrelated to eating)	0	1	4	8
7. Feel worse standing: legs get heavy and fatigued	0	1	4	8
8. Leg discomfort or fatigue relieved by elevating legs	0	1	4	8
9. Fingers and toes get numb in cold weather even when protected	0	1	4	8
10. Notice changes in your ability to feel pain or differentiate between sensations of hot or cold	(0)No			(8)Yes
11. Body hair (on arms, hands, fingers, legs and toes) is thinning or has disappeared	(0)No			(8)Yes
12. Do you notice a decline in your ability to make decisions, concentrate, focus attention or follow directions?	(0)No			(8)Yes
Total points				

PART VI

	No/Rarely	Occasionally	Often	Frequently
SECTION A				
1. Family, friends, work, hobbies or activities you hold dear are no longer of interest	0	1	4	8
2. Do you cry?	0	1	4	8
3. Does life look entirely hopeless?	0	1	4	8
4. Would you describe yourself as feeling miserable and sad, unhappy or blue?	0	1	4	8
5. Do you find it hard to make the best of difficult situations?	0	1	4	8
6. Sleep problems—too much or too little sleep	0	1	4	8
7. Changes in your appetite and weight	(0)No			(8)Yes
8. Lately you've noticed an inability to think clearly or concentrate	(0)No			(8)Yes
9. Difficulty making decisions and/or clarifying and achieving your goals	(0)No			(8)Yes
Total points				
SECTION B				
1. Does worrying get you down?	0	1	4	8
2. Does every little thing get on your nerves and wear you out?	0	1	4	8
3. Would you consider yourself a nervous person?	0	1	4	8
4. Do you feel easily agitated?	0	1	4	8
5. Do you shake and tremble?	0	1	4	8
6. Are you keyed up and jittery?	0	1	4	8
7. Do you tremble or feel weak when someone shouts at you?	0	1	4	8
8. Do you become scared at sudden movements or noises at night?	0	1	4	8
9. Do you find yourself sighing a lot?	0	1	4	8
10. Are you awakened out of your sleep by frightening dreams?	0	1	4	8
11. Do frightening thoughts keep coming back in your mind?	0	1	4	8

	No/Rarely	Occasionally	Often	Frequently
SECTION B *(cont.)*				
12. Do you become suddenly scared for no reason?	0	1	4	8
13. Do you break out in a cold sweat?	0	1	4	8
14. "Butterflies in your stomach," nausea and/or diarrhea	0	1	4	8
Total points				
SECTION C				
1. Do you feel pent up and ready to explode?	0	1	4	8
2. Are you prone to noisy and emotional outbursts?	0	1	4	8
3. Do you do things on impulse?	0	1	4	8
4. Are you easily upset or irritated?	0	1	4	8
5. Do you go to pieces if you don't control yourself?	0	1	4	8
6. Do little annoyances get on your nerves and make you angry?	0	1	4	8
7. Does it make you angry to have anyone tell you what to do?	0	1	4	8
8. Do you flare up in anger if you can't have what you want right away?	0	1	4	8
Total points				

PART VII

1. Eyes water or tear	0	1	4	8
2. Mucus discharge from the eyes	0	1	4	8
3. Ears ache, itch, feel congested or sore	0	1	4	8
4. Discharge from ears	0	1	4	8
5. Is your nose continually congested?	0	1	4	8
6. Are you prone to loud snoring?	(0)No			(8)Yes
7. Does your nose run?	0	1	4	8
8. Nosebleeds	(0)No			(8)Yes
9. Hoarse voice	0	1	4	8
10. Do you have to clear your throat?	0	1	4	8
11. Do you feel a choking lump in your throat?	0	1	4	8
12. Do you suffer from severe colds?	(0)No			(8)Yes
13. Do frequent colds keep you miserable all winter?	(0)No			(8)Yes
14. Flu symptoms last longer than 5 days	(0)No			(8)Yes
15. Do infections settle in your lungs?	(0)No			(8)Yes
16. Chest discomfort or pain	0	1	4	8
17. Do you experience sudden breathing difficulties?	0	1	4	8
18. Do you struggle with shortness of breath?	0	1	4	8
19. Difficulty exhaling (breathing out)	0	1	4	8
20. Breathlessness followed by coughing during exertion, no matter how slight	0	1	4	8
21. Inability to breathe comfortably while lying down	0	1	4	8
22. Do you cough up lots of phlegm?	0	1	4	8
23. Can you hear noisy rattling sounds when breathing in and out?	0	1	4	8
24. Are you troubled with coughing?	0	1	4	8
25. Do you wheeze?	0	1	4	8
26. Do you have severe soaking sweats at night?	0	1	4	8
27. Do your lips and/or nails have a bluish hue?	0	1	4	8
28. Are you sleepy during the day?	0	1	4	8

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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

	No/Rarely	Occasionally	Often	Frequently
SECTION B *(cont.)*				
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.)

	No/Rarely	Occasionally	Often	Frequently
SECTION A *(cont.)*				
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)

	No/Rarely	Occasionally	Often	Frequently
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
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				

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PART XII (cont.)

	No/Rarely	Occasionally	Often	Frequently
SECTION D				
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

	No/Rarely	Occasionally	Often	Frequently
SECTION E *(cont.)*				
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 fogginess, 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				

Please mark an "X" to indicate areas where you feel pain, swelling or discomfort, or areas of your skin that have changed color or texture (e.g., moles, rashes, etc.). Describe what you feel or observe in your own words. Write anywhere in this area.