SYMPTOM - QUESTIONNAIRE

NAME: ______________________________ DATE: ______________

Your answers to this health appraisal questionnaire will assist your Practitioner in gaining information about your current symptoms and health concerns. Please answer all questions, in each section.

Circle the number which best describes the frequency of your symptoms over the previous **month**, or answer the **yes** or **no** questions by circling the appropriate letter.

You may note that some questions are repeated throughout the questionnaire. We would appreciate it if you can answer **all** questions, as this will ensure the most accurate interpretation of your results. You may however leave a question blank if you are unsure of the answer.

SECTION 1: GASTROINTESTINAL

Section 1.1 Stomach: Hypoacidity

	Never	Occasionally	Moderately / Often	Frequently / Daily
1. Indigestion	0	1	2	3
2. Excessive belching, burping	0	1	2	3
3. Bloating or fullness commencing during or shortly after a meal	0	1	2	3
4. Sensation of food sitting in stomach for a prolonged period after a meal	0	1	2	3
5. Bad breath	0	1	2	3
6. Loss of appetite, or nausea	0	1	2	3
7. History of anaemia	N			Y (3)

TOTAL:______

Section 1.2 Stomach: Hyperacidity

	Never	Occasionally	Moderately / Often	Frequently / Daily
1. Stomach pain, burning or aching, 1-4 hours after eating	0	1	2	3
2. Feeling hungry just an hour or two after eating	0	1	2	3
3. Indigestion or heartburn from spicy or fatty food, citrus, alcohol, or caffeine	0	1	2	3
4. Stomach discomfort or pain in response to strong emotions, thoughts, or smell of food	0	1	2	3
5. Heartburn aggravated by lying down or bending forward	0	1	2	3
6. Antacids, carbonated beverages, milk, cream or food relieve the above symptoms	0	1	2	3
7. Constipation	0	1	2	3
8. Difficulty or pain when swallowing	**0**	**2**	**4**	**6**
9. Black tarry stools	**0**	**4**	**8**	**10**
10. Vomiting blood or vomitus has appearance of coffee-grounds	**0**	**4**	**8**	**10**

TOTAL:______

Section 1.3 Small Intestine/Pancreas

	Never	Occasionally	Moderately / Often	Frequently / Daily
1. Indigestion, bloating and fullness for several hours after eating	0	1	2	3
2. Abdominal cramps or aches	0	1	2	3
3. Nausea and/or vomiting	0	1	2	3
4. Excessive passage of gas	0	1	2	3
5. Diarrhoea (loose, watery or frequent bowel movements)	0	1	2	3
6. Constipation (requiring straining, or a hard, dry or small stool)	0	1	2	3
7. Alternating constipation and diarrhoea	0	1	2	3
8. Undigested food in stools	0	1	2	3
9. Stools greasy, smelly or stick to toilet bowl	0	1	2	3
10. Black tarry stools	**0**	**4**	**8**	**10**
11. Certain foods worsen abdominal symptoms	N			Y (3)
12. Dry flaky skin and dry brittle hair	N			Y (3)
13. Difficulty gaining weight	N			Y (3)

TOTAL:______

Section 1.4 Colon

	Never	Occasionally	Moderately / Often	Frequently / Daily
1. Lower abdominal pain, cramping and/or spasms	0	1	2	3
2. Lower abdominal pain relieved by passing gas or stool	0	1	2	3
3. Excessive gas and bloating	0	1	2	3
4. Certain foods or stress aggravate lower abdominal pain	0	1	2	3
5. Diarrhoea (loose, watery or frequent bowel movements)	0	1	2	3
6. Constipation (requiring straining, or a hard, dry or small stool)	0	1	2	3
7. Alternating diarrhoea and constipation	0	1	2	3
8. Sensation of incomplete emptying of bowel	**0**	**2**	**4**	**6**
9. Extremely narrow stools	**0**	**2**	**4**	**10**
10. Mucus or pus in stool	**0**	**2**	**4**	**6**
11. Red blood with bowel movement	**0**	**2**	**8**	**10**
12. Rectal pain or cramps	0	1	2	3
13. Anal itching	0	1	2	3

TOTAL:______

Section 1.5 Liver/Gall Bladder/Pancreas

	Never	Occasionally	Moderately / Often	Frequently / Daily
1. Upper abdominal pain, or pain under ribs	0	1	2	3
2. Bloating or feeling of fullness after eating	0	1	2	3
3. Excessive belching or gas	0	1	2	3
4. Fatty foods cause indigestion or nausea	0	1	2	3
5. Loss of appetite	0	1	2	3
6. Nausea and/or vomiting	0	1	2	3
7. Unexplained itchy skin	0	1	2	3
8. Yellowish discolouration of skin or eyes, or dark coloured urine	**N**			**Y (8)**
9. Pale clay-coloured stools	**0**	**2**	**4**	**8**
10. Fatigue, malaise or weakness	0	1	2	3
11. Fluid retention, oedema	0	1	2	3
12. Easy bruising, or bleeding (e.g. of gums)	0	1	2	3
13. Loss or thinning of body hair	N			Y (3)
14. Red skin, particularly on palms	N			Y (3)
15. Dry, flaky skin, or dry hair	N			Y (3)

TOTAL:______

SECTION 2: ENDOCRINE

Section 2.1 Symptoms of underactive thyroid

	Never	Occasionally	Moderately / Often	Frequently / Daily
1. Fatigue, sluggishness	0	1	2	3
2. Feeling cold, or intolerance to cold	0	1	2	3
3. Swelling or tightness in front of neck	N			Y (8)
4. Constipation (requiring straining, or a hard, dry or small stool)	0	1	2	3
5. Dry skin and hair	N			Y (3)

pin & tonic
Acupuncture and Natural Medicine

Section 2.1 Symptoms of underactive thyroid (continued)

	Never	Occasionally	Moderately / Often	Frequently / Daily
6. Puffy face, hands or feet	0	1	2	3
7. Gaining of weight, or decreased appetite	N			Y (3)
8. Low mood	0	1	2	3
9. Difficulty concentrating, poor memory	0	1	2	3
10. Low libido	0	1	2	3
11. Infertility	N			Y (3)
12. Heavier or more frequent menstrual periods	N			Y (3)

TOTAL:______

Section 2.2 Symptoms of overactive thyroid

	Never	Occasionally	Moderately / Often	Frequently / Daily
1. Fatigue, notable weakness in limbs	0	1	2	3
2. Feeling hot, or intolerance to heat, sweaty	0	1	2	3
3. Swelling or tightness in front of neck	N			Y (8)
4. Diarrhoea (loose, watery or frequent bowel movements)	0	1	2	3
5. Weight loss, possibly with increased appetite	N			Y (3)
6. Palpitations	0	1	2	3
7. Nervousness, irritability, restlessness	0	1	2	3
8. Tremor	0	1	2	3
9. Insomnia	0	1	2	3
10. Visual disturbance, problems with eyes, or development of staring gaze	0	2	4	6
11. Poor libido	0	1	2	3
12. Light, infrequent or absent menstrual periods	N			Y (3)

TOTAL:______

Section 2.3 Stress, fatigue and adrenals

	Never	Occasionally	Moderately / Often	Frequently / Daily
1. Feeling stressed, nervous, or tense, or unable to relax	0	1	2	3
2. Feeling irritable or oversensitive	0	1	2	3
3. Feeling overwhelmed, unable to cope	0	1	2	3
4. Low mood, mood swings	0	1	2	3
5. Difficulty concentrating or thinking clearly, memory problems	0	1	2	3
6. Need coffee, tea, tobacco, sugar or chocolate as pick me ups	0	1	2	3
7. Fatigued, tire easily	0	1	2	3
8. Find it hard to get up and going in the morning	0	1	2	3
9. Difficulty staying awake during day	0	1	2	3
10. Insomnia	0	1	2	3
11. Palpitations or chest pain	0	1	2	3
12. Nausea, dizziness	0	1	2	3
13. Change in appetite	0	1	2	3

TOTAL:______

SECTION 3: IMMUNE

Section 3.1 Low immunity

	Never	Occasionally	Moderately / Often	Frequently / Daily
1. Frequent colds or 'flu	N			Y (3)
2. Frequent infections in other locations (e.g. bladder, skin)	0			3
3. Diarrhoea (loose, watery or frequent bowel movements)	0	1	2	3
4. Ears continuously drain	0	1	2	3
5. Nasal congestion or discharge	0	1	2	3
6. Sore throat	0	1	2	3
7. Cough with mucus	0	1	2	3
8. Cold sores	0	1	2	3
9. Inflamed or bleeding gums, or swollen, red lips or tongue	0	1	2	3
10. Wounds heal slowly	N			Y (3)
11. Excessive loss of hair	N			Y (3)
12. Neck, armpit or groin swelling	0	1	2	6

TOTAL:______

Section 3.2 Allergy

	Never	Occasionally	Moderately / Often	Frequently / Daily
1. Migraine or non-migraine headache	0	1	2	3
2. Sensitivity to light (skin or eyes)	0	1	2	3
3. Dark circles under eyes	0	1	2	3
4. Swollen eyes, lips, face, or other body parts	0	1	2	3
5. Localised or general itching – eyes, ears, throat, nose, skin	0	1	2	3
6. Rashes or eczema	0	1	2	3
7. Clear watery discharge from nose or eyes	0	1	2	3
8. Sneezing, coughing or wheezing	0	1	2	3
9. Irritability, fatigue	0	1	2	3
10. Certain foods worsen symptoms, or cause palpitations	N			Y (3)

TOTAL:______

SECTION 4: DETOXIFICATION (capacity)

As far as you are aware, do you have a sensitivity or allergy to …

	None	Mild	Moderate	Severe
1. The preservatives sodium benzoate or potassium benzoate	0	1	2	3
2. Tyramine (red wine, cheese, bananas, chocolate)	0	1	2	3
3. Caffeine	0	1	2	3
4. Chemicals such as fragrances, exhaust fumes, cigarette smoke or other strong odours	0	1	2	3
5. Even small amounts of alcohol	0	1	2	3
6. Do you have a history of exposure to chemicals such as herbicides, insecticides, pesticides or organic solvents?	N			Y (3)
7. Alcohol (number of drinks per week)	0	1-7 (1)	8-14 (2)	15+ (3)
8. Coffee or other caffeinated drinks (number per day)	0	1-2 (1)	3-4 (2)	5+ (3)
9. Smoking (number per day)?	0	1-8 (3)	9-19 (3)	20+ (6)
10. Type__________________________				
11. If not currently smoking, have you quit smoking in the last year?	N			Y (2)
12. Recreational drugs?	N			Y (3)
13. Type__________________________				
14. What is your blood type? ______________________________				

TOTAL:______

SECTION 5: GENERAL HEALTH HISTORY

1. Frequency of exercise (days per week)	6-7 (0)	3-5 (1)	1-2 (2)	0 (3)
2. Vegetarian or vegan	N			Y (2)
3. Age >50 years	N			Y (3)
4. Planning to have a baby in the next 3-6 months	N			Y (3)
5. Pregnant or breastfeeding	N			Y (3)

TOTAL:______

Other Comments:____
____
____
____
____
____