

# NAQ

Name:

Date:

Gender:

Date of Birth:

## TOP 5 HEALTH CONCERNS

1:

2:

3:

4:

5:

**Directions:** Please read the following questions and circle the number that applies. Unless otherwise noted, use the default scale shown at the top of each section or page. Trust your instincts and choose quickly without overthinking.

## Part 1

### DIET

Section Subtotal / 58

0:   Never Consume	1:   Consume 1-2x/month	2:   Consume Weekly	3:   Consume Daily
1. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Alcohol		11. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Processed Lunch Meats	
2. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Artificial Sweeteners		12. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Margarine	
3. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Candy, Desserts, Sugar		13. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Milk Products	
4. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Carbonated Beverages		14. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Radiation Exposure (0=No, 1=Yes)	
5. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Chewing Tobacco		15. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Refined Flour & Baked Goods	
6. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Cigarettes		16. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Vitamins & Minerals	
7. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Cigars or Pipes		17. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Distilled Water	
8. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Caffeinated Beverages		18. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Tap Water	
9. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Fast Food		19. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Well Water	
10. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Fried Foods		20. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Restrict Calories for Weight Control	

### LIFESTYLE

Section Subtotal / 12

See each question below for the rating key.

21. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Exercise Sessions Per Week	0 = 2+ times/week; 1 = 1 time/week; 2 = 1-2 times/month; 3 = < 1 time/month
22. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Changed Jobs	0 = over 12 mo. ago; 1 = last 12 mo.; 2 = last 6 mo.; 3 = last 2 mo.
23. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Divorced	0 = never or over 2 years ago; 1 = last 2 years.; 2 = last year; 3 = last 6 mo.
24. <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 Work 60+ Hours Per Week	0 = never; 1 = occasionally; 2 = usually; 3 = always

## MEDICATIONS

Section Subtotal / 27

0: No (Not Taking or Have Not Taken in the Last Month)			1: Yes (Currently Taking or Have Taken in the Last Month)				
25.	<input type="checkbox"/>	<input type="checkbox"/>	Antacids	39.	<input type="checkbox"/>	<input type="checkbox"/>	Diuretics
26.	<input type="checkbox"/>	<input type="checkbox"/>	Antianxiety Medications	40.	<input type="checkbox"/>	<input type="checkbox"/>	Estrogen or Progesterone (Prescript.)
27.	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics	41.	<input type="checkbox"/>	<input type="checkbox"/>	Estrogen or Progesterone (Natural)
28.	<input type="checkbox"/>	<input type="checkbox"/>	Anticonvulsants	42.	<input type="checkbox"/>	<input type="checkbox"/>	Heart Medications
29.	<input type="checkbox"/>	<input type="checkbox"/>	Antidepressants	43.	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure Medications
30.	<input type="checkbox"/>	<input type="checkbox"/>	Antifungals	44.	<input type="checkbox"/>	<input type="checkbox"/>	Laxatives
31.	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin/Ibuprofen	45.	<input type="checkbox"/>	<input type="checkbox"/>	Recreational Drugs
32.	<input type="checkbox"/>	<input type="checkbox"/>	Asthma Inhalers	46.	<input type="checkbox"/>	<input type="checkbox"/>	Relaxants/Sleeping Pills
33.	<input type="checkbox"/>	<input type="checkbox"/>	Beta Blockers	47.	<input type="checkbox"/>	<input type="checkbox"/>	Testosterone (Prescript. or Natural)
34.	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pill/Implant	48.	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Medication
35.	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	49.	<input type="checkbox"/>	<input type="checkbox"/>	Acetaminophen (Tylenol®)
36.	<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol Lowering Medications	50.	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer Medications
37.	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone/Steroids	51.	<input type="checkbox"/>	<input type="checkbox"/>	Sildenafil Citrate (Viagra®)
38.	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic Medications/Insulin				

## Part 2

### SECTION 1

Section Subtotal / 55

0: Never Occurs		1: Minor; Rarely Occurs (1x/month)		2: Moderate; Occasional (Weekly)		3: Severe; Frequent (Daily)				
52.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	62.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel Better if You Don't Eat
53.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	63.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleepy After Meals
54.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	64.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fingernails Chip, Peel or Break Easily
55.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	65.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia Unresponsive to Iron
56.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	66.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Pains or Cramps
57.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	67.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Diarrhea
58.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	68.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea Shortly After Meals
59.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	69.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Black or Tarry Colored Stools
60.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	70.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Undigested Food in Stool
61.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*0 = No    1 = Yes    No animal products (meat, fish, eggs, dairy, etc.)					

0: | Never Occurs    1: | Minor; Rarely Occurs (1x/month)    2: | Moderate; Occasional (Weekly)    3: | Severe; Frequent (Daily)

## SECTION 2

**Section Subtotal / 64**

71.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain Between Shoulder Blades	85.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily Hungover from Wine <sup>1</sup>
72.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Upset by Greasy Foods	86.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholic Beverages Per Week <sup>3</sup>
73.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Greasy or Shiny Stools	87.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recovering Alcoholic <sup>1</sup>
74.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea <sup>1</sup>	88.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Drug Abuse <sup>1</sup>
75.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Motion Sickness (Sea, Car, Airplane)	89.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Hepatitis <sup>1</sup>
76.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Morning Sickness <sup>1</sup>	90.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Long-term Use of Prescript./Rec. Drugs <sup>1</sup>
77.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Light or Clay Colored Stools	91.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to Chemicals (e.g. Perfume, Cleaning Agents, etc.)
78.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Skin, Itchy or Peeling Feet	92.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to Tobacco Smoke
79.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache Over Eyes	93.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to Diesel Fumes
80.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Attacks <sup>2</sup>	94.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain Under Right Side of Rib Cage
81.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Removed <sup>1</sup>	95.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids or Varicose Veins
82.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bitter Taste in Mouth, Especially After Meals	96.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consume NutraSweet® (Aspartame)
83.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Become Sick When Drinking Wine <sup>1</sup>	97.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to Aspartame
84.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily Intoxicated from Wine <sup>1</sup>	98.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue or Fibromyalgia

<sup>1</sup> 0 = No    1 = Yes    <sup>2</sup> 0 = Never    1 = Years Ago    2 = Within Last Year    3 = Within Past 3 Months    <sup>3</sup> 0 = < 3    1 = < 7    2 = < 14    3 = > 14

## SECTION 3

**Section Subtotal / 47**

99.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies	108.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease <sup>2</sup>
100.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Bloating 1-2 Hours After Meal	109.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheat or Grain Sensitivity
101.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specific Foods Make You Tired / Bloating <sup>1</sup>	110.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dairy Sensitivity
102.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pulse Speeds After Eating	111.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are There Any Foods You Can't Give Up? <sup>1</sup>
103.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Airborne Allergies	112.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma, Sinus Infections, Stuffy Nose
104.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Experience Hives	113.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bizarre, Vivid Dreams; Nightmares
105.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion, "Stuffy Head"	114.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use Over-the-Counter Pain Meds
106.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave Bread or Noodles	115.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel Spacey or Unreal
107.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alternating Constipation/Diarrhea						

<sup>1</sup> 0 = No    1 = Yes    <sup>2</sup> 0 = No    1 = Yes in the Past    2 = Currently Mild    3 = Currently Severe

0: Never Occurs    1: Minor; Rarely Occurs (1x/month)    2: Moderate; Occasional (Weekly)    3: Severe; Frequent (Daily)

## SECTION 4

**Section Subtotal / 58**

116.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anus Itches	126.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stools Have Corners/Edges, are Flat, or Ribbon Shaped
117.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coated Tongue	127.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stools are Not Well Formed (Loose)
118.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel Worse in Moldy/Musty Places	128.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel or Mucus Colitis
119.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Total Antibiotic Use <sup>2</sup>	129.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Stool
120.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fungal or Yeast Infections	130.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mucus in Stool
121.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ring Worm, Jock Itch, Athletes Foot, Nail Fungus	131.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive, Foul Smelling Flatulence
122.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yeast Symptoms Increase with Sugar, Starch, or Alcohol Consumption	132.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bad Breath or Strong Body Odors
123.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hard or Difficult to Pass Stool	133.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful to Press Along Outer Thighs (Iliotibial Bands)
124.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Parasites <sup>1</sup>	134.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps in Lower Abdominal Region
125.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Less Than 1 Bowel Movement/Day	135.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dark Circles Under Eyes

<sup>1</sup>0 = No    1 = Yes    <sup>2</sup>0 = Never    1 = Less than 1 Month    2 = Less than 3 Months    3 = More than 3 Months

## SECTION 5

**Section Subtotal / 75**

136.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Carpal Tunnel Syndrome <sup>1</sup>	151.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Morning Stiffness
137.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Lower Right Abdominal Pains or Ileocecal Valve Problems <sup>1</sup>	152.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea with Vomiting
138.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Stress Fracture <sup>1</sup>	153.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave Chocolate
139.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone Loss (Reduced Density on Bone Scan)	154.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feet Have a Strong Odor
140.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are You Shorter Than You Used to Be? <sup>1</sup>	155.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Anemia
141.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Calf, Foot, or Toe Cramps at Rest	156.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Whites of Eyes (Sclera) are Blue Tinted
142.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores, Fever Blisters, or Herpes Lesions	157.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
143.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Fevers	158.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing
144.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Skin Rashes or Hives	159.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lump in Throat
145.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Herniated Disc <sup>1</sup>	160.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth, Eyes, or Nose
146.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessively Flexible Joints / "Double Jointed"	161.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gag Easily
147.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joints Pop or Click	162.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	White Spots on Fingernails
148.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain or Swelling in Joints	163.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cuts Heal Slowly and/or Scar Easily
149.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis or Tendonitis	164.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decreased Sense of Taste or Smell
150.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Bone Spurs <sup>1</sup>						

<sup>1</sup>0 = No    1 = Yes

0: | Never Occurs    1: | Minor; Rarely Occurs (1x/month)    2: | Moderate; Occasional (Weekly)    3: | Severe; Frequent (Daily)

## SECTION 6

**Section Subtotal / 22**

165.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Experience Pain Relief with Aspirin <sup>1</sup>	169.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches When Out in the Hot Sun
166.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave Fatty or Greasy Foods	170.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sunburn Easily or Get "Sun Poisoning"
167.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low-Fat or Reduced-Fat Diet <sup>2</sup>	171.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscles Easily Fatigued
168.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tension Headaches at Base of Skull	172.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry, Flaky Skin or Dandruff

<sup>1</sup>0 = No    1 = Yes    <sup>2</sup>0 = Never    1 = Years Ago    2 = Within Past Year    3 = Currently

## SECTION 7

**Section Subtotal / 39**

173.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Awaken a Few Hours After Falling Asleep & Have Difficulty Falling Back to Sleep	180.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache if Meals are Skipped / Delayed
174.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave Sweets	181.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Before Meals
175.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Binging or Uncontrolled Eating	182.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shaky if Meals are Delayed
176.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Appetite	183.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Members with Diabetes <sup>1</sup>
177.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave Coffee or Sugar in the Afternoon	184.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Thirst
178.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep in the Afternoon	185.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
179.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue that is Relieved by Eating	<sup>1</sup> 0 = None    1 = 1-2 People    2 = 3-4 People    3 = > 4 People					

## SECTION 8

**Section Subtotal / 79**

186.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscles Become Easily Fatigued	200.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can Hear Heartbeat on Pillow at Night
187.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel Exhausted or Sore After Moderate Exercise	201.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Whole Body or Limb Jerk as Falling Asleep
188.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vulnerable to Insect Bites	202.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats
189.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Muscle Tone, Heaviness in Arms/Legs	203.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restless Leg Syndrome
190.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Heart or Congestive Heart Failure	204.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cracks at Corner of Mouth (Cheilosis)
191.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pulse Below 65 Beats Per Minute <sup>1</sup>	205.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fragile, Easily Chaffed Skin (e.g. When Shaving)
192.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ring in the Ears (Tinnitus)	206.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polyps or Warts
193.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness, Tingling, or Itching in Hands & Feet	207.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MSG Sensitivity
194.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depressed	208.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wake Up Without Remembering Dreams
195.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fear of Impending Doom	209.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Small Bumps on Back of Arms
196.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Worrier, Apprehensive, Anxious	210.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strong Light at Night Irritates Eyes
197.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous or Agitated	211.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds and/or Tends to Bruise Easily
198.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feelings of Insecurity	212.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Gums, Especially When Brushing
199.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Races	<sup>1</sup> 0 = No    1 = Yes					

0: | Never Occurs    1: | Minor; Rarely Occurs (1x/month)    2: | Moderate; Occasional (Weekly)    3: | Severe; Frequent (Daily)

## SECTION 9

**Section Subtotal / 78**

213.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tend to be a "Night Person"	226.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritic Tendencies
214.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Falling Asleep	227.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave Salty Foods
215.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow Starter in the Morning	228.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Salt Foods Before Tasting
216.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tend to be "Keyed Up", Trouble Calming Down	229.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perspire Easily
217.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure Above 120/80	230.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue or Get Drowsy Often
218.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache After Exercising	231.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Afternoon Yawning
219.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling Wired or Jittery After Drinking Coffee	232.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Afternoon Headache
220.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clench or Grind Teeth	233.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma, Wheezing, or Difficulty Breathing
221.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Calm on the Outside, Troubled on the Inside	234.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain on the Medial or Inner Side of Knee
222.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Lower Back Pain, Worse with Fatigue	235.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to Sprain Ankles or Get "Shin Splints"
223.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Become Dizzy When Standing Up Quickly	236.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to Need Sunglasses
224.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Maintaining Manipulative Correction	237.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies and/or Hives
225.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain After Manipulative Correction	238.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness, Dizziness

## SECTION 10

**Section Subtotal / 29**

239.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Height Over 6' 6" <sup>1</sup>	246.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decreased Libido
240.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Early Sexual Development <sup>1</sup> (Before Age 10)	247.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
241.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increased Libido	248.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain Around Hips or Waist
242.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Splitting Type Headache	249.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Disorders
243.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory Failing	250.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delayed Sexual Development <sup>1</sup> (After Age 13)
244.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tolerate / Feel Fine When Eating Sugar <sup>1</sup>	251.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to Ulcers or Colitis
245.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Height Under 4' 10" <sup>1</sup>						

<sup>1</sup>0 = No    1 = Yes

0: | Never Occurs    1: | Minor; Rarely Occurs (1x/month)    2: | Moderate; Occasional (Weekly)    3: | Severe; Frequent (Daily)

## SECTION 11

**Section Subtotal / 48**

252.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive/Allergic to Iodine	260.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mentally Sluggish / Reduced Initiative
253.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Gaining Weight (Even With Large Appetite)	261.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily Fatigued / Sleepy During the Day
254.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous or Emotional (Can't Work Under Pressure)	262.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to Cold / Poor Circulation (Cold Hands & Feet)
255.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inward Trembling	263.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Constipation
256.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flush Easily	264.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Hair Loss and/or Course Hair
257.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fast Pulse at Rest	265.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Morning Headaches (Wear Off During the Day)
258.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intolerance to High Temperatures	266.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Lateral (Outside) 1/2 of Eyebrow
259.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Losing Weight	267.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Sadness

## SECTION 12: MEN ONLY

**Section Subtotal / 27**

268.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	273.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interruption of Stream During Urination
269.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with Urination / Dribbling	274.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain on Inside of Legs or Heels
270.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult to Start & Stop Urine Stream	275.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling of Incomplete Bowel Evacuation
271.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain or Burning During Urination	276.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decreased Sexual Function*
272.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Waking to Urinate at Night	* Dysfunction related to prostate issues only.					

## SECTION 13: WOMEN ONLY

**Section Subtotal / 60**

If you are in menopause or no longer menstruating, please indicate the average symptoms that occurred when you were last menstruating.

277.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression During Periods	287.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast Fibroids / Benign Masses
278.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mood Swings Associated with Periods (Premenstrual Syndrome)	288.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Intercourse (Dyspareunia)
279.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave Chocolate Around Periods	289.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge
280.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast Tenderness Associated with Cycle	290.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Dryness
281.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Menstrual Flow	291.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Itchiness
282.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scanty Blood Flow During Periods	292.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gain Weight Around Hips, Thighs & Buttocks
283.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Occasional Skipped Periods	293.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excess Facial or Body Hair
284.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Variations in Menstrual Cycles	294.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes
285.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	295.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats (in Menopausal Women)
286.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Uterine Fibroids	296.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thinning Skin

0: Never Occurs    1: Minor; Rarely Occurs (1x/month)    2: Moderate; Occasional (Weekly)    3: Severe; Frequent (Daily)

## SECTION 14

**Section Subtotal / 30**

297.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aware of Heavy or Irregular Breathing	302.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ankles Swell, Especially at End of Day
298.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Discomfort at High Altitudes	303.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough at Night
299.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	“Air Hunger” or Sigh Frequently	304.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blush / Face Turns Red for No Reason
300.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Compelled to Open Windows in a Closed Room	305.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dull Pain or Tightness in Chest and/or Radiating Into Right Arm (Worse with Exertion)
301.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath with Moderate Exertion	306.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Cramps with Exertion

## SECTION 15

**Section Subtotal / 13**

307.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Mid-Back Region	310.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cloudy, Bloody, or Darkened Urine
308.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Puffy / Dark Circles Around the Eyes	311.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urine Has a Strong Odor
309.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Kidney Stones <sup>1</sup>	<sup>1</sup> 0 = No    1 = Yes					

## SECTION 16

**Section Subtotal / 30**

312.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny or Drippy Nose	317.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Never Get Sick <sup>2</sup>
313.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Catch Colds at the Beginning of Winter	318.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adult Acne
314.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mucus Producing Cough	319.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itchy Skin (Dermatitis)
315.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds of Flu <sup>1</sup>	320.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cysts, Boils, or Rashes
316.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Infections <sup>1</sup> (e.g. Sinus, Ear, Lung, Skin, Bladder, Kidney, etc.)	321.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Chronic Viral Condition <sup>3</sup> (e.g. Mono, Epstein Bar, Herpes, Shingles, Chronic Fatigue Syndrome)

<sup>1</sup> 0 = 1 or Less Per Year    1 = 2 to 3 per Year    2 = 4 to 5 Per Year    3 = 6 or More Per Year

<sup>2</sup> 0 = Sick Only 1 or 2 Times in Last 2 Years    1 = Not Sick in Last 2 Years    2 = Not Sick in Last 4 Years    3 = Not Sick in Last 7 Years

<sup>3</sup> 0 = No    1 = Yes in the Past    2 = Currently Mild Condition    3 = Severe