# Comprehensive Assessment Questionnaire

**Name:** _____ **Date:** _____ **Age:** ___ **Sex:** ___ **Height:** _____ **Weight:** _____

## PART I - Health Priorities

**Please list your 5 major health concerns in order of importance:**

1. _____
2. _____
3. _____
4. _____
5. _____

## PART II - Symptom Survey

**Please mark the appropriate box on all questions below based on your health in the past year.**

| | Never | Sometimes | Always |
|---|---|---|---|
| Feeling that bowels do not empty completely | ☐ | ☐ | ☐ |
| Lower abdominal pain or discomfort following meals | ☐ | ☐ | ☐ |
| Sense of fullness during and after meals | ☐ | ☐ | ☐ |
| Diarrhea, urgent, loose, watery stools | ☐ | ☐ | ☐ |
| More than 3 bowel movements daily | ☐ | ☐ | ☐ |
| Constipation, dry, hard, infrequent stools | ☐ | ☐ | ☐ |
| Use of laxatives | ☐ | ☐ | ☐ |
| Stools are foul smelling | ☐ | ☐ | ☐ |
| Stools are mucous-like, greasy, or poorly formed | ☐ | ☐ | ☐ |
| Undigested foods found in stools | ☐ | ☐ | ☐ |
| Pass large amount of foul-smelling gas | ☐ | ☐ | ☐ |
| Excessive belching, burping, or bloating | ☐ | ☐ | ☐ |
| Heartburn | ☐ | ☐ | ☐ |
| Stomach pain, burning or aching 1-4 hours after eating | ☐ | ☐ | ☐ |
| Use of antacids | ☐ | ☐ | ☐ |
| Pain, tenderness, soreness on left side under rib cage | ☐ | ☐ | ☐ |
| Greasy or high fat foods cause nausea or discomfort | ☐ | ☐ | ☐ |
| Nausea and/or vomiting | ☐ | ☐ | ☐ |
| Certain foods cause sinus congestion, headaches | ☐ | ☐ | ☐ |
| Offensive breath | ☐ | ☐ | ☐ |
| Bitter metallic taste in mouth, especially in morning | ☐ | ☐ | ☐ |
| Asthma or difficulty breathing | ☐ | ☐ | ☐ |
| Frequent colds or recurrent infections | ☐ | ☐ | ☐ |
| Frequent urination | ☐ | ☐ | ☐ |
| Urinary tract infection | ☐ | ☐ | ☐ |
| Increased thirst and appetite | ☐ | ☐ | ☐ |
| Unexplained itchy skin | ☐ | ☐ | ☐ |
| Eczema, psoriasis, recurrent rashes | ☐ | ☐ | ☐ |
| Dry or flaky skin and/or hair | ☐ | ☐ | ☐ |
| Thinning of hair on scalp, face, or genitals | ☐ | ☐ | ☐ |
| Weak nails | ☐ | ☐ | ☐ |
| Outer third of eyebrow thins | ☐ | ☐ | ☐ |
| Gallbladder attacks or stones | ☐ | ☐ | ☐ |
| Have you had your gallbladder removed? | Yes | No | |
| Crave sweets during the day | ☐ | ☐ | ☐ |
| Eating sweets does not relieve cravings for sugar | ☐ | ☐ | ☐ |
| Must have sweets after meals | ☐ | ☐ | ☐ |
| If meals are missed feel irritable, lightheaded or shaky | ☐ | ☐ | ☐ |
| Slow starter in the morning | ☐ | ☐ | ☐ |
| Depend on coffee to keep yourself going or started | ☐ | ☐ | ☐ |
| Poor memory, forgetful, mental sluggishness | ☐ | ☐ | ☐ |
| Cannot fall asleep, insomnia | ☐ | ☐ | ☐ |
| Cannot stay asleep | ☐ | ☐ | ☐ |
| Wake up tired even after 6 or more hours of sleep | ☐ | ☐ | ☐ |
| Require excessive amounts of sleep to function properly | ☐ | ☐ | ☐ |
| Crave salt | ☐ | ☐ | ☐ |
| Dizziness when standing up quickly | ☐ | ☐ | ☐ |
| Headaches | ☐ | ☐ | ☐ |
| Migraines | ☐ | ☐ | ☐ |
| Excessive perspiration or with little or no activity | ☐ | ☐ | ☐ |
| General fatigue, tired, sluggish most of day | ☐ | ☐ | ☐ |
| Fatigue after meals | ☐ | ☐ | ☐ |
| Afternoon fatigue | ☐ | ☐ | ☐ |
| Feel cold - hands, feel, all over | ☐ | ☐ | ☐ |
| Depression, lack of motivation | ☐ | ☐ | ☐ |
| Heart palpations, increased pulse at rest | ☐ | ☐ | ☐ |
| Nervousness or anxious | ☐ | ☐ | ☐ |
| Night sweats | ☐ | ☐ | ☐ |
| Difficulty gaining weight | ☐ | ☐ | ☐ |
| Difficulty losing weight | ☐ | ☐ | ☐ |
| Diminished sex drive | ☐ | ☐ | ☐ |
| Increased sex drive | ☐ | ☐ | ☐ |

| | Never | Sometimes | Always |
|---|---|---|---|
| Urination difficulty or dribbling | ☐ | ☐ | ☐ |
| Pain inside of legs or heels | ☐ | ☐ | ☐ |
| Leg nervousness at night, restless leg | ☐ | ☐ | ☐ |
| Inability to concentrate or stay focused | ☐ | ☐ | ☐ |
| Muscle soreness, stiffness, achy joints | ☐ | ☐ | ☐ |
| Decrease in physical stamina | ☐ | ☐ | ☐ |
| Increase in fat distribution around abdomen and hips | ☐ | ☐ | ☐ |
| <u>For Women:</u> | | | |
| Menstrual disorders or lack of menstruation | ☐ | ☐ | ☐ |
| Are you experiencing menopause | Yes | No | |
| Extended menstrual cycle (greater than 32 days) | Yes | No | |
| Shortened menses (less than every 24 days) | Yes | No | |
| Pain and cramping during periods | ☐ | ☐ | ☐ |
| Scanty blood flow | ☐ | ☐ | ☐ |
| Heavy blood flow | ☐ | ☐ | ☐ |
| Breast pain and swelling during menses | ☐ | ☐ | ☐ |
| Irritable and depressed during menses | ☐ | ☐ | ☐ |
| Acne breakouts | ☐ | ☐ | ☐ |
| Facial hair growth | ☐ | ☐ | ☐ |
| How many years have you been post-menopausal? | _____ | | |
| Do you ever have uterine bleeding since menopause? | Yes | No | |
| Hot flashes | ☐ | ☐ | ☐ |
| Mood swings | ☐ | ☐ | ☐ |
| Painful intercourse | ☐ | ☐ | ☐ |
| Increased vaginal, pain, dryness, or itching | ☐ | ☐ | ☐ |
| <u>For Men:</u> | | | |
| Decrease in spontaneous morning erections | ☐ | ☐ | ☐ |
| Decrease in fullness of erections | ☐ | ☐ | ☐ |
| <u>Other:</u> | | | |
| Please list any conditions or symptoms not listed above: _____ | | | |

## PART III - Lifestyle

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

Do you exercise? ____ If yes, how often and what type(s)? _____

List the three worst foods you eat during the average week:

1. _____
2. _____
3. _____

List the three healthiest foods you eat during the average week:

1. _____
2. _____
3. _____

Do you smoke? _____ If yes, how many times a day _____

Rate your stress levels on a scale of 1-10 during the average week (1 as the least stress to 10 as the most stress) _____

Please list any medications you currently take and the conditions you take them for: _____

Please list any natural supplements you currently take and the conditions you take them for: _____

How many times a day do you eat? _____

What do you usually eat for: _____

Breakfast? _____

Lunch? _____

Dinner? _____

Snacks? _____