# Health Assessment

Name_____Date_____

## Detox Indicator

Please rate each question on a scale of 1-4. Leave blank any questions that do not apply.

**(1)** Occasionally have, effect not severe.
**(2)** Occasionally have, effect is severe.
**(3)** Frequently have, effect not severe.
**(4)** Frequently have, effect is severe.

Nausea or vomiting _____
Diarrhea _____
Bloated feeling _____
Stiffness, limitation of movement _____
Heart burn _____
Watery or itchy eyes _____
Hives, dry skin, or rashes _____
Bags or darkness under eyes_____
Hair loss _____
Flushing or hot flashes _____
Dizziness _____
Itchy Ears _____
Ear drainage _____
Fatigue or sluggish _____
Hyperactivity _____
Mood swings _____
Anger, hostility, or aggressive_____
Stuffy nose _____
Hay Fever _____
Excessive mucus formation_____
Gagging, need to clear throat_____
Canker sores _____
Irregular or skipped heart beat_____
Sore throat, loss of voice, or hoarseness _____
Asthma or bronchitis _____
Difficulty breathing _____
Confusion poor comprehension_____

Pain or aches in joints _____
Arthritis _____
Constipation _____
Pain or aches in muscles_____
Belching or gas _____
Weakness or tiredness _____
Acne _____
Swollen, red or sticky eyes____
Blurred or tunnel vision _____
Faintness _____
Excessive sweating _____
Insomnia _____
Earaches or infections _____
Ring or hearing loss in ears___
Apathy or Lethargy _____
Restlessness _____
Anxiety, fear or nervous_____
Depression _____
Sinus problems _____
Sneezing attacks _____
Chronic coughing _____
Swollen or discolored tongue gums or lips _____
Rapid or pounding heart_____
Chest Pain _____
Chest congestion _____
Shortness of breath _____
Poor memory _____
Poor concentration _____

| | | | |
|---|---|---|---|
| Poor physical condition | _____ | Difficulty w/decisions | _____ |
| Stuttering or stammering | _____ | Slurred speech | _____ |
| Learning disabilities | _____ | Binge eating/drinking | _____ |
| Craving certain foods | _____ | Excessive weight | _____ |
| Compulsive eating | _____ | Water retention | _____ |
| Underweight | _____ | Frequent illness | _____ |
| Frequent or urgent urination | _____ | Genital itch or discharge | _____ |

Total _____

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Leave **blank** any questions that **do not apply**. Please answer by how you have been feeling in the last **4 months.**

**(1) occasionally (4) often (8) frequently**

**PART I**

**Section A**

Indigestion, food repeats on you after you eat. _____
Excessive belching or bloating following meals _____
Stomach cramping and spasms during or after eating _____
Feeling of food just sitting after a meal causing pressure or discomfort_____
Bad taste in mouth _____
Small amounts of food fill you up immediately. _____
Skip meal or eat erratically because of lack of appetite. _____
TOTAL_____

**Section B**

The thought or smell of food aggravates you or your stomach. _____
Feel hungry 1-2 hrs after a good sized meal _____
Stomach pain, burning or aching over 1-4hrs after eating _____
Stomach pain, aching, burning that is relieved by eating or drinking carbonated items, ice cream, milk or taking antacids _____
Burning in upper chest when lying down or bending over _____
Digestive problems that subside with lying down and resting _____
Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache _____
Feel a sense of nausea when you eat _____
Difficult or pain when swallowing food or beverage _____
TOTAL _____

**Section C**

When pressing your left side under your rib cage, is it sore or tender_____
2-4 hrs after eating do you have indigestion or fullness in the abdomen_____
Abdominal discomfort relieved by bowel movements or gas release_____
Do certain foods/beverages aggravate indigestion _____
Consistency or form of stool change throughout the day _____
Stool odor embarrassing _____
Undigested food in stool _____
Three or more large bowel movements daily _____
Frequently loose watery stool _____
Bowel movements shortly (up to 1 hr) after meals _____
TOTAL_____

**Section D**

Discomfort or pain in colon (lower abdomen) _____
Eating raw fruits and vegetables creates bloating, pain or gas. _____
Generally constipated (have to strain for bowel movements) _____
Stools are small hard or dry _____
Alternate between diarrhea and constipation _____
Rectal itching, pain, or cramping _____
No urge to have bowel movements _____
An almost continual urge to have bowel movements _____
TOTAL_____

**Part II**

When pressing on right side under ribs is there pain or discomfort _____
Abdominal pain worsens with deep breaths _____
Pain at night that moves to back or right shoulder _____
Bitter fluid taste after eating _____
Feel abdominal discomfort or nausea when eating greasy or rich foods_____
Throbbing temples or dull pain in forehead after overeating _____
Unexplained itchy skin that worsens at night _____
Stool color alternates from clay colored to almond colored _____
General feeling of poor health _____
Aching muscles (not from working out) _____
Retain fluid and feel swollen around abdominal area _____
Reddened skin especially palms _____
Very strong body odor _____
Do you have bad breath _____
Bruise easily _____
Yellow cast to eyes _____
TOTAL_____

**Part III**
**Section A**

Feel cold or chilled on hands and feet for no reason _____
Upper eyelids seem swollen _____
Muscles are weak, cramp, or tremble _____
Are you forgetful _____
Do you feel like your heart beats slowly _____
Reaction time seems slowed down _____
Do you have a low sex drive _____
Feel sluggish and slowed down _____
Constipation _____
Dryness discoloration of skin and or hair _____
Is voice deepening _____
Thick brittle nails _____
Weight gain for reason _____
Outer third of eyebrow is thinning or gone _____
Swelling of the neck _____

TOTAL_____

**Section B**

Lingering mild fatigue stress or exertion _____
Do you get tired and exhaust easily _____
Craving for salty foods _____
Sensitive to minor weather changes _____
Dizzy when rising from a kneeling position _____
Dark blue or black circles under eyes _____
Have bouts with nausea with and without vomiting _____
Catch colds or infections easily _____
Wounds heal slowly _____
Have spots on your body that are either hot, painful or tender _____
Feel puffy and swollen all over _____
Skin is changing color without sun exposure or large doses of carrots_____

TOTAL_____

**Part IV**
**Section A**

When you miss meal or go without food for extended period of time do you experience any of the following symptoms:

A sense of weakness _____ Anxiety when hungered_____
Hands tingle _____ Heart beating too quickly_____
Shaky trembling hands _____ Clammy skin or sweating_____
Nightmares _____ Restlessness during night_____

Agitated, nervous, upset easily_____ Poor memory, forgetful_____
Confused or disoriented _____ Dizzy or faint _____
Cold or numb _____ Mild headaches _____
Blurred or double vision _____ Clumsy or uncoordinated____
TOTAL_____

**Section B**

Frequent urination during night and day_____ Unusual hunger _____
Unusual thirst _____ Vision blurs _____
Feel itchy all over _____ Drowsy during day____
Tingling or numb in feet _____ Sores heal slowly_____
Starchy foods cause weight gain _____ Hair loss on legs _____
TOTAL_____

**Part V**

**Section A**

Feel jittery _____
First movement of day causes chest pain, pressure or tightness _____
Exhaustion with minor exertion _____
Heavy sweating (not exertion or hot flashes) _____
Hard time catching breath esp. during exercise _____
Heart pounding, irregularity, or too fast or too slow _____
Swelling in feet, ankles, or legs that comes and goes _____
TOTAL_____

**Section B**

Muscle pain at rest _____
Cramps in legs, ankles and calves _____
Numbness tingling in hands and feet _____
Cold feet or toes and can appear blue in color _____
Brief hearing loss _____
Nausea comes and goes without food consumption _____
Feel worse standing, legs get heavy and fatigued _____
Leg discomfort and fatigue that is relieved by elevating _____
Fingers and toes get cold and numb even when covered _____
Notice changes in pain perception and hot and cold changes _____
Body hair is thinning or disappearing _____
Lack of ability in decision making, concentrate, focus attention and follow directions _____
TOTAL_____

**Part VI**

**Section A**

Lack of interest in anything _____ Do you cry _____

Does life look hopeless _____ Are you blue, sad or unhappy___

Is it hard to make good out of bad_____ Sleep issues _____

Weight and appetite changes _____ Can't think clearly _____

Can't make goals/decisions _____ TOTAL_____

**Section B**

Does worrying get you down _____ Are you irritable and wore out____

Are you nervous _____ Easily aggitated ____

Shake or tremble _____ Keyed up or jittery ____

Tremble when shouted at _____ Night noises scare you ____

Do you sigh a lot _____ Frightening dreams ____

Do fearful thought plague you _____ Scared for no reason ____

Cold sweats _____ Butterflies, nausea, diarrhea _____

TOTAL_____

**Section C**

Pent up ready for explosion_____ Noisy or emotional outbursts____

Impulsive _____ Irritable or upset easily _____

Go to pieces if no self control_____ Easily angered by nothing ____

Angry when told what to do _____ Anger flares when things do not happen immediately_____

TOTAL_____

**Part VII**

**Section A**

Eyes water or tear _____ Mucus discharge from eyes _____

Ears ache, itch, stuffed or sore_____ Discharge from ears _____

Nose congested _____ Snore loudly _____

Nose run _____ Nose bleeds _____

Hoarse voice _____ Clear throat frequently _____

Choking lump in throat _____ Severe colds _____

Do colds hang on _____ Does flu last longer than 5 days_____

Lung infections _____ Chest discomfort or pain _____

Sudden breathing difficulties _____ Shortness of breath _____

Difficulty in exhaling _____ Breathless next after exertion_____

Inability to breath when lying _____ Hack up phlegm _____

Rattling when breathing _____ Troubled with coughing _____

Wheezing _____ Night sweats _____

Lips or nails have a blue hue _____ Sleepy during the day _____

Difficulty concentrating _____
Eyes, ears, nose, throat and lungs have problems when dairy or wheat products are consumed _____
Ears, eyes, throat, lungs and nose show problems with seasonal changes _____ TOTAL_____

**Part VIII**

Involuntary loss of urine when strain, cough, or lift something heavy _____
Mild low back ache or pain _____
Abdominal aches or pains ____
Pain or burning when urinating _____
Rarely feel the urge to urinate _____
Feel the need to urinate every 2 hours day or night ____
Strong smelling urine _____
Back or leg pain after dripping from urinating _____
Sore or painful genitals _____
Urine is a rose color _____
Water retention throughout body _____

TOTAL_____

**Part IX**

**Section A**

Bones throughout body feel tender, ache or sore _____
Localized bone pain _____
Hands, feet or throat get tight, spasm or feel numb _____
Difficulty sitting straight _____
Upper back pain _____
Lower back pain _____
Pain while sitting or walking _____
Limp or favor a leg _____
Shins hurt during or after exercise _____

TOTAL_____

**Section B**

Stiff when wake _____
Joint swelling, stiffness or pain in more than One area at a time _____
Pain, numbness, tingling, or prickling in neck or shoulder or arms _____
Hard to chew or open mouth_____
Pain, aching down back of leg____
Injure, sprain, or strain easily_____
Difficulty bending to floor _____
Joints hurt with movement _____
Knees swell or hurt _____
Hard time to open jars _____
Intermittent pain or ache on one side of head spreading to cheek, temple, lower jaw, ear, neck or shoulder _____
Trouble standing _____
TOTAL_____

**Section C**

Muscles stiff, sore, tense or achy _____
Burning, throbbing, shooting, or stabbing muscle pain _____
Muscle cramps or spasms _____
Muscle pain greater in the morning _____
Specific points on body feel sore when pressed _____
Do not feel refreshed when waking _____
Headaches _____
Pain in sides of head or in face when wake _____
Jaw clicks or pops _____
Muscles twitch or tremor (ie. eyelids, thumb, calf muscles) _____
Restless legs _____
Legs move during sleep _____
Crawling sensation inside legs when lying down _____
Hand and wrist numbness or pain _____
Feelings of pins and needles in thumb and first 3 fingers _____
Pain in forearm and sometimes into the shoulder _____
TOTAL_____

**Part X**

**Section A**

Head feels heavy _____
Dizziness _____
Difficulty standing, rolling over in bed or turning head _____
Hands tremble for no reason _____
Feet feel heavy when walking _____
Feel clumsy, bump into things etc. _____
Difficulty breathing _____
Difficulty swallowing _____

You speak softly, others ask you to speak up _____
Speaking and forming words does not feel automatic _____
Need 10-12 hrs of sleep to feel rested _____
Lack strength, hard time picking up arms or head _____
Hands get tired when you write and writing is smaller and illegible _____
Muscles in arms and legs seem smaller _____
Senses of smell, sight, hearing and taste seem worse _____
Do you feel like you move slower than you used to _____
TOTAL_____

**Section B**

Difficulty absorbing new information _____
Tend to forget things _____
Trouble thinking or concentrating _____
Easily distracted _____
Frustrate quickly _____
Inability to sit still, even at meal time _____
Hard time finishing things _____
Trouble solving problems and managing time _____
Low tolerance for stress and day to day problems _____
TOTAL_____

**Part XI <u>MEN ONLY</u>**

Sensation of not emptying your bladder completely _____
Need to urinate less than 2 hrs after going _____
Need to start and stop several time while urinating _____
Find it difficult to wait to urinate _____
Have a week urinary stream _____
Need to push or strain to begin urination _____
Dripping after urination _____
Urge to urinate several times a night _____
TOTAL_____

**Part XII <u>WOMEN ONLY FROM HERE ON, MENOPAUSAL WOMEN GO TO SECTIONS E & F.</u>**

**Section A**

Do you experience any of these symptoms within 3 days to 2 weeks before menstruation?

Anxious, irritable or nervous _____ Numbness in hands and feet _____
Easy to anger, resentful _____ Aggressive or hostile _____
Abdominal bloating and swelling_____ Temporary weight gain _____
Breast tenderness and swelling _____ Breast lumps _____
Discharge from nipples _____ Nausea or vomiting _____

| | | | |
|---|---|---|---|
| Diarrhea or constipation | _____ | Aches and pains | _____ |
| Cravings for sweats | _____ | Increased apatite, binge | _____ |
| Headaches | _____ | Overwhelmed shaky/clumsy | _____ |
| Heart pounding | _____ | Dizziness or fainting | _____ |
| Confused and forgetful | _____ | Sadness and worthlessness | _____ |
| Trouble sleeping and falling asleep | ____ | Self destructive behavior | _____ |

TOTAL_____

**Section B**

Do you experience any of these symptoms during your period?

| | |
|---|---|
| Cramping in lower abdomen or pelvic area | _____ |
| Lower abdominal pain, sharp, dull or intermittent | _____ |
| Bloating and sense of abdominal fullness | _____ |
| Diarrhea or constipation | _____ |
| Nausea or vomiting | _____ |
| Low back or legs ache | _____ |
| Headaches | _____ |
| Unusual fatigue causing you to miss work | _____ |
| Painful or swollen breasts | _____ |
| Scanty blood flow | _____ |

TOTAL_____

**Section C**

| | |
|---|---|
| Painful or difficult sexual intercourse | _____ |
| Low back, abdominal, and vaginal pain throughout the month | _____ |
| Pelvic pressure or pain relieved by lying down | _____ |
| Vaginal bleeding OTHER than when having your period | _____ |
| Painful bowel movements | _____ |
| Difficult urination | _____ |
| Abnormal vaginal discharge | _____ |
| Smelly vaginal discharge | _____ |
| Vaginal itching or burning with or without intercourse | _____ |
| Pain during periods is getting worse | _____ |
| Unable to get pregnant | _____ |

TOTAL_____

**Section D**

| | |
|---|---|
| Absence of periods for 6 months or longer (not pregnant) | _____ |
| Periods occur irregularly | _____ |
| Profuse heavy bleeding during periods | _____ |
| Menstrual blood has tissue and/or clots | _____ |
| Bleeding between periods can happen at any time | _____ |
| Periods occur greater than every 35 days | _____ |

Intense upper stomach pain at the time you ovulate _____
Bleeding occurs during ovulation _____
Monthly abdominal pain without bleeding _____
Large amounts of cervical mucus _____
Acne and/or oily skin during period _____
Overwhelming urges for sexual intercourse _____
Aggressive feelings _____
Increased growth of dark facial or body hair _____
Poor sense of smell _____
Voice becoming deeper _____
Breasts seem to be getting smaller _____
Receding hair line _____

TOTAL_____

**Section E**

Vaginal discharge _____ Vaginal secretions are watery and thin___
Vaginal dryness _____ Sexual intercourse is uncomfortable____
Lack of sex drive _____ Enlarged breasts _____
Breast tenderness/soreness _____ Lack of or difficulty in orgasm _____
Vaginal bleeding after sex_____

TOTAL_____

**Section F**

Sense of wellbeing fluctuates throughout the day for no reason _____
Sudden hot flashes _____
Spontaneous sweating _____
Chills ____
Cold hands and feet ____
Heart beats rapidly or fluttery ____
Numbness, tingling or prickling sensations ____
Dizziness _____
Mental fogginess, forgetful or distracted ____
Inability to concentrate _____
Depression, anxiety, nervousness or irritability _____
Difficulty sleeping _____
Aware of new feelings of danger and frustration _____
Skin, hair, vagina and or eyes are dry _____
Stop menstruation 6 months ago, yet some vaginal bleeding _____

TOTAL_____