

Wellness Profile Questionnaire

Tab from one field to the next. Enter data, if known and as appropriate, in each field.

| | | | | | | | | | | | | | | |
|---------------------------|--|--|----------|--|-------|----------------|--|-----|--------|-----|--|--------|--|--|
| Name | | | | | Date | | | | | | | | | |
| Address | | | | | | | | | | | | | | |
| City | | | | | State | | | Zip | | | | | | |
| Email | | | | | Phone | | | | | Fax | | | | |
| Age | | | Sex(M/F) | | | Blood Pressure | | | | | | | | |
| Total Cholesterol | | | HDL | | | LDL | | | Height | | | Weight | | |
| List Medications You Take | | | | | | | | | | | | | | |

Instructions

- A) **If a statement does not apply, leave it blank.** Otherwise **place a 1, 2, or 3 in the box** to the left of the statement.
Mild or Infrequent = 1
Moderate or Occasional = 2
Severe or Frequent = 3
- B) Do not agonize over each question.
- C) Some questions are repeated. It is important that you mark all appropriate statements, even if marked previously.
- D) Mark YES or NO questions by checking the appropriate spot.

Supplemental Information

- | | | | |
|--------------------------|-----|--------------------------|---|
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No — Trying to lose weight |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No — Interested in preventing Cancer |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No — Exercise frequently |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No — Want to strengthen the immune system |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No — Eat vegetarian diet |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No — Are you overweight |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No — Eat less than 3 servings per day of milk, yogurt or cheese |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No — Eat fried and processed foods |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No — Eat less than 3-5 servings of vegetables daily |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No — Eat low fiber, high fat diet |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No — Eat less than 6-11 servings of whole grain daily |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No — Eat less than 2 servings of fruit daily |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No — Are you pregnant |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No — Interested in preventing Heart Disease |

Questionnaire

Yes or No section

- Yes No —Do you have High Blood Pressure?
 Yes No —Do you have Type I Diabetes or medically diagnosed Reactive Hypoglycemia?
 Yes No —Do you or does anyone in your immediate household smoke?
 Yes No —Do you have high cholesterol?
 Yes No —Do you have joint or muscle aches or tenderness, OR abnormal muscle aches from exercise, OR backache?
-

Points section

Section 1

- | | |
|---|---|
| <input type="checkbox"/> —Acne, Blackheads or Warts | <input type="checkbox"/> —Inability to adjust eyes when entering a dark room. |
| <input type="checkbox"/> —Dry, Rough Skin | <input type="checkbox"/> —Difficulty seeing at night. |
| <input type="checkbox"/> —Poor Appetite | <input type="checkbox"/> —Frequent Colds, Respiratory Infections |
| <input type="checkbox"/> —Permanent Goose Bumps on back of arms | |

Group Score 1

Section 2

- | | |
|--|--|
| <input type="checkbox"/> —Frequent Fatigue | <input type="checkbox"/> —Hurt all over (general) |
| <input type="checkbox"/> —Irritability | <input type="checkbox"/> —Heart Palpitations |
| <input type="checkbox"/> —Depression | <input type="checkbox"/> —Graying Hair |
| <input type="checkbox"/> —Craving for Sweets | <input type="checkbox"/> —Use antibiotics; eat red meat or chicken, drink milk |
| <input type="checkbox"/> —Can't Concentrate | |
| <input type="checkbox"/> —Fits of Temper | |

Group Score 2

Section 3

- | | |
|--|--|
| <input type="checkbox"/> —Bleeding Gums | <input type="checkbox"/> —Slow Healing of Cuts or Scrapes |
| <input type="checkbox"/> —Bruise Easily | <input type="checkbox"/> —Nose Bleeds |
| <input type="checkbox"/> —Frequent Colds or Flu | <input type="checkbox"/> —Cuticles Tear Easily, Hang Nails |
| <input type="checkbox"/> —Varicose Veins or Broken Capillaries | |

Group Score 3 **Group Score 4**

Section 5

- | | |
|---|--|
| <input type="checkbox"/> —Poor Circulation | <input type="checkbox"/> —Heavy Menstrual Flow |
| <input type="checkbox"/> —Lack of Stamina | <input type="checkbox"/> —Thin, Fragile, Brittle Nails |
| <input type="checkbox"/> —Dark Circles under Eyes | <input type="checkbox"/> —Pale Skin, Palms very pale |
| <input type="checkbox"/> —History of Anemia | |

Group Score 5

Section 6

- | | |
|--|--|
| <input type="checkbox"/> —Menstrual Cramps | <input type="checkbox"/> —Muscle Tension |
| <input type="checkbox"/> —Muscle Twitching or Tics | <input type="checkbox"/> —Joints Pop or Crack |
| <input type="checkbox"/> —Fingernails won't Grow | <input type="checkbox"/> —Frequent Backaches |
| <input type="checkbox"/> —Foot or Leg Cramps | <input type="checkbox"/> —Aching Joints or Muscles |
| <input type="checkbox"/> —Insomnia | <input type="checkbox"/> —Crave Chocolate |

Group Score 6

Section 7

- | | |
|--|---|
| <input type="checkbox"/> —Bad Breath | <input type="checkbox"/> —Slow Healing of Wounds |
| <input type="checkbox"/> —White coated Tongue | <input type="checkbox"/> —Stress |
| <input type="checkbox"/> —White Spots on Fingernails | <input type="checkbox"/> — <input type="checkbox"/> Yes <input type="checkbox"/> No —Taking Estrogen (The Pill or Premarin)? If so, put a 2 in the box to the left. |
| <input type="checkbox"/> —Diminished Smell or Taste | |

Group Score 7 **Group Score 8** **Group Score 9**

Section 10

- Nausea, Headache, Migraine
- History of Constipation
- Bad Breath, Bad taste in Mouth
- History of Hepatitis, Jaundice, Malaria
- Occasional Body Odor, Including Feet
- Undigested Food in Bowel Movement

- Gall Bladder or Stones Removed. Year
- Frequent Tension in Neck and Shoulders
- Occasional Abdominal Pain after big meal
- Coated Tongue
- Yellow-colored Bowel Movements
- Ingest alcohol (more than 1 oz. OR 1 beer per day)

Group Score 10

Section 11

- History of Colitis, Diverticulitis
- Desire to eat often, Especially Starches
- History of Hemorrhoids
- Alternating Constipation and Diarrhea
- Constipation during Menstruation

- Thin, Pencil-like Bowel Movements
- Painful, Hard Bowel Movements
- History of Rectal Fissure
- Rarely have daily Bowel Movements

Group Score 11

Section 12

- Gas after Eating
- Stomach Bloating after Eating

- Belching, Burping after Meals

Group Score 12

Section 12A

- Heavy, Tired Feeling after Eating
- Drowsy after eating
- Very Flabby Tissues

- Fingernails Break and Split
- Chronic Fluid Retention

Group Score 12A **Group Score 13**

Section 14

- Stomach Pain 5-6 Hours after Meals, often at Night. Relieved by Drinking Cream or Milk
- Above Complaints Aggravated by Worry and tension. Relieved by Vacationing

- Taking Pills or Vitamins Causes Stomach Discomfort
- History of Ulcers

Group Score 14 **Group Score 15**

Section 16

- Puffy Eyes
- Ankles Swell Frequently
- History of Kidney or Bladder Infections
- Difficult or Painful Urination
- Infrequent Urination

- Legs often Feel Heavy
- Sleep Disturbed by Urge to Urinate 2 or More Times/Night
- Severe Pre-Menstrual Bloating

Group Score 16

Section 17

- Blood Pressure Fluctuates, Sometimes too Low
- Craving for Salt
- Overly Worried or Concerned about Things Left Undone
- Occasional Cold Sweats
- Constriction in Throat, Lump that Hurts when Emotionally Disturbed

- Perfectionist, Set High Standards
- Emotional Upsets cause Exhaustion. Must go and Lie Down
- Eyes Sensitive to Headlights, Sun
- Easily Startled, Heart Pounds from Unexpected Noise
- Allergies, Skin Rash, Hay Fever, Sneezing Attacks

Group Score 17

Section 18

(FEMALE — Complete this section then proceed to Section 20)

(MALE — Proceed to Section 19)

- | | |
|--|---|
| <input type="checkbox"/> —Missing Periods | <input type="checkbox"/> —Mood changes |
| <input type="checkbox"/> —Irregular or Uncomfortable Periods | <input type="checkbox"/> —Abnormal sleep patterns |
| <input type="checkbox"/> —Menopause, Hot Flashes, night sweats | <input type="checkbox"/> — <input type="checkbox"/> Yes <input type="checkbox"/> No —Had Ovaries or Uterus Removed (Hysterectomy)? If so, put 2 in the box to the left. |
| <input type="checkbox"/> —Feel Nervous, Depressed before Periods | Year |
| <input type="checkbox"/> —Diminished Sex Drive | |

Group Score 18

Section 19

(MALE — Complete this Section then proceed to Section 20)

(FEMALE — Proceed to Section 20)

- | | |
|---|--|
| <input type="checkbox"/> —Prostate Trouble | <input type="checkbox"/> —Get Up at Night to Urinate |
| <input type="checkbox"/> —Difficulty Urinating, Starting, Burning | <input type="checkbox"/> —Back or Leg Pains |
| <input type="checkbox"/> —Diminished Sex drive | |

Group Score 19

Section 20

- | | |
|--|--|
| <input type="checkbox"/> —Irritable if Late for a Meal or Missing a Meal | <input type="checkbox"/> —Irritable before Breakfast |
| <input type="checkbox"/> —Urinate a Lot | <input type="checkbox"/> —Nervous, Shaky Feeling, Headaches relieved by eating Sweets or Starches |
| <input type="checkbox"/> —Wake Up at Night Feeling Hungry | <input type="checkbox"/> —Weak Spells, Tiredness in Mid-Afternoon |
| <input type="checkbox"/> —Emotional on Empty Stomach | <input type="checkbox"/> —Bouts of Faintness, Dizziness, Lack of Concentration <input type="checkbox"/> in Morning <input type="checkbox"/> in Mid-Afternoon <input type="checkbox"/> in Evening |
| <input type="checkbox"/> —Craving for Sweets, Alcohol or Coffee | |
| <input type="checkbox"/> —Intense, Frequent Thirst | |
| <input type="checkbox"/> —Cold Sweat on Hands even when Warm | |

Group Score 20

Section 21

- | | |
|--|---|
| <input type="checkbox"/> —Crave Sweets and Starches, but Eating doesn' t Provide Much Relief | <input type="checkbox"/> —Diabetes in Family |
| <input type="checkbox"/> —Occasional Night Sweats | <input type="checkbox"/> —Chronic Fatigue, Lowered Resistance |
| <input type="checkbox"/> —History of Sores, Especially in Legs, Slow Healing | <input type="checkbox"/> —Very Thirsty all the Time |

Group Score 21

Section 22

- | | |
|---|---|
| <input type="checkbox"/> —Feel Better when Resting, Low Exercise Tolerance, Low Endurance | <input type="checkbox"/> —Bruise Easily, Black and Blue Spots |
| <input type="checkbox"/> —Require Extra Amount of Sleep | <input type="checkbox"/> —Short of Breath when Climbing Stairs |
| | <input type="checkbox"/> —Cold Hands and Feet, Need Extra Covers at Night |

Group Score 22

Section 22A

- | | |
|---|---|
| <input type="checkbox"/> —Numbness or Heaviness in Arms or Legs | <input type="checkbox"/> —Memory Getting Worse |
| <input type="checkbox"/> —Hands Cramp when Writing | <input type="checkbox"/> —Short Walks Cause Aches and Pains |
| <input type="checkbox"/> —Tingling Sensation in Lips or Fingers | <input type="checkbox"/> —Arms and Legs Often go to Sleep |

Group Score 22A **Group Score 23**

Section 22B

- | | |
|--|--|
| <input type="checkbox"/> —Chest Pains, Sometimes Down Left Arm | <input type="checkbox"/> —Shortness of Breath on Exertion |
| <input type="checkbox"/> —Heart Sometimes Flip-Flops | <input type="checkbox"/> —Diabetes |
| <input type="checkbox"/> —Very Slow Heart Beat (under 50/minute) | <input type="checkbox"/> —Very Rapid Heart Beat (over 90/minute) |
| <input type="checkbox"/> —Unexplained Headache or Dizziness | <input type="checkbox"/> —History of Heart Disease in Family |

Group Score 22B **Group Score 24**

Section 25

- History of Bronchitis, Asthma, Pneumonia, Emphysema, Pleurisy
- Chronic Cough

- Working in a Factory, or with Chemicals or Fumes
- History of Colds, Lung Problems
- Chronic Mucus in Throat or Sinus

Group Score 25

Section 26

- History of Cancer, Multiple Sclerosis, Parkinson' s, Rheumatoid Arthritis
- Unusual Number of Cavities
- Swollen Glands in Groin, Tonsils, Throat, Armpits

- Very Susceptible to Infection
- Flu-like Symptoms often occur
- Feel Puffiness in Throat

Group Score 26

Section 27

- Frequent Use of Antibiotics
- Chronic Diarrhea
- Rectal Itching
- Bladder Infections
- Abnormal Muscle Aches from Exercise
- Feel Tired a Lot
- Severe Reaction to Tobacco, Perfume, Chemical Odors

- Unexpected Weight Gain
- Hives, Psoriasis, Acne, Skin Rashes
- Endometriosis/Ovary Problems
- Recurrent Heartburn/Digestive Upsets
- Crave Sugars, Breads, Alcohol
- Gas, Abdominal Bloating
- Yes No —Are you answering ALL the questions? If so, give yourself a pat on the back.

Group Score 27

Section 28

- Fluid Retention
- Anemia
- Low Hormone Levels
- Nausea or Dizziness
- Weakness in General
- Premature Aging
- Slow Recovery of Wounds/Illness

- Low Resistance to Infection
- High Stress Lifestyle
- Yes No —Did you put your name on the form and answer all the questions at the beginning? If so, give yourself a pat on the back.

Group Score 28

Section 29

(If this section does not apply to you, proceed to Section 30)

DO THE FOLLOWING OCCUR WITHIN 14 DAYS BEFORE MENSTRUAL PERIOD?

- Headaches
- Weight Gain
- Increased Appetite
- Frequent Crying
- Bloating
- Depression
- Fatigue
- Breast Tenderness

- Swelling Hands and Feet
- Backache
- Nervous Tension, Irritability
- Confusion
- Crave Sweets
- Forgetfulness
- Cramps

Group Score 29

Section 30

- Low energy
- Caffeine addiction
- Stress

- Poor immunity
- Chronic illness
- Poor endurance

Group Score 30

Section 31

- Atherosclerosis
- Irregular heartbeat
- Chronic Heart Failure

- High Blood Pressure
- Poor mental alertness
- Memory loss

Group Score 31 0

Section 32

- Joint pain and/or tenderness
- Swollen joints
- Cartilage degeneration

- Decreased mobility
- Osteoarthritis

Group Score 32 0

Section 33

- Yes No —Are you exposed to chemicals or chemical fumes?

- Score 3 for Yes answer in Section 33.

Group Score 33 0

Section 34

- Motion sickness: sea, car, plane, etc.
- Morning sickness
- Gas, indigestion

- Abdominal cramps
- Diarrhea
- Nausea

Group Score 34 0

Section 35

- Chronic fatigue or sluggishness
- Mood swings
- Excessive crying

- Suicidal thoughts
- Lack of drive or motivation
- Persistent sadness or empty feeling

Group Score 35 0

Section 36

- Anxiety
- Nervousness
- Exhaustion
- Insomnia

- Muscle tension, Fibromyalgia
- Headache, Migraines
- ADD, Learning disorder, Hyperactivity
- Nervous tension

Group Score 36 0

Section 37

- Excessive Hair Loss
- Thinning Hair
- Dandruff

- Hair Breaks Easily
- Hair Won't Grow

Group Score 37 0

Section 38

- Yes No —Are you interested in preventing respiratory diseases?
- Yes No —Are you interested in preventing heart disease?
- Yes No —Are you interested in preventing cancer?
- Yes No —Do you have a mold or similar problem in your home?
- Yes No —Do you or does anyone in your immediate household have allergies?
- Yes No —Do you or does anyone in your immediate household smoke?
- Yes No —Are you interested in the quality of indoor air in your home?
- Score 1 for each Yes answer in Section 38

Group Score 38 0

Please read finishing instruction on next page.

Please double check that you: 1) followed the instructions carefully, 2) answered ALL the relevant questions, and 3) entered all the information, including your name, at the very beginning of the questionnaire.

When finished: Go to the File menu and select Save As... Save the file in a convenient location that you can remember. Send an email back to the person who emailed you this Questionnaire and attach the file you just saved. If you select Save rather than Save As... from the File menu it will be very difficult to find the file to attach to a return email.

Group Score Summary

| | | | | | | | | | | | |
|---------|---|-----------|---|----------|---|-----------|---|----------|---|----------|---|
| Field 1 | 0 | Field 8 | 0 | Field 14 | 0 | Field 21 | 0 | Field 26 | 0 | Field 33 | 0 |
| Field 2 | 0 | Field 9 | 0 | Field 15 | 0 | Field 22 | 0 | Field 27 | 0 | Field 34 | 0 |
| Field 3 | 0 | Field 10 | 0 | Field 16 | 0 | Field 22A | 0 | Field 28 | 0 | Field 35 | 0 |
| Field 4 | 0 | Field 11 | 0 | Field 17 | 0 | Field 23 | 0 | Field 29 | 0 | Field 36 | 0 |
| Field 5 | 0 | Field 12 | 0 | Field 18 | 0 | Field 22B | 0 | Field 30 | 0 | Field 37 | 0 |
| Field 6 | 0 | Field 12A | 0 | Field 19 | 0 | Field 24 | 0 | Field 31 | 0 | Field 38 | 0 |
| Field 7 | 0 | Field 13 | 0 | Field 20 | 0 | Field 25 | 0 | Field 32 | 0 | | |