Female Intake Questionnaire

General Information

Name____________________ Age_____ Today's Date ____________

Date of Birth ____________ Email ____________________

Address ________________ City__________ State ____ Zip_______

Phone (Home)____________ (Cell) ____________ (Work) ____________

Genetic Background: ☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian
☐ Native American ☐ Caucasian ☐ Northern European
☐ Other ____________________

When, where and from whom did you last receive medical or health care? ________________

____

Emergency Contact: ________________ Relationship ____________

Phone (Home)____________ (Cell) ____________ (Work) ____________

How did you hear about our practice?

☐ Clinic website ☐ IFM website ☐ Referral from doctor ☐ Referral from friend/family member
☐ Social media ☐ Other____________________

Current Health Concerns

Please rank current and ongoing health concerns in order of priority

Describe Problem	Severity	Mild	Moderate	Severe	Prior Treatment/Approach	Success	Excellent	Good	Fair
Example: Post Nasal Drip		*X*			*Elimination Diet*		*X*		
1.									
2.									
3.									
4.									
5.									
7.									
8.									
9.									
9.									
10.									

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Allergies

Name of Medication/Supplement/Food:	Reaction:
1.	
2.	
3.	
4.	
5.	

Lifestyle Review

Sleep

How many hours of sleep do you get each night on average?___________________________

Do you have problems falling asleep? ☐ Yes ☐ No Staying asleep? ☐ Yes ☐ No

Do you have problems with insomnia? ☐ Yes ☐ No Do you snore? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No

If yes, explain:____

Exercise

Current Exercise Program:

Activity	Type	# of Times Per Week	Time/Duration (Minutes)
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure (e.g., golf)			
Other:			

Do you feel motivated to exercise? ☐ Yes ☐ A little ☐ No

Are there any problems that limit exercise? ☐ Yes ☐ No

If yes, explain:____

Do you feel unusually fatigued or sore after exercise? ☐ Yes ☐ No

If yes, explain:____

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Nutrition

Do you currently follow any of the following special diets or nutritional programs? *(Check all that apply)*

☐ Vegetarian ☐ Vegan ☐ Allergy ☐ Elimination ☐ Low Fat ☐ Low Carb ☐ High Protein
☐ Blood Type ☐ Low sodium ☐ No Dairy ☐ No Wheat ☐ Gluten Free
☐ Other: ______________________________

Do you have sensitivities to certain foods? ☐ Yes ☐ No
If yes, list food and symptoms: ______________________________

Do you have an aversion to certain foods? ☐ Yes ☐ No
If yes, explain: ______________________________

Do you adversely react to: *(Check all that apply)*

☐ Monosodium glutamate (MSG) ☐ Artificial sweeteners ☐ Garlic/onion ☐ Cheese ☐ Citrus foods
☐ Chocolate ☐ Alcohol ☐ Red wine ☐ Sulfite–containing foods (wine, dried fruit, salad bars)
☐ Preservatives ☐ Food colorings ☐ Other food substances: ______________________________

Are there any foods that you crave or binge on? ☐ Yes ☐ No
If yes, what foods? ______________________________

Do you eat 3 meals a day? ☐ Yes ☐ No If no, how many ______________________________

Does skipping a meal greatly affect you? ☐ Yes ☐ No

How many meals do you eat out per week? ☐ 0–1 ☐ 1–3 ☐ 3–5 ☐ >5 meals per week

Check the factors that apply to your current lifestyle and eating habits:

☐ Fast eater
☐ Eat too much
☐ Late-night eating
☐ Dislike healthy foods
☐ Time constraints
☐ Travel frequently
☐ Eat more than 50% of meals away from home
☐ Healthy foods not readily available
☐ Poor snack choices
☐ Significant other or family members don't like healthy foods
☐ Significant other or family members have special dietary needs
☐ Love to eat
☐ Eat because I have to
☐ Have negative relationship to food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely, bored, etc.)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Confused about nutrition advice

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Diet

Please record what you eat in a typical day:

Breakfast ____________________

Lunch ____________________

Dinner ____________________

Snacks ____________________

Fluids ____________________

How many servings do you eat in a typical week of these foods:

Fruits (not juice)______ Vegetables (not including white potatoes) ______

Legumes (beans, peas, etc) ______ Red meat ______ Fish ______

Dairy/Alternatives ______ Nuts & Seeds ______ Fats & Oils ______

Cans of soda (regular or diet) ______ Sweets (candy, cookies, cake, ice cream, etc.) ______

Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, check amounts:

Coffee (cups per day) ☐ 1 ☐ 2-4 ☐ >4 Tea (cups per day) ☐ 1 ☐ 2-4 ☐ >4

Caffeinated sodas—regular or diet (cans per day) ☐ 1 ☐ 2-4 ☐ >4

Do you have adverse reactions to caffeine? ☐ Yes ☐ No

If yes, explain: ____________________

When you drink caffeine do you feel: ☐ Irritable or wired ☐ Aches or pains

Smoking

Do you smoke currently? ☐ Yes ☐ No Packs per day: _______ Number of years ______

What type? ☐ Cigarettes ☐ Smokeless ☐ Pipe ☐ Cigar ☐ E-Cig

Have you attempted to quit? ☐ Yes ☐ No

If yes, using what methods: ____________________

If you smoked previously: Packs per day: ______ Number of years ______

Are you regularly exposed to second-hand smoke? ☐ Yes ☐ No

Alcohol

How many alcoholic beverages do you drink in a week? *(1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)*

☐ 1–3 ☐ 4–6 ☐ 7–10 ☐ >10 ☐ None

Previous alcohol intake? ☐ Yes (☐ Mild ☐ Moderate ☐ High) ☐ None

Have you ever had a problem with alcohol? ☐ Yes ☐ No

If yes, when? ____________________

Explain the problem: ____________________

Have you ever thought about getting help to control or stop your drinking? ☐ Yes ☐ No

Other Substances

Are you currently using any recreational drugs? ☐ Yes ☐ No

If yes, type: ____________________

Have you ever used IV or inhaled recreational drugs? ☐ Yes ☐ No

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Stress

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No

How much stress do each of the following cause on a daily basis *(Rate on scale of 1-10, 10 being highest)*

Work _____ Family _____ Social _____ Finances _____ Health _____ Other_____

Do you use relaxation techniques? ☐ Yes ☐ No

If yes, how often? ____________________

Which techniques do you use? *(Check all that apply)*

☐ Meditation ☐ Breathing ☐ Tai Chi ☐ Yoga ☐ Prayer ☐ Other: ____________________

Have you ever sought counseling? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No

If yes, describe: ____________________

Have you ever been abused, a victim of crime, or experienced a significant trauma? ☐ Yes ☐ No

What are your hobbies or leisure activities?____________________

Relationships

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Gay/Lesbian ☐ Long-Term Partner ☐ Widow/er

With whom do you live? (Include children, parents, relatives, friends, pets) ____________________

____

Current occupation: ____________________

Previous occupations:____________________

Do you have resources for emotional support? ☐ Yes ☐ No *(Check all that apply)*

☐ Spouse/Partner ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other:____________________

Do you have a religious or spiritual practice? ☐ Yes ☐ No

If yes, what kind? ____________________

How well have things been going for you? *(Mark on scale of 1–10, or N/A if not applicable)*

	N/A	Poorly				Fine					Very Well
Overall	☐	1	2	3	4	5	6	7	8	9	10
At school	☐	1	2	3	4	5	6	7	8	9	10
In your job	☐	1	2	3	4	5	6	7	8	9	10
In your social life	☐	1	2	3	4	5	6	7	8	9	10
With close friends	☐	1	2	3	4	5	6	7	8	9	10
With sex	☐	1	2	3	4	5	6	7	8	9	10
With your attitude	☐	1	2	3	4	5	6	7	8	9	10
With your boyfriend/girlfriend	☐	1	2	3	4	5	6	7	8	9	10
With your children	☐	1	2	3	4	5	6	7	8	9	10
With your parents	☐	1	2	3	4	5	6	7	8	9	10
With your spouse	☐	1	2	3	4	5	6	7	8	9	10

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History

Patient's Birth/Childhood History:

You were born: ☐ Term ☐ Premature ☐ Don't know

Were there any pregnancy or birth complications? ☐ Yes ☐ No
If yes, explain: ____________________

You were: ☐ Breast-fed/How long? ________ ☐ Bottle-fed/Type of formula: ____________ ☐ Don't know

Age of introduction of: Solid food: _______ Wheat ________ Dairy ________

As a child, were there any foods that were avoided because they gave you symptoms? ☐ Yes ☐ No
If yes, what foods and what symptoms? (Example: milk—gas and diarrhea)

____

____

Did you eat a lot of sugar or candy as a child? ☐ Yes ☐ No

Dental History:

Check if you have any of the following, and provide number if applicable:

☐ Silver mercury fillings ____ ☐ Gold fillings ____ ☐ Root canals ____ ☐ Implants ____
☐ Caps/Crowns ____ ☐ Tooth pain ____ ☐ Bleeding gums ____ ☐ Gingivitis ______
☐ Problems with chewing ____ ☐ Other dental concerns (explain): _____

Have you had any mercury fillings removed? ☐ Yes ☐ No If yes, when: ____________________

How many fillings did you have as a kid? _______________

Do you brush regularly? ☐ Yes ☐ No Do you floss regularly? ☐ Yes ☐ No

Environmental/Detoxification History

Do any of these significantly affect you?

☐ Cigarette smoke ☐ Perfume/colognes ☐ Auto exhaust fumes ☐ Other: ____________________

In your work or home environment are you regularly exposed to: *(Check all that apply)*

☐ Mold ☐ Water leaks ☐ Renovations ☐ Chemicals ☐ Electromagnetic radiation
☐ Damp environments ☐ Carpets or rugs ☐ Old paint ☐ Stagnant or stuffy air ☐ Smokers
☐ Pesticides ☐ Herbicides ☐ Harsh chemicals (solvents, glues, gas, acids, etc) ☐ Cleaning chemicals
☐ Heavy metals (lead, mercury, etc.) ☐ Paints ☐ Airplane travel ☐ Other ____________________

Have you had a significant exposure to any harmful chemicals? ☐ Yes ☐ No
If yes: Chemical name, length of exposure, date: ____________________

Do you have any pets or farm animals? ☐ Yes ☐ No
If yes, do they live: ☐ Inside ☐ Outside ☐ Both inside and outside

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Women's History

Obstetric History: *(Check box and provide number if applicable)*

☐ Pregnancies ______ ☐ Miscarriages ______ ☐ Abortions ______ ☐ Living children ______
☐ Vaginal deliveries______ ☐ Cesarean ______ ☐ Term births ______ ☐ Premature birth______

Birth weight of largest baby__________________ Birth weight of smallest baby _________________

Did you develop any problems in or after pregnancy, for example, toxemia (high blood pressure), diabetes, post-partum depression, issues with breast feeding, etc.? ☐ Yes ☐ No

If yes, please explain ____

Menstrual History:

Age at first period ______ Date of last menstrual period ______________________
Length of cycle ________________________________ Time between cycles ___________________________

Cramping? ☐ Yes ☐ No Pain? ☐ Yes ☐ No

Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.)? ☐ Yes ☐ No

If yes, please describe:____

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)? ☐ Yes ☐ No

If yes, please describe:____

Use of hormonal birth control: ☐ Birth control pills ☐ Patch ☐ Nuva ring
☐ Other____ How Long ______________________

Any problems with hormonal birth control? ☐ Yes ☐ No

If yes, explain ____

Use of other contraception? ☐ Yes ☐ No ☐ Condoms ☐ Diaphragm ☐ IUD ☐ Partner vasectomy

Are you in menopause? ☐ Yes ☐ No If yes, age at last period:________________

Was it surgical menopause? ☐ Yes ☐ No If yes, explain surgery:_________________________________

____

Do you currently have symptomatic problems with menopause? *(Check all that apply)*

☐ Hot flashes ☐ Mood swings ☐ Concentration/memory problems ☐ Headaches ☐ Joint pain
☐ Vaginal dryness ☐ Weight gain ☐ Decreased libido ☐ Loss of control of urine ☐ Palpitations

Are you on hormone replacement therapy? ☐ Yes ☐ No

If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)?________________________

____

Other Gynecological Symptoms: *(Check if applicable)*

☐ Endometriosis ☐ Infertility ☐ Fibrocystic breasts ☐ Vaginal infection ☐ Fibroids
☐ Ovarian cysts ☐ Pelvic inflammatory disease ☐ Reproductive cancer
☐ Sexually transmitted disease (describe) ____

____

Gynecological Screening/Procedures: *(If applicable, provide date)*

Last Pap test: ________________________ ☐ Normal ☐ Abnormal
Last mammogram: __________________ ☐ Normal ☐ Abnormal
Last bone density: __________________ Results: ☐ High ☐ Low ☐ Within Normal Range
Other tests/procedures (list type and dates)____

____

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Family History:

Check family members that have/had any of the following

	Mother	Father	Brother (s)	Sister (s)	Child	Child	Child	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age (if still alive)													
Age at death (if deceased)													
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures/epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: ____________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Medical History: Illnesses/Conditions

Check YES = a condition you currently have, **Check PAST** = a condition you've had in the past.

Gastrointestinal	Yes	Past
Irritable bowel syndrome	☐	☐
GERD (reflux)	☐	☐
Crohn's disease/ulcerative colitis	☐	☐
Peptic ulcer disease	☐	☐
Celiac disease	☐	☐
Gallstones	☐	☐
Other:	☐	☐
Respiratory		
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Sinusitis	☐	☐
Sleep apnea	☐	☐
Other:	☐	☐
Urinary/Genital		
Kidney stones	☐	☐
Gout	☐	☐
Interstitial cystitis	☐	☐
Frequent yeast infections	☐	☐
Frequent urinary tract infections	☐	☐
Sexual dysfunction	☐	☐
Sexually transmitted diseases	☐	☐
Other:	☐	☐
Endocrine/Metabolic		
Diabetes	☐	☐
Hypothyroidism (low thyroid)	☐	☐
Hyperthyroidism (overactive thyroid)	☐	☐
Polycystic Ovarian Syndrome	☐	☐
Infertility	☐	☐
Metabolic syndrome/insulin resistance	☐	☐
Eating disorder	☐	☐
Hypoglycemia	☐	☐
Other:	☐	☐
Inflammatory/Immune		
Rheumatoid arthritis	☐	☐
Chronic fatigue syndrome	☐	☐
Food allergies	☐	☐
Environmental allergies	☐	☐
Multiple chemical sensitivities	☐	☐
Autoimmune disease	☐	☐
Immune deficiency	☐	☐
Mononucleosis	☐	☐
Hepatitis	☐	☐
Other:	☐	☐

Musculoskeletal	Yes	Past
Fibromyalgia	☐	☐
Osteoarthritis	☐	☐
Chronic pain	☐	☐
Other:	☐	☐
Skin		
Eczema	☐	☐
Psoriasis	☐	☐
Acne	☐	☐
Skin cancer	☐	☐
Other:	☐	☐
Cardiovascular		
Angina	☐	☐
Heart attack	☐	☐
Heart failure	☐	☐
Hypertension (high blood pressure)	☐	☐
Stroke	☐	☐
High blood fats (cholesterol, triglycerides)	☐	☐
Rheumatic fever	☐	☐
Arrythmia (irregular heart rate)	☐	☐
Murmur	☐	☐
Mitral valve prolapse	☐	☐
Other:	☐	☐
Neurologic/Emotional		
Epilepsy/Seizures	☐	☐
ADD/ADHD	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Autism	☐	☐
Multiple sclerosis	☐	☐
Parkinson's disease	☐	☐
Dementia	☐	☐
Other:	☐	☐
Cancer		
Lung	☐	☐
Breast	☐	☐
Colon	☐	☐
Ovarian	☐	☐
Skin	☐	☐
Other:	☐	☐

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Medical History *(cont.)*

Diagnostic Studies	Date	Comments
Bone density		
CT scan		
Colonoscopy		
Cardiac stress test		
EKG		
MRI		
Upper endoscopy		
Upper GI series		
Chest X-ray		
Other X-rays		
Barium enema		
Other:		
Injuries		
Broken bone(s)		
Back injury		
Neck injury		
Head injury		
Other:		
Surgeries		
Appendectomy		
Dental		
Gallbladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Joint replacement		
Heart surgery		
Other:		
Hospitalizations	**Date**	**Reason**

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Symptom Review

Please check if these symptoms occur presently or have occurred in the last 6 months

General	Mild	Moderate	Severe
Cold hands and feet	☐	☐	☐
Cold intolerance	☐	☐	☐
Daytime sleepiness	☐	☐	☐
Difficulty falling asleep	☐	☐	☐
Early waking	☐	☐	☐
Fatigue	☐	☐	☐
Fever	☐	☐	☐
Flushing	☐	☐	☐
Heat intolerance	☐	☐	☐
Night waking	☐	☐	☐
Nightmares	☐	☐	☐
Can't remember dreams	☐	☐	☐
Low body temperature	☐	☐	☐
Head, Eyes, and Ears			
Conjunctivitis	☐	☐	☐
Distorted sense of smell	☐	☐	☐
Distorted taste	☐	☐	☐
Ear fullness	☐	☐	☐
Ear ringing/buzzing	☐	☐	☐
Eye crusting	☐	☐	☐
Eye pain	☐	☐	☐
Eyelid margin redness	☐	☐	☐
Headache	☐	☐	☐
Hearing loss	☐	☐	☐
Hearing problems	☐	☐	☐
Migraine	☐	☐	☐
Sensitivity to loud noises	☐	☐	☐
Vision problems	☐	☐	☐
Musculoskeletal			
Back muscle spasm	☐	☐	☐
Calf cramps	☐	☐	☐
Chest tightness	☐	☐	☐
Foot cramps	☐	☐	☐
Joint deformity	☐	☐	☐
Joint pain	☐	☐	☐
Joint redness	☐	☐	☐
Joint stiffness	☐	☐	☐
Muscle pain	☐	☐	☐
Muscle spasms	☐	☐	☐
Muscle stiffness	☐	☐	☐
Muscle twitches:	☐	☐	☐
Around eyes	☐	☐	☐
Arms or legs	☐	☐	☐
Muscle weakness	☐	☐	☐

Musculoskeletal *(cont.)*	Mild	Moderate	Severe
Neck muscle spasm	☐	☐	☐
Tendonitis	☐	☐	☐
Tension headache	☐	☐	☐
TMJ problems	☐	☐	☐
Mood/Nerves			
Agoraphobia	☐	☐	☐
Anxiety	☐	☐	☐
Auditory hallucinations	☐	☐	☐
Blackouts	☐	☐	☐
Depression	☐	☐	☐
Difficulty:	☐	☐	☐
Concentrating	☐	☐	☐
With balance	☐	☐	☐
With thinking	☐	☐	☐
With judgment	☐	☐	☐
With speech	☐	☐	☐
With memory	☐	☐	☐
Dizziness (spinning)	☐	☐	☐
Fainting	☐	☐	☐
Fearfulness	☐	☐	☐
Irritability	☐	☐	☐
Light-headedness	☐	☐	☐
Numbness	☐	☐	☐
Other phobias	☐	☐	☐
Panic attacks	☐	☐	☐
Paranoia	☐	☐	☐
Seizures	☐	☐	☐
Suicidal thoughts	☐	☐	☐
Tingling	☐	☐	☐
Tremor/trembling	☐	☐	☐
Visual hallucinations	☐	☐	☐
Cardiovascular			
Angina/chest pain	☐	☐	☐
Breathlessness	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
High blood pressure	☐	☐	☐
Irregular pulse	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Palpitations	☐	☐	☐
Phlebitis	☐	☐	☐
Swollen ankles/feet	☐	☐	☐
Varicose veins	☐	☐	☐

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Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Urinary	Mild	Moderate	Severe
Bed wetting	☐	☐	☐
Hesitancy	☐	☐	☐
Infection	☐	☐	☐
Kidney disease	☐	☐	☐
Kidney stone	☐	☐	☐
Leaking/incontinence	☐	☐	☐
Pain/burning	☐	☐	☐
Urgency	☐	☐	☐
Digestion			
Anal spasms	☐	☐	☐
Bad teeth	☐	☐	☐
Bleeding gums	☐	☐	☐
Bloating of:	☐	☐	☐
Lower abdomen	☐	☐	☐
Whole abdomen	☐	☐	☐
Bloating after meals	☐	☐	☐
Blood in stools	☐	☐	☐
Burping	☐	☐	☐
Canker sores	☐	☐	☐
Cold sores	☐	☐	☐
Constipation	☐	☐	☐
Cracking at corner of lips	☐	☐	☐
Dentures w/poor chewing	☐	☐	☐
Diarrhea	☐	☐	☐
Difficulty swallowing	☐	☐	☐
Dry mouth	☐	☐	☐
Farting	☐	☐	☐
Fissures	☐	☐	☐
Foods "repeat" (reflux)	☐	☐	☐
Heartburn	☐	☐	☐
Hemorrhoids	☐	☐	☐
Intolerance to:	☐	☐	☐
Lactose	☐	☐	☐
All dairy products	☐	☐	☐
Gluten (wheat)	☐	☐	☐
Corn	☐	☐	☐
Eggs	☐	☐	☐
Fatty foods	☐	☐	☐
Yeast	☐	☐	☐
Liver disease/jaundice	☐	☐	☐
(yellow eyes or skin)			
Lower abdominal pain	☐	☐	☐
Mucus in stools	☐	☐	☐

Digestion *(cont.)*	Mild	Moderate	Severe
Nausea	☐	☐	☐
Periodontal disease	☐	☐	☐
Sore tongue	☐	☐	☐
Strong stool odor	☐	☐	☐
Undigested food in stools	☐	☐	☐
Upper abdominal pain	☐	☐	☐
Vomiting	☐	☐	☐
Eating			
Binge eating	☐	☐	☐
Bulimia	☐	☐	☐
Can't gain weight	☐	☐	☐
Can't lose weight	☐	☐	☐
Carbohydrate craving	☐	☐	☐
Carbohydrate intolerance	☐	☐	☐
Poor appetite	☐	☐	☐
Salt cravings	☐	☐	☐
Frequent dieting	☐	☐	☐
Sweet cravings	☐	☐	☐
Caffeine dependency	☐	☐	☐
Respiratory			
Bad breath	☐	☐	☐
Bad odor in nose	☐	☐	☐
Cough – dry	☐	☐	☐
Cough – productive	☐	☐	☐
Hayfever:	☐	☐	☐
Spring	☐	☐	☐
Summer	☐	☐	☐
Fall	☐	☐	☐
Change of season	☐	☐	☐
Hoarseness	☐	☐	☐
Nasal stuffiness	☐	☐	☐
Nose bleeds	☐	☐	☐
Post nasal drip	☐	☐	☐
Sinus fullness	☐	☐	☐
Sinus infection	☐	☐	☐
Snoring	☐	☐	☐
Sore throat	☐	☐	☐
Wheezing	☐	☐	☐
Winter stuffiness	☐	☐	☐

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Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Nails	Mild	Moderate	Severe
Bitten	☐	☐	☐
Brittle	☐	☐	☐
Curve up	☐	☐	☐
Frayed	☐	☐	☐
Fungus – fingers	☐	☐	☐
Fungus – toes	☐	☐	☐
Pitting	☐	☐	☐
Ragged cuticles	☐	☐	☐
Ridges	☐	☐	☐
Soft	☐	☐	☐
Thickening of:	☐	☐	☐
Finger nails	☐	☐	☐
Toenails	☐	☐	☐
White spots/lines	☐	☐	☐
Lymph Nodes			
Enlarged/neck	☐	☐	☐
Tender/neck	☐	☐	☐
Other enlarged/tender	☐	☐	☐
lymph nodes			
Skin, Dryness of			
Eyes	☐	☐	☐
Feet	☐	☐	☐
Any cracking?	☐	☐	☐
Any peeling?	☐	☐	☐
Hair	☐	☐	☐
And unmanageable?	☐	☐	☐
Hands	☐	☐	☐
Any cracking?	☐	☐	☐
Any peeling?	☐	☐	☐
Mouth/throat	☐	☐	☐
Scalp	☐	☐	☐
Any dandruff?	☐	☐	☐
Skin in general	☐	☐	☐
Skin Problems			
Acne on back	☐	☐	☐
Acne on chest	☐	☐	☐
Acne on face	☐	☐	☐
Acne on shoulders	☐	☐	☐
Athlete's foot	☐	☐	☐
Bumps on back of upper arms	☐	☐	☐
Cellulite	☐	☐	☐
Dark circles under eyes	☐	☐	☐

Skin Problems *(cont.)*	Mild	Moderate	Severe
Ears get red	☐	☐	☐
Easy bruising	☐	☐	☐
Eczema	☐	☐	☐
Herpes – genital	☐	☐	☐
Hives	☐	☐	☐
Jock itch	☐	☐	☐
Lackluster skin	☐	☐	☐
Moles w color/size change	☐	☐	☐
Oily skin	☐	☐	☐
Pale skin	☐	☐	☐
Patchy dullness	☐	☐	☐
Psoriasis	☐	☐	☐
Rash	☐	☐	☐
Red face	☐	☐	☐
Sensitive to bites	☐	☐	☐
Sensitive to poison ivy/oak	☐	☐	☐
Shingles	☐	☐	☐
Skin cancer	☐	☐	☐
Skin darkening	☐	☐	☐
Strong body odor	☐	☐	☐
Thick calluses	☐	☐	☐
Vitiligo	☐	☐	☐
Itching Skin			
Anus	☐	☐	☐
Arms	☐	☐	☐
Ear canals	☐	☐	☐
Eyes	☐	☐	☐
Feet	☐	☐	☐
Hands	☐	☐	☐
Legs	☐	☐	☐
Nipples	☐	☐	☐
Nose	☐	☐	☐
Genitals	☐	☐	☐
Roof of mouth	☐	☐	☐
Scalp	☐	☐	☐
Skin in general	☐	☐	☐
Throat	☐	☐	☐

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Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Female Reproductive	Mild	Moderate	Severe
Breast cysts	☐	☐	☐
Breast lumps	☐	☐	☐
Breast tenderness	☐	☐	☐
Ovarian cyst	☐	☐	☐
Poor libido (sex drive)	☐	☐	☐
Endometriosis	☐	☐	☐
Fibroids	☐	☐	☐
Infertility	☐	☐	☐
Vaginal discharge	☐	☐	☐
Vaginal odor	☐	☐	☐
Vaginal itch	☐	☐	☐
Vaginal pain	☐	☐	☐
Premenstrual:	☐	☐	☐
Bloating	☐	☐	☐
Breast tenderness	☐	☐	☐
Carbohydrate craving	☐	☐	☐
Chocolate craving	☐	☐	☐
Constipation	☐	☐	☐
Decreased sleep	☐	☐	☐
Diarrhea	☐	☐	☐
Fatigue	☐	☐	☐
Increased sleep	☐	☐	☐
Irritability	☐	☐	☐
Menstrual:	☐	☐	☐
Cramps	☐	☐	☐
Heavy periods	☐	☐	☐
Irregular periods	☐	☐	☐
No periods	☐	☐	☐
Scanty periods	☐	☐	☐
Spotting between	☐	☐	☐

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Medications/Supplements

Current medications (include prescription and over-the-counter)

Medication	Dosage	Start Date (mo/yr)	Reason for Use

Nutritional supplements (vitamins/minerals/herbs etc.)

Name and Brand	Dosage	Start Date (mo/yr)	Reason for Use

Have medications or supplements ever caused unusual side effects or problems? ☐ Yes ☐ No
If yes, describe: ____________________

Have you used any of these regularly or for a long time:
NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No Tylenol (acetaminophen)? ☐ Yes ☐ No
Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)? ☐ Yes ☐ No

How many times have you taken antibiotics?

	< 5	> 5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

Have you ever taken long term antibiotics? ☐ Yes ☐ No
If yes, explain: ____________________

How often have you taken oral steroids (e.g., cortisone, prednisone, etc.)?

	< 5	> 5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

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Readiness Assessment and Health Goals

Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health, how willing are you to:

Significantly modify your diet	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Take several nutritional supplements each day	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Keep a record of everything you eat each day	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Modify your lifestyle (e.g., work demands, sleep habits)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Practice a relaxation technique	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Engage in regular exercise	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you of your ability to organize and follow through on the above health-related activities? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through? ____

____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much ongoing support (e.g., telephone consults, email correspondence) from our professional staff would be helpful to you as you implement your personal health program? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments ____

____

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Health Goals

What do you hope to achieve in your visit with us? ______________________________

When was the last time you felt well? ______________________________

Did something trigger your change in health? ______________________________

What makes you feel better? ______________________________

What makes you feel worse? ______________________________

How does your condition affect you? ______________________________

What do you think is happening and why? ______________________________

What do you feel needs to happen for you to get better? ______________________________

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Medical Symptoms Questionnaire (MSQ)

Patient Name______________________________ Date______________

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale

0 – ***Never or almost never*** have the symptom
1 – ***Occasionally*** have it, effect is ***not severe***
2 – ***Occasionally*** have it, effect is ***severe***
3 – ***Frequently*** have it, effect is ***not severe***
4 – ***Frequently*** have it, effect is ***severe***

HEAD

______ Headaches
______ Faintness
______ Dizziness
______ Insomnia

Total ______

EYES

______ Watery or itchy eyes
______ Swollen, reddened or sticky eyelids
______ Bags or dark circles under eyes
______ Blurred or tunnel vision
(Does not include near or far-sightedness)

Total ______

EARS

______ Itchy ears
______ Earaches, ear infections
______ Drainage from ear
______ Ringing in ears, hearing loss

Total ______

NOSE

______ Stuffy nose
______ Sinus problems
______ Hay fever
______ Sneezing attacks
______ Excessive mucus formation

Total ______

MOUTH/THROAT

______ Chronic coughing
______ Gagging, frequent need to clear throat
______ Sore throat, hoarseness, loss of voice
______ Swollen or discolored tongue, gums, lips
______ Canker sores

Total ______

SKIN

______ Acne
______ Hives, rashes, dry skin
______ Hair loss
______ Flushing, hot flashes
______ Excessive sweating

Total ______

HEART

______ Irregular or skipped heartbeat
______ Rapid or pounding heartbeat
______ Chest pain

Total ______

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

_______ Chest congestion
_______ Asthma, bronchitis
_______ Shortness of breath
_______ Difficulty breathing

Total _______

DIGESTIVE TRACT

_______ Nausea, vomiting
_______ Diarrhea
_______ Constipation
_______ Bloated feeling
_______ Belching, passing gas
_______ Heartburn
_______ Intestinal/stomach pain

Total _______

JOINTS/MUSCLE

_______ Pain or aches in joints
_______ Arthritis
_______ Stiffness or limitation of movement
_______ Pain or aches in muscles
_______ Feeling of weakness or tiredness

Total _______

WEIGHT

_______ Binge eating/drinking
_______ Craving certain foods
_______ Excessive weight
_______ Compulsive eating
_______ Water retention
_______ Underweight

Total _______

ENERGY/ACTIVITY

_______ Fatigue, sluggishness
_______ Apathy, lethargy
_______ Hyperactivity
_______ Restlessness

Total _______

MIND

_______ Poor memory
_______ Confusion, poor comprehension
_______ Poor concentration
_______ Poor physical coordination
_______ Difficulty in making decisions
_______ Stuttering or stammering
_______ Slurred speech
_______ Learning disabilities

Total _______

EMOTIONS

_______ Mood swings
_______ Anxiety, fear, nervousness
_______ Anger, irritability, aggressiveness
_______ Depression

Total _______

OTHER

_______ Frequent illness
_______ Frequent or urgent urination
_______ Genital itch or discharge

Total _______

Grand Total _______

Daily Activity Questionnaire

Patient Name________________________________ Date______________

Please check the one best response for each activity described below:

SEDENTARY BEHAVIOR

Sitting while watching TV, at a computer, driving, talking on the phone, or reading

- ☐ 1 Most of the day
- ☐ 2 Half of the day
- ☐ 3 Some of the day
- ☐ 4 Rarely

Total__________

ACTIVITIES OF DAILY LIVING

Bathing, dressing, feeding self, toilet

- ☐ 1 Need some assistance
- ☐ 2 Slight difficulty
- ☐ 3 Minimal difficulty
- ☐ 4 No problem

Total__________

LAUNDRY

- ☐ 1 Unable
- ☐ 2 Occasionally
- ☐ 3 Regularly in small steps or with help
- ☐ 4 Regularly without help

Total__________

COOKING

- ☐ 1 Unable
- ☐ 2 Take-out, breakfast, or simple lunch only
- ☐ 3 Simple microwave or crockpot meal
- ☐ 4 Regular meals

Total__________

HOUSEKEEPING

- ☐ 1 Unable
- ☐ 2 Light dusting, straighten up
- ☐ 3 Regular housekeeping in small steps or with help
- ☐ 4 Fully capable

Total__________

GROCERY SHOPPING

- ☐ 1 Unable
- ☐ 2 Occasional (once or twice per month)
- ☐ 3 Frequent, but with assistance
- ☐ 4 No problem

Total__________

SOCIAL ACTIVITIES

Church, temple, family and friends

- ☐ 1 Unable
- ☐ 2 Infrequently
- ☐ 3 Occasionally (once or twice per month)
- ☐ 4 Frequently (weekly or more often)

Total__________

DRIVING

- ☐ 1 Unable
- ☐ 2 Very limited
- ☐ 3 Cautious, local trips
- ☐ 4 Distant trips or traffic

Total__________

ERRANDS OR LIGHT CHORES

Post office, drop off a child

- ☐ 1 None
- ☐ 2 0–1 per day
- ☐ 3 2–3 per day
- ☐ 4 No or few restrictions

Total__________

Grand Total__________

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Sleep Questionnaire

Patient Name________________________________ Date______________

Sleep is important for musculoskeletal healing and for healthy immune function, mood, cognitive and brain function, and for many physiological functions.

Please answer the following questions as accurately and fully as possible. For Yes / No questions, please check the correct answer and provide an explanation if one is requested. The information will help to determine whether you are getting the sleep you need and to identify possible strategies to help you sleep better.

Sleep Problems:

1. Do you have a sleep problem that has been diagnosed? ☐ Yes ☐ No
   If yes, what?________________________________
2. Do you feel that you have a sleep problem? ☐ Yes ☐ No
   If yes, how would you describe it? ________________________________

Sleepiness Questions:

3. Do you feel well rested in the morning? ☐ Yes ☐ No
   Please explain ________________________________
4. Are there times during the day or evening that you feel sleepy? ☐ Yes ☐ No
   If yes, what times are these?________________________________
5. What do you do to wake up when you feel sleepy? ________________________________
6. Have you ever had an accident at work, at home or on your job because you were sleepy? ☐ Yes ☐ No
   If yes, please explain ________________________________
7. Do you take naps? ☐ Yes ☐ No
   If yes, for how many minutes and at what time of day? ________________________________
8. Do you feel well rested after a nap? ☐ Yes ☐ No

Insomnia Questions:

9. Can you usually fall asleep within 20 minutes of lying in bed? ☐ Yes ☐ No
10. How long does it usually take you to fall asleep? ________________________________
11. Do you ever feel so wired at night that it is difficult to fall asleep? ☐ Yes ☐ No
12. Have you had a saliva cortisol test? ☐ Yes ☐ No
    If yes, what was your night time level? ________________________________

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Insomnia Questions:

13 Do you currently take, or have you tried, any of the following sleep aids to fall asleep? ☐ Yes ☐ No
If yes, how many times per week do you take them? Please answer with an **E** for effective or an **N** for not effective in helping you to sleep:

Sleep Aids	Tried in the past?	Taking now?	Dosage?	E or N?
Ambien (zolpidem)				
Sonata (zaleplon)				
Valium (diazepam)				
Ativan (lorazepam)				
Restoril (temazepam)				
Tylenol PM				
Benadryl				
Calcium/Magnesium				
Valerian				
Kava				
Melatonin				
L-Tryptophan				
Other? *(Please specify)* ____________				

14 Do you wake up in the middle of the night? ☐ Yes ☐ No
If yes, how many times times and for what reasons? ____________

15 Do you have any trouble falling back asleep when you wake up? ☐ Yes ☐ No
If yes, how long does it usually take you? ____________

16 Does feeling the need to move your feet or legs at night keep you awake or have you been diagnosed with Restless Legs Syndrome? ☐ Yes ☐ No

17 Do you have disturbing dreams at night? ☐ Yes ☐ No

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Caffeine and Other Stimulants:

18 If you drink or eat any of the following, please indicate how much (number of ounces, cups, glasses, etc.), how often per day, and at what times per day?

Do you use...	How much?	How often per day?	When during the day?
Coffee			
Caffeinated sodas *(Coke, Pepsi, Mountain Dew, etc.)*			
Caffeinated water			
Green tea			
Black tea			
Other tea			
Chocolate			
Coffee or espresso ice creams			
Sudafed or other OTC cold medications			
Alcohol			

19 What medications are you on and what time do you take them?

____

____

____

Stress and Stress Reduction:

20 What kind of stress have you been under in the past few months? ______________________

21 What do you do for stress management? ______________________

22 Do you have a journal to write in that is near your bed? ☐ Yes ☐ No

23 Do you exercise aerobically? ☐ Yes ☐ No
If yes, what do you do, how often do you exercise, and at what time of day? ______________________

____

Sleep Hygiene:

24 What time do you usually go to bed? ______________________

25 What time do you usually wake up? ______________________

26 Do you feel that you go to bed too late? ☐ Yes ☐ No
If yes, what time would you like to go to bed? ______________________

27 Do you watch TV in the evenings ☐ Yes ☐ No
If yes, what hours do you watch it? ______________________

28 Is the TV in your bedroom or in a family room? ______________________

29 On the weekend or days off do you vary your sleep schedule? ☐ Yes ☐ No

30 How many hours are you physically in your bed? ______________________

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Sleep Hygiene:

31 How many hours of the time spent in bed are you actually asleep? ____________________

32 Do you have much light coming into your bedroom? ☐ Yes ☐ No

33 What can you see at night without any lights on? ____________________

34 Do you have little children who wake you up? ☐ Yes ☐ No

Bedroom, Breathing and Environment:

35 Is the air in your bedroom clean or dirty? ____________________

36 Are there any unusual smells in your bedroom? ☐ Yes ☐ No
If yes, please describe ____________________

37 Do you snore, stop breathing, or have trouble breathing at night? ☐ Yes ☐ No

38 Do you use Breathe-Easy strips on your nose? ☐ Yes ☐ No If yes, do they help you to breath? ☐ Yes ☐ No

39 Do you have carpets or hardwood floors in your bed room? ____________________

40 How many rooms in your home have carpets and how old are the carpets? ____________________

41 What type of heat is in your home: forced air or radiant? ____________________

42 How often do you change the furnace filter in your home? ____________________

43 Have you seen any black mold in your window sills or in a basement? ☐ Yes ☐ No

44 Do you have a HEPA air filter for your bedroom? ☐ Yes ☐ No
If yes, what brand is it and how long do you run it each day? ____________________

45 What type of vacuum cleaner do you use and does it have a HEPA filter in it? ____________________

46 How often do you clean the dust in your bedroom? ____________________

47 Do you sleep with an animal that snores or moves around and disturbs you? ☐ Yes ☐ No

48 Do you sleep with a bed partner who snores, moves around at night or disturbs you when you are trying to sleep?
☐ Yes ☐ No

49 Do noises wake you up? ☐ Yes ☐ No
If yes, what are they? ____________________

50 Do you live on a noisy street? ☐ Yes ☐ No

51 Do you feel safe in your bed at night? ☐ Yes ☐ No
If not, explain ____________________

Bed, Pillows, and Pain:

52 What type of bed do you have and what size is it? ____________________

53 Do you wake up because of pain? ☐ Yes ☐ No
If yes, at what time and where is the pain? ____________________

54 What type of pillow is most comfortable for you and what type have you tried that did not work?
____

55 Do you use body pillows? ☐ Yes ☐ No
If yes, how many and how do you use them? ____________________

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Depression Anxiety Stress Scales

Patient Name________________________________ Date______________

Please read each statement and circle a number 0, 1, 2 or 3 that indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 – ***Did not apply*** to me at all
1 – ***Applied to me to some degree,*** or some of the time
2 – ***Applied to me to a considerable degree,*** or a good part of time
3 – ***Applied to me very much,*** or most of the time

	SYMPTOMS	Rating Scale			
1	I found myself getting upset by quite trivial things	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I just couldn't seem to get going	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I had a feeling of shakiness (e.g., legs going to give way)	0	1	2	3
8	I found it difficult to relax	0	1	2	3
9	I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting upset rather easily	0	1	2	3
12	I felt that I was using a lot of nervous energy	0	1	2	3
13	I felt sad and depressed	0	1	2	3
14	I found myself getting impatient when I was delayed in any way (e.g., elevators, traffic lights, being kept waiting)	0	1	2	3
15	I had a feeling of faintness	0	1	2	3
16	I felt that I had lost interest in just about everything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I perspired noticeably (e.g., hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life wasn't worthwhile	0	1	2	3

From: Lovibond, SH and Lovibond PF. (1995) Manual for the Depression Anxiety Stress Scales (2nd Ed.). Sydney: Psychology Foundation

Please turn the page

The rating scale is as follows:

0 – ***Did not apply*** to me at all

1 – ***Applied to me to some degree,*** or some of the time

2 – ***Applied to me to a considerable degree,*** or a good part of time

3 – ***Applied to me very much,*** or most of the time

SYMPTOMS (continued)	Rating Scale			
22 I found it hard to wind down	0	1	2	3
23 I had difficulty in swallowing	0	1	2	3
24 I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25 I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3
26 I felt down-hearted and blue	0	1	2	3
27 I found that I was very irritable	0	1	2	3
28 I felt I was close to panic	0	1	2	3
29 I found it hard to calm down after something upset me	0	1	2	3
30 I feared that I would be "thrown" by some trivial but unfamiliar task	0	1	2	3
31 I was unable to become enthusiastic about anything	0	1	2	3
32 I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33 I was in a state of nervous tension	0	1	2	3
34 I felt I was pretty worthless	0	1	2	3
35 I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
36 I felt terrified	0	1	2	3
37 I could see nothing in the future to be hopeful about	0	1	2	3
38 I felt that life was meaningless	0	1	2	3
39 I found myself getting agitated	0	1	2	3
40 I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
41 I experienced trembling (e.g., in the hands)	0	1	2	3
42 I found it difficult to work up the initiative to do things	0	1	2	3

From: Lovibond, SH and Lovibond PF. (1995) Manual for the Depression Anxiety Stress Scales (2nd Ed.). Sydney: Psychology Foundation