#### Ayurvedic **Detailed Health Self Assessmen**t Form

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_e-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_\_\_\_Height: \_\_\_\_\_\_\_Weight: Past\_\_\_\_\_\_\_ Current\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_

Birthday: \_\_\_\_\_\_\_\_\_ M / F Marital Status: M / S / D / W



What do you want to achieve with this Ayurvedic consultation?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear of Vedic Health ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your present health concerns, when they began and their duration:

How long have you had the chronic conditions about which you are consulting us?

□ Less than 6 months □ 6 months to 2 years □ 2 to 5 years □ More than 5 years

How has your health problem progressed since it began?

□ Stable □ Gradually improving □ Rapidly improving □ Fluctuating

□ Gradually worsening □ Rapidly worsening

Please explain the overall intensity of your symptoms?

□ Very severe □ Severe □ Moderate □ Mild

Is your sleep disturbed by the symptoms?

□ Not at all □ Somewhat □ Moderately □ Severely □ Very severely

To what extent are you having any degree of bodily pain or discomfort?

□ Not at all □ Mild □ Moderate □ Severe □ Very severe

How often are you having pain or discomfort?

□ Always □ Less than once a week □ Several times per week □ Several times a day

How long does the pain or discomfort last on the average?

□ No pain □ 10-15 min □ 30 minutes □ One hour □ Many hours □ All the time

Are you currently under the care of family physician or any other health professional?

□ Yes □ No If yes, mention details : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is their opinion about your health?

□ Easily cured □ Difficult to cure □ Incurable □ Did not say

Have you undergone any investigations for blood, urine, stools, x-ray, ultra-sound, MRI etc?

If yes, please specify in detail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any medications and/or receiving any medical treatment for your health condition?

If so, please list all medications/treatments and their dosage:

|  |  |  |
| --- | --- | --- |
| **Type of Medicines** | **Past** | **Present** |
| Prescription Medicines |  |  |
| Over the counter Medicines |  |  |
| Herbs / Vitamins |  |  |

Do you experience any of the following symptoms in various seasons?

|  |  |  |
| --- | --- | --- |
| **WINTER** | **SUMMER** | **SPRING** |
| * Attention Deficit
* Anxiety
* Constipation
* Dry / rough skin
* Depression
* Fatigue
* Headache
* Hyperactivity
* Insomnia
* Intolerance to cold
* Restlessness
* Stomachaches
* Underweight / weight loss
* Worry
 | * Acne
* Anger
* Boils
* Burning in the eyes
* Diarrhea
* Excessive body heat
* Excessive competition
* Excessive Hunger
* Frustration
* Hostility
* Inflammation of skin
* Irritability
* Rashes
* Visual problems
 | * Asthma
* Apathy
* Bronchitis
* Depression
* Difficulty paying attention
* Nasal allergies
* Neediness
* Oily skin
* Overweight
* Slow digestion
* Sinus congestion
* Spaceyness
* Skin growths
* Possessiveness
 |
| **Total** | **Total** | **Total** |

Is there a family history of this health problem?

□ Yes □ No If yes*,* please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Concern | Father | Mother | Brothers | Sisters | Spouse | Child | Other |
| Age (if living) |  |  |  |  |  |  |  |
| Age (at death) |  |  |  |  |  |  |  |
| Cause of death |  |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |
| Epilepsy |  |  |  |  |  |  |  |
| Glaucoma |  |  |  |  |  |  |  |
| Heart disease |  |  |  |  |  |  |  |
| High blood pressure |  |  |  |  |  |  |  |
| Hay fever |  |  |  |  |  |  |  |
| Hives |  |  |  |  |  |  |  |
| Kidney disease |  |  |  |  |  |  |  |
| Mental disease |  |  |  |  |  |  |  |
| Rheumatic arthritis |  |  |  |  |  |  |  |
| Tuberculosis |  |  |  |  |  |  |  |
| Syphilis |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |
| Others |  |  |  |  |  |  |  |

Do you have any past medical history? If yes, please specify the age of occurrence, duration and its treatment.

Please indicate if you have ever had any of the following:

|  |  |  |
| --- | --- | --- |
| **Disease** | **Past** | **Present** |
| Measles |  |  |
| Migraine |  |  |
| Arthritis |  |  |
| Rheumatism |  |  |
| Bone disease |  |  |
| Joint Disease |  |  |
| Alcoholism |  |  |
| Neuritis |  |  |
| Thyroid disease |  |  |
| Other headaches |  |  |
| Meningitis |  |  |
| Tension |  |  |
| Anxiety |  |  |
| Depression |  |  |
| Drug Abuse |  |  |
| Nervous breakdown |  |  |
| Venereal disease |  |  |
| Cancer |  |  |
| Anemia |  |  |
| High Blood pressure |  |  |
| Hay Fever |  |  |
| Poison ivy / oak |  |  |
| Rheumatic fever |  |  |
| Scarlet fever |  |  |
| Childhood hyperactivity |  |  |
| Genetic disease |  |  |
| Tuberculosis |  |  |
| Skin disorders |  |  |
| Liver disorders |  |  |
| Stroke |  |  |
| Blood disease |  |  |
| Yellow Jaundice |  |  |
| Asthma |  |  |
| Chickenpox |  |  |
| Polio |  |  |
| Diphtheria |  |  |
| Smallpox |  |  |
| Diverticulosis |  |  |
| Hemorrhoids |  |  |
| Hernia |  |  |
| Kidney disease |  |  |
| Kidney stones |  |  |
| Gallbladder stones |  |  |
| Chronic sinusitis |  |  |
| Broken bones |  |  |
| Concussion |  |  |
| Nasal Allergies |  |  |
| Skin Allergies |  |  |
| Bronchitis |  |  |
| Mumps |  |  |
| Emphysema |  |  |
| Pneumonia |  |  |
| Pancreatitis |  |  |
| Ulcers |  |  |
| Bursitis |  |  |
| Sciatica |  |  |
| Low back pain |  |  |
| Diabetes |  |  |
| Heart Trouble |  |  |
| Head Injury |  |  |
| Malaria |  |  |
| Others |  |  |

## How severe are your symptoms?

## □ Very severe □ severe □ moderate □ Mild

Are you allergic to any substances? Please specify: food, pollen, dust etc., and list the details of the allergic reaction.

Health as a child: □ Good □ Fair □ Poor

Childhood illnesses:

□ Scarlet Fever □ German measles □ Measles □ Mumps

□ Bronchial problems □ Rheumatic fever □ Diphtheria □ Other \_\_\_\_\_\_\_\_\_\_\_\_

Immunizations / Vaccinations:

□ Smallpox □ Polio □ Typhoid □ Mumps □ Tetanus □ Influenza □ Others\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Vaccination Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any of the following regularly?

□ Microwave □ Nonstick/Tephlon □ Aluminum Cookware □ Hair dye

Do you have Mercury fillings (Amalgams)?

□ Yes □ No, if yes, please explain since how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your usual energy level?

□ Very high □ High □ Moderate □ Low □ Very low

Describe your bowel movements?

□ Once every 2-3 days □ Once daily □ 2-3 times per day

□ First thing in the morning □ Late in daytime □ Immediately after meals

□ Immediately after dinner□ Need laxative daily □ Other, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_

Bowel nature: □ Soft □ Medium □ Hard

Bowel movement associated with: □ Pain □ Gas □ Blood □ Mucous □ Foul smell

□ Other \_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following urinary problems?

□ Pain □ Burning sensation □ Discoloration □ Other discharges

□ Frequent urination during the day □ Urination several times during the night

□ Urine retention □ Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you delay or suppress any of the following?

□ Bowel movements □ Gas □ Urination □ Sleep □ Yawning □ Burping

□ Breathing □ Sneezing □ Hunger □ Thirst □ Semen □ Cry, tears

Do you practice any type of meditation or prayer? Please explain.

Do you practice any Yoga techniques? Please explain.

What is your present state of mind and emotions? □ Good □ Fair □ Poor

Do you often experience any of the following?

□ Worry □ Anxiety □ Fear or panic
□ Loneliness □ Depression □ High stress level

□ Lack of memory □ Light-headedness □ Lack of energy

□ Suicidal tendency □ Anger □ Irritation

What are your work hours? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you work late? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wake up early? □ Yes □ No At what time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Do you go to bed early? □ Yes □ No At what time\_\_\_\_\_\_\_\_\_\_\_\_\_

## Do you sleep in the daytime? □ Yes □ No

How do you generally feel upon arising in the morning?

□ Fresh and rested □ Little tired □ Moderately tired □ Fairly tired

How is your sleep?

□ Sound, normal duration □ Light, interrupted □ Too little sleep

□ Too heavy and or too long □ Difficulty falling asleep □ Difficulty waking up

□ Awaken too early □ Frequently nightmares

To what direction does your head point during sleep?

□ East □ West □ North □ South

□ Northeast □ Northwest □ Southwest □ Southeast

What is your sleeping position?

□ On back □ On tummy □ Left side □ Right side □ Other, please specify\_\_\_\_\_\_\_\_\_\_\_\_\_

How regular is your daily routine (for example, do you go to bed early, eat your meals on time, exercise regularly etc?)

□ Very regular □ Somewhat regular □ Irregular

What is your body build? □ Thin □ Large □ Average □ Muscular

## Are you overweight? □ Yes □ No If so, by how much?

## □ Less than 15 pounds □ 15-30 pounds □ 30-50 pounds □ More about 50 pounds

## Do you travel frequently? □ Yes □ No If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you exercise?

□ 1x per week □ 2x per week □ 3x per week □ 4x per week □ Every day □ Not at all

How long do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_What type of exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your exercise: (choose one) □ Vigorous □ Moderate □ Light

Type of exercise:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke cigarettes, or have you ever? □ Yes □ No

## If yes, how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## How often do you drink alcohol?

□ Never □ 1x per week □ 2-3x per week □ 4-5x per week □ Every day

How much alcohol each time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you drink caffeinated (coffee, tea etc) beverages?

□ Never □ 1 cup per day □ 2-3 cups per day □ 4-5 cups day □ More than I can count

Which type of weather makes you feel most uncomfortable?

□ Cold □ Hot/humid □ Damp/rainy

**HOW OFTEN DO YOU EAT THE FOLLOWING FOOD GROUPS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Food groups | Daily | Weekly | Monthly | Never |
| Grains / Cereals |  |  |  |  |
| Vegetables |  |  |  |  |
| Fruits |  |  |  |  |
| Dairy |  |  |  |  |
| Eggs |  |  |  |  |
| Poultry |  |  |  |  |
| Meat |  |  |  |  |
| Seafood |  |  |  |  |
| Sugar / Honey |  |  |  |  |
| Desserts |  |  |  |  |
| Juices |  |  |  |  |
| Other |  |  |  |  |

Please explain your typical diet:

Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you eat between meals? □ Yes □ No

Do you eat your meals on time? □ Yes □ No

Which is your main meal? □ Breakfast □ Lunch □ Dinner

Rate your digestion: □ Good □ Fair □ Poor

How much water do you drink per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My eating habits include:

□ Eat with full attention on food □ Eat regular times

□ Talk while eating □ Eat very fast

□ Watch television while eating □ Stand to eat □ Never on time

Describe your diet: □ Vegan □ Lacto-vegetarian □ Ova-lacto-vegetarian □ Others please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Non-vegetarian:

□ Beef □ Pork □ Chicken □ Turkey □ Seafood □ Eggs

Have you experienced any changes in your sense of taste?

□ Loss of taste □ Sweet taste in mouth □ Sour taste in mouth

□ Bitter taste in mouth □ Pungent taste in mouth □ Not specific

## What taste(s) do you like or crave?

## □ Sweet □ Salty □ Bitter □ Sour □ Hot/Spicy □ Starches □Oily

Are there any particular foods that create discomfort when you eat them?

□ Sweet □ Sour □ Oily or fatty □ Hot □ Salty □ Bitter

□ Astringent □ Dairy products (including cheese)

How are your family relationships? □ Excellent □ Good □ Fair □ Poor

How is your social life? □ Excellent □ Good □ Fair □ Poor

How is your mental status? □ Excellent □ Good □ Fair □ Poor

How is your career? □ Love it □ Like it □ Can stand it □ Cannot stand it

How purposeful is your life? □ Completely □ somewhat □ neutral □ not happy

Rate your spiritual life: □ Fully satisfying □ somewhat satisfying □ neutral □ empty

As a child, did you experience any abuse or trauma? □ None □ Emotional □ Physical

□ Sexual □ Verbal □ Other, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Men only:**

Do you have any problems?

□ Hernias □ Testicular masses □ Sexually active □ Sexual difficulties

□ Prostate problems □ Venereal disease □ Discharge or sores □ Libido

□ Problem starting urination □ Problem stopping urination □ Erection problems

□ Birth control □ Tenderness, enlargement of breast

**For Women only:**

Age menses began\_\_\_\_\_\_\_\_

Which of the following describes your menstruation? (You may choose more than one)

□ Regular □ Irregular □ Too frequent □ Absent □ Ceased due to menopause

## How many days does your menstrual period last?

□ Zero to four days □ Five to seven days □ More than seven days

□ Spotty irregularly throughout the month □ Others, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## How is your menstrual flow? □ Heavy □ Light □ Normal □ Abnormal vaginal discharges

Associated symptoms (before or during menstruation):

□ None □ Pain □ Fluid retention □ Migraine □ Depression

□ Acne □ Tension □ Anger □ Frustration □ Loneliness

□ Nightmares □Suicidal tendency □ Other, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any discharge outside of your menstrual period? □ Yes □ No

Do you experience pain during intercourse? □ Yes □No

Do you have any sexual difficulties? □ Yes □ No

*If yes, please explain : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

## Are you pregnant now? □ Yes □ No □ Don’t know

Do you take contraceptive pills or other devices? □ Yes □ No

Number of previous pregnancies (choose one) 0 / 1 / 2 / 3 / 4 / 5 / 6 / 7 or more

Do you have any history of abortion, miscarriage, etc? If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many children do you have? \_\_\_\_\_\_\_\_\_\_ Children’s ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you self-exam breasts regularly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience any problems in breasts? □ Lumps □ Pain or tenderness □ Nipple discharge □ Others

**Questionnaire Regarding Impurities**

Please circle that the following statements apply to you

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Signs & Symptoms** | **None** | **Mild** | **Moderate** | **Severe** |
| I generally feel constipated.  | 0 | 1 | 2 | 3 |
| I often get congestion in my head and sinuses  | 0 | 1 | 2 | 3 |
| I often get infections.  | 0 | 1 | 2 | 3 |
| I feel my immune system is weak  | 0 | 1 | 2 | 3 |
| I feel non-clarity of mind  | 0 | 1 | 2 | 3 |
| I feel physically exhausted without any reason  | 0 | 1 | 2 | 3 |
| I feel mentally exhausted easily  | 0 | 1 | 2 | 3 |
| My stress levels are  | 0 | 1 | 2 | 3 |
| I have no desire to eat food  | 0 | 1 | 2 | 3 |
| I tend to feel indigestion frequently  | 0 | 1 | 2 | 3 |
| I tend to get lot of salivation in the mouth  | 0 | 1 | 2 | 3 |
| I easily get angry and irritated without any real reason  | 0 | 1 | 2 | 3 |
| I feel that my breathing pattern altered  | 0 | 1 | 2 | 3 |
| I frequently get cold throughout the year  | 0 | 1 | 2 | 3 |
| I tend to get allergies throughout the year  | 0 | 1 | 2 | 3 |
| I feel heaviness in the body  | 0 | 1 | 2 | 3 |
| I feel something is not well in my mind-body  | 0 | 1 | 2 | 3 |
| Total  |  |  |  |  |

1 to 17 = Mild 17 to 34 = Moderate 35 to 51 = Severe

**Questionnaire Regarding Digestion**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Signs & Symptoms** | **None** | **Mild** | **Moderate** | **Severe** |
| Abdominal pain | 0 | 1 | 2 | 3 |
| Anorexia | 0 | 1 | 2 | 3 |
| Body aches  | 0 | 1 | 2 | 3 |
| Fainting  | 0 | 1 | 2 | 3 |
| Fever | 0 | 1 | 2 | 3 |
| Flatulence | 0 | 1 | 2 | 3 |
| Giddiness / dizziness | 0 | 1 | 2 | 3 |
| Gripping pain / colic | 0 | 1 | 2 | 3 |
| Headache | 0 | 1 | 2 | 3 |
| Heaviness in abdomen | 0 | 1 | 2 | 3 |
| Improper digestion | 0 | 1 | 2 | 3 |
| Malaise | 0 | 1 | 2 | 3 |
| Slow digestion | 0 | 1 | 2 | 3 |
| Stiffness in back or waist | 0 | 1 | 2 | 3 |
| Thirst (excessive) | 0 | 1 | 2 | 3 |
| Nausea | 0 | 1 | 2 | 3 |
| Vomiting | 0 | 1 | 2 | 3 |
| **TOTAL** |  |  |  |  |

**Questionnaire Regarding Parasites**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Abdominal bloating | 0 | 1 | 2 | 3 |
| Abdominal pain | 0  | 1 | 2 | 3 |
| Allergy | 0  | 1 | 2 | 3 |
| Anal itching | 0 | 1 | 2 | 3 |
| Anemia | 0 | 1 | 2 | 3 |
| Arthritis | 0 | 1 | 2 | 3 |
| Bloody stool | 0 | 1 | 2 | 3 |
| Cervicitis | 0  | 1 | 2 | 3 |
| Chronic fatigue | 0 | 1 | 2 | 3 |
| Colitis | 0 | 1 | 2 | 3 |
| Constipation | 0  | 1 | 2 | 3 |
| Crohn’s disease | 0 | 1 | 2 | 3 |
| Decreased libido | 0  | 1 | 2 | 3 |
| Depression | 0  | 1 | 2 | 3 |
| Diarrhea | 0 | 1 | 2 | 3 |
| Fever | 0 | 1 | 2 | 3 |
| Flatulence | 0 | 1 | 2 | 3 |
| Food allergies | 0 | 1 | 2 | 3 |
| Foul-smelling stool | 0  | 1 | 2 | 3 |
| Heartburn | 0 | 1 | 2 | 3 |
| Hives | 0 | 1 | 2 | 3 |
| Hyperactivity | 0  | 1 | 2 | 3 |
| Insomnia | 0 | 1 | 2 | 3 |
| Irritability | 0  | 1 | 2 | 3 |
| Itching | 0  | 1 | 2 | 3 |
| Loss of appetite | 0 | 1 | 2 | 3 |
| Mood swings | 0 | 1 | 2 | 3 |
| Mucous stool | 0 | 1 | 2 | 3 |
| Night sweats | 0 | 1 | 2 | 3 |
| Nightmares | 0  | 1 | 2 | 3 |
| Pelvic inflammatory disease | 0 | 1 | 2 | 3 |
| Rashes | 0 | 1 | 2 | 3 |
| Spaceyness | 0  | 1 | 2 | 3 |
| Vaginitis | 0 | 1 | 2 | 3 |
| Vomiting | 0 | 1 | 2 | 3 |
| Weight loss | 0  | 1 | 2 | 3 |
| **TOTAL** |  |  |  |  |

0-17 Mild 18-34 Moderate 35-70 Severe 71-108 Very Severe