My Naturopath.....Leanne Jenkins

HEALTH APPRAISAL QUESTIONNAIRE – (HAQ) INSTRUCTIONS

This questionnaire is designed to give us a very thorough assessment of your nutritional strengths and weaknesses.

For the best results, please fill out the attached questionnaire according to these instructions.

- 1. Fill out only one answer per question.
- 2. Some questions are asked more than one time. This is not a mistake. Each section of the questionnaire is related to a different part of your body and your symptoms may be related to more than one condition.
- 3. If you are unsure how to answer a particular question, do not hesitate to ask for help, we will be happy to assist you.

CONTEXT OF HEALTH QUESTIONNAIRE

Thank you for your time and thoughtfulness in completing this questionnaire. It will allow for a greater insight into your health and lifestyle, which will ultimately lead you to realizing your greatest health potential.

1.	How did you hear abou	t our clinic?			
	Friend () Family member () Health Practitioner () Newspaper () Television () Yellow Pages ()				
	Flyer () Brochure () W				
2.	What level of Healthcan	re are you interested in?			
	() Symptomatic Care	ie: Support and relief from symptoms			
	() Corrective Care	ie: Provides symptomatic relief and looks into the causes through diet and lifestyle			
		Corrective Care also looks deeply into your health issues and creates powerful life changes.			
3.	B. How long do you think it will take you to achieve your health potential?				
4.	Why is your health imp	ortant to you?			

- 5. Do you think the signs and symptoms you are experiencing at the present are trying to tell you something? Yes () No ()
- 6. Do you feel the signs and symptoms are a result of either short term () or long term () factors?
- 7. Do you use? Tobacco () recreational drugs () coffee () alcohol () sweets () chocolate () Other ()
- 8. If you answered yes to any of these, do you believe that these habits can/will compromise your health and vitality? Yes () No ()

8a.	What current behavioural/lifestyle habits do you believe need to change to benefit your health? Diet () Exercise () Rest () Relaxation () Occupation () Creative Expression () Addictive Behaviour Emotional Responses ()	rs ()						
8b.	Which of these areas of your life would you like to improve on first?							
8c.	What behaviours or lifestyle habits do you currently engage in regularly, that you believe support you Health?	ır						
9.	What is your present level of commitment in addressing your health issues and their underlying cause? 1-10. One being low – ten being high.	Rate						
10.	Reflect on your priorities and list the highest 3 in your life at present.							
	2							
	3							
	f you did not include health as one of your top priorities, how would you rate it? Low () Med () High	()						
12.	Do you believe your present lifestyle and state of health is affecting any of the following: Income () Vitality () Quality of Life () Relationships () Future Health () Emotions () Career ()							
	What level of resources are you prepared to commit to your health and wellbeing?							
	Fime Low() Medium() High() Energy Low() Medium() High()							
	Finance Low() Medium() High()							
	What do you think could stop you from achieving your health potential? Time constraints () Commitments () Financial Resources () Emotional Support () Lack of Interest () Effectiveness () Other ()							
	15. In order to achieve your true health potential, how much education/training/motivation do you feel you need? Rate 1-10. One being low – ten being high.							
	1 2 3 4 5 6 7 8 9 10							

SYMPTOMATIC SCREENING QUESTIONAIRE (SSQ)

Name Date

0 = never or rarely 1 = twice a week or less 2 = 3 to 6 times a week 3 = daily or several times a day Circle the number which best describes the frequency of your symptoms. If you do not know the answer to the question, leave it blank. When you are finished, please add the number of points in each section and enter the number on the Total Points line. The score for Yes is the number inside the brackets.

Section A ND DYSBIOSIS	line. The score for Yes is the number inside the bra	ackets.		
1. Bad Breath	DIGESTION AND DYSBIOSIS		STRESS	
1. Bad Breath	Section A			
2. Bad body odour 3. Excessive helching, burping or bloating 4. Indigestion & fullness lasts 2.4 hrs after eating 5. Excessive gas & bloating 6. Abdominal cramping, aches and pains 7. Specific food & beverage aggravation Indigestion and causing bloating 8. Crave sugar, breads, sweets or alcohol 9. Rumbling noises aller food 10. Gas immediately alter meals 11. Sweet of fibre cause constipation 12. Stool-undigested food present 12. Sirapit red blood following bowel movement 15. Bright red blood following bowel movement 19. On birth control pill more than 2 years 19. Cately 11. Separation from partner 12. Divorce 12. Total points 12. Successful for the control pill more than 2 years 19. Feel in gride of poor health 2. Fatty foods cause indigestion on the skin or nails. 19. Feel in gride of the control pill more than 2 years 19. Feel in gride of the control pill more than 2 years 19. Feel in gride of the control pill more than 2 years 19. Feel in gride of the control pill more than 2 years 19. Feel in gride of poor health 2. Fatty foods cause indigestion 2. Fatty foods cause indigestion 2. Fatty foods cause indigestion 2. Feel in gride of poor health 2. Fatty foods cause indigestion 2. Feel in gride of poor health 2. Fatty foods cause indigestion 2. Feel in gride of poor health 2. Fatty foods cause indigestion 2. Feel in gride of poor health 2. Fatty foods cause indigestion 2. Feel in gride of poor health 2. Fatty foods cause indigestion 3. Feeling of extreme drynes 2. Feel in gride of poor health 2. Fatty foods cause indigestion 3. Feeling of extreme drynes 2. Feel in gride of poor health 2. Feel		0 1 2 3		
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SYMPTOMATIC SCREENING QUESTIONNAIRE GRAPH

		A. Digestition & Dysbiosis	B. Liver	C. Stress	D. Vitality	E. Weight
	100%	15	15	15	15	15
High Priority		11	11	11	11	11
	75%	9	9	9	9	9
Moderate Priority		7	7	7	7	7
Thority	50%	5	5	5	5	5
	25%	4	4	4	4	4
Low Priority		3	3	3	3	3
		1	1	1	1	1
	0%	0	0	0	0	0

LIFESTYLE APPRAISAL

Please indicate on each of these scales where you think and feel you are currently functioning in these areas of your life. There are obviously no right or wrong answers here so just be honest with yourself, listen to your intuition and mark your response by putting a cross at the appropriate level.

Scale. 0 – Non existent									
10	10	10	10	10	10	10	10	10	10
5	5	5	5	5	5	5	5	5	5
1	1	1	1	1	1	1	1	1	1
Mental Index	Emotional Index	Physical Index	Social Index	Spiritual Index	Family Index	Creativity Index	Fun Index	Financial Index	Career Index
muex	HIUCX	muex	mucx	HIUCX	HIUCX	mucx	mucx	muex	muex