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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.

Fill out only one answer per question.

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.

1. How did you hear about my clinic?
   Friend ( ) Family member ( ) Health Practitioner ( ) Newspaper ( ) Television ( ) Yellow Pages ( )
   Flyer ( ) Brochure ( ) Web Page ( ) Other ( )

2. What level of Healthcare 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. How long do you think it will take you to achieve your health potential?

4. Why is your health important 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 ( )

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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 ( )

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 your Health?

9. What is your present level of commitment in addressing your health issues and their underlying cause? Rate 1-10. One being low – ten being high.

10. Reflect on your priorities and list the highest 3 in your life at present.

1._____

2._____

3. _____

11. If 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 ( )

13. What level of resources are you prepared to commit to your health and wellbeing?

Time	Low ( )	Medium ( )	High ( )
Energy	Low ( )	Medium ( )	High ( )
Finance	Low ( )	Medium ( )	High ( )

14. 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

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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.

DIGESTION AND DYSBIOSIS

Section A

1. Bad Breath	0 1 2 3
2. Bad body odour	0 1 2 3
3. Excessive belching, burping or bloating	0 1 2 3
4.Indigestion & fullness lasts 2-4 hrs after eating	0 1 2 3
5. Excessive gas & bloating	0 1 2 3
6. Abdominal cramping, aches and pains	0 1 2 3
7. Specific food & beverage aggravation Indigestion and causing bloating	0 1 2 3
8.Crave sugar,breads,sweets or alcohol	0 1 2 3
9. Rumbling noises after food	0 1 2 3
10. Gas immediately after meals	0 1 2 3
11. Roughage or fibre cause constipation	0 1 2 3
12. Stool-undigested food present	0 1 2 3
13. Stool –yellowish, foul smelling	0 1 2 3
14. Painful, difficult straining during bowel movement	0 1 2 3
15.Bright red blood following bowel movement	0 1 2 3
16. Frequent or urgent urination	0 1 2 3
17. Antibiotic use 4 or more times per year	0 1 2 3
18. Long term antibiotic use – greater than 1 month	N Y (3)
19. On birth control pill more than 2 years	N Y (5)
20. Athlete's foot, ringworm or any chronic fungal Infections on the skin or nails.	N Y (4)
Total Points	_____

LIVER FUNCTION &DETOXIFICATION

1. General feeling of poor health	0 1 2 3
2. Fatty foods cause indigestion	0 1 2 3
3. Feeling of extreme dryness	0 1 2 3
4. Dry flaky skin and/or hair	0 1 2 3
5. Bags or dark circles under eyes	0 1 2 3
6. Deterioration of eyesight, spots	0 1 2 3
7. Yellowish colour of skin or eyes	0 1 2 3
8. Hives, rashes or itchy skin	0 1 2 3
9. Sinus Problems	0 1 2 3
10. Excess mucous formation	0 1 2 3
11. Chronic coughing	0 1 2 3
12. Asthma, bronchitis	0 1 2 3
13. Soar throat, hoarseness, loss of voice	0 1 2 3
14. Swollen of discoloured tongue, gums, lips	0 1 2 3
15. Rapid or pounding heartbeat	0 1 2 3
16. Pain or aches in joints	0 1 2 3
17. Pains or aches in muscles	0 1 2 3
18. Headaches	0 1 2 3
19. History of migraines	0 1 2 3
20. Insomnia	0 1 2 3
21. Feel restless, agitated, angry	0 1 2 3
22. anxious or depressed (mood swings)	0 1 2 3
23. Poor concentration and/or memory	0 1 2 3
24. Exposure to perfumes, tobacco smoke, exhaust fumes or other chemicals provoking symptoms.	N Y(5)
Total Points	_____

STRESS

Section C

Do you….

1. Have coffee, tea, tobacco, sugar or other stimulants and pick me ups	0 1 2 3
2. Do you suffer from Brain Fog, clouded thinking	0 1 2 3
3. Experience difficulty concentrating and thinking clearly	0 1 2 3
4. Feel irritable or oversensitive	0 1 2 3
5. Feel stressed, nervous or tense	0 1 2 3

In The Past Two Years Have You Experienced…

6.Losing or starting work	N Y (3)
7. Moving house	N Y (3)
8. Bankruptcy	N Y (4)
9. Breaking the laws	N Y (4)
10. Death in the family	N Y (4)
11. Separation from partner	N Y (4)
12. Divorce	N Y (5)
Total points	_____

VITALITY

Section D

Do you…

1. Wake up tired	0 1 2 3
2. Have difficulty staying awake	0 1 2 3
3. Often feel tired or overworked	0 1 2 3
4.Have inadequate energy or fatigue	0 1 2 3
5. Suffer from Chronic Fatigue syndrome	0 1 2 3
6. Find it hard to get up or become motivated in the morning	0 1 2 3
7. Experience mental confusion or sluggishness	0 1 2 3
Total Points	_____

WEIGHT MANAGEMENT

Section E

0 is very satisfied and 3 is very concerned, rate how you feel about….

1. The way my body looks	0 1 2 3
2. The way my body feels	0 1 2 3
3. My attractiveness	0 1 2 3
4. My present weight	0 1 2 3
5. My muscle tone	0 1 2 3
6. My fluid retention	0 1 2 3
7. My body fat	0 1 2 3
8. My strength	0 1 2 3
9. My endurance	0 1 2 3
10. My flexibility	0 1 2 3
Total Points	_____

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 is 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 = Nonexistent……to……..10 = ideal.

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

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Office use only: SYMPTOMATIC SCREENING QUESTIONNAIRE GRAPH

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