Health Appraisal Questionnaire
Brief Patient Form

NAME: _____

DATE: _____

Your answers to this Health Appraisal Questionnaire will assist your Practitioner in gaining information about your current symptoms and health concerns. Please answer all questions in each section.

Circle the number which best describes the frequency or severity of your symptoms over the previous **month**, or answer the **yes** or **no** questions by circling the appropriate letter.

You may note that some questions are repeated throughout the questionnaire. We would appreciate it if you can answer **all** questions, as this will ensure the most accurate interpretation of your results. You may, however, leave a question blank if you are unsure of the answer.

SECTION 1: GASTROINTESTINAL

SECTION 1.1 – Stomach: Hypoacidity

		Never	Occasionally	Moderately / Often	Frequently / Daily
1	Indigestion	☐ 0	☐ 1	☐ 2	☐ 3
2	Excessive belching, burping	☐ 0	☐ 1	☐ 2	☐ 3
3	Bloating or fullness commencing during or shortly after a meal	☐ 0	☐ 1	☐ 2	☐ 3
4	Sensation of food sitting in stomach for a prolonged period after a meal	☐ 0	☐ 1	☐ 2	☐ 3
5	Bad breath	☐ 0	☐ 1	☐ 2	☐ 3
6	Loss of appetite, or nausea	☐ 0	☐ 1	☐ 2	☐ 3
7	History of anaemia	☐ N (0)		☐ Y (3)	
	TOTAL	0			

SECTION 1.2 – Stomach: Hyperacidity

1	Stomach pain, burning or aching, 1 to 4 hours after eating	☐ 0	☐ 1	☐ 2	☐ 3
2	Feeling hungry just an hour or two after eating	☐ 0	☐ 1	☐ 2	☐ 3
3	Indigestion or heartburn from spicy or fatty food, citrus, alcohol or caffeine	☐ 0	☐ 1	☐ 2	☐ 3
4	Stomach discomfort or pain in response to strong emotions, thoughts or smell of food	☐ 0	☐ 1	☐ 2	☐ 3
5	Heartburn aggravated by lying down or bending forward	☐ 0	☐ 1	☐ 2	☐ 3
6	Antacids, carbonated beverages, milk, cream or food relieve the above symptoms	☐ 0	☐ 1	☐ 2	☐ 3
7	Constipation	☐ 0	☐ 1	☐ 2	☐ 3
8	**Difficulty or pain when swallowing**	☐ **0**	☐ **2**	☐ **4**	☐ **6**
9	**Black tarry stools**	☐ **0**	☐ **4**	☐ **8**	☐ **10**
10	**Vomiting blood or vomitus has appearance of coffee-grounds**	☐ **0**	☐ **4**	☐ **8**	☐ **10**
	TOTAL	0			

SECTION 1.3 – Small intestine/Pancreas

1	Indigestion, bloating and fullness for several hours after eating	☐ 0	☐ 1	☐ 2	☐ 3
2	Abdominal cramps or aches	☐ 0	☐ 1	☐ 2	☐ 3
3	Nausea and/or vomiting	☐ 0	☐ 1	☐ 2	☐ 3
4	Excessive passage of gas	☐ 0	☐ 1	☐ 2	☐ 3
5	Diarrhoea (loose, watery or frequent bowel movements)	☐ 0	☐ 1	☐ 2	☐ 3
6	Constipation (requiring straining, or a hard, dry or small stool)	☐ 0	☐ 1	☐ 2	☐ 3
7	Alternating constipation and diarrhoea	☐ 0	☐ 1	☐ 2	☐ 3
8	Undigested food in stools	☐ 0	☐ 1	☐ 2	☐ 3
9	Stools greasy, smelly or stick to toilet bowl	☐ 0	☐ 1	☐ 2	☐ 3
10	**Black tarry stools**	☐ **0**	☐ **4**	☐ **8**	☐ **10**
11	Certain foods worsen abdominal symptoms	☐ N (0)		☐ Y (3)	
12	Dry flaky skin and dry brittle hair	☐ N (0)		☐ Y (3)	
13	Difficulty gaining weight	☐ N (0)		☐ Y (3)	
	TOTAL	0			

SECTION – 1.4 Colon

1	Lower abdominal pain, cramping and/or spasms	☐ 0	☐ 1	☐ 2	☐ 3
2	Lower abdominal pain relieved by passing gas or stool	☐ 0	☐ 1	☐ 2	☐ 3
3	Excessive gas and bloating	☐ 0	☐ 1	☐ 2	☐ 3
4	Certain foods or stress aggravate lower abdominal pain	☐ 0	☐ 1	☐ 2	☐ 3
5	Diarrhoea (loose, watery or frequent bowel movements)	☐ 0	☐ 1	☐ 2	☐ 3
6	Constipation (requiring straining, or a hard, dry or small stool)	☐ 0	☐ 1	☐ 2	☐ 3
7	Alternating diarrhoea and constipation	☐ 0	☐ 1	☐ 2	☐ 3
8	**Sensation of incomplete emptying of bowel**	☐ **0**	☐ **2**	☐ **4**	☐ **6**
9	**Extremely narrow stools**	☐ **0**	☐ **2**	☐ **4**	☐ **10**
10	**Mucus or pus in stool**	☐ **0**	☐ **2**	☐ **4**	☐ **6**
11	**Red blood with bowel movement**	☐ **0**	☐ **2**	☐ **8**	☐ **10**
12	Rectal pain or cramps	☐ 0	☐ 1	☐ 2	☐ 3
13	Anal itching	☐ 0	☐ 1	☐ 2	☐ 3
	TOTAL	0			

SECTION 1.5 – Liver/Gall bladder/Pancreas

1	Upper abdominal pain, or pain under ribs	☐ 0	☐ 1	☐ 2	☐ 3
2	Bloating or feeling of fullness after eating	☐ 0	☐ 1	☐ 2	☐ 3
3	Excessive belching or gas	☐ 0	☐ 1	☐ 2	☐ 3
4	Fatty foods cause indigestion or nausea	☐ 0	☐ 1	☐ 2	☐ 3
5	Loss of appetite	☐ 0	☐ 1	☐ 2	☐ 3
6	Nausea and/or vomiting	☐ 0	☐ 1	☐ 2	☐ 3
7	Unexplained itchy skin	☐ 0	☐ 1	☐ 2	☐ 3
8	**Yellowish discolouration of skin or eyes, or dark coloured urine**	☐ **N (0)**		☐ **Y (8)**	
9	**Pale clay-coloured stools**	☐ **0**	☐ **2**	☐ **4**	☐ **8**
10	Fatigue, malaise or weakness	☐ 0	☐ 1	☐ 2	☐ 3
11	Fluid retention, oedema	☐ 0	☐ 1	☐ 2	☐ 3
12	Easy bruising or bleeding (e.g. of gums)	☐ 0	☐ 1	☐ 2	☐ 3
13	Loss or thinning of body hair	☐ N (0)		☐ Y (3)	
14	Red skin, particularly on palms	☐ N (0)		☐ Y (3)	
15	Dry, flaky skin or dry hair	☐ N (0)		☐ Y (3)	
	TOTAL	0			

SECTION 2: ENDOCRINE

SECTION 2.1 – Symptoms of underactive thyroid

1	Fatigue, sluggishness	☐ 0	☐ 1	☐ 2	☐ 3
2	Feeling cold, or intolerance to cold	☐ 0	☐ 1	☐ 2	☐ 3
3	**Swelling or tightness in front of neck**	☐ **N (0)**		☐ **Y (8)**	
4	Constipation (requiring straining, or a hard, dry or small stool)	☐ 0	☐ 1	☐ 2	☐ 3
5	Dry skin and hair	☐ N (0)		☐ Y (3)	
6	Puffy face, hands or feet	☐ 0	☐ 1	☐ 2	☐ 3
7	Gaining of weight, or decreased appetite	☐ N (0)		☐ Y (3)	
8	Low mood	☐ 0	☐ 1	☐ 2	☐ 3
9	Difficulty concentrating, poor memory	☐ 0	☐ 1	☐ 2	☐ 3
10	Low libido	☐ 0	☐ 1	☐ 2	☐ 3
11	Infertility	☐ N (0)		☐ Y (3)	
12	Heavier or more frequent menstrual periods	☐ N (0)		☐ Y (3)	
	TOTAL	0			

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		Never	Occasionally	Moderately / Often	Frequently / Daily
SECTION 2.2 – Symptoms of overactive thyroid					
1	Fatigue, notable weakness in limbs	☐ 0	☐ 1	☐ 2	☐ 3
2	Feeling hot or intolerance to heat, sweaty	☐ 0	☐ 1	☐ 2	☐ 3
3	**Swelling or tightness in front of neck**	☐ **N (0)**		☐ **Y (8)**	
4	Diarrhoea (loose, watery or frequent bowel movements)	☐ 0	☐ 1	☐ 2	☐ 3
5	Weight loss, possibly with increased appetite	☐ N (0)		☐ Y (3)	
6	Palpitations	☐ 0	☐ 1	☐ 2	☐ 3
7	Nervousness, irritability, restlessness	☐ 0	☐ 1	☐ 2	☐ 3
8	Tremor	☐ 0	☐ 1	☐ 2	☐ 3
9	Insomnia	☐ 0	☐ 1	☐ 2	☐ 3
10	Visual disturbance, problems with eyes, or development of staring gaze	☐ 0	☐ 2	☐ 4	☐ 6
11	Poor libido	☐ 0	☐ 1	☐ 2	☐ 3
12	Light, infrequent or absent menstrual periods	☐ N (0)		☐ Y (3)	
	TOTAL	0			

		Never	Occasionally	Moderately / Often	Frequently / Daily
SECTION 2.3 – Stress, fatigue and adrenals					
1	Feeling stressed, nervous, tense or unable to relax	☐ 0	☐ 1	☐ 2	☐ 3
2	Feeling irritable or oversensitive	☐ 0	☐ 1	☐ 2	☐ 3
3	Feeling overwhelmed, unable to cope	☐ 0	☐ 1	☐ 2	☐ 3
4	Low mood, mood swings	☐ 0	☐ 1	☐ 2	☐ 3
5	Difficulty concentrating or thinking clearly, memory problems	☐ 0	☐ 1	☐ 2	☐ 3
6	Need coffee, tea, tobacco, sugar or chocolate as pick me ups	☐ 0	☐ 1	☐ 2	☐ 3
7	Fatigued, tire easily	☐ 0	☐ 1	☐ 2	☐ 3
8	Find it hard to get up and going in the morning	☐ 0	☐ 1	☐ 2	☐ 3
9	Difficulty staying awake during day	☐ 0	☐ 1	☐ 2	☐ 3
10	Insomnia	☐ 0	☐ 1	☐ 2	☐ 3
11	**Palpitations or chest pain**	☐ **0**	☐ **1**	☐ **2**	☐ **3**
12	Nausea, dizziness	☐ 0	☐ 1	☐ 2	☐ 3
13	Change in appetite	☐ 0	☐ 1	☐ 2	☐ 3
	TOTAL	0			

SECTION 3: IMMUNE

SECTION 3.1 – Low immunity					
1	Frequent colds or flu	☐ N (0)		☐ Y (3)	
2	Frequent infections in other locations (e.g. bladder, skin)	☐ N (0)		☐ Y (3)	
3	Diarrhoea	☐ 0	☐ 1	☐ 2	☐ 3
4	Ears continuously drain	☐ 0	☐ 1	☐ 2	☐ 3
5	Nasal congestion or discharge	☐ 0	☐ 1	☐ 2	☐ 3
6	Sore throat	☐ 0	☐ 1	☐ 2	☐ 3
7	Cough with mucus	☐ 0	☐ 1	☐ 2	☐ 3
8	Cold sores	☐ 0	☐ 1	☐ 2	☐ 3
9	Inflamed or bleeding gums, or swollen, red lips or tongue	☐ 0	☐ 1	☐ 2	☐ 3
10	Wounds heal slowly	☐ N (0)		☐ Y (3)	
11	Excessive loss of hair	☐ N (0)		☐ Y (3)	
12	**Neck, armpit or groin swelling**	☐ **0**	☐ **1**	☐ **2**	☐ **6**
	TOTAL	0			

SECTION – 3.2 Allergy					
1	Migraine or non-migraine headache	☐ 0	☐ 1	☐ 2	☐ 3
2	Sensitivity to light (skin or eyes)	☐ 0	☐ 1	☐ 2	☐ 3
3	Dark circles under eyes	☐ 0	☐ 1	☐ 2	☐ 3
4	Swollen eyes, lips, face or other body parts	☐ 0	☐ 1	☐ 2	☐ 3
5	Localised or general itching – eyes, ears, throat, nose, skin	☐ 0	☐ 1	☐ 2	☐ 3
6	Rashes or eczema	☐ 0	☐ 1	☐ 2	☐ 3
7	Clear watery discharge from nose or eyes	☐ 0	☐ 1	☐ 2	☐ 3
8	Sneezing, coughing or wheezing	☐ 0	☐ 1	☐ 2	☐ 3
9	Irritability, fatigue	☐ 0	☐ 1	☐ 2	☐ 3
10	Certain foods worsen symptoms or cause palpitations	☐ N (0)		☐ Y (3)	
	TOTAL	0			

SECTION 4: DETOXIFICATION (CAPACITY)

As far as you are aware, do you have a sensitivity or allergy to...

1	The preservatives sodium benzoate or potassium benzoate	☐ 0	☐ 1	☐ 2	☐ 3
2	Tyramine (red wine, cheese, bananas, chocolate)	☐ 0	☐ 1	☐ 2	☐ 3
3	Caffeine	☐ 0	☐ 1	☐ 2	☐ 3
4	Chemicals such as fragrances, exhaust fumes, cigarette smoke or other strong odours	☐ 0	☐ 1	☐ 2	☐ 3
5	Even small amounts of alcohol	☐ 0	☐ 1	☐ 2	☐ 3
6	Do you have a history of exposure to chemicals such as herbicides, insecticides, pesticides or organic solvents?	☐ N (0)		☐ Y (3)	
7	Alcohol (number of drinks per week)	0: ☐ 0	1-7: ☐ 1	8-14: ☐ 2	15+: ☐ 3
8	Coffee or other caffeinated drinks (number per day)	0: ☐ 0	1-2: ☐ 1	3-4: ☐ 2	5+: ☐ 3
9	Smoking (number per day)? Type	0: ☐ 0	1-8: ☐ 3	9-19: ☐ 3	20+: ☐ 6
10	If not currently smoking, have you quit smoking in the last year?	☐ N (0)		☐ Y (2)	
11	Recreational drugs? Type	☐ N (0)		☐ Y (3)	
12	What is your blood type?				
	TOTAL	0			

SECTION 5: GENERAL HEALTH HISTORY

1	Frequency of exercise (days per week)	6-7: ☐ 0	3-5: ☐ 1	1-2: ☐ 2	0: ☐ 3
2	Vegetarian or vegan	☐ N (0)		☐ Y (2)	
3	Age >50 years	☐ N (0)		☐ Y (3)	
4	Planning to have a baby in the next 3 to 6 months	☐ N (0)		☐ Y (3)	
5	Pregnant or breastfeeding	☐ N (0)		☐ Y (3)	
	TOTAL	0			

Other Comments:

Thank you for taking the time to complete this questionnaire.