HEALTH APPRAISAL - 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 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			Y (3)

TOTAL:_____

Section 1.2 Stomach: Hyperacidity

1. Stomach pain, burning or aching, 1-4 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:_____

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			Y (3)
12. Dry flaky skin and dry brittle hair	N			Y (3)
13. Difficulty gaining weight	N			Y (3)

TOTAL:_____

Section 1.4 Colon

	Never	Occasionally	Moderately / Often	Frequently / Daily
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:_____

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**			**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			Y (3)
14. Red skin, particularly on palms	N			Y (3)
15. Dry, flaky skin, or dry hair	N			Y (3)

TOTAL:_____

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			Y (8)
4. Constipation (requiring straining, or a hard, dry or small stool)	0	1	2	3
5. Dry skin and hair	N			Y (3)

Section 2.1 Symptoms of underactive thyroid (continued)	Never	Occasionally	Moderately / Often	Frequently / Daily
6. Puffy face, hands or feet	0	1	2	3
7. Gaining of weight, or decreased appetite	N			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			Y (3)
12. Heavier or more frequent menstrual periods	N			Y (3)
TOTAL:_____				

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			Y (8)
4. Diarrhoea (loose, watery or frequent bowel movements)	0	1	2	3
5. Weight loss, possibly with increased appetite	N			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			Y (3)
TOTAL:_____				

Section 2.3 Stress, fatigue and adrenals				
1. Feeling stressed, nervous, or 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:_____				

SECTION 3: IMMUNE

Section 3.1 Low immunity				
1. Frequent colds or 'flu	N			Y (3)
2. Frequent infections in other locations (e.g. bladder, skin)	0			3
3. Diarrhoea (loose, watery or frequent bowel movements)	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			Y (3)
11. Excessive loss of hair	N			Y (3)
12. Neck, armpit or groin swelling	0	1	2	6
TOTAL:_____				

Section 3.2 Allergy	Never	Occasionally	Moderately / Often	Frequently / Daily
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			Y (3)
TOTAL:_____				

SECTION 4: DETOXIFICATION (capacity)

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

	None	Mild	Moderate	Severe
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			Y (3)
7. Alcohol (number of drinks per week)	0	1-7 (1)	8-14 (2)	15+ (3)
8. Coffee or other caffeinated drinks (number per day)	0	1-2 (1)	3-4 (2)	5+ (3)
9. Smoking (number per day)?	0	1-8 (3)	9-19 (3)	20+ (6)
10. Type_____				
11. If not currently smoking, have you quit smoking in the last year?	N			Y (2)
12. Recreational drugs?	N			Y (3)
13. Type_____				
14. What is your blood type? _____				
TOTAL:_____				

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			Y (2)
3. Age >50 years	N			Y (3)
4. Planning to have a baby in the next 3-6 months	N			Y (3)
5. Pregnant or breastfeeding	N			Y (3)
TOTAL:_____				

Other Comments:_____

THYROID (Iodine/Adrenal) SYMPTOM SURVEY

PATIENT NAME: _____**DOB:**___ __/____/_____**Ht:**_____**Wt:**_____**Date:**_____

I understand that the Thyroflex™ uses a reflex hammer that may leave a bruise, as such; I will not hold the Practitioner or Nitek Medical Inc. responsible for such any injury._____**initial here please**

Do you suffer from any of the following?

Rate your symptoms below from a scale of: 0 to 3 (0= None, 1= Mild, 2= Moderate, 3= Severe)

Thyroid

- _____ Tired & sluggish, lethargic
- _____ Dry hair and/or skin (thick, dry ,scaly)
- _____ Sleep more than usual
- _____ Weaker muscles
- _____ Constant feeling of cold (fingers / hands/ feet)
- _____ Frequent muscle cramps
- _____ Poorer memory
- _____ More depressed (mood change easily)
- _____ Slower thinking
- _____ Puffy eyes
- _____ Difficulty with maths and sums
- _____ Hoarser or deeper voice
- _____ Constipation
- _____ Coarse hair / hair loss / brittle
- _____ Muscle / joint pain
- _____ Low sex drive / impotence
- _____ Puffy hands and feet
- _____ Unsteady gait (bump into things)
- _____ Gain weight easily
- _____ Outer third of eyebrows thin
- _____ Menses irregular (should be 28 Days)
- _____ Heavier menses (clotting / 3+ days)
- _____ Carpel tunnel syndrome

_____ **Total HYPO Score** (8)

- _____ Palpitations (skipping of heart beat)
- _____ Insomnia
- _____ Tachycardia (rapid or irregular heart beat)
- _____ Shakiness
- _____ Increased sweating
- _____ Brittle nails
- _____Loss of appetite

_____ **Total HYPER Score** (0)

DHEA

- _____Constantly exhausted & tired
- _____Cannot tolerate noise
- _____Low libido
- _____Muscles are getting flabby (losing muscle tone)

_____**Total DHEA** (2)

Adrenals (Cortisol)

- ____Rapid heart beat
- ____Feel stressed
- ____Have eczema, psoriasis, skin allergies, rashes
- ____Digestive problems
- ____Easily confused
- ____Wake up tired The following 6xQ's are: Y=1, N=0↓
- ____Wake up full of energy Y/N
- ____2 to 4 pm feel tired, seek snack/tea/coffee/coke Y/N
- ____Fall asleep in front of TV/reading (before bed) Y/N
- ____As soon as I go to bed I drop straight to sleep Y/N
- ____Need to read/TV 10 to 15 mins to drift into sleep Y/N

_____**Total Adrenal** (3)

Iodine/Iodide

- _____Fibrocystic breast / lumps/ ovarian cysts
- _____Goiter bulge or band around the neck
- _____Slow speech
- _____Enlarged tongue
- _____Puffy face, puffy hands

_____**Total Iodine/Iodide symptoms** (0)

- _____Do you use salt with idine added Y=1 N=0
- _____Number of days per week you eat seafood/shellfish*

_____**Total iodine** (6)* Excludes Salmon/Tilapia/Trout/Fresh water fish

Melatonin, Serotonin, Tryptophan

- _____Upon waking feel tired
- _____Wake up during the night
- _____If awakening,(in middle of night),cannot get back to sleep
- _____Trouble falling asleep
- _____Use a sleep aid, or drink alcohol to relax
- _____My mind is busy when I want to sleep

_____**Total Melatonin** (2)

CoQ10 (1)

- _____Do you have stamina Y=1, N=0

ACTH

- _____Do you lack willpower & energy Y=1, N=0
- _____Patches of hair loss Y=1, N=0
- _____Pale complexion/sunburn easily Y=1, N=0
- _____Often have memory loss Y=1, N=0

_____**Total ACTH** (2)

Check Here for : Antibodies test = If: (Hypo = 12+, Hyper = 7+, Includes-Tachycardia and or Palpitations Yes / No

Test Results:

Hypo/Hyper: _____/_____ **(8 / 0)**

Reflex Time: _____**<Hyper = 52 = >Hypo = 136, (optimal 52-100) (B/L 120 – 136)**

RMR: _____(*Women*=2,250 cal/day, *Men*=2,750 +/- 250 cal/day for over/underweight or aged)

RMR: Will show a reading of about 400 calories below baseline (before treatment)

TREATMENT

Thyroid_____

Iodine/dide_____

Adrenal_____

DHEA__VitD___CoQ10___ACTH___Adre____Mela___5HTP__Other___

Manifestation of misdiagnosed hypothyroidism:

- Neurological symptoms

Headache s
Paresthesias
Cerebellar ataxia (incoordination)
Deafness (nerve or conduction)
Vertigo or Tinnitus (ringing in the ear)

- Cognitive Deficits

Calculation, memory, reduced attention span
Sleep apnea
Myxedema coma

- Psychiatric Syndromes

Depression
Schizoid or affective psychoses
Bipolar disorders

- Skeletal System

Arthralgias (joint stiffness)
Joint effusions & pseudo gout
Carpal Tunnel Syndrome

- Other Risks

Essential hypertension
Difficulty swallowing

Polymyalgia
Sudden death
High or low blood pressure
High cholesterol & other blood fats
Vascular (blood vessel) disease
Diabetes
Neurological (Parkinson's like diseases)
Double Alzheimer's Risk
Arthritis and inflammatory diseases
Miscarriage & premature birth
Pregnancy complications & birth defects