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

	Never	Occasionally	Moderately / Often	Frequently / Daily
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

	Never	Occasionally	Moderately / Often	Frequently / Daily
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

	Never	Occasionally	Moderately / Often	Frequently / Daily
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

	Never	Occasionally	Moderately / Often	Frequently / Daily
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)

MET2826 - HAQS - 04/11

9115771026168

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	Never	Occasionally	Moderately / Often	Frequently / Daily
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	Never	Occasionally	Moderately / Often	Frequently / Daily
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	Never	Occasionally	Moderately / Often	Frequently / Daily
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 (Core Hormone) 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

Do you suffer from any of the following? **Fill areas marked in Yellow**

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

Thyroid

0 1 2 3 ☐ **doctor check if applicable*

☐ ☐ ☐ ☐ Tiredness & Sluggishness, lethargic
☐ ☐ ☐ ☐ Dryer Hair 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
☐ ☐ ☐ ☐ Puffier Eyes
☐ ☐ ☐ ☐ Difficulty with Math
☐ ☐ ☐ ☐ 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 Easy
☐ ☐ ☐ ☐ Outer Third Of Eyebrows Thin
☐ ☐ ☐ ☐ Menses More Irregular (should be 28 Days)
☐ ☐ ☐ ☐ Heavier Menses (clotting / 3+ days)
☐ ☐ ☐ ☐ Carpel Tunnel Syndrome

_______ **Total HYPO Score** (8) BIOTHROID 1G ☐ 2G ☐ Titrate ☐

☐ ☐ ☐ ☐ 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 / D3 / Pregnen / GABA + B's

☐ ☐ ☐ ☐ Constantly exhausted & tired
☐ ☐ ☐ ☐ Cannot tolerate noise**
☐ ☐ ☐ ☐ My Libido is low
☐ ☐ ☐ ☐ Muscles are getting flabby (Loosing muscle tone)

_______ **Total DHEA** (2) ☐ D3 ☐ Preg ☐ **Gaba ☐ B's ☐

Adrenals (Cortisol)

** Probiotics 13 = RT3 ☐ Saliva ☐ Hump ☐

0 1 2 3

☐ ☐ ☐ ☐ Rapid heart beat
☐ ☐ ☐ ☐ I'm stressed out
☐ ☐ ☐ ☐ Have eczema, psoriasis, skin allergies, rashes
☐ ☐ ☐ ☐ Digestive problems**
☐ ☐ ☐ ☐ Easily confused
☐ N ☐ Y *Wake up tired (The following 6xQ's are: N=0, Y=1↓)*
☐ N ☐ Y *Wake up full of energy Y/N*
☐ N ☐ Y *2 to 4 pm feel tired, seek snack/Tea/Coffee/Coke N/Y*
☐ N ☐ Y *Fall asleep in front of TV/reading/computer(before bed) N/Y*
☐ N ☐ Y *As soon as I go to bed - Drop straight to sleep N/Y*
☐ N ☐ Y *Need to read/TV -10 to 15 mins to drift into sleep N/Y*

_______ **Total Adrenal** (3) Bioadren ☐ BioBiotic ☐

Iodine/Iodide

12.5 Maint ☐ 6.25 ☐ 50 protocol ☐

☐ ☐ ☐ ☐ Fibrocystic Breast/lumps/ ovarian cysts /Fibroids/Prostate
☐ ☐ ☐ ☐ Goiter Bulge or Band Around the Neck (Dr Confirm)
☐ ☐ ☐ ☐ Slow Speech
☐ ☐ ☐ ☐ Enlarged tongue / Teeth impressions (Dr Confirm)
☐ ☐ ☐ ☐ Puffy Face Puffy Hands (Dr Confirm)

_______ **Total Iodine/Iodide Symptoms** (0)

☐ N ☐ Y *Do you use salt with Iodine added N=0 Y=1*
_______ Number of days per week you eat seafood/shellfish*
_______ **Total Iodine In** (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 = M ☐ **2= 5HTP ☐ *Mag* ☐ *D3* ☐

CoQ10

(1) *BIO COQ10* ☐

☐ N ☐ Y *Do you have stamina N=0, Y=1* Palp ☐ Tach ☐

ACTH

☐ N ☐ Y *Do you lack willpower & energy N=0, Y=1*
☐ N ☐ Y *Patches of hair loss (alopecia) N=0, Y=1*
☐ N ☐ Y *Pale complexion/sunburn easily N=0, Y=1*
☐ N ☐ Y *Often have Memory Loss N=0, Y=1*

_______ **Total ACTH** (3) *TEST* ☐ (Dr. Challenge)

Aromatase Inhibitor/Chrysin ☐ Sugar/Lipids: Berberine ☐ Bio IGF ☐ Bio Andro Test ☐ BIO HGH ☐ BIO Woman's Radiance-P ☐ BIO Woman's Radiance-E ☐ BIO Woman ☐ BIO OXY ☐ BIO Nox ☐ BIO MAN ☐ ED/NAC ☐ Gluten Free ☐ Paleo ☐

Check Here for : Antibodies Test (TPOab/Tgab) = If: (Hypo = 12+, Hyper = 7+, Includes-Tachycardia and or Palpitations **Yes / No**
Additional Blood Tests: Hashimoto's / Graves Refer to Protocol's …. Start…. Gluten free / Paleo RT3 Yes / No

Test Results: *Practitioner's Name:__________ Patient's Menses start Date______ A1C_____Lipids____Fe___Iron_______*
Hypo/Hyper: ____/____(8 / 0)
Reflex Time: _________Hyper = <50 .Hypo = >120. **Reflex of 50 to 100 = (Optimal).** 100 to 120 = (Satisfactory). 120 to 135 = B/L.(Supplements). 136+ = (Nat Hormones)
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)

Manifestation of Misdiagnosed Hypothyroidism:
Neurological symptoms
- Headache •
- 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 & Pseudogout •
- 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