Todd A. Mangum, M.D., PC
770 East South Temple, Ste. 100, Salt Lake City, Utah 84102
801.531.8340, F 801.531.8350
THEPEOPLE@WEBOFLIFEWC.COM, WEBOFLIFEWC.COM

Web of Life
Wellness Center

Dear New Patient:

Welcome to the Web of Life Wellness Center!

Thank you for your interest in exploring the benefits of Integrative Medicine. Your interest reflects a desire to become an active participant in your own health care. Integrative medicine is an evolutionary process that weaves together a wide variety of healing modalities, which may range from conventional western medicine to acupuncture and herbology.

Our goal is to assist you on your path to optimal well-being. Because this perspective seeks to uncover root causes of disease while simultaneously treating the symptomatic branches, it requires a thorough examination of one's current situation, lifestyle and history. This comprehensive approach to health requires commitment, time and energy from all of us.

The forms we have included will save valuable time in your appointment when completed thoughtfully and thoroughly. In addition to organizing and gathering information these questions are meant to increase your awareness of your body, mind, emotions and habits. The experience of vibrant well-being can never be achieved in isolation from the entirety of your life. All of our choices, from the food we eat to our financial investments, ultimately affect our health and well-being.

We value you as our patient and look forward to serving you in your journey towards wellness.

Sincerely,

Todd Mangum, M.D., PC

P.S. These forms are confidential. However, if for any reason, you feel uncomfortable answering any questions or having specific written information in your medical records, please leave those specific sections blank and discuss them with me during your appointment. All information that is written or recorded in your chart becomes part of your permanent record and cannot be changed.

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YOUR FIRST VISIT WITH DR. TODD MANGUM
PATIENT CONTRACT

1) It is mandatory that you completely fill out the NEW PATIENT PACKET in its entirety as indicated in the cover letter and bring it with you the day of your appointment. This information can also be emailed, mailed or dropped off ahead of time.
2) Please bring copies of all relevant medical test results conducted in the last 12 months. If you are having them sent, our fax is: 801.531.8350.
3) Bring any medications, vitamins or nutritional supplements you are taking, including any you take intermittently.

NOTE: If you arrive more than 15 minutes late for your scheduled appointment time, or do not have your New Patient Packet completed, it will be necessary to reschedule your appointment. It is not possible to cover everything required in a shortened appointment or with inadequate information. If this occurs, you will be expected to pay for the missed appointment as per our Cancellation & Late Arrival Policy (see below).

EMERGENCY COVERAGE: IN CASE OF AN EMERGENCY, **DIAL 911 OR GO TO YOUR LOCAL HOSPITAL EMERGENCY ROOM OR THE CRISIS UNIT OF YOUR LOCAL MENTAL HEALTH CENTER**. Please be advised, our office does NOT handle urgent, or emergency care and we do not check messages after hours or on weekends.

For these and other reasons we highly encourage all patients to maintain care with a Primary Care Provider.

PATIENT INTIALS: _____

INSURANCE COVERAGE: DR. MANGUM IS NOT A LISTED PROVIDER WITH ANY INSURANCE COMPANY.
Some insurance companies, however, do cover our services as an Out-of-Network provider. We will generate a "Super Bill" receipt at the end of your visit, which you can send to your insurance company for possible reimbursement. This Super Bill can also be kept as proof of services for those who pay with an HSA and for those who keep track of their medical expenses for tax purposes.

IF YOU HAVE INSURANCE COVERAGE your first step is to determine whether your plan has any Out-of-Network benefits. If you are uncertain, we strongly advise you to call your insurance company prior to your visit to find out more. When you call your insurance company please tell them the following:

- You are coming in for a Comprehensive First Visit
- Dr. Mangum is an OUT-OF-NETWORK provider
- The billing code for the standard 90-minute visit is 99204

As a courtesy, our office provides copies of the patient check-out sheet, lab results and Super Bill when you check out. Please create a file and keep track of all these copies from our office as there will be a charge for duplicates. Remember, your insurance coverage is a contract between you and your insurance carrier. If your insurance company requests additional information from our office to process your claim you will be responsible for additional fees. The cost for both processing the insurance claims and creating duplicates will be dependent upon the time required as per our Convenience Fees (see below).

MEDICARE OR MEDICAID: **Dr. Mangum is NOT a provider for Medicare or Medicaid**; therefore, you cannot submit a Super Bill to them or to your supplemental insurance if you have one. Medicare and Medicaid, however, often cover some blood work and other labs ordered by our office. Medicare/Medicaid patients must sign the Medicare Opt Out Private Contract form in addition to this contract.

PATIENT INTIALS: _____

PHONE MESSAGE POLICY: **It may take 72 business hours for us to get back to you**. **Please do NOT leave multiple messages**. Multiple messages delay our ability to promptly respond.

FEES MAY CHANGE WITHOUT NOTICE

FEES AND BILLING: OUR PAYMENT POLICY IS FEE–FOR–SERVICE.

- **For new patients payment is due at the time of booking.**
- **For established patients payment is due at the time of service.**

FEE SCHEDULE	LENGTH OF VISIT	COST
New Patient Comprehensive Consultation	90 minutes	$475
Comprehensive Follow Up Consultation	31-45 minutes	$215
Follow-Up Consultation	16-30 minutes	$165
Follow-Up Consultation	11-15 minutes	$115
Extended Comprehensive Follow-up	46-60 minutes	$265
Extended Comprehensive Follow-up	61-75 minutes	$315
Extended Comprehensive Follow-up	76-90 minutes	$365

If you are scheduled for a 45-minute follow-up appointment, but only use 15 or 30 minutes, you will be charged according to the fee schedule above. The converse is also true. If the doctor spends additional time working on your file, you will be charged accordingly.

NOTE: A credit card is required at the time an appointment is made. This card will be charged for missed appointments based on our Cancellation & Late Arrival Policy (see below).

CANCELLATION & LATE ARRIVAL POLICY: Please be aware, Dr. Mangum does not overbook appointments. We require ample notification when rescheduling or canceling an appointment. Your initials and signature below indicate your acknowledgement and acceptance of our Cancellation & Late Arrival Policy.

PLEASE BE ADVISED:
"Sufficient Notice" of appointment cancellation is 24 hours or more before appointment time = NO charge.
Cancellation less than 24 hours and "NO SHOW's" will be billed 100%.

Patients arriving 15 minutes or later, to their appointment, will be considered a "NO SHOW" and billed at 100%.
The 15-minute rule applies to phone appointments.
The 15-minute rule applies even if you call to let the office know you are running late.
It is not possible for the doctor to cover everything required in a shortened appointment.

OUR CANCELLATION & LATE ARRIVAL POLICY APPLIES TO ALL PATIENTS, INCLUDING FIRST TIME PATIENT VISITS.
This Policy applies regardless of the reason for your cancellation.

PATIENT INTIALS: _____

ADDITIONAL COSTS: Additional costs may include recommended supplements, lab fees if choosing the pre-pay option and any lab tests that will be paid for at the time they are completed such as: specialized blood tests, saliva, stool, urine or hair analysis. These items are not typically reimbursed by insurance, but an HSA or flex-spending account may be used to cover these expenses.

PHONE APPOINTMENTS: Phone appointments are available for follow-up consultations. Phone appointments are made like regular appointments and will be billed at the same fee schedule as above. For phone appointments, we will call you at your scheduled appointment time. NOTE: You will need to provide a credit card number prior to your phone appointment, which will be charged following your appointment. Our Cancellation & Late Policy applies to phone appointments as well.

CONVENIENCE FEES: These fees apply whenever a patient; calls, emails or shows up at the office with a question or request outside of a scheduled appointment. The costs range from $40 on up depending on the time required to fulfill the request. If the request requires more than 15 minutes you will likely be encouraged to schedule an appointment. The fee covers the time required by the doctor and staff to review charts or records, make an assessment, answer questions, complete forms, change a prescription, etc.

CONFIDENTIALITY: Professional ethics as well as the laws of the State of Utah (as well as other States) require that we honor your right to privacy and the confidentiality of our work together. We will not provide information about you to others without your informed consent and written permission. We are, however, required by law, to report clear and present danger to human life and any form of child abuse. You will be given a HIPPA form that must also be signed.

I have read the above and agree to follow the parameters of this contract.

Patient Signature: _____ **Date:** _____

WEB OF LIFE WITNESS SIGNATURE: _____ **Date:** _____

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Medicare Opt-Out Private Contract
For Medicare Patients Only

I **Todd Mangum MD** have not been excluded from Medicare under sections 1128, 1156 or 1892 of the Social Security Act **1114138021.**

I (the Medicare beneficiary) or my legal representative accept full responsibility for payment of charges for all services furnished by **Todd Mangum MD**.

I (the Medicare beneficiary) or my legal representative understand that Medicare limits do not apply to what **Todd Mangum MD** may charge for items or services furnished.

I (the Medicare beneficiary) or my legal representative agree not to submit a claim to Medicare or to ask **Todd Mangum MD** to submit a claim to Medicare.

I (the Medicare beneficiary) or my legal representative understand that Medicare payment will not be made for any items or services furnished by **Todd Mangum MD** that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

I (the Medicare beneficiary) or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

The expected or known effective date and expected or known expiration date of the opt-out period is February 12, 2016 (effective date) and ongoing (expiration date).

I (the Medicare beneficiary) or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

This contract cannot be entered into by me, (the Medicare beneficiary), or by my legal representative during a time when I, (the Medicare beneficiary), require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 3044.28 of the Medicare Carriers Manual).

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For Medicare Patients Only

I (the Medicare beneficiary) or my legal representative will receive or have received a copy (a photocopy is permissible) of this contract, before items or services are furnished to me under the terms of this contract.

I **Todd Mangum MD** will retain the original contract (original signatures of both parties required) for the duration of the opt-out period.

I **Todd Mangum MD** will supply CMS with a copy of this contract upon request.

I **Todd Mangum MD** understand that the current private contract remains in effect from 2016 onward.

Provider's NPI: **1114138021**

Provider's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Legal Representative Signature: _____ Date: _____

Witness: _____Date: _____

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HIPPA – PATIENT CONSENT
FOR USE OF DISCLOSURE OF HEALTH INFORMATION

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for healthcare providers to obtain their patients' consent for uses and disclosures of Health Information to carry out treatment, payment or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical information, and we will do all we can to secure and protect your privacy. When it is necessary, we provide the minimum amount of information, to only those we feel are in need of your healthcare information, in order to provide healthcare that is in your best interest. We may need to disclose healthcare information to:

- Another healthcare provider or hospital to determine the diagnosis, assessment or treatment of your health condition.
- A potential party responsible for the payment of services you receive.
- A Spouse, parent, parent of a minor, power of attorney, guardian or caregiver designated by the patient.
- And, within our own practice for quality control or other operational purposes.

We have a complete notice in the lobby of our office that provides a detailed description of how your health information may be used or disclosed as per HIPPA (Health Insurance Portability and Accountability Act of 1996). After reading this form and/or reviewing the notice in the lobby, you may place restrictions on our use of your information in writing. We are not required to agree to your restrictions.

If you revoke this authorized consent, it must be in writing. Your insurance company may have the right to your health information if they decide to contest any of your claims.

Patient Name (printed): _____

Signature: _____ Date: _____

Patients Spouse, Parent, Parent of a Minor, Power of Attorney, Guardian, Caregiver: (please circle)

Name (printed): _____

Signature: _____ Date: _____

Authorized Provider Witness Signature: _____

Date: _____

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VITAL INFORMATION REGARDING ALL LAB WORK

*** * * Please be advised * * ***
If you fail to read the following and fail to obtain the necessary information (and go to the wrong lab, for example) there is NOTHING our office can do to fix the problem after the fact.

Please arrive to your appointment prepared with this information!

** **IF YOU DO NOT HAVE INSURANCE (or you have a high deductible)** we recommend the **PRE-PAID OPTION** for blood work (through our office) as this can result in substantial savings for you. Pre-paid labs are NOT eligible for reimbursement by insurance companies**.** Pre-paid labs will need to be drawn within 6 months. After the 6 month point the requisition becomes void and is not eligible for reimbursement.

** **IF YOU HAVE INSURANCE, IT IS ESSENTIAL TO DETERMINE WHICH LAB IS IN-NETWORK OR PREFERRED BY YOUR INSURANCE COMPANY prior** to your visit with Dr. Mangum.

THE BELOW INFORMATION IS NEEDED FOR ALL PATIENTS WITH INSURANCE:

(1) Who is your insurance company?_____
(2) What lab(s) are covered/preferred by your insurance plan i.e., Quest Diagnostics, LabCorp, IHC?
_____
(3) Will your insurance cover labs before the deductible is met?_____
(4) What is your deductible?_____
(5) Have you met or do you expect to meet your deductible for the calendar year?_____
(6) Are in network labs covered if an out-of-network doctor orders them? _____

Your signature indicates you have carefully read the above information and **accept full responsibility** for obtaining this information prior to your appointment with Dr. Mangum. **This strict new policy has become necessary due to so many patients arriving unprepared, without this information.** Coming unprepared wastes valuable time with the doctor. Thank you for understanding and for your full attention to this important matter.

_____ _____
PATIENT SIGNATURE **DATE**

_____ _____
WEB OF LIFE WITNESS SIGNATURE **DATE**

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PATIENT INFORMATION

*Who referred you, or how did you hear about our office?*_____

Patient Name:_____ Date: _____

Profession/work status:_____ Birthdate:_____

Cell Phone:_____ Home Phone:_____

Address:_____ City/State/Zip:_____

E-Mail (we don't share!):_____ Work Phone:_____

COMPLETE IF PATIENT IS A MINOR

Who is patient living with:_____ Relationship to patient: _____

Guarantor:_____ Home Phone:_____

E-Mail:_____ Cell Phone:_____

IN CASE OF EMERGENCY WHOM MAY WE CONTACT?

Name:_____ Relationship: _____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Other Phone:_____

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PATIENT MEDICAL HISTORY—PART I

Patient name _____ Date _____

Age _____ Weight _____ Height _____ Birth Sex ___M ___F Gender Identity (Optional) _____

How willing are you to examine your current lifestyle and make focused changes in diet, exercise, stress management and behavior that may be required to achieve your desired state of health?

Very Willing 1 2 3 4 5 6 Reluctant
I'll do anything necessary! **I want few lifestyle changes.**

---

1. **Chief Complaint(s).** Please list your current health concern(s) or medical conditions in order of importance or severity; include the date of onset and pertinent history. It can be extremely helpful and more efficient if you bring to your appointment any relevant medical tests and blood work reports (especially done in the past 12 months) that you have or can obtain.

   A. _____

   B. _____

   C. _____

   D. _____

2. **Past Medical History**. Please circle any other problems you have had in the past. If this list includes any problems you **CURRENTLY** have, but have not mentioned already, please put a **'C'** by it.

Hemophilia	Pace Maker	High Cholesterol
Bleeding Disorders	Tuberculosis	Sexually Transmitted Diseases
Diabetes	Seizures	Anemia
Gastrointestinal Complaints	Arrhythmias	Parasites
Osteoporosis	COPD/Emphysema	Depression
Asthma	Eczema	Psychiatric Illness
Bronchitis	Pneumonia	Addictions
Cancer	Menstrual Disorders	Musculoskeletal Problems
Prostatitis	HIV	Neurological Problems
Irritable Bowel	Multiple Sclerosis	Serious Infections
Fibromyalgia	Adrenal Insufficiency	Immune Dysfunction
Lupus	Hypertension	Chronic Fatigue
Ulcers or Gastritis	Liver disease	Other (please specify):
Autoimmune Problems	Hyper or Hypothyroid	_____
Rheumatoid Arthritis	Kidney disease	_____
Heart Disease	Hepatitis	_____

3. **Past Surgeries and Trauma**. Please list any significant accidents, injuries, surgeries or hospitalizations:

_____

_____

_____

4. **Allergies, Intolerances and Sensitivities**. Please list all of which you are aware:

Medicine _____

_____

_____

Foods _____

_____

_____

Environmental _____

_____

_____

5. **Family History**. Please circle those problems which have occurred in your immediate family, i.e. siblings, parents, grandparents, aunts, and uncles:

Addictions	Diabetes	Osteoporosis
Alzheimer's	Heart Disease	Parkinson's
Asthma	Hepatitis	Tuberculosis
Autoimmune Disease	HIV	Other: _____
Cancer	Mental Illness	_____
		_____

6. **Current Medications**. **(DO NOT LIST SUPPLEMENTS HERE, SEE QUESTION 3, PG 2 MEDICAL HISTORY – PART II).** Please list date, type, dose, and frequency of any prescription or over-the-counter medications that you take on a regular basis, including pain relievers, sinus/allergy medications, birth control pills, etc.

	DATE STARTED	MEDICATION	DOSAGE	FREQUENCY
(1)	_____	_____	_____	_____
(2)	_____	_____	_____	_____
(3)	_____	_____	_____	_____
(4)	_____	_____	_____	_____
(5)	_____	_____	_____	_____
(6)	_____	_____	_____	_____
(7)	_____	_____	_____	_____
(8)	_____	_____	_____	_____

7. **Examination History.**

When was your last complete physical examination? _____

Was anything significant uncovered in the exam? _____

Have you ever had a colonoscopy? ____Y ____N Results _____

Women:

When was your last gynecological exam? _____ Results _____

When was your last breast exam? _____ Results _____

Have you ever had a mammogram? ____Y ____N Results _____

Men:

Have you ever had a prostate exam? ____Y ____N Results _____

Have you ever had a PSA blood test? ____Y ____N Results _____

8. **Sleep**. Rate you sleep on the following scale (1=poor and 10=good): _____

Circle any of the following descriptions that apply to your sleep:

Dream-disturbed sleep	Awaken with anxiety	Awaken early in the morning and unable to fall back to sleep
Trouble falling asleep	Feel rested upon waking	
Trouble staying asleep		

How many hours do you sleep at a time? _____

Is your schedule regular? _____Y _____N

Do you sleep at night? _____Y _____N

9. **Substance Use.**

Do you smoke? ____Y ____N Tobacco _____ Marijuana _____ Other _____

If yes how much and how frequently? _____

Do you use any drugs recreationally or addictively? ____Y ____N

10. **Sexual History**, if applicable:

Have you been or are you now sexually active?	____Y	____N
If heterosexual, do you use birth control?	____Y	____N
Are you familiar with the risks of HIV and other STD transmission?	____Y	____N
Have you ever had an HIV test?	____Y	____N
Do you take precautions against the transmission of STDs?	____Y	____N

If you answered “NO” to the above question, please indicate why:

____I am in a committed monogamous relationship in which the HIV status of both partners is known, positive or negative.

____I am unaware or unconcerned about transmission.

Other (please specify): _____

_____

_____

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PATIENT MEDICAL HISTORY—PART II

1. **Diet**. *Please record on average how often you eat the following foods as follows.*

1 (with every meal)
2 (Daily)
3 (4-6 times per week)
4 (1-3 times per week)
5 (2-3 times per month)
6 (Less than once a month or never)

____ Nuts and Seeds	____ Wheat Products	____ Fried Foods
____ Organic Foods	____ Whole Grains	____ Frozen Foods
____ Dairy	____ Soy Products	____ White Sugar Products
____ Meat (beef, pork)	____ Beans	____ White Flour Products
____ Fish	____ Rice	____ Hydrogenated Fats (margarine, shortening, etc.)
____ Chicken	____ Pasta	____ Fast Food
____ Eggs	____ Sweets	____ Artificial additives (colors, flavors, preservatives, sweeteners etc.)
____ Fruits	____ Canned Foods	
____Vegetables		

2. **Beverages and Water.**

How much water do you drink per day? _____ (number of 8 oz. glasses)

Is it purified, spring, tap, or filtered? _____

Do you drink beverages with your meals? ____Y ___N

What Beverages do you consume regularly?

SUBSTANCE	OUNCES/DAY	DAYS/MONTH
Coffee		
Decaf		
Black tea		
Green tea		
Herbal tea		
Alcohol		
Soda		
Diet Soda		
Juice		

3. **Supplements, Natural Remedies and Therapies**. Please circle all of the supplements you are currently taking. Bring any multi-ingredient preparations you are taking to your first visit for easier review.

A. **Vitamins and Minerals and Antioxidants:** (single vitamins if you take them separately or in addition to a multi-vitamin)

A	B5	C	bioflavonoids
B1	B12	D	
B2	Folic Acid	E	
B3	Biotin	K	

Single Minerals:

Magnesium	Iron	Iodine	Boron
Calcium	Manganese	Selenium	
Potassium	Copper	Molybdenum	
Zinc	Chromium	Vanadium	

Other Nutrients:

Pycnogenol	Soy Isoflavones	CoQ10	Glutathione
Grape Skin		NAC	Lipoic Acid

B. **Oils and Essential**:

Fatty Acids	Flax	Evening Primrose
Borage	Fish	

Others _____

C. **Hormones and Glandulars**:

Melatonin	Adrenal	Progesterone	Androstenedione
Thyroid	DHEA	Testosterone	Thymus

Others _____

D. **Digestive Enzymes and Digestive Aids**:

Plant Based	Animal based	Hydrochloric acid

Others _____

E. **Protein Powders and Supplements**:

_____

Amino Acids _____

F. **Whole Foods**:

Wheat Grass	Blue Green Algae	Aloe Vera	Brewer's Yeast
Spirulina		Bee Pollen	

Others _____

G. **Colon Cleansers**:

Fiber	Stool Softeners	Laxatives

Others _____

H. **Probiotics**:

Lactobacillus	Acidophilus	Bifidobacterium	Laterosporus

Others _____

I. **Herbs**: Western, Chinese or Combination preparations.

_____

_____

_____

_____

_____

_____

_____

4. **Exercise and Relaxation**.

Please list the types and frequency of exercise and relaxation you practice:

EXERCISE/RELAXATION	FREQUENCY/WEEK	HOURS PER SESSION

5. **Home and Work Environment**

A.	Are you content with your work?	Y _____	N _____
B.	Do you work in a building with windows?	Y _____	N _____
	If yes, do the windows open?	Y _____	N _____
C.	Do you work outside?	Y _____	N _____
D.	Are you under florescent lights at home?	Y _____	N _____
E.	Are you under florescent lights at work?	Y _____	N _____
F.	Do you get outside during the day for at least 30 minutes?	Y _____	N _____
G.	Do you wear sunglasses, contacts, or eyeglasses?	Y _____	N _____
H.	Do you use any full spectrum lighting at home or work?	Y _____	N _____
I.	Are you exposed to toxic fumes, solvents, chemicals, pesticides or cleaning agents at home or work?	Y _____	N _____

If yes, please list: _____

6. **Hygiene and Cleaning Products**

Please circle all the types of products you use regularly with contain synthetic ingredient.

Shampoo	Hair Color	Cleaning Solution(s)
Soap	Cosmetics	Laundry Soap
Toothpaste	Air Freshener	Fabric Softener
Hairspray	Perfume	

Do you use all-natural, additive free products for any of the above? Y _____ N _____

HEALTH APPRAISAL QUESTIONNAIRE

Name _____ **Date** _____

DIRECTIONS

This questionnaire asks you to assess how you have been feeling **during the last four months**. This information will help to keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

For each question, circle the number that best describes your symptoms:

- **0 = No or Rarely**—You have never experienced the symptom or symptom is familiar to you but you perceive it as insignificant (monthly or less)
- **1 = Occasionally**—Symptom comes and goes and is linked in your mind to stress, diet, fatigue or some identifiable trigger
- **4 = Often**—Symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it
- **8 = Frequently**—Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis

Some questions require a YES or NO response. 0 = NO 8 = YES

PART I

	No/Rarely	Occasionally	Often	Frequently
SECTION A				
1. Indigestion, food repeats on you after you eat	0	1	4	8
2. Excessive burping, belching and/or bloating following meals	0	1	4	8
3. Stomach spasms and cramping during or after eating	0	1	4	8
4. A sensation that food just sits in your stomach creating uncomfortable fullness, pressure and bloating during or after a meal	0	1	4	8
5. Bad taste in your mouth	0	1	4	8
6. Small amounts of food fill you up immediately	0	1	4	8
7. Skip meals or eat erratically because you have no appetite	0	1	4	8
Total points				
SECTION B				
1. Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt	0	1	4	8
2. Feel hungry an hour or two after eating a good-sized meal	0	1	4	8
3. Stomach pain, burning and/or aching over a period of 1-4 hours after eating	0	1	4	8
4. Stomach pain, burning and/or aching relieved by eating food, drinking carbonated beverage, cream or milk, or taking antacids	0	1	4	8
5. Burning sensation in the lower part of your chest, especially when lying down or bending forward	0	1	4	8
6. Digestive problems subside with rest and relaxation	(0)No			(8)Yes
7. Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache	0	1	4	8
8. Feel a sense of nausea when you eat	0	1	4	8
9. Difficulty or pain when swallowing food or beverage	0	1	4	8
Total points				
SECTION C				
1. When massaging under your rib cage *on your left side*, there is pain, tenderness or soreness	0	1	4	8
2. Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal	0	1	4	8
3. Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement	0	1	4	8
4. Specific foods/beverages aggravate indigestion	0	1	4	8
5. The consistency or form of your stool changes (e.g., from narrow to loose) within the course of a day	0	1	4	8

	No/Rarely	Occasionally	Often	Frequently
SECTION C *(cont.)*				
6. Stool odor is embarrassing	0	1	4	8
7. Undigested food in your stool	0	1	4	8
8. Three or more large bowel movements daily	0	1	4	8
9. Diarrhea (frequent loose, watery stool)	0	1	4	8
10. Bowel movement shortly after eating (within 1 hour)	0	1	4	8
Total points				
SECTION D				
1. Discomfort, pain or cramps in your colon (lower abdominal area)	0	1	4	8
2. Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas	0	1	4	8
3. Generally constipated (or straining during bowel movements)	0	1	4	8
4. Stool is small, hard and dry	0	1	4	8
5. Pass mucous in your stool	0	1	4	8
6. Alternate between constipation and diarrhea	0	1	4	8
7. Rectal pain, itching or cramping	0	1	4	8
8. No urge to have a bowel movement	(0)No			(8)Yes
9. An almost continual need to have a bowel movement	(0)No			(8)Yes
Total points				

PART II

1. When massaging under your rib cage *on your right side*, there is pain, tenderness or soreness	0	1	4	8
2. Abdominal pain worsens with deep breathing	0	1	4	8
3. Pain at night that may move to your back or right shoulder	0	1	4	8
4. Bitter fluid repeats after eating	0	1	4	8
5. Feel abdominal discomfort or nausea when eating rich, fatty or fried foods	0	1	4	8
6. Throbbing temples and/or dull pain in forehead associated with overeating	0	1	4	8
7. Unexplained itchy skin worse at night	0	1	4	8
8. Stool color alternates from clay colored to normal brown	0	1	4	8
9. General feeling of poor health	0	1	4	8

PART II

	No/Rarely	Occasionally	Often	Frequently
10. Aching muscles not due to exercise	0	1	4	8
11. Retain fluid and feel swollen around the abdominal area	0	1	4	8
12. Reddened skin, especially palms	0	1	4	8
13. Very strong body odor	0	1	4	8
14. Are you embarrassed by your breath?	0	1	4	8
15. Bruise easily	(0)No			(8)Yes
16. Yellowish cast to eyes	(0)No			(8)Yes

Total points ____

PART III

SECTION A

1. Feel cold or chilled—hands, feet, all over—for no apparent reason	0	1	4	8
2. Your upper eyelids look swollen	0	1	4	8
3. Muscles are weak, cramp and/or tremble	0	1	4	8
4. Are you forgetful?	0	1	4	8
5. Do you feel like your heart beats slowly?	0	1	4	8
6. Reaction time seems slowed down	0	1	4	8
7. In general, are you disinterested in sex because your desire is low?	0	1	4	8
8. Feel slow-moving, sluggish	0	1	4	8
9. Constipation	0	1	4	8
10. Dryness, discoloration of skin and/or hair	(0)No			(8)Yes
11. Have you noticed recently that your voice is deepening?	(0)No			(8)Yes
12. Thick, brittle nails	(0)No			(8)Yes
13. Weight gain for no apparent reason	(0)No			(8)Yes
14. Outer third of your eyebrow is thinning or disappearing	(0)No			(8)Yes
15. Swelling of the neck	(0)No			(8)Yes

Total points ____

SECTION B

1. Lingering mild fatigue after exertion or stress	0	1	4	8
2. Do you find that you get tired and exhaust very easily?	0	1	4	8
3. Craving for salty foods	0	1	4	8
4. Sensitive to minor changes in weather and surroundings	0	1	4	8
5. Dizzy when rising or standing up from a kneeling position	0	1	4	8
6. Dark bluish or black circles under your eyes	0	1	4	8
7. Have bouts of nausea with or without vomiting	0	1	4	8
8. Catch colds or infections easily	(0)No			(8)Yes
9. Wounds heal slowly	(0)No			(8)Yes
10. Your body or parts of your body feel tender, sore, sensitive to the touch, hot and/or painful	0	1	4	8
11. Feel puffy and swollen all over your body	0	1	4	8
12. Skin is gradually tanning without exposure to sun or the ingestion of high levels of carotene-rich foods (e.g., daily carrot juice intake) or supplements	(0)No			(8)Yes

Total points ____

PART IV

	No/Rarely	Occasionally	Often	Frequently

SECTION A

When you miss meals or go without food for extended periods of time, do you experience any of the following symptoms?

1. A sense of weakness	0	1	4	8
2. A sudden sense of anxiety when you get hungry	0	1	4	8
3. Tingling sensation in your hands	0	1	4	8
4. A sensation of your heart beating too quickly or forcefully	0	1	4	8
5. Shaky, jittery, hands trembling	0	1	4	8
6. Sudden profuse sweating and/or your skin feels clammy	0	1	4	8
7. Nightmares possibly associated with going to bed on an empty stomach	0	1	4	8
8. Wake up at night feeling restless	0	1	4	8
9. Agitation, easily upset, nervous	0	1	4	8
10. Poor memory, forgetful	0	1	4	8
11. Confused or disoriented	0	1	4	8
12. Dizzy, faint	0	1	4	8
13. Cold or numb	0	1	4	8
14. Mild headaches or head pounding	0	1	4	8
15. Blurred vision or double vision	0	1	4	8
16. Feel clumsy and uncoordinated	0	1	4	8

Total points ____

SECTION B

1. Frequent urination day and night	0	1	4	8
2. Unusual thirst—feeling like you can't drink enough water	0	1	4	8
3. Unusual hunger—eating all the time	0	1	4	8
4. Vision blurs	0	1	4	8
5. Feel itchy all over	0	1	4	8
6. Tingling or numbness in your feet	0	1	4	8
7. Sense of drowsiness, lethargy during the day not associated with missing meals or not sleeping	0	1	4	8
8. Eating starchy foods, even if they are healthy and unprocessed (like rice, corn, beans, whole wheat or oats), causes you to gain weight or prevents you from losing weight	(0)No			(8)Yes
9. Sores heal slowly	(0)No			(8)Yes
10. Loss of hair on your legs	(0)No			(8)Yes

Total points ____

PART V

SECTION A

1. Feel jittery	0	1	4	8
2. First effort of the day causes pain, pressure, tightness or heaviness around the chest	0	1	4	8
3. Exhaustion with minor exertion	0	1	4	8
4. Heavy sweating (no exertion, no hot flashes)	0	1	4	8
5. Difficulty catching breath, especially during exercise	0	1	4	8
6. Heart pounding, sensation of heart beating too quickly, too slowly or irregularly	0	1	4	8
7. Swelling in feet, ankles and/or legs comes and goes for no apparent reason	0	1	4	8

Total points ____

PART V

SECTION B

	No/Rarely	Occasionally	Often	Frequently
1. Muscle pain at rest	0	1	4	8
2. Cramp-like pains in your ankles, calves or legs	0	1	4	8
3. Numbness, tingling and prickling sensation in hands and feet	0	1	4	8
4. Cold feet and/or toes appear blue	0	1	4	8
5. Brief moments of hearing loss	0	1	4	8
6. Nausea comes and goes quickly unrelated to eating	0	1	4	8
7. Feel worse standing: legs get heavy and fatigued	0	1	4	8
8. Leg discomfort or fatigue relieved by elevating legs	0	1	4	8
9. Fingers and toes numb in cold weather even when protected	0	1	4	8
10. Notice changes in your ability to feel pain or discriminate sensations of hot or cold	(0)No		(8)Yes	
11. Body hair (on arms, hands, fingers, legs and toes) is thinning or has disappeared	(0)No		(8)Yes	
12. Do you notice a decline in your ability to make decisions, concentrate, focus attention or follow directions?	(0)No		(8)Yes	

Total points ____

PART VI

SECTION A

1. Family, friends, work, hobbies or activities you hold dear are no longer of interest	0	1	4	8
2. Do you cry?	0	1	4	8
3. Does life look entirely hopeless?	0	1	4	8
4. Would you describe yourself as feeling miserable and sad, unhappy or blue?	0	1	4	8
5. Do you find it hard to make the best of difficult situations?	0	1	4	8
6. Sleep problems—too much or too little	0	1	4	8
7. Changes in your appetite and weight	(0)No		(8)Yes	
8. Lately you've noticed an inability to think clearly or concentrate	(0)No		(8)Yes	
9. Difficulty making decisions and/or clarifying and achieving your goals	(0)No		(8)Yes	

Total points ____

SECTION B

1. Does worrying get you down?	0	1	4	8
2. Does every little thing get on your nerves and wear you out?	0	1	4	8
3. Would you consider yourself a nervous person?	0	1	4	8
4. Do you feel easily agitated?	0	1	4	8
5. Do you shake and tremble?	0	1	4	8
6. Are you keyed up and jittery?	0	1	4	8
7. Do you tremble or feel weak when someone shouts at you?	0	1	4	8
8. Do you become scared at sudden movements or noises at night?	0	1	4	8
9. Do you find yourself sighing a lot?	0	1	4	8
10. Are you awakened out of your sleep by frightening dreams?	0	1	4	8
11. Do frightening thoughts keep coming back in your mind?	0	1	4	8

SECTION B *(cont.)*

	No/Rarely	Occasionally	Often	Frequently
12. Do you become suddenly scared for no good reason?	0	1	4	8
13. Do you break out in a cold sweat?	0	1	4	8
14. "Butterflies in your stomach", nausea and/or diarrhea	0	1	4	8

Total points ____

SECTION C

1. Do you feel pent up and ready to explode?	0	1	4	8
2. Are you prone to noisy and emotional outbursts?	0	1	4	8
3. Do you do things on impulse?	0	1	4	8
4. Are you easily upset or irritated?	0	1	4	8
5. Do you go to pieces if you don't control yourself?	0	1	4	8
6. Do little annoyances get on your nerves and make you angry?	0	1	4	8
7. Does it make you angry to have anyone tell you what to do?	0	1	4	8
8. Do you flare up in anger if you can't have what you want right away?	0	1	4	8

Total points ____

PART VII

1. Eyes water or tear	0	1	4	8
2. Mucous discharge from the eyes	0	1	4	8
3. Ears ache, itch, feel congested or sore	0	1	4	8
4. Discharge from ears	0	1	4	8
5. Is your nose continually congested?	0	1	4	8
6. Are you prone to loud snoring?	(0)No		(8)Yes	
7. Does your nose run?	0	1	4	8
8. Nosebleeds	(0)No		(8)Yes	
9. Hoarse voice	0	1	4	8
10. Do you have to clear your throat?	0	1	4	8
11. Do you feel a choking lump in your throat?	0	1	4	8
12. Do you suffer from severe colds?	(0)No		(8)Yes	
13. Do frequent colds keep you miserable all winter?	(0)No		(8)Yes	
14. Flu symptoms last longer than 5 days	(0)No		(8)Yes	
15. Do infections settle in your lungs?	(0)No		(8)Yes	
16. Chest discomfort or pain	0	1	4	8
17. Do you experience sudden breathing difficulties?	0	1	4	8
18. Do you struggle with shortness of breath?	0	1	4	8
19. Difficulty exhaling (breathing out)	0	1	4	8
20. Breathlessness followed by coughing during exertion, no matter how slight	0	1	4	8
21. Inability to breathe comfortably while lying down	0	1	4	8
22. Do you cough up lots of phlegm?	0	1	4	8
23. Can you hear noisy rattling sounds when breathing in and out?	0	1	4	8
24. Are you troubled with coughing?	0	1	4	8
25. Do you wheeze?	0	1	4	8
26. Do you have severe soaking sweats at night?	0	1	4	8
27. Do your lips and/or nails have a bluish hue?	0	1	4	8
28. Are you sleepy during the day?	0	1	4	8

PART VII

	No/Rarely	Occasionally	Often	Frequently
29. Do you have difficulty concentrating?	0	1	4	8
30. Eyes, ears, nose, throat and lung symptoms seem associated with specific foods like dairy or wheat products	(0)No			(8)Yes
31. Eyes, ears, nose, throat and lung symptoms are associated with seasonal change	(0)No			(8)Yes

Total points ____

PART VIII

1. Involuntary loss of urine when you cough, lift something or strain during an activity	0	1	4	8
2. Mild lower back ache or pain	0	1	4	8
3. Abdominal achiness or pain	0	1	4	8
4. Pain or burning when urinating	0	1	4	8
5. Rarely feel the urge to urinate	0	1	4	8
6. Feel the need to urinate less than every two hours day or night	0	1	4	8
7. Strong smelling urine	0	1	4	8
8. Back or leg pains are associated with dripping after urination	0	1	4	8
9. Sore or painful genitals	0	1	4	8
10. Urine is a rose color	0	1	4	8
11. Sudden urge to void causes involuntary loss of urine	0	1	4	8
12. Generalized sense of water retention throughout your body	0	1	4	8

Total points ____

PART IX

SECTION A

1. Bones throughout your entire body ache, feel tender or sore	0	1	4	8
2. Localized bone pain	0	1	4	8
3. Hands, feet or throat get tight, spasm or feel numb	0	1	4	8
4. Difficulty sitting straight	0	1	4	8
5. Upper back pain	0	1	4	8
6. Lower back pain	0	1	4	8
7. Pain when sitting down or walking	0	1	4	8
8. Find yourself limping or favoring one leg	0	1	4	8
9. Shins hurt during or after exercise	0	1	4	8

Total points ____

SECTION B

1. Are you stiff in the morning when you wake up?	0	1	4	8
2. Difficulty bending down and picking up clothing or anything from the floor	0	1	4	8
3. Joint swelling, pain or stiffness involving one or more areas (fingers, hands, wrists, elbows, shoulders, toes, arches, feet, ankles, knees, ankles)	0	1	4	8
4. Joints hurt when moving or when carrying weight	0	1	4	8
5. A routine exercise program, like daily walking, causes your knees to swell or hurt	0	1	4	8
6. Difficulty opening jars that were previously easy to open	0	1	4	8
7. Discomfort, numbness, prickling or tingling sensation, or pain in neck, shoulder or arm	0	1	4	8

	No/Rarely	Occasionally	Often	Frequently
SECTION B *(cont.)*				
8. Intermittent pain or ache on one side of head spreading to cheek, temple, lower jaw, ear, neck and shoulder	0	1	4	8
9. Difficulty chewing food or opening mouth	0	1	4	8
10. Difficulty standing up from a sitting position	0	1	4	8
11. Shooting, aching, tingling pain down the back of leg	0	1	4	8
12. Is it difficult to reach up and get a 5-pound object like a bag of flour from just above your head?	(0)No			(8)Yes
13. Injure, strain or sprain easily	(0)No			(8)Yes

Total points ____

SECTION C

1. Muscles stiff, sore, tense and/or ache	0	1	4	8
2. Burning, throbbing shooting or stabbing muscle pain	0	1	4	8
3. Muscle cramps or spasms (involuntary, after exertion/exercise)	0	1	4	8
4. Is muscle pain or stiffness greater in the morning than other times of the day?	0	1	4	8
5. Specific points on body feel sore when pressed	0	1	4	8
6. Feel unrefreshed upon awakening	0	1	4	8
7. Headaches	0	1	4	8
8. Pain at the sides of your head or in your face especially when awakening	0	1	4	8
9. Your jaw clicks or pops	0	1	4	8
10. Muscle twitch or tremor—eyelids, thumb, calf muscle	0	1	4	8
11. Irresistible urge to move legs	0	1	4	8
12. Legs move during sleep	0	1	4	8
13. Unpleasant crawling sensation inside calves when lying down	0	1	4	8
14. Hand and wrist numbness or pain (e.g., interferes with writing, buttoning or unbuttoning your clothes)	0	1	4	8
15. Feeling of "pins and needles" in your thumb and first three fingers	0	1	4	8
16. Pain in forearm and sometimes in shoulder	0	1	4	8

Total points ____

PART X

SECTION A

1. Head feels heavy	0	1	4	8
2. Dizziness	0	1	4	8
3. Difficulty bending over, standing up from sitting, rolling over in bed and/or turning your head from side to side	0	1	4	8
4. Your hands tremble, ever so slightly, for no apparent reason	0	1	4	8
5. When walking you feel like you're wearing heavy weights on your feet	0	1	4	8
6. Bump into things, trip, stumble and feel clumsy	0	1	4	8
7. Difficulty breathing	0	1	4	8
8. Difficulty swallowing	0	1	4	8
9. People tell you to speak up because they have trouble hearing you	0	1	4	8
10. Speaking and forming words does not feel automatic	0	1	4	8
11. Need 10-12 hours of sleep to feel rested	0	1	4	8

PART X

SECTION A *(cont.)*

	No/Rarely	Occasionally	Often	Frequently
12. Lack strength (your grip is weak, holding your head or picking your arms up takes effort)	0	1	4	8
13. Hands get tired when you write and your handwriting is less legible and smaller than it used to be	(0)No			(8)Yes
14. Muscles in arms and legs seem softer and smaller	(0)No			(8)Yes
15. Is your eyesight, sense of smell and taste or ability to hear not as sharp as it used to be?	(0)No			(8)Yes
16. Do you find yourself moving slower than you used to?	(0)No			(8)Yes

Total points ____

SECTION B

1. Difficulty absorbing new information	0	1	4	8
2. Tend to forget things	0	1	4	8
3. Trouble thinking or concentrating	0	1	4	8
4. Easily distracted	0	1	4	8
5. Do you have a tendency to become frustrated quickly?	0	1	4	8
6. Inability to sit still for any length of time, even at mealtime	0	1	4	8
7. Finishing tasks is easier said than done	0	1	4	8
8. Do you have more trouble solving problems or managing your time than usual?	0	1	4	8
9. Low tolerance for stress and otherwise ordinary problems	0	1	4	8

Total points ____

PART XI

Men Only

1. Sensation of not emptying your bladder completely	0	1	4	8
2. Need to urinate less than 2 hours after you have finished urinating	0	1	4	8
3. Find yourself needing to stop and start again several times while urinating	0	1	4	8
4. Find it difficult to postpone urination	0	1	4	8
5. Have a weak urinary stream	0	1	4	8
6. Need to push or strain to begin urinating	0	1	4	8
7. Dripping after urination	0	1	4	8
8. Urge to urinate several times a night	0	1	4	8

Total points ____

PART XII

Women Only

(Menopausal women should skip to Sections E and F)

SECTION A

Do you persistently experience any of these symptoms within three days to two weeks *prior to menstruation?* **0 = NO 8 = YES**

[A]

1. Anxious, irritable or restless	(0)No	(8)Yes
2. Numbness, tingling in hands and feet	(0)No	(8)Yes
3. Easy to anger, resentful	(0)No	(8)Yes
4. Aggressive or hostile toward family/friends	(0)No	(8)Yes

SECTION A *(cont.)*

	No/Rarely	Occasionally	Often	Frequently
[B]				
5. Abdominal bloating, feeling swollen (e.g., feet)	(0)No			(8)Yes
6. Temporary weight gain	(0)No			(8)Yes
7. Breast tenderness, swelling	(0)No			(8)Yes
8. Appearance of breast lumps	(0)No			(8)Yes
9. Discharge from nipples	(0)No			(8)Yes
10. Nausea and/or vomiting	(0)No			(8)Yes
11. Diarrhea or constipation	(0)No			(8)Yes
12. Aches and pains (back, joints, etc.)	(0)No			(8)Yes
[C]				
13. Craving for sweets	(0)No			(8)Yes
14. Increased appetite or binge eating	(0)No			(8)Yes
15. Headaches				
16. Being easily overwhelmed, shaky or clumsy	(0)No			(8)Yes
17. Heart pounding	(0)No			(8)Yes
18. Dizziness or fainting	(0)No			(8)Yes
[D]				
19. Confused and forgetful to the point that work suffers	(0)No			(8)Yes
20. Overwhelmed with feelings of sadness and worthlessness	(0)No			(8)Yes
21. Difficulty sleeping or falling asleep	(0)No			(8)Yes
22. Engaging in self destructive behavior	(0)No			(8)Yes

Total points ____

SECTION B

Do you experience any of these symptoms *during your period?*

1. Cramping in lower abdomen or pelvic area	(0)No	(8)Yes
2. Pain is sharp and/or dull or intermittent	(0)No	(8)Yes
3. Bloating and sense of abdominal fullness	(0)No	(8)Yes
4. Diarrhea or constipation	(0)No	(8)Yes
5. Nausea and/or vomiting	(0)No	(8)Yes
6. Low back and/or legs ache	(0)No	(8)Yes
7. Headaches	(0)No	(8)Yes
8. Unusual fatigue (take naps) resulting in missed work	(0)No	(8)Yes
9. Painful and/or swollen breasts	(0)No	(8)Yes
10. Scanty blood flow	(0)No	(8)Yes

Total points ____

SECTION C

1. Painful or difficult sexual intercourse	0	1	4	8
2. Low abdominal, back and vaginal pain throughout the month	0	1	4	8
3. Pelvic pressure or pain while sitting down or standing up, relieved by lying down	0	1	4	8
4. Vaginal bleeding other than during your period	0	1	4	8
5. Painful bowel movements	0	1	4	8
6. Difficult (straining) urination	0	1	4	8
7. Abnormal vaginal discharge	0	1	4	8
8. Offensive vaginal discharge	0	1	4	8
9. Vaginal itching or burning with or without intercourse	0	1	4	8
10. Pain during periods is getting progressively worse	(0)No			(8)Yes
11. Profuse or prolonged menstrual bleeding	(0)No			(8)Yes
12. Unable to get pregnant	(0)No			(8)Yes

Total points ____

PART XII

SECTION D

	No/Rarely	Occasionally	Often	Frequently
1. Absence of periods for six months or longer	(0)No			(8)Yes
2. Periods occur irregularly (e.g., 3 to 6 times a year)	(0)No			(8)Yes
3. Profuse heavy bleeding during periods	0	1	4	8
4. Menstrual blood contains clots and tissue	0	1	4	8
5. Bleeding between periods can occur anytime	0	1	4	8
6. Menstrual bleeding at cycles greater than every 35 days	(0)No			(8)Yes
7. Intense upper stomach pain, lasting several hours at the time you ovulate (approximately day 14 of your cycle)	0	1	4	8
8. Bleeding occurs at ovulation (approximately day 14 of your cycle)	0	1	4	8
9. Monthly abdominal pain without bleeding	0	1	4	8
10. Abundant cervical mucous	0	1	4	8
11. Acne and/or oily skin	0	1	4	8
12. Overwhelming urges for sexual intercourse	0	1	4	8
13. Aggressive feelings	0	1	4	8
14. Increased growth of dark facial and/or body hair	(0)No			(8)Yes
15. Poor sense of smell	(0)No			(8)Yes
16. Voice is becoming deeper	(0)No			(8)Yes
17. Breasts seem to be getting smaller	(0)No			(8)Yes
18. Receding hairline	(0)No			(8)Yes
Total points				

SECTION E

	No/Rarely	Occasionally	Often	Frequently
1. Vaginal discharge	0	1	4	8
2. Vaginal secretions are watery and thin	0	1	4	8
3. Vaginal dryness	0	1	4	8
4. Sexual intercourse is uncomfortable	0	1	4	8

SECTION E *(cont.)*

	No/Rarely	Occasionally	Often	Frequently
5. Interest in having sex is low	0	1	4	8
6. Engorged breasts	0	1	4	8
7. Breast tenderness, soreness	0	1	4	8
8. Difficulty with orgasm	0	1	4	8
9. Vaginal bleeding after sexual intercourse	0	1	4	8
10. Do you skip periods?	(0)No			(8)Yes
11. The length (number of days) of your period varies month to month, with the number of days of bleeding getting less	(0)No			(8)Yes
Total points				

SECTION F

	No/Rarely	Occasionally	Often	Frequently
1. Sense of well-being fluctuates throughout the day for no apparent reason	0	1	4	8
2. Sudden hot flashes	0	1	4	8
3. Spontaneous sweating	0	1	4	8
4. Chills	0	1	4	8
5. Cold hands and feet	0	1	4	8
6. Heart beats rapidly or feels like it is fluttering	0	1	4	8
7. Numbness, tingling or prickling sensations	0	1	4	8
8. Dizziness	0	1	4	8
9. Mental fogginess, forgetful, distracted	0	1	4	8
10. Inability to concentrate	0	1	4	8
11. Depression, anxiety, nervousness and/or irritability	0	1	4	8
12. Difficulty sleeping	0	1	4	8
13. Conscious of new feelings of anger and frustration	0	1	4	8
14. Skin, hair, vagina and/or eyes feel dry	0	1	4	8
15. Stopped menstruating around six months ago, yet still experience some vaginal bleeding	(0)No			(8)Yes
Total points				

Please mark an "X" to indicate areas where you feel pain, swelling or discomfort, or areas of your skin that have changed color or texture (e.g., moles, rashes, etc.). Describe what you feel or observe in your own words. Write anywhere in this area.