HEALTH APPRAISAL - BRIEF

NAME____ DATE____________

CIRCLE the number which best describes the ***frequency*** of your symptoms. If you do not know the answer the the question, leave it blank. When you are finished, please add the number of points in each section and enter the number in the **Total Point** box. The score for YES is the number inside the parenthesis ( ).

(0) never or rarely (1) twice a week or less (2) three to six times a week (3) daily or several times a day

PART I

Section A

1. Indigestion	0	1	2	3
2. Belching, burping	0	1	2	3
3. Gas immediately following a meal	0	1	2	3
4. Sense of fullness during meals	0	1	2	3
5. Poor appetite, picky eater	0	1	2	3
6. Difficult bowel movements	0	1	2	3
7. Difficulty swallowing	0	1	2	3
8. History of anemia, unresponsive to iron	N			Y (10)
9. Vegetarian (no eggs, dairy)	N			Y (5)
10. Spoon shaped nails	N			Y (3)
11. Unintentional weight loss	N			Y (3)
12. Partial loss of taste or smell	N			Y (3)

Total Points________

Section B

1. Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
2. Pain, tenderness, soreness on left side under rib cage	0	1	2	3
3. Bloated	0	1	2	3
4. Excessive passage of gas	0	1	2	3
5. Abdominal cramps, aches	0	1	2	3
6. Nausea and/or vomiting	0	1	2	3
7. Specific foods/beverages aggravate indigestion	0	1	2	3
8. Roughage and fiber causes constipation	0	1	2	3
9. Three or more large bowel movements daily	0	1	2	3
10. Alternating constipation and diarrhea	0	1	2	3
11. Undigested food in stool	0	1	2	3
12. Mucus in stool	0	1	2	3
13. Dry, flaky skin, dry brittle hair	N			Y (3)
14. Difficulty gaining weight	N			Y (3)

Total Points________

Section C

1. Stomach pain, burning, aching 1-4 hours after eating	0	1	2	3
2. Feeling hungry an hour or two after eating	0	1	2	3
3. Stomach discomfort, pain in response to strong emotions, thoughts, smell of food	0	1	2	3
4. Heartburn, especially when lying down, bending forward	0	1	2	3
5. Heartburn due to spicy and fatty foods, chocolate, peppers, citrus, alcohol, caffeine	0	1	2	3
6. Difficulty or pain when swallowing	0	1	2	3
7. Chest pain or infections, difficulty breathing	0	1	2	3
8. For relief from carbonated beverages, cream/milk/food	0	1	2	3
9. Constipation	0	1	2	3
10. Black, tarry stool	0	1	2	3

Total Points________

Section D

1. Lower abdominal pain, cramping and/or spasms	0	1	2	3
2. Lower abdominal pain relief by passing stool or gas	0	1	2	3
3. Raw fruits, vegetables and stress aggravate bowel pain	0	1	2	3
4. Diarrhea (loose watery stool)	0	1	2	3
5. More than three bowel movements daily	0	1	2	3
6. Excessive gas and bloating	0	1	2	3
7. Painful, difficult, straining during bowel movements	0	1	2	3
8. Hard, dry or small stool	0	1	2	3
9. Extremely narrow stools	0	1	2	3
10. Alternating diarrhea/constipation	0	1	2	3
11. Mucus, pus in stool	0	1	2	3
12. Feeling that bowels do not empty completely	0	1	2	3
13. Bright red blood following bowel movement	0	1	2	3
14. Anal itching	0	1	2	3

Total Points________

PART II.

Section A

1. Moderate to severe pain under right side of rib cage	0	1	2	3
2. Abdominal pain worsens with deep breathing	0	1	2	3
3. Regurgitate bitter fluid	0	1	2	3
4. Bloated, full feeling	0	1	2	3
5. Belching, heartburn, gas	0	1	2	3
6. Fatty foods cause indigestion	0	1	2	3
7. Nausea or vomiting	0	1	2	3
8. Feel restless, agitated	0	1	2	3
9. Unexplained itchy skin worse at night	0	1	2	3
10. Stool color alternates from clay colored to normal brown	0	1	2	3
11. Feeling of poor health	0	1	2	3
12. Fatigue, weakness, exhaustion	0	1	2	3
13. Unable to concentrate, irritable, confused	0	1	2	3
14. Swollen feet and/or legs	0	1	2	3
15. Easy bruising	0	1	2	3
16. Feeling of extreme dryness	0	1	2	3
17. Reddened skin, especially palms	0	1	2	3
18. Dark urine, diminished flow	0	1	2	3
19. Dry, flaky skin, hair	N			Y (3)
20. Yellowish cast to skin, eyes	N			Y (3)

Total Points________