



Welcome! We are looking forward to meeting you and helping you improve your health! The Wellness Center For Sport & Spine offers a menu of services designed to support people with active lifestyles. Dr. Coleman has over 20 years of experience working with children, families, and the elderly. Professional and competitive athletes and people living active lifestyles appreciate our personalized service and diverse treatment methods.

Over the years, chiropractic and physical medicine has evolved with technology. While we have kept up with technology, good old fashioned customer service with kindness takes priority over our modern equipment. Each person is treated personally and uniquely for their needs.

Services to Optimize Your Health:

Chiropractic	Physical Therapy	Rehabilitation
Spine & Extremity Adjustments	Cold Laser	Spinal Decompression
Multiple Techniques	Mechanical Traction	Muscle Activation Therapy
Cranial Adjusting	Myofascial Release	Joint Rehabilitation
Family & Children	Electrical Muscle Stimulation	Flexion Distraction Therapy
Hand & Instrument Treatment	Muscle Rehabilitation	Exercise Therapy
Digital Foot Scan & Custom Orthotics		

- In-depth chiropractic structural and functional evaluations and treatment for acute and chronic conditions for spine, extremity, nerve, muscle and joint disorders.
- Health and wellness consultations
- Health Coaching & Consulting for individuals, sports teams and corporate clients
- Second opinions offered for alternative methods for diagnosed conditions
- Lifestyle and health skills training and education
- Customized nutritional and supplement programs
- Individualized health optimizing strategies
- Healthcare Teamwork - collaboration with medical physicians, physical therapists, coaches, trainers, and other healthcare providers

Diagnostic Evaluations:

- In-depth biomechanical testing including spine, extremity and muscle function
- Computerized foot evaluations
- Sports injury evaluations
- Second and third opinions
- Offering alternatives to frequently prescribed surgical procedures in spine and extremity conditions
- Nutritional screening
- X-ray diagnostics for structural and functional evaluations
- Analysis of gastrointestinal function and health

Other Services:

- Health and personal growth coaching
- Nutritional supplementation
- Detoxification strategies using approaches customized to your situation

The Wellness Center For Sport & Spine Inc. • Dr. Gil Z. Coleman, D.C.
181 W. Boardwalk Drive • Suite 204 • Fort Collins, CO 80525 • 970-493-3100

Warren Federal Bank Building 2nd Floor • Between REI & Olive Garden

www.PremierFortCollinsChiropractor.com



The Wellness Center For Sport & Spine
Dr. Gil Z. Coleman, D.C.
181 W. Boardwalk Drive
Suite 204
Fort Collins, CO 80525
970-493-3100

Warren Federal Building 2nd Floor
Located between REI & Olive Garden

Directions to Our Office

Directions from Fort Collins

Our office is located in the **Warren Federal Credit Union Building** on West Boardwalk between REI and the Olive Garden Restaurant.

Please use the elevator in the lobby at the South side of the building. We are on the 2nd floor.

If you get lost, please call 970-493-3100.

Directions from Denver

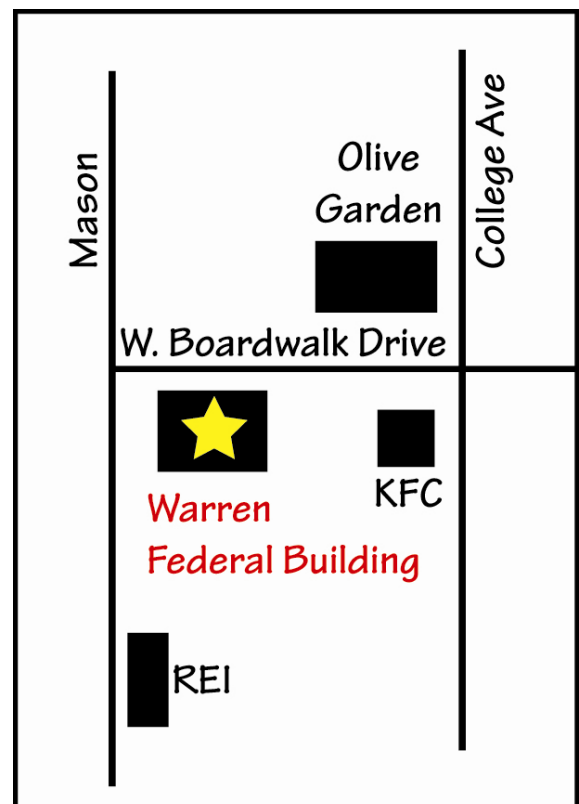
Merge onto I-25 N/US-87 N toward FT COLLINS
Take the HARMONY ROAD exit, EXIT 265.
Turn LEFT onto E HARMONY RD/CO-68 W. 4.5 miles
Turn RIGHT onto S COLLEGE AVE/US-287 N. 0.6 miles
Turn LEFT onto W BOARDWALK DR. 0.1 miles
181 W BOARDWALK DR Suite 204 is on the LEFT in the
Warren Federal Building 2nd Floor.

Directions From Cheyenne, Wyoming

Merge onto I-25 S/US-87 S toward DENVER
Take the HARMONY ROAD exit, EXIT 265.
Turn RIGHT onto E HARMONY RD/CO-68 W. 4.4 miles
Turn RIGHT onto S COLLEGE AVE/US-287 N. 0.6 miles
Turn LEFT onto W BOARDWALK DR. 0.1 miles
181 W BOARDWALK DR Suite 204 is on the LEFT in the
Warren Federal Building 2nd Floor.

If you get lost, please call 970-493-3100.

Please drive safely.





Thank you for choosing The Wellness Center For Sport & Spine and Dr. Gil Coleman. We look forward to meeting you and promise to provide a great experience and do our best work for you!

The Wellness Center For Sport & Spine offers our new patient forms online so they can be completed in the comfort of your home or office.

These forms require Adobe Reader. <http://get.adobe.com/reader/> to install the Adobe Reader application.

We have blocked off **60 minutes** for your appointment with Dr. Coleman. Please arrive 15 minutes early to process your paperwork.

What to bring:

1. Printed filled out new patient intake forms
2. Copies of imaging DVD media, x-rays, MRI/CT scans, radiology reports, and or surgical reports
3. Typed chronological detail (in outline form) of your personal health history

In chronological order past to present, please type an outline of your personal health history that includes details of your medical history, injuries, accidents, broken bones, surgery, treatment, imaging studies, and other health information.

How to download your new patient forms

Please download, print, and complete the new patient forms prior to your office visit by following the steps below: NOTE: DO NOT EMAIL SENSITIVE HEALTH INFORMATION.

Go to www.PremierFortCollinsChiropractor.com.

1. Click on **New Patients**
2. Click on the first link: **Adult NP Forms Package (ONLY)**
3. Print, fill out, and sign forms

In the meantime, if you have any questions, please feel free to call our office at 970-493-3100. We are dedicated to providing you a great experience. **If for any reason you are unable to keep your scheduled new patient appointment, we require 24 hours advanced notice, and reserve the right to charge \$50 for missed appointments.** We understand that some delays are unavoidable. If you are late, please call our office and be aware that you may have to wait or be rescheduled.

Thank you for choosing The Wellness Center for Sport and Spine. We look forward to meeting with you! **Congratulations!** You're one step closer to a happier and healthier life!

Dr. Gil Z. Coleman - Sports & Family Chiropractor
The Wellness Center For Sport & Spine



ATTENTION NEW PATIENTS:

DO NOT FILL THESE FORMS OUT UNLESS YOU ARE SEEING DR. COLEMAN FOR A METABOLIC HEALTH APPRAISAL. **If you are unsure, call the office before filling out this extensive questionnaire.**

Directions for filling out the Metabolic Screening Questionnaire and Health Appraisal Questionnaire

1. Write your name and date of initial or follow up test at the top of the page.
2. Fill out all sections based on the last 60 days.
3. Subtotal # of points in each section in the box at the bottom of the section.
4. Bring your completed form to your next appointment.

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 you 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 the 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

SECTION A

	No/Rarely	Occasionally	Often	Frequently
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 beverages, 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 that 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 <i>on your left side</i> , 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

SECTION C (cont.)

	No/Rarely	Occasionally	Often	Frequently
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 mucus 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 <i>on your right side</i> , 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 that's 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				<input type="text"/>

PART III

SECTION A

1. Feel cold or chilled—hands, feet or 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				<input type="text"/>

SECTION B

1. Lingering mild fatigue after exertion or stress	0	1	4	8
2. Do you find that you get tired and exhaust 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				<input type="text"/>

PART IV

	No/Rarely	Occasionally	Often	Frequently
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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				<input type="text"/>

SECTION B

1. Frequent urination during the 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				<input type="text"/>

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				<input type="text"/>

PART V (cont.)**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 get numb in cold weather even when protected	0	1	4	8
10. Notice changes in your ability to feel pain or differentiate between 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 sleep	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.)

12. Do you become suddenly scared for no 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. Mucus 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 (cont.)

	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 changes	(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 during the 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 or 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

SECTION B (cont.)

	No/Rarely	Occasionally	Often	Frequently
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 achy	0	1	4	8
2. Burning, throbbing, shooting or stabbing muscle pain	0	1	4	8
3. Muscle cramps or spasms (involuntary or 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 or with 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. You feel like you're wearing heavy weights on your feet when walking	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 (cont.)

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?

[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

Total points

SECTION A (cont.)

[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	(0)No	(8)Yes
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. Lower abdominal 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 (cont.)

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. Periods occur 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 mucus	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

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 fewer	(0)No	(8)Yes		

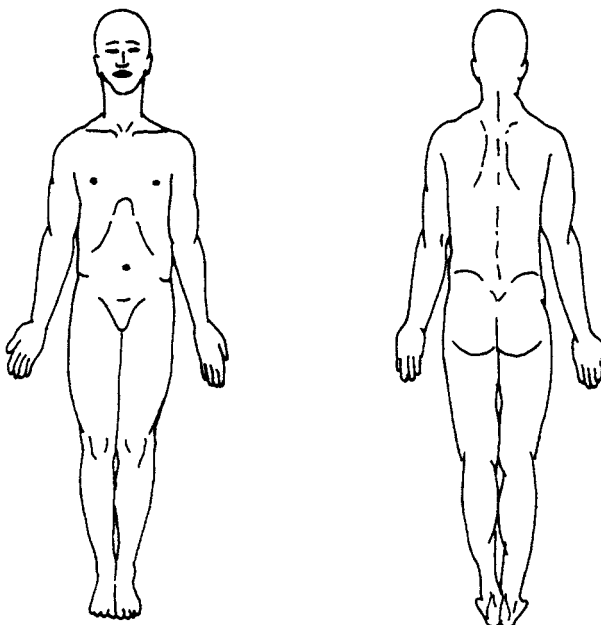
Total points

SECTION F

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 foginess, forgetful or 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.



NUTRITION & IMMUNE STATUS

Physical assessment of common markers of malnutrition, maldigestion, malabsorption, hypermetabolic stress syndrome and protein calorie malnutrition. Exam to be conducted by a healthcare professional.

General Appearance:

- Undernourished, skinny (especially the temporal muscles)

Hair:

- Dull, dry
- Thin, fine, straight
- Easily plucked
- Areas of lighter or darker spots
- Hair loss

Face:

- Pale complexion
- Generalized swelling
- Dark areas on cheeks
- Dark circles under eyes
- Lumpy or flaky skin around the nose and mouth
- Enlarged parotid glands

Eyes:

- Difficulty adjusting to the dark
- Dull appearance
- Dry and either pale or red membranes
- Triangular, shiny gray spots on conjunctivas
- Red and fissured eyelid corners
- Bloodshot ring around cornea

Lips:

- Red and swollen, especially at corners
- Cheilosis (fissures and chapping of lips)

Tongue:

- Swollen
- Purple and raw-looking with sores and abnormal papillae

Teeth:

- Missing, or emerging abnormally
- Visible cavities or dark spots
- Bleeding gums

Nails:

- Spoon-shaped
- Brittle
- Ridged

Neck:

- Swollen thyroid gland

Skin:

- Dry, flaky
- Swollen, with lighter and darker spots, some resembling bruises
- Tight and drawn, with poor turgor (elasticity)
- Dermatitis
- Retarded wound healing
- Skin lesions

Smell and Taste:

- Partial loss of taste
- Partial loss of smell

Musculoskeletal System:

- Muscle wasting
- Muscle weakness
- Muscle atrophy
- Knock-knee or bowlegs
- Bumps on ribs
- Swollen joints
- Musculoskeletal hemorrhages
- Stunted growth, loss of height
- Dowager's hump
- Tetany (muscle twitches and/or cramps)

Cardiovascular System:

- Heart rate above 100 beats/minute
- Arrhythmias
- Elevated blood pressure

Abdomen:

- Enlarged liver and spleen

Reproductive System:

- Decreased libido
- Amenorrhea
- Retarded development of the reproductive system

Nervous System:

- Irritability
- Mental confusion
- Abnormal behavior
- Depression
- Paresthesias (tingling) in hands and feet
- Loss of proprioception (unable to maintain balance with eyes closed)
- Decreased ankle and knee reflexes
- Paralysis (no spinal cord injury)
- Tremor

Consider blood deficiency (pernicious anemia) with the following clinical picture:

- Considerable weight loss without apparent cause
- Burning tongue
- General weakness, malaise and fatigue
- Numbness and tingling in the extremities
- Alternating constipation and diarrhea
- Abdominal pain
- Nausea and vomiting
- Bleeding gums
- Ataxia (incoordination and irregularity of voluntary, purposeful movements)
- Diplopia (double vision) and blurred vision
- Irritability
- Headache

Ethnic Background:

- White (non-Hispanic origin)
- Hispanic
- African American
- Asian
- Pacific Islander
- Native North American
- East Indian