

Name: \_\_\_\_\_

ANXIETY

Read each description in this section. Based on how the symptom applies to you, choose a Point Score number from this group below, and mark it in the column on the right.

If symptom is not present: 0  
Mild symptom: 1  
Moderate: 2  
Severe: 3  
Very Severe: 4

**Point Score**

1. Anxious Mood  
(worry, anticipate the worst, have fear of what will happen, am irritable) \_\_\_\_\_
2. Tension  
(feel tension, tired, easily startled, cry easily, tremble, feel restlessness, am unable to relax) \_\_\_\_\_
3. Fears  
(afraid of darkness, strangers, being left alone, animals, traffic, crowds) \_\_\_\_\_
4. Insomnia  
(difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors) \_\_\_\_\_
5. Intellectual  
(difficulty concentrating, poor memory) \_\_\_\_\_
6. Depressed Mood  
(loss of interest, lack of pleasure in hobbies, depression, early waking, mood swings during the day) \_\_\_\_\_
7. Somatic (Muscular)  
(aches and pains, twitching, stiffness, jerking of my muscles, teeth grinding, unsteady voice, tight muscles) \_\_\_\_\_

TOTAL THIS PAGE \_\_\_\_\_

- 8. Somatic (Sensory)  
(ringing or buzzing in my ears, blurred vision,  
hot and cold flushes, feelings of weakness,  
pricking sensation) \_\_\_\_\_
- 9. Cardiovascular Symptoms  
(rapid heartbeat, feel my heart is skipping beats,  
chest pain, throbbing of vessels, fainting feelings,  
sighing, shortness of breath) \_\_\_\_\_
- 10. Respiratory Symptoms  
(pressure or tightness in my chest, choking feelings,  
sighing, shortness of breath) \_\_\_\_\_
- 11. Gastrointestinal Symptoms  
(difficulty in swallowing, gas, abdominal pain,  
burning sensations in my stomach, abdominal fullness,  
nausea, vomiting, growling bowels, looseness of bowels,  
weight loss, constipation) \_\_\_\_\_
- 12. Genitourinary Symptoms  
(Frequency of urination, urgency of urination,  
women; lack of periods, painful periods, development  
of frigidity, men; premature ejaculation, loss of libido,  
impotence) \_\_\_\_\_
- 13. Autonomic Symptoms  
(dry mouth, tendency to sweat, giddiness,  
tension headache, raising of my hair, flush or go pale) \_\_\_\_\_
- 14. Behavior  
(People notice my fidgeting, being restless or pacing,  
hand tremor, furrowed brow, strained face, sighing  
or breathing rapidly, pale face and frequent swallowing) \_\_\_\_\_

TOTAL THIS PAGE \_\_\_\_\_

TOTAL PAGE 1 \_\_\_\_\_

**Total pp 1 & 2** \_\_\_\_\_

COMPULSIONS

Answer each question below by circling YES or NO. Then count up your Total YES Score for each section.

- |  |     |       |
|--|-----|-------|
| 1. Are there things you feel you must do excessively, or thoughts you must think repeatedly, in order to feel comfortable? | YES | NO    |
| 2. Do you excessively wash yourself or things around you?  | YES | NO    |
| 3. Do you have to check things over and over again or repeat actions many times to be sure they are done properly?         | YES | NO    |
| 4. Do you avoid situations or people you worry about hurting through aggressive words or actions?                          | YES | NO    |
| 5. Do you keep many useless things because you feel that you can't safely throw them away?                                 | YES | NO    |
| <b>Total YES Score</b>   |     | _____ |

OBSESSIONS

Answer each question below by circling YES or NO. Then count up your Total YES Score.

- |   |     |       |
|---|-----|-------|
| 1. Do you have unwanted ideas, images or impulses that seem silly, nasty or horrible?   | YES | NO    |
| 2. Do you worry excessively about dirt, germs or chemicals?   | YES | NO    |
| 3. Are you constantly worried that something bad will happen because you forgot something important-- such as locking the door or turning off appliances? | YES | NO    |
| 4. Are you afraid you will act or speak aggressively when you really don't want to?   | YES | NO    |
| 5. Are you always afraid you will lose something important?   | YES | NO    |
| <b>Total YES Score</b>  |     | _____ |

## DEPRESSION

For each category below, circle the Point Score for the description that most characterizes you. Add the total of your Point Scores to get your Total Score.

	<b>Point Score</b>
<b>1. <u>Depressed Mood</u></b> (Feelings of sadness, hopelessness, helplessness, worthlessness.)	
No problem.	0
If asked, I will admit having these feelings.	1
I have verbally reported having these feelings.	2
I have non verbally reported these feelings--that is, through facial expressions, posture, voice, and tendency to weep.	3
The only thing I talk about is my depression.	4
<b>2. <u>Feelings of Guilt</u></b>	
No problem.	0
I have let people down.	1
I feel guilty over past errors or sinful deeds.	2
I think my present illness is a punishment for doing wrong.	3
I hear voices that accuse or blame me, or experience threatening visual hallucinations.	4
<b>3. <u>Suicide</u></b>	
No problem.	0
I think life is not worth living.	1
I wish I were dead, or I think about my possible death.	2
I have suicidal ideas or have made minor suicidal gestures.	3
I have attempted suicide.	4
<b>4. <u>Insomnia (Early)</u></b>	
No difficulty.	0
I occasionally need more than a half hour to fall asleep.	1
Every night I have trouble falling asleep.	2
<b>5. <u>Insomnia (Middle)</u></b>	
No difficulty.	0
I am restless and disturbed during the night. If I get up, it is only to go to the bathroom.	1
I wake up during the night, and get out of bed to eat, read, watch TV, or do other things.	2
<b>6. <u>Insomnia (Late)</u></b>	
No difficulty.	0
I wake earlier than I need to get up, but then go back to sleep.	1
If I get out of bed too early in the morning, I am unable to go back to sleep.	2

TOTAL PAGE 4 \_\_\_\_\_

7.	<u>Work and Activities</u>	
	No difficulty.	0
	I feel too tired or weak, and unable to do activities, work or hobbies.	1
	I have lost interest in activities; work or hobbies. I feel listless, indecisive, keep changing my mind, and feel a need to push myself.	2
	I can't do any more than three hours of essential chores. I've stopped working because of present illness. I can't even do my basic chores without help.	3
		4
8.	<u>Retardation</u>	
	When I talk to people, I think my speech and thought are normal.	0
	I pause occasionally to get my thoughts together.	1
	I pause often, and feel my thoughts are blocked.	2
	I really feel I can't talk at all, except maybe when answering yes or no.	3
	I just can't talk to people at all.	4
9.	<u>Agitation</u>	
	None.	0
	I play with my hands and hair.	1
	I wring my hands, bite my nails or lips, or pull my hair.	2
10.	<u>Anxiety Psychic</u>	
	No difficulty.	0
	Sometimes I feel tense or irritable.	1
	I worry about minor matters.	2
	An apprehensive attitude shows in my face or speech.	3
	I express fears without being questioned.	4
11.	<u>Anxiety Somatic</u> (dry mouth, gas, indigestion, diarrhea, cramps, belching, palpitations, headaches, hyperventilation, sighing, urinary frequency, sweating)	
	None.	0
	Mild.	1
	Moderate.	2
	Severe.	3
	Incapacitating	4
12.	<u>Gastrointestinal Symptoms</u>	
	None.	0
	Loss of appetite, heavy feeling in abdomen.	1
	Difficulty eating, require laxatives or medication for GI symptoms.	2
13.	<u>General Symptoms</u>	
	None.	0
	Heaviness in limbs, backaches headache, muscle aches, loss of energy, tired.	1
	Any especially strong symptom.	2

TOTAL PAGE 5 \_\_\_\_\_

14. <u>Genital Symptoms</u> (Loss of sexual drive, menstrual disturbances)	
None.	0
Mild.	1
Severe.	3
15. <u>Hypochondria</u>	
None.	0
Self absorbed with own body.	1
Preoccupation with health.	2
Frequent complaints, calls to doctors, requests for help with problems.	3
Convinced I have horrible disease and no one is telling me.	4
16. <u>Loss of Weight</u>	
No weight loss.	0
Loss associated with present illness.	1
Definite weight loss.	2
17. <u>Insight</u>	
I know I am depressed and ill.	0
I think it is just a problem of bad food, climate, overwork, virus.	1
People tell me I'm ill, but I don't think so.	2
18. <u>Overall Symptoms</u>	
My symptoms are worse (choose 1)	
in the morning	
in the evening	
there is no difference	
If a difference, it is	
Mild.	1
Severe.	2
19. <u>Feelings of Unreality (I'm not real, the world's not real)</u>	
None.	0
Mild.	1
Moderate.	2
Severe.	3
Incapacitating.	4
20. <u>Feeling Paranoid</u>	
None.	0
I think people are out to get me	1
I go into a room and feel people are talking badly about me	2
There are aliens sending messages to me; I am being persecuted.	3
21. <u>Obsessional and Compulsive Feelings</u>	
None.	0
Mild.	1
Severe.	2

TOTAL PAGE 6 \_\_\_\_\_

**SCORING FOR DEPRESSION SECTION:**

TOTAL PAGE 4 \_\_\_\_\_

TOTAL PAGE 5 \_\_\_\_\_

TOTAL PAGE 6 \_\_\_\_\_

TOTAL OF SECTION \_\_\_\_\_

HYPERACTIVITY-IMPULSIVITY

For each item which applies to you or your child, mark a 1 for your Point Score if the condition has appeared often, and for at least six months. Otherwise, mark a 0 for the score.

Add the points to get your Total Score.

	<b>Point Score</b>
1. Fidget with hands or feet, or squirm in seat.	_____
2. Leave seat in classroom or other situations when remaining seated is expected.	_____
3. Run about or climb excessively in situations where this is not appropriate.	_____
4. Difficulty playing or engaging in <u>quiet</u> leisure activities.	_____
5. On the go, acting as though driven by a motor.	_____
6. Talking excessively.	_____
7. Blurt out answers before questions have been completed.	_____
8. Difficulty waiting for a turn.	_____
9. Interrupt or intrude on others during games and/or conversations.	_____
<b>Total Score</b>	_____

INATTENTION

For each item which applies to you or your child, mark a 1 for your Point Score if the condition has appeared often, and for at least six months. Otherwise, mark a 0 for the score.

Add the points to get your Total Score.

	<b>Point Score</b>
1. Failure to give close attention to details, or make careless mistakes in schoolwork, work, or other activities.	_____
2. Difficulty sustaining attention in tasks or play activities.	_____
3. Do not seem to listen when spoken to directly.	_____
4. Do not follow through on instructions, and failure to finish schoolwork, chores or work. (not because of oppositional behavior or failure to understand instructions)	_____
5. Difficulty organizing tasks and activities.	_____
6. Avoid, dislike, or reluctant to engage in tasks that require sustained mental effort, such as schoolwork or homework.	_____
7. Lose things necessary for tasks or activities. (toys, school assignments, pencils, books or tools)	_____
8. Easily distracted and forgetful during daily activities.	_____
<b>Total Score</b>	_____

MANIA

For each item which applies to you, mark a 1 for your Point Score.  
Otherwise, mark a 0 for the score.

Add the points to get your Total Score.

	Point Score
1. A period of elevated, expansive or irritable mood, requiring hospitalization or lasting at least one week.	_____
2. Inflated self-esteem or grandiosity.	_____
3. Decreased need for sleep. (such as rested after only three hours)	_____
4. More talkative than usual or pressure to keep talking.	_____
5. Flight of ideas or subjective experience that thoughts are racing.	_____
6. Distractibility. (attention too easily drawn to unimportant or irrelevant external stimuli)	_____
7. Increase in goal directed activity (socially, at work or school, or sexually) or psychomotor agitation.	_____
8. Excessive involvement in pleasurable activities that have a high potential for painful consequences. (unrestrained buying sprees, sexual indiscretions, or foolish business investments)	_____
9. Impairment in occupational functioning, in usual social activities, or relationships with others, requiring hospitalization.	_____
<b>Total Score</b>	_____

PANIC ATTACKS

Do not complete these two pages if this is your general state of emotions. To qualify for a Point, the symptom must occur in a non-threatening context, out of the blue, and peak within ten minutes.

For each item which applies to you as described above, mark a 1 for your Point Score. Otherwise, mark a 0 for the score. Add the points to get your Total Score.

	Point Score
1. Palpitations, pounding heart, or accelerated heart rate.	_____
2. Sweating.	_____
3. Trembling or shaking.	_____
4. Sensations of shortness of breath or smothering.	_____
5. Feeling of choking.	_____
6. Chest pain or discomfort.	_____
7. Nausea or abdominal distress.	_____
8. Feeling dizzy, unsteady, lightheaded, or faint.	_____
9. Feelings of unreality, or being detached from oneself.	_____
10. Fear of losing control or going crazy.	_____
11. Fear of dying.	_____

TOTAL PAGE 11 \_\_\_\_\_

12. Numbness or tingling sensations. \_\_\_\_\_

13. Chills or hot flushes. \_\_\_\_\_

ONE month or more of the following:

14. Persistent concern about having anxiety attacks. \_\_\_\_\_

15. Worry about implications and consequences of an anxiety attack. (losing control, heart attack, going crazy) \_\_\_\_\_

16. Significant change in behavior related to attacks. \_\_\_\_\_

TOTAL THIS PAGE \_\_\_\_\_

TOTAL PG 11 \_\_\_\_\_

**Total pp 11 & 12** \_\_\_\_\_

AGORAPHOBIA

SCORE the same as previous section.

1. Anxiety about being in places or situations from which escape might be difficult or embarrassing, or in which help may not be available. \_\_\_\_\_

2. Situations such as travel are avoided, or endured with marked distress or anxiety. \_\_\_\_\_

TOTAL OF SECTION \_\_\_\_\_

POST TRAUMATIC STRESS SYNDROME

For each item which applies to you, mark a 1 for your Point Score.  
Otherwise, mark a 0 for the score.

Add the points to get your Total Score.

**Point Score**

1. Experienced, witnessed, or were confronted with an event that involved threatened or actual serious injury or death, or a threat to the physical integrity of yourself or others.\*

\_\_\_\_\_

\*Your age when event occurred: \_\_\_\_\_

What was/were the event(s)? Please check the list below.

- War \_\_\_\_\_
- Rape \_\_\_\_\_
- Incest \_\_\_\_\_
- Domestic violence \_\_\_\_\_
- Sexual abuse \_\_\_\_\_
- Physical assault \_\_\_\_\_
- Other \_\_\_\_\_

2. Your response to the above event involved intense fear, helplessness, or horror.

\_\_\_\_\_

3. Recurrent and intrusive, distressing recollections of the event, through images, thoughts, or perceptions.

\_\_\_\_\_

4. Recurrent, distressing dreams of the event.

\_\_\_\_\_

5. Acting or feeling as if the event were happening again. (includes a sense of reliving the experience, illusions, hallucinations, or flashback episodes, and which can occur on awakening or when intoxicated)

\_\_\_\_\_

TOTAL THIS PAGE \_\_\_\_\_

- 6. Intense psychological stress if exposed to internal or external cues that symbolize or resemble part of the event. \_\_\_\_\_
- 7. Physiological reactivity if exposed to internal or external cues that symbolize or resemble part of the event. \_\_\_\_\_
- 8. Attempt to avoid thoughts, feelings, or conversations about the event. \_\_\_\_\_
- 9. Attempt to avoid activities, places, or people that bring memories of the event. \_\_\_\_\_
- 10. Unable to recall something important about the event. \_\_\_\_\_
- 11. Much less interest or participation in significant activities. \_\_\_\_\_
- 12. Feeling of detachment or estrangement from others. \_\_\_\_\_
- 13. Restricted ability or unable to have loving feelings. \_\_\_\_\_
- 14. Feeling of having a bleak future. (do not expect to have a career, marriage, children, or a normal life span) \_\_\_\_\_
- 15. Difficulty falling or staying asleep. \_\_\_\_\_
- 16. Irritability or outbursts of anger. \_\_\_\_\_
- 17. Difficulty concentrating. \_\_\_\_\_
- 18. Hypervigilance. \_\_\_\_\_
- 19. Easily startled, or exaggerated response when startled. \_\_\_\_\_

TOTAL THIS PAGE \_\_\_\_\_

TOTAL PAGE 13 \_\_\_\_\_

**Total Score pp 13 & 14**\_\_\_\_\_

Pg 14

*Pt. Initials*\_\_\_\_\_

*PTSS Revised 1/28/04*

## SOCIAL ANXIETY

For each item which applies to you, mark a 1 for your Point Score.  
Add the total of your Point Scores to get your Total Score.

	<b>Point Score</b>
1. Persistent fear of situations in which you might be among unfamiliar people or be closely watched. Especially a fear of acting in a way (or showing symptoms of anxiety) that might be humiliating or embarrassing.	_____
2. Feared social situations invariably provoke anxiety.	_____
3. See your fear as excessive or unreasonable.	_____
4. Avoid feared situations, or endure them with intense anxiety or distress.	_____
5. Avoidance and distress interfere with your normal routine, occupation, social activities and relationships.	_____
<b>Total Score</b>	_____

## EATING DISORDERS

For each item which applies to you, mark a 1 for your Point Score if the condition has appeared often, and for at least six months. Then count up your Total YES Score for each section.

### ANOREXIA

**Point Score**

1. Refuse to maintain body weight at or above a minimally normal weight for age and height. \_\_\_\_\_
  2. Intense fear of gaining weight or becoming fat, even though underweight. \_\_\_\_\_
  3. Undue influence of body weight or shape on self esteem, or denial of the seriousness of the current low body weight. \_\_\_\_\_
  4. If female, absence of at least three consecutive menstrual cycles. \_\_\_\_\_
- Total Score** \_\_\_\_\_

### BULEMIA

**Point Score**

1. Recurrent episodes of binge eating (within any 2 hour period, eating an amount of food definitely larger than most people would eat during a similar period of time under similar circumstances, AND/OR a sense of lack of control of what or how much to eat or when to stop) \_\_\_\_\_
  2. Recurrent inappropriate self induced vomiting, misuse of laxatives, diuretics, enemas, other medications, excessive exercise to prevent weight gain. \_\_\_\_\_
  3. Above behaviors both occur on average at least twice a week for 3 months. \_\_\_\_\_
  4. Undue influence of body weight or shape on self esteem. \_\_\_\_\_
- Total Score** \_\_\_\_\_

## RELATIONSHIPS

Where do you place your highest priorities? **Rank** the following in order of your priorities, with 1 representing your highest, and 5 representing your lowest. (Do NOT use a number more than once)

\_\_\_ Children \_\_\_ Peers and other family members \_\_\_ God

\_\_\_ Spouse or Significant Other \_\_\_ Self

From whom do you receive emotional support ? (e.g. comfort, compassion, concern, curiosity, empathy, joy, love, nurturance, respect, trust) **Rate** each one from 1 to 10, with 1 representing the least support, and 10 representing the most. (You MAY use any number more than once)

\_\_\_ Children \_\_\_ Peers \_\_\_\_\_ Other family members \_\_\_ God

\_\_\_ Spouse or Significant Other \_\_\_ Self \_\_\_ Therapist

With whom do you have the most conflict? (e.g. alienation, anger, anxiety, confusion, fear, grief-loss, guilt, hopelessness, shame) **Rate** each one from 1 to 10, with 1 representing the least conflict, and 10 representing the most. (You MAY use any number more than once)

\_\_\_ Children \_\_\_ Peers \_\_\_ Other family members \_\_\_ God

\_\_\_ Spouse or Significant Other \_\_\_ Self \_\_\_ Therapist

Pg 17

*Pt. Initials* \_\_\_\_\_

*Relationships Revised 1/04/09*

Date: \_\_\_\_\_

How many doctor visits in the last six months? for what?

Name \_\_\_\_\_

Health: \_\_\_poor\_\_\_fair\_\_\_good\_\_\_v. good

Have you ever been treated for any of the following?

Alcoholism: \_\_\_\_\_Yes \_\_\_\_\_No

Allergies: \_\_\_\_\_Yes \_\_\_\_\_No

Bleeding (excessive) \_\_\_\_\_Yes \_\_\_\_\_No

Cancer/Tumors: \_\_\_\_\_Yes \_\_\_\_\_No

Diabetes: \_\_\_\_\_Yes \_\_\_\_\_No

Drug abuse/addiction: \_\_\_\_\_Yes \_\_\_\_\_No

Epilepsy/seizures: \_\_\_\_\_Yes \_\_\_\_\_No

Gastritis: \_\_\_\_\_Yes \_\_\_\_\_No

Glaucoma: \_\_\_\_\_Yes \_\_\_\_\_No

Headaches: \_\_\_\_\_Yes \_\_\_\_\_No

Head injury: \_\_\_\_\_Yes \_\_\_\_\_No

Heart disease: \_\_\_\_\_Yes \_\_\_\_\_No

High blood pressure: \_\_\_\_\_Yes \_\_\_\_\_No

Injuries: \_\_\_\_\_Yes \_\_\_\_\_No

Kidney Disease \_\_\_\_\_Yes \_\_\_\_\_No

Liver Disease

(hepatitis/jaundice) \_\_\_\_\_Yes \_\_\_\_\_No

Lung Disease: \_\_\_\_\_Yes \_\_\_\_\_No

Pancreatitis: \_\_\_\_\_Yes \_\_\_\_\_No

Pregnancy \_\_\_\_\_Yes \_\_\_\_\_No

(how many times?) \_\_\_\_\_

Psychiatric Problems \_\_\_\_\_Yes \_\_\_\_\_No

Surgery \_\_\_\_\_Yes \_\_\_\_\_No

Thyroid Disease \_\_\_\_\_Yes \_\_\_\_\_No

Urinary/Prostate \_\_\_\_\_Yes \_\_\_\_\_No

Weight Gain \_\_\_\_\_Yes \_\_\_\_\_No

Weight Loss: \_\_\_\_\_Yes \_\_\_\_\_No

Names of doctors and their specialties:

Hospitalizations:

Date, Hospital, Reason:

OTHER (please specify)

\_\_\_\_\_

What medical problems are you currently being treated for?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Important medical problems in family members:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## COMMON SYMPTOMS OF HIDDEN FOOD ALLERGY

In which of the following organ systems have you had problems in the past year? (Symptoms in parenthesis are examples only, and not inclusive.)

Circle the number in the Point Score column which most applies to you.

No symptoms: 0 points

A few symptoms: 1 point

Many symptoms: 2 points

Too many symptoms to count: 3 points

Add the total of your Point Scores to get your Total Score.

	<b>Point Score</b>			
1. Eyes/Ears/Nose/Throat (headache, dizzy, unsteadiness, lightheaded)	0	1	2	3
2. Lungs and Throat (shortness of breath, hoarseness, tightness of chest, excess phlegm)	0	1	2	3
3. Heart and Circulation (fainting spells, flushing, sweating spells, clotting)	0	1	2	3
4. Stomach and Digestion (rectal bleeding, nervous stomach, irritable bowel, spastic colon)	0	1	2	3
5. Skin (rash, acne, scaley, flakey)	0	1	2	3
6. Muscle/joint (muscle cramps, weakness, stiff joints, leg aches, arthritis, fibrositis)	0	1	2	3
7. Nervous System (mental confusion, brain fatigue, spacey, unreal feeling)	0	1	2	3
8. Urinary and Sexual Organs (PMS, impotence, frigidity, prostate problems)	0	1	2	3
9. Metabolism and Endocrine Systems (bloating, uncontrolled anxiety, compulsive eating)	0	1	2	3

**Total Score** \_\_\_\_\_

YEAST ALLERGIES

1. For each “yes” answer in Section A, circle the Point Score.
2. Total your score and record it at the end of this section.
3. Then move on to Section B and Section C, and score as indicated.
4. Add all of your Point Scores to get your Total Score.  
(Men: ignore questions related to pregnancy, etc.)

<b>Section A: History</b>	<b>Point Score</b>
1. Have you taken Tetracyclines (Sumycin, Panmycin, Vibramycin, Minocin, etc.) or other antibiotics for one month or longer?	35
2. Have you, at any time in your life, taken other “broad spectrum” antibiotics for respiratory, urinary or other infections for 2 months or longer, or in shorter courses 4 or more times in a one-year period?	35
3. Have you taken a broad spectrum antibiotic drug*--even a single course?	6
4. Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis or other problems affecting your reproductive organs?	25
5. Have you been pregnant...	
2 or more times?	5
1 time?	3

\*Including Keflex, ampicillin, amoxicillin, Ceclor, Bactrim and Septra.

TOTAL THIS PAGE \_\_\_\_\_

- |   |    |
|---|----|
| 6. Have you taken birth control pills...<br>for more than 2 years?  | 15 |
| for 6 months to 2 years?  | 8  |
| 7. Have you taken prednisone, Decadron or other Cortisone-<br>type drugs...   |    |
| for more than 2 weeks?  | 15 |
| for 2 weeks or less?  | 8  |
| 8. Does exposure to perfumes, insecticides, fabric shop odors<br>and other chemicals provoke...   |    |
| moderate to severe symptoms?  | 20 |
| mild symptoms?  | 5  |
| 9. Are your symptoms worse on damp, muggy days, or in<br>moldy places?  | 20 |
| 10. Have you had athlete's foot, ringworm, "jock itch" or other chronic<br>fungus infections of the skin or nails? Have such infections been... |    |
| severe or persistent?   | 20 |
| mild or moderate?   | 10 |
| 11. Do you crave sugar?   | 10 |
| 12. Do you crave breads?  | 10 |
| 13. Do you crave alcoholic beverages?   | 10 |
| 14. Does tobacco smoke really bother you?   | 10 |

TOTAL THIS PAGE \_\_\_\_\_  
TOTAL PAGE 4 \_\_\_\_\_

**Total Score (Section A) pp 4 & 5 \_\_\_\_\_**

YEAST ALLERGIES--continued

For each of your symptoms, circle the appropriate figure in the Point Score column.

If you do not have the symptom: 0 points

If the symptom is occasional or mild: 3 points

If the symptom is frequent and/or moderately severe: 6 points

If the symptom is severe and/or disabling: 9 points

Add the total of your Point Scores to get your Section B Total Score.

<b>Section B: Major Symptoms</b>	<b>Point Score</b>			
1. Fatigue or lethargy.	0	3	6	9
2. Feeling of being drained.	0	3	6	9
3. Poor memory.	0	3	6	9
4. Feeling spacey or unreal.	0	3	6	9
5. Depression	0	3	6	9
6. Inability to make decisions.	0	3	6	9
7. Numbness, burning or tingling.	0	3	6	9
8. Muscle aches or weakness	0	3	6	9
9. Pain and/or swelling in joints.	0	3	6	9
10. Abdominal pain.	0	3	6	9
11. Constipation.	0	3	6	9
12. Diarrhea.	0	3	6	9

13. Bloating, belching or intestinal gas.	0	3	6	9
14. Troublesome vaginal burning, itching or discharge.	0	3	6	9
15. Persistent vaginal burning or itching.	0	3	6	9
16. Prostatitis.	0	3	6	9
17. Impotence.	0	3	6	9
18. Loss of sexual desire or feeling.	0	3	6	9
19. Endometriosis or infertility.	0	3	6	9
20. Cramps and/or other menstrual irregularities.	0	3	6	9
21. Premenstrual tension.	0	3	6	9
22. Attacks of anxiety or crying.	0	3	6	9
23. Cold hands or feet and/or chillness.	0	3	6	9
24. Shaking or irritable when hungry.	0	3	6	9

TOTAL THIS PAGE \_\_\_\_\_

TOTAL PAGE 6 \_\_\_\_\_

**Total Score (Section B) pp 6 & 7\_\_\_\_\_**

Pg 7

*Pt. Initials*\_\_\_\_\_

*Yeast Allergies B revised 1/28/04*

YEAST ALLERGIES--continued

For each of your symptoms, circle the appropriate figure in the Point Score column.  
If you do not have the symptom: 0 points  
If the symptom is occasional or mild: 1 point  
If the symptom is frequent and/or moderately severe: 2 points  
If the symptom is severe and/or disabling: 3 points  
Add the total of your Point Scores to get your Section C Total Score.  
Then obtain your Grand Total Score by adding the totals of all three sections on Yeast Allergies.

<b>Section C: Other Symptoms</b>	<b>Point Score</b>			
1. Drowsiness.	0	1	2	3
2. Irritability or jitteriness.	0	1	2	3
3. Poor coordination.	0	1	2	3
4. Inability to concentrate.	0	1	2	3
5. Frequent mood swings.	0	1	2	3
6. Headache.	0	1	2	3
7. Dizziness, loss of balance.	0	1	2	3
8. Pressure above ears, feeling of head swelling.	0	1	2	3
9. Tendency to bruise easily.	0	1	2	3
10. Chronic rashes or itching.	0	1	2	3
11. Numbness, tingling.	0	1	2	3
12. Indigestion or Heartburn	0	1	2	3
13. Food sensitivity or intolerance.	0	1	2	3
14. Mucous in stools.	0	1	2	3
15. Rectal itching.	0	1	2	3
16. Dry mouth or throat.	0	1	2	3
17. Rash or blisters in mouth.	0	1	2	3
18. Bad breath.	0	1	2	3

TOTAL THIS PAGE \_\_\_\_\_

19. Foot, body or hair odor not relieved by washing.	0	1	2	3
20. Nasal congestion or postnasal drip.	0	1	2	3
21. Nasal itching.	0	1	2	3
22. Sore throat.	0	1	2	3
23. Laryngitis, loss of voice.	0	1	2	3
24. Cough or recurrent bronchitis.	0	1	2	3
25. Pain or tightness in chest.	0	1	2	3
26. Wheezing or shortness of breath.	0	1	2	3
27. Urgency or urinary frequency.	0	1	2	3
28. Burning on urination.	0	1	2	3
29. Spots in front of eyes or erratic vision.	0	1	2	3
30. Burning or tearing of eyes.	0	1	2	3
31. Recurrent ear infections or fluid in ears.	0	1	2	3
32. Ear pain or deafness.	0	1	2	3

TOTAL THIS PAGE \_\_\_\_\_

TOTAL PAGE 8 \_\_\_\_\_

**Total Score (Section C) pp 8 & 9\_\_\_\_\_**

**Total Section A \_\_\_\_\_**

**Total Section B \_\_\_\_\_**

**Total Section C \_\_\_\_\_**

**GRAND TOTAL(A,B,C) \_\_\_\_\_**

Pg 9

*Pt. Initials*\_\_\_\_\_

*Yeast Allergies C Revised 1/28/04*

Patient Name \_\_\_\_\_ Clinician \_\_\_\_\_ Date \_\_\_\_\_

Smoking tobacco products, drinking alcohol, and using drugs other than those prescribed by your physician can interfere with certain medicines and treatments. Therefore, it is important that we ask you some questions about your alcohol, tobacco, and drug use. Your answers will remain confidential, so please be honest. If we find you are using more than you or we feel is good for you, we have services that can help you take better care of yourself. In each case, circle the answer that best describes your situation.

**Smoking**

Do you usually smoke your first cigarette of the day within 30 minutes of waking up?	Yes	No
Do you find it hard not to smoke in places where it's not allowed, such as the library, theater, or doctor's office?	Yes	No
Do you smoke 10 or more cigarettes per day?	Yes	No
Do you smoke 25 or more cigarettes a day?	Yes	No
Do you smoke more in the morning than the rest of the day?	Yes	No
Do you smoke even when you are so ill that you are in bed most of the day?	Yes	No
<b>Total</b>		

**Alcohol**

	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
How many drinks containing alcohol do you have on a typical day you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the past year have you failed to do what you was expected of you because you were drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the past year have you needed a drink first thing in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the past year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the past year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else been injured because of your drinking?	No		Yes, but not in the past year		Daily or almost daily
Has a relative, friend, doctor, or other health care worker been concerned about your drinking and suggested that you cut down?	No		Yes, but not in the past year		Yes, during the past year
					<b>Total</b>

**Drug Use**

Do you use any drugs other than tobacco or those prescribed by a physician?	Yes	No
Have you ever felt you should cut down on your drug use?	Yes	No
Have people ever annoyed you by criticizing your drug use?	Yes	No
Have you ever felt bad or guilty about your drug use?	Yes	No
Have you ever used a drug first thing in the morning to steady the nerves or to get rid of a hangover?	Yes	No
Has a physician or other professional ever told you to cut down or quit use of drugs?	Yes	No
Has your drug use caused family problems?	Yes	No
When using drugs, have you ever had a memory loss or blackout?	Yes	No

Which drugs do you use?      marijuana      cocaine/crack      heroin      pain pills      downers/sedatives      ecstasy/club drugs      amphetamines/speed/crank

Would you be interested in discussing your or a loved one's use of alcohol, tobacco or other drug use?      Yes      No

No Intervention ( )      Advise Patient's Response \_\_\_\_\_      Referral Follow Up \_\_\_\_\_