Health Questionnaire (NTAF)

Name: _____ Age: _____ Sex: _____ Date: _____

*** Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.**

SECTION A

- Is your memory noticeably declining? 0 1 2 3
- Are you having a hard time remembering names and phone numbers? 0 1 2 3
- Is your ability to focus noticeably declining? 0 1 2 3
- Has it become harder for you to learn things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament getting worse in general? 0 1 2 3
- Are you losing your attention span endurance? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you fatigue when driving compared to the past? 0 1 2 3
- How often do you fatigue when reading compared to the past? 0 1 2 3
- How often do you walk into rooms and forget why? 0 1 2 3
- How often do you pick up your cell phone and forget why? 0 1 2 3

SECTION B

- How high is your stress level? 0 1 2 3
- How often do you feel that you have something that must be done? 0 1 2 3
- Do you feel you never have time for yourself? 0 1 2 3
- How often do you feel you are not getting enough sleep or rest? 0 1 2 3
- Do you find it difficult to get regular exercise? 0 1 2 3
- Do you feel uncared for by the people in your life? 0 1 2 3
- Do you feel you are not accomplishing your life's purpose? 0 1 2 3
- Is sharing your problems with someone difficult for you? 0 1 2 3

SECTION C

SECTION C1

- How often do you get irritable, shaky, or have lightheadedness between meals? 0 1 2 3
- How often do you feel energized after eating? 0 1 2 3
- How often do you have difficulty eating large meals in the morning? 0 1 2 3
- How often does your energy level drop in the afternoon? 0 1 2 3
- How often do you crave sugar and sweets in the afternoon? 0 1 2 3
- How often do you wake up in the middle of the night? 0 1 2 3
- How often do you have difficulty concentrating before eating? 0 1 2 3
- How often do you depend on coffee to keep yourself going? 0 1 2 3
- How often do you feel agitated, easily upset, and nervous between meals? 0 1 2 3

SECTION C2

- Do you get fatigued after meals? 0 1 2 3
- Do you crave sugar and sweets after meals? 0 1 2 3
- Do you feel you need stimulants such as coffee after meals? 0 1 2 3
- Do you have difficulty losing weight? 0 1 2 3
- How much larger is your waist girth compared to your hip girth? 0 1 2 3
- How often do you urinate? 0 1 2 3
- Have your thirst and appetite been increased? 0 1 2 3
- Do you have weight gain when under stress? 0 1 2 3
- Do you have difficulty falling asleep? 0 1 2 3

SECTION 1 - S

- Are you losing your pleasure in hobbies and interests? 0 1 2 3
- How often do you feel overwhelmed with ideas to manage? 0 1 2 3
- How often do you have feelings of inner rage (anger)? 0 1 2 3
- How often do you have feelings of paranoia? 0 1 2 3
- How often do you feel sad or down for no reason? 0 1 2 3
- How often do you feel like you are **not** enjoying life? 0 1 2 3
- How often do you feel you lack artistic appreciation? 0 1 2 3
- How often do you feel depressed in overcast weather? 0 1 2 3
- How much are you losing your enthusiasm for your favorite activities? 0 1 2 3
- How much are you losing enjoyment for your favorite foods? 0 1 2 3
- How much are you losing your enjoyment of friendships and relationships? 0 1 2 3
- How often do you have difficulty falling into deep restful sleep? 0 1 2 3
- How often do you have feelings of dependency on others? 0 1 2 3
- How often do you feel more susceptible to pain? 0 1 2 3
- How often do you have feelings of unprovoked anger? 0 1 2 3
- How much are you losing interest in life? 0 1 2 3

SECTION 2 - D

- How often do you have feelings of hopelessness? 0 1 2 3
- How often do you have self-destructive thoughts? 0 1 2 3
- How often do you have an inability to handle stress? 0 1 2 3
- How often do you have anger and aggression while under stress? 0 1 2 3
- How often do you feel you are not rested even after long hours of sleep? 0 1 2 3
- How often do you prefer to isolate yourself from others? 0 1 2 3
- How often do you have unexplained lack of concern for family and friends? 0 1 2 3
- How easily are you distracted from your tasks? 0 1 2 3
- How often do you have an inability to finish tasks? 0 1 2 3
- How often do you feel the need to consume caffeine to stay alert? 0 1 2 3
- How often do you feel your libido has been decreased? 0 1 2 3
- How often do you lose your temper for minor reasons? 0 1 2 3
- How often do you have feelings of worthlessness? 0 1 2 3

SECTION 3 - G

- How often do you feel anxious or panic for no reason? 0 1 2 3
- How often do you have feelings of dread or impending doom? 0 1 2 3
- How often do you feel knots in your stomach? 0 1 2 3
- How often do you have feelings of being overwhelmed for no reason? 0 1 2 3
- How often do you have feelings of guilt about everyday decisions? 0 1 2 3
- How often does your mind feel restless? 0 1 2 3
- How difficult is it to turn your mind off when you want to relax? 0 1 2 3
- How often do you have disorganized attention? 0 1 2 3
- How often do you worry about things you were not worried about before? 0 1 2 3
- How often do you have feelings of inner tension and inner excitability? 0 1 2 3

SECTION 4 - ACH

- Do you feel your visual memory (shapes & images) is decreased? 0 1 2 3
- Do you feel your verbal memory is decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity been decreased? 0 1 2 3
- Has your comprehension been diminished? 0 1 2 3
- Do you have difficulty calculating numbers? 0 1 2 3
- Do you have difficulty recognizing objects & faces? 0 1 2 3
- Do you feel like your opinion about yourself has changed? 0 1 2 3
- Are you experiencing excessive urination? 0 1 2 3
- Are you experiencing slower mental response? 0 1 2 3

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.

Date: _____

Patient: _____

Patient Instructions: Please check any condition that you have ever had in the past or that you are currently experiencing, that you consider to be SIGNIFICANT.

1.	General	☐ Fever ☐ Weight loss ☐ Weight gain	☐ Chills ☐ Fatigue ☐ Sweats	☐ Sleep Disturbances ☐ Change in daily routines ☐ Nausea
2.	Head	☐ Headache ☐ Trauma	☐ Dizziness ☐ Loss of consciousness	☐ Other
3.	Eyes	☐ Contacts ☐ Glasses ☐ Cataracts	☐ Blurry vision ☐ Flashes in front of eyes ☐ Spots in front of eyes	☐ Double vision ☐ Sensitive to lights ☐ Other
4.	Ears	☐ Ringing in ears ☐ Frequent infections	☐ Hearing loss ☐ Drainage	☐ Pain ☐ Other
5.	Nose	☐ Post-nasal drip ☐ Sinus	☐ Nosebleeds	☐ Other
6.	Mouth	☐ Gum bleeds ☐ Dentures ☐ Changes in taste	☐ Cold sores ☐ Difficulty swallowing ☐ Sore throat	☐ Jaw pain ☐ Swelling ☐ Other
7.	Neck	☐ Masses ☐ Swelling	☐ Stiffness	☐ Other
8.	Lungs	☐ Asthma ☐ Cough ☐ Tuberculosis	☐ Pneumonia ☐ Coughing up sputum ☐ Coughing up blood	☐ Wheezing ☐ Difficulty breathing
9.	Vascular	☐ Chest pain ☐ Palpitations ☐ High blood pressure	☐ Swelling ☐ Leg cramps ☐ Low blood pressure	☐ Calf pain ☐ Ankle swelling ☐ Varicose veins
10.	Gastro-Intestinal	☐ Gas ☐ Diarrhea ☐ Digestion	☐ Vomiting ☐ Constipation ☐ Abdominal pain	☐ Heartburn ☐ Blood in stool ☐ Hemorrhoid
11.	Urinary	☐ Difficulty with urination ☐ Pain with urination ☐ Blood in urine	☐ Increased urination ☐ Decreased urination ☐ Incontinence	☐ Foul odor of urine ☐ Urinary tract infections
12.	Skin	☐ Rash ☐ Bruising ☐ Hair loss	☐ Warts ☐ Brittle nails ☐ Changes in moles	☐ Itching ☐ Other
13.	Neurology	☐ Seizures ☐ Strokes	☐ Tingling sensation ☐ Numbness	☐ Weakness ☐ Difficulty walking
14.	Musculo-Skeletal	☐ Joint pain ☐ Stiffness ☐ Muscle ache	☐ Arthritis ☐ Deformities ☐ Bone pain	☐ Fractures ☐ Dislocations
15.	Psychiatric	☐ Depression	☐ Mood swings	☐ Anxiety
16.	Diagnosed Medical Condition	☐ Hypertension ☐ Diabetes ☐ Thyroid Condition	☐ Heart Condition ☐ Rheumatoid Arthritis ☐ Epilepsy	☐ Alcoholism ☐ Cancer / Tumor ☐ Other
17.	Current Medication	☐ Prescribed ☐ Allergies	☐ Recreational drugs	☐ Self-medicated (i.e. aspirin. Motrin)
18.	Past Medical History	☐ Surgery - any area ☐ Hospitalization	☐ History of medications ☐ Prescribed	☐ Substance Abuse
19.	Social History	☐ Consume Alcohol ☐ Smoker Past or Present	☐ Exercise regularly ☐ Consume Coffee	☐ Consume Teas ☐ Consume Soft Drinks
20.	Female Only OB-GYN	☐ Hysterectomy ☐ Pregnancy past/present ☐ Age period began:	☐ PMS ☐ Last PAP date: ☐ Breast Exam date:	☐ Lumps in breast ☐ Mastectomy ☐ Discharge from nipple

I have completed the above survey to the best of my ability.

Signature: _____