



# Functional Assessment Form

## A New Way Clinic

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

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

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

Gender: \_\_\_\_\_

Please list your five major health concerns in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Notes:

### PART I Read the following questions and circle the number that applies:

KEY: 0 = Do not consume or use  
1 = Consume or use 2 to 3 times monthly

2 = Consume or use weekly  
3 = Consume or use daily

#### DIET

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|---|----------------------------------|---|
| 1. 0 1 2 3 Alcohol                        | 7. 0 1 2 3 Cigars/pipes          | 14. 0 1 Radiation exposure (0=no, 1=yes)  |
| 2. 0 1 2 3 Artificial sweeteners          | 8. 0 1 2 3 Caffeinated beverages | 15. 0 1 2 3 Refined flour/baked goods     |
| 3. 0 1 2 3 Candy, desserts, refined sugar | 9. 0 1 2 3 Fast foods            | 16. 0 1 2 3 Vitamins and minerals         |
| 4. 0 1 2 3 Carbonated beverages           | 10. 0 1 2 3 Fried foods          | 17. 0 1 2 3 Water, distilled              |
| 5. 0 1 2 3 Chewing tobacco                | 11. 0 1 2 3 Luncheon meats       | 18. 0 1 2 3 Water, tap                    |
| 6. 0 1 2 3 Cigarettes                     | 12. 0 1 2 3 Margarine            | 19. 0 1 2 3 Water, well                   |
|   | 13. 0 1 2 3 Milk products        | 20. 0 1 2 3 Diet often for weight control |

#### LIFESTYLE

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21. 0 1 2 3 Exercise per week (0 = 2 or more times a week, 1 = 1 time a week, 2 = 1 or 2 times a month, 3 = never, less than once a month)
22. 0 1 2 3 Changed jobs (0 = over 12 months ago, 1 = within last 12 months, 2 = within last 6 months, 3 = within last 2 months)
23. 0 1 2 3 Divorced (0 = never, over 2 years ago, 1 = within last 2 years, 2 = within last year, 3 = within last 6 months)
24. 0 1 2 3 Work over 60 hours/week (0 = never, 1 = occasionally, 2 = usually, 3 = always)

#### MEDICATIONS Indicate any medications you're currently taking or have taken in the last month (0=no, 1=yes):

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|--|---|
| 25. 0 1 Antacids                                   | 39. 0 1 Diuretics   |
| 26. 0 1 Antianxiety medications                    | 40. 0 1 Estrogen or progesterone (pharmaceutical, prescription) |
| 27. 0 1 Antibiotics                                | 41. 0 1 Estrogen or progesterone (natural)                      |
| 28. 0 1 Anticonvulsants                            | 42. 0 1 Heart medications                                       |
| 29. 0 1 Antidepressants                            | 43. 0 1 High blood pressure medications                         |
| 30. 0 1 Antifungals                                | 44. 0 1 Laxatives   |
| 31. 0 1 Aspirin/Ibuprofen                          | 45. 0 1 Recreational drugs                                      |
| 32. 0 1 Asthma inhalers                            | 46. 0 1 Relaxants/Sleeping pills                                |
| 33. 0 1 Beta blockers                              | 47. 0 1 Testosterone (natural or prescription)                  |
| 34. 0 1 Birth control pills/implant contraceptives | 48. 0 1 Thyroid medication                                      |
| 35. 0 1 Chemotherapy                               | 49. 0 1 Acetaminophen (Tylenol)                                 |
| 36. 0 1 Cholesterol lowering medications           | 50. 0 1 Ulcer medications                                       |
| 37. 0 1 Cortisone/steroids                         | 51. 0 1 Sildenafil citrate (Viagra)                             |
| 38. 0 1 Diabetic medications/insulin               |   |

### PART II (See key at bottom of page)

#### Section 1 – Upper Gastrointestinal System

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|---|--|
| 52. 0 1 2 3 Belching or gas within one hour after eating        | 61. 0 1 2 3 Feel like skipping breakfast           |
| 53. 0 1 2 3 Heartburn or acid reflux                            | 62. 0 1 2 3 Feel better if you don't eat           |
| 54. 0 1 2 3 Bloating within one hour after eating               | 63. 0 1 2 3 Sleepy after meals                     |
| 55. 0 1 Vegan diet (no dairy, meat, fish or eggs) (0=no, 1=yes) | 64. 0 1 2 3 Fingernails chip, peel or break easily |
| 56. 0 1 2 3 Bad breath (halitosis)                              | 65. 0 1 2 3 Anemia unresponsive to iron            |
| 57. 0 1 2 3 Loss of taste for meat                              | 66. 0 1 2 3 Stomach pains or cramps                |
| 58. 0 1 2 3 Sweat has a strong odor                             | 67. 0 1 2 3 Diarrhea, chronic                      |
| 59. 0 1 2 3 Stomach upset by taking vitamins                    | 68. 0 1 2 3 Diarrhea shortly after meals           |
| 60. 0 1 2 3 Sense of excess fullness after meals                | 69. 0 1 2 3 Black or tarry colored stools          |
|   | 70. 0 1 2 3 Undigested food in stool               |

KEY: 0=No, symptom does not occur  
1=Yes, minor or mild symptom, rarely occurs (monthly)  
2=Moderate symptom, occurs occasionally (weekly)  
3=Severe symptom, occurs frequently (daily)

**Section 2 – Liver and Gallbladder**

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|-------------|--|-------------|--|
| 71. 0 1 2 3 | Pain between shoulder blades   | 85. 0 1     | Easily hung over if you were to drink wine (0=no, 1=yes)       |
| 72. 0 1 2 3 | Stomach upset by greasy foods  | 86. 0 1 2 3 | Alcohol per week (0=<3, 1=<7, 2=<14, 3=>14)                    |
| 73. 0 1 2 3 | Greasy or shiny stools   | 87. 0 1     | Recovering alcoholic (0=no, 1=yes)                             |
| 74. 0 1 2 3 | Nausea   | 88. 0 1     | History of drug or alcohol abuse (0=no, 1=yes)                 |
| 75. 0 1 2 3 | Sea, car, airplane or motion sickness  | 89. 0 1     | History of hepatitis (0=no, 1=yes)                             |
| 76. 0 1     | History of morning sickness (0 = no, 1 = yes)  | 90. 0 1     | Long term use of prescription/recreational drugs (0=no, 1=yes) |
| 77. 0 1 2 3 | Light or clay colored stools   | 91. 0 1 2 3 | Sensitive to chemicals (perfume, cleaning agents, etc.)        |
| 78. 0 1 2 3 | Dry skin, itchy feet or skin peels on feet   | 92. 0 1 2 3 | Sensitive to tobacco smoke                                     |
| 79. 0 1 2 3 | Headache over eyes   | 93. 0 1 2 3 | Exposure to diesel fumes                                       |
| 80. 0 1 2 3 | Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within past 3 months) | 94. 0 1 2 3 | Pain under right side of rib cage                              |
| 81. 0 1     | Gallbladder removed (0=no, 1=yes)  | 95. 0 1 2 3 | Hemorrhoids or varicose veins                                  |
| 82. 0 1 2 3 | Bitter taste in mouth, especially after meals  | 96. 0 1 2 3 | Nutrasweet (aspartame) consumption                             |
| 83. 0 1     | Become sick if you were to drink wine (0=no, 1=yes)                                    | 97. 0 1 2 3 | Sensitive to Nutrasweet (aspartame)                            |
| 84. 0 1     | Easily intoxicated if you were to drink wine (0=no, 1=yes)                             | 98. 0 1 2 3 | Chronic fatigue or Fibromyalgia                                |

**Section 3 – Small Intestine**

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|--------------|--|--------------|--|
| 99. 0 1 2 3  | Food allergies   | 108. 0 1 2 3 | Crohn's disease (0 =no, 1=yes in the past, 2=current mild condition, 3=severe) |
| 100. 0 1 2 3 | Abdominal bloating 1 to 2 hours after eating           | 109. 0 1 2 3 | Wheat or grain sensitivity   |
| 101. 0 1     | Specific foods make you tired or bloated (0=no, 1=yes) | 110. 0 1 2 3 | Dairy sensitivity  |
| 102. 0 1 2 3 | Pulse speeds after eating                              | 111. 0 1     | Are there foods you could not give up (0=no, 1=yes)                            |
| 103. 0 1 2 3 | Airborne allergies                                     | 112. 0 1 2 3 | Asthma, sinus infections, stuffy nose  |
| 104. 0 1 2 3 | Experience hives                                       | 113. 0 1 2 3 | Bizarre vivid dreams, nightmares   |
| 105. 0 1 2 3 | Sinus congestion, "stuffy head"                        | 114. 0 1 2 3 | Use over-the-counter pain medications  |
| 106. 0 1 2 3 | Crave bread or noodles                                 | 115. 0 1 2 3 | Feel spacey or unreal  |
| 107. 0 1 2 3 | Alternating constipation and diarrhea                  |              |  |

**Section 4 – Large Intestine**

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|--------------|---|--------------|--|
| 116. 0 1 2 3 | Anus itches   | 126. 0 1 2 3 | Stools have corners or edges, are flat or ribbon shaped        |
| 117. 0 1 2 3 | Coated tongue   | 127. 0 1 2 3 | Stools are not well formed (loose)                             |
| 118. 0 1 2 3 | Feel worse in moldy or musty place  | 128. 0 1 2 3 | Irritable bowel or mucus colitis                               |
| 119. 0 1 2 3 | Taken antibiotic for a total accumulated time of (0=never, 1= <1 month, 2= <3 months, 3= >3 months) | 129. 0 1 2 3 | Blood in stool   |
| 120. 0 1 2 3 | Fungus or yeast infections  | 130. 0 1 2 3 | Mucus in stool   |
| 121. 0 1 2 3 | Ring worm, "jock itch", "athletes foot", nail fungus  | 131. 0 1 2 3 | Excessive foul smelling lower bowel gas                        |
| 122. 0 1 2 3 | Yeast symptoms increase with sugar, starch or alcohol   | 132. 0 1 2 3 | Bad breath or strong body odors                                |
| 123. 0 1 2 3 | Stools hard or difficult to pass  | 133. 0 1 2 3 | Painful to press along outer sides of thighs (Iliotibial Band) |
| 124. 0 1     | History of parasites (0=no, 1=yes)  | 134. 0 1 2 3 | Cramping in lower abdominal region                             |
| 125. 0 1 2 3 | Less than one bowel movement per day  | 135. 0 1 2 3 | Dark circles under eyes  |

**Section 5 – Mineral Needs**

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|--------------|--|--------------|-------------------------------------|
| 136. 0 1     | History of carpal tunnel syndrome (0=no, 1=yes)                                  | 150. 0 1     | History of bone spurs (0=no, 1=yes) |
| 137. 0 1     | History of lower right abdominal pains or ileocecal valve problems (0=no, 1=yes) | 151. 0 1 2 3 | Morning stiffness                   |
| 138. 0 1     | History of stress fracture (0=no, 1=yes)   | 152. 0 1 2 3 | Nausea with vomiting                |
| 139. 0 1 2 3 | Bone loss (reduced density on bone scan)   | 153. 0 1 2 3 | Crave chocolate                     |
| 140. 0 1     | Are you shorter than you used to be? (0=no, 1=yes)                               | 154. 0 1 2 3 | Feet have a strong odor             |
| 141. 0 1 2 3 | Calf, foot or toe cramps at rest   | 155. 0 1 2 3 | History of anemia                   |
| 142. 0 1 2 3 | Cold sores, fever blisters or herpes lesions                                     | 156. 0 1 2 3 | Whites of eyes (sclera) blue tinted |
| 143. 0 1 2 3 | Frequent fevers  | 157. 0 1 2 3 | Hoarseness                          |
| 144. 0 1 2 3 | Frequent skin rashes and/or hives  | 158. 0 1 2 3 | Difficulty swallowing               |
| 145. 0 1     | Herniated disc (0=no, 1=yes)   | 159. 0 1 2 3 | Lump in throat                      |
| 146. 0 1 2 3 | Excessively flexible joints, "double jointed"                                    | 160. 0 1 2 3 | Dry mouth, eyes and/or nose         |
| 147. 0 1 2 3 | Joints pop or click  | 161. 0 1 2 3 | Gag easily                          |
| 148. 0 1 2 3 | Pain or swelling in joints   | 162. 0 1 2 3 | White spots on fingernails          |
| 149. 0 1 2 3 | Bursitis or tendonitis   | 163. 0 1 2 3 | Cuts heal slowly and/or scar easily |
|              |  | 164. 0 1 2 3 | Decreased sense of taste or smell   |

KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

**Section 6 – Essential Fatty Acids**

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|--------------|--|--------------|--|
| 165. 0 1     | Experience pain relief with aspirin (0=no, 1=yes)                                | 169. 0 1 2 3 | Headaches when out in the hot sun      |
| 166. 0 1 2 3 | Crave fatty or greasy foods  | 170. 0 1 2 3 | Sunburn easily or suffer sun poisoning |
| 167. 0 1 2 3 | Low- or reduced-fat diet (0=never, 1=years ago, 2=within past year, 3=currently) | 171. 0 1 2 3 | Muscles easily fatigued                |
| 168. 0 1 2 3 | Tension headaches at base of skull   | 172. 0 1 2 3 | Dry flaky skin or dandruff             |

**Section 7 – Sugar Handling**

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|--------------|--|--------------|--|
| 173. 0 1 2 3 | Awaken a few hours after falling asleep, hard to get back to sleep | 180. 0 1 2 3 | Headache if meals are skipped or delayed                                 |
| 174. 0 1 2 3 | Crave sweets   | 181. 0 1 2 3 | Irritable before meals   |
| 175. 0 1 2 3 | Binge or uncontrolled eating                                       | 182. 0 1 2 3 | Shaky if meals delayed   |
| 176. 0 1 2 3 | Excessive appetite   | 183. 0 1 2 3 | Family members with diabetes (0=none, 1=1 or 2, 2=3 or 4, 3=more than 4) |
| 177. 0 1 2 3 | Crave coffee or sugar in the afternoon                             | 184. 0 1 2 3 | Frequent thirst  |
| 178. 0 1 2 3 | Sleepy in afternoon  | 185. 0 1 2 3 | Frequent urination   |
| 179. 0 1 2 3 | Fatigue that is relieved by eating                                 |              |  |

**Section 8 – Vitamin Need**

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|--------------|---|--------------|--|
| 186. 0 1 2 3 | Muscles become easily fatigued                  | 200. 0 1 2 3 | Can hear heart beat on pillow at night       |
| 187. 0 1 2 3 | Feel exhausted or sore after moderate exercise  | 201. 0 1 2 3 | Whole body or limb jerk as falling asleep    |
| 188. 0 1 2 3 | Vulnerable to insect bites                      | 202. 0 1 2 3 | Night sweats                                 |
| 189. 0 1 2 3 | Loss of muscle tone, heaviness in arms/legs     | 203. 0 1 2 3 | Restless leg syndrome                        |
| 190. 0 1 2 3 | Enlarged heart or congestive heart failure      | 204. 0 1 2 3 | Cracks at corner of mouth (Cheilosis)        |
| 191. 0 1 2 3 | Pulse below 65 per minute (0=no, 1=yes)         | 205. 0 1 2 3 | Fragile skin, easily chaffed, as in shaving  |
| 192. 0 1 2 3 | Ringing in the ears (Tinnitus)                  | 206. 0 1 2 3 | Polyps or warts                              |
| 193. 0 1 2 3 | Numbness, tingling or itching in hands and feet | 207. 0 1 2 3 | MSG sensitivity                              |
| 194. 0 1 2 3 | Depressed                                       | 208. 0 1 2 3 | Wake up without remembering dreams           |
| 195. 0 1 2 3 | Fear of impending doom                          | 209. 0 1 2 3 | Small bumps on back of arms                  |
| 196. 0 1 2 3 | Worrier, apprehensive, anxious                  | 210. 0 1 2 3 | Strong light at night irritates eyes         |
| 197. 0 1 2 3 | Nervous or agitated                             | 211. 0 1 2 3 | Nose bleeds and/or tend to bruise easily     |
| 198. 0 1 2 3 | Feelings of insecurity                          | 212. 0 1 2 3 | Bleeding gums especially when brushing teeth |
| 199. 0 1 2 3 | Heart races                                     |              |  |

**Section 9 – Adrenal**

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|--------------|--|--------------|--|
| 213. 0 1 2 3 | Tend to be a "night person"                    | 226. 0 1 2 3 | Arthritic tendencies                         |
| 214. 0 1 2 3 | Difficulty falling asleep                      | 227. 0 1 2 3 | Crave salty foods                            |
| 215. 0 1 2 3 | Slow starter in the morning                    | 228. 0 1 2 3 | Salt foods before tasting                    |
| 216. 0 1 2 3 | Tend to be keyed up, trouble calming down      | 229. 0 1 2 3 | Perspire easily                              |
| 217. 0 1 2 3 | Blood pressure above 120/80                    | 230. 0 1 2 3 | Chronic fatigue, or get drowsy often         |
| 218. 0 1 2 3 | Headache after exercising                      | 231. 0 1 2 3 | Afternoon yawning                            |
| 219. 0 1 2 3 | Feeling wired or jittery after drinking coffee | 232. 0 1 2 3 | Afternoon headache                           |
| 220. 0 1 2 3 | Clench or grind teeth                          | 233. 0 1 2 3 | Asthma, wheezing or difficulty breathing     |
| 221. 0 1 2 3 | Calm on the outside, troubled on the inside    | 234. 0 1 2 3 | Pain on the medial or inner side of the knee |
| 222. 0 1 2 3 | Chronic low back pain, worse with fatigue      | 235. 0 1 2 3 | Tendency to sprain ankles or "shin splints"  |
| 223. 0 1 2 3 | Become dizzy when standing up suddenly         | 236. 0 1 2 3 | Tendency to need sunglasses                  |
| 224. 0 1 2 3 | Difficulty maintaining manipulative correction | 237. 0 1 2 3 | Allergies and/or hives                       |
| 225. 0 1 2 3 | Pain after manipulative correction             | 238. 0 1 2 3 | Weakness, dizziness                          |

**Section 10 – Pituitary**

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|--------------|---|--------------|---|
| 239. 0 1     | Height over 6' 6" (0=no, 1=yes)                           | 245. 0 1     | Height under 4' 10" (0=no, 1=yes)                       |
| 240. 0 1     | Early sexual development (before age 10) (0=no, 1=yes)    | 246. 0 1 2 3 | Decreased libido  |
| 241. 0 1 2 3 | Increased libido  | 247. 0 1 2 3 | Excessive thirst  |
| 242. 0 1 2 3 | Splitting type headache                                   | 248. 0 1 2 3 | Weight gain around hips or waist                        |
| 243. 0 1 2 3 | Memory failing  | 249. 0 1 2 3 | Menstrual disorders                                     |
| 244. 0 1     | Tolerate sugar, feel fine when eating sugar (0=no, 1=yes) | 250. 0 1     | Delayed sexual development (after age 13) (0=no, 1=yes) |
|              |   | 251. 0 1 2 3 | Tendency to ulcers or colitis                           |

KEY: 0=No, symptom does not occur

1=Yes, minor or mild symptom, rarely occurs (monthly)

2=Moderate symptom, occurs occasionally (weekly)

3=Severe symptom, occurs frequently (daily)



**Section 11 – Thyroid**

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|------|---------|---|------|---------|---|
| 252. | 0 1 2 3 | Sensitive/allergic to iodine                        | 260. | 0 1 2 3 | Mentally sluggish, reduced initiative                     |
| 253. | 0 1 2 3 | Difficulty gaining weight, even with large appetite | 261. | 0 1 2 3 | Easily fatigued, sleepy during the day                    |
| 254. | 0 1 2 3 | Nervous, emotional, can't work under pressure       | 262. | 0 1 2 3 | Sensitive to cold, poor circulation (cold hands and feet) |
| 255. | 0 1 2 3 | Inward trembling                                    | 263. | 0 1 2 3 | Constipation, chronic                                     |
| 256. | 0 1 2 3 | Flush easily  | 264. | 0 1 2 3 | Excessive hair loss and/or coarse hair                    |
| 257. | 0 1 2 3 | Fast pulse at rest                                  | 265. | 0 1 2 3 | Morning headaches, wear off during the day                |
| 258. | 0 1 2 3 | Intolerance to high temperatures                    | 266. | 0 1 2 3 | Loss of lateral 1/3 of eyebrow                            |
| 259. | 0 1 2 3 | Difficulty losing weight                            | 267. | 0 1 2 3 | Seasonal sadness  |

**Section 12 – Men Only**

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|------|---------|--|------|---------|---|
| 268. | 0 1 2 3 | Prostate problems                        | 272. | 0 1 2 3 | Waking to urinate at night              |
| 269. | 0 1 2 3 | Difficulty with urination, dribbling     | 273. | 0 1 2 3 | Interruption of stream during urination |
| 270. | 0 1 2 3 | Difficult to start and stop urine stream | 274. | 0 1 2 3 | Pain on inside of legs or heels         |
| 271. | 0 1 2 3 | Pain or burning with urination           | 275. | 0 1 2 3 | Feeling of incomplete bowel evacuation  |
|      |         |  | 276. | 0 1 2 3 | Decreased sexual function               |

**Section 13 – Women Only**

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|------|---------|---|------|---------|--|
| 277. | 0 1 2 3 | Depression during periods                 | 287. | 0 1 2 3 | Breast fibroids, benign masses               |
| 278. | 0 1 2 3 | Mood swings associated with periods (PMS) | 288. | 0 1 2 3 | Painful intercourse (dysparenia)             |
| 279. | 0 1 2 3 | Crave chocolate around periods            | 289. | 0 1 2 3 | Vaginal discharge                            |
| 280. | 0 1 2 3 | Breast tenderness associated with cycle   | 290. | 0 1 2 3 | Vaginal dryness                              |
| 281. | 0 1 2 3 | Excessive menstrual flow                  | 291. | 0 1 2 3 | Vaginal itchiness                            |
| 282. | 0 1 2 3 | Scanty blood flow during periods          | 292. | 0 1 2 3 | Gain weight around hips, thighs and buttocks |
| 283. | 0 1 2 3 | Occasional skipped periods                | 293. | 0 1 2 3 | Excess facial or body hair                   |
| 284. | 0 1 2 3 | Variations in menstrual cycles            | 294. | 0 1 2 3 | Hot flashes                                  |
| 285. | 0 1 2 3 | Endometriosis                             | 295. | 0 1 2 3 | Night sweats (in menopausal females)         |
| 286. | 0 1 2 3 | Uterine fibroids                          | 296. | 0 1 2 3 | Thinning skin                                |

**Section 14 – Cardiovascular**

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|------|---------|--|------|---------|--|
| 297. | 0 1 2 3 | Aware of heavy and/or irregular breathing  | 302. | 0 1 2 3 | Ankles swell, especially at end of day   |
| 298. | 0 1 2 3 | Discomfort at high altitudes               | 303. | 0 1 2 3 | Cough at night   |
| 299. | 0 1 2 3 | "Air hunger" or sigh frequently            | 304. | 0 1 2 3 | Blush or face turns red for no reason  |
| 300. | 0 1 2 3 | Compelled to open windows in a closed room | 305. | 0 1 2 3 | Dull pain or tightness in chest and/or radiate into right arm, worse with exertion |
| 301. | 0 1 2 3 | Shortness of breath with moderate exertion | 306. | 0 1 2 3 | Muscle cramps with exertion  |

**Section 15 – Kidney and Bladder**

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|------|---------|--|------|---------|----------------------------------|
| 307. | 0 1 2 3 | Pain in mid-back region                        | 310. | 0 1 2 3 | Cloudy, bloody or darkened urine |
| 308. | 0 1 2 3 | Puffy around the eyes, dark circles under eyes | 311. | 0 1 2 3 | Urine has a strong odor          |
| 309. | 0 1     | History of kidney stones (0=no, 1=yes)         |      |         |                                  |

**Section 16 – Immune system**

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|------|---------|---|------|---------|--|
| 312. | 0 1 2 3 | Runny or drippy nose  | 317. | 0 1 2 3 | Never get sick (0 = sick only 1 or 2 times in last 2 years, 1 = not sick in last 2 years, 2 = not sick in last 4 years, 3 = not sick in last 7 years)  |
| 313. | 0 1 2 3 | Catch colds at the beginning of winter  | 318. | 0 1 2 3 | Acne (adult)   |
| 314. | 0 1 2 3 | Mucus producing cough   | 319. | 0 1 2 3 | Itchy skin (Dermatitis)  |
| 315. | 0 1 2 3 | Frequent colds or flu (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)  | 320. | 0 1 2 3 | Cysts, boils, rashes   |
| 316. | 0 1 2 3 | Other infections (sinus, ear, lung, skin, bladder, kidney, etc.) (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year) | 321. | 0 1 2 3 | History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition (0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe) |

KEY: 0=No, symptom does not occur      2=Moderate symptom, occurs occasionally (weekly)  
 1=Yes, minor or mild symptom, rarely occurs (monthly)      3=Severe symptom, occurs frequently (daily)