

CAAB-25

(Chronic Ailment Assessment Booklet)

Please complete this booklet based upon your health profile over the last 30 days. Upon completion, return to your practitioner for evaluation.

Thank you.

Name: _____

Address: _____

Phone #: _____

Reassess Date: _____

MSQ - Medical Symptoms Questionnaire

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

Point Scale:

0 = Never or almost never have the symptom

1 = Occasionally have it, effect is not severe

2 = Frequently have it, effect is not severe

3 = Occasionally have it, effect is severe

4 = Frequently have it, effect is severe

Digestive Tract	<input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloating Feeling <input type="checkbox"/> Belching or passing gas <input type="checkbox"/> Heartburn	Total _____	Lungs	<input type="checkbox"/> Chest Congestion <input type="checkbox"/> Asthma, bronchitis <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty Breathing	Total _____
Ears	<input type="checkbox"/> Itchy Ears <input type="checkbox"/> Ear aches, ear infections <input type="checkbox"/> Drainage from ears <input type="checkbox"/> Ringing in ears, hearing loss	Total _____	Mind	<input type="checkbox"/> Poor memory <input type="checkbox"/> Confusion, poor comprehension <input type="checkbox"/> Difficulty in making decisions <input type="checkbox"/> Stuttering or stammering <input type="checkbox"/> Slurred speech <input type="checkbox"/> Learning disabilities	Total _____
Emotions	<input type="checkbox"/> Mood swings <input type="checkbox"/> Anxiety, fear or nervousness <input type="checkbox"/> Anger, irritability or aggressiveness <input type="checkbox"/> Depression	Total _____	Mouth/ Throat	<input type="checkbox"/> Chronic coughing <input type="checkbox"/> Gagging frequently; need to clear throat <input type="checkbox"/> Sore throat, hoarseness, loss of voice <input type="checkbox"/> Swollen or discolored tongue, gums, lips <input type="checkbox"/> Canker sores	Total _____
Energy & Activity	<input type="checkbox"/> Fatigue, sluggishness <input type="checkbox"/> Apathy, lethargy <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Restlessness	Total _____	Nose	<input type="checkbox"/> Stuffy nose <input type="checkbox"/> Sinus problems <input type="checkbox"/> Hay fever <input type="checkbox"/> Sneezing attacks <input type="checkbox"/> Excessive mucus formation	Total _____
Eyes	<input type="checkbox"/> Watery or itchy eyes <input type="checkbox"/> Swollen, reddened or sticky eyelids <input type="checkbox"/> Bags or dark circles under eyes <input type="checkbox"/> Blurred or tunnel vision (does not include near or far sightedness)	Total _____	Skin	<input type="checkbox"/> Acne <input type="checkbox"/> Hives, rashes, or dry skin <input type="checkbox"/> Hair loss <input type="checkbox"/> Flushing or hot flashes <input type="checkbox"/> Excessive sweating	Total _____
Head	<input type="checkbox"/> Headaches <input type="checkbox"/> Faintness <input type="checkbox"/> Dizziness <input type="checkbox"/> Insomnia	Total _____	Weight	<input type="checkbox"/> Binge eating <input type="checkbox"/> Craving certain foods <input type="checkbox"/> Excessive weight <input type="checkbox"/> Compulsive eating <input type="checkbox"/> Water retention <input type="checkbox"/> Underweight	Total _____
Heart	<input type="checkbox"/> Irregular or skipped heartbeat <input type="checkbox"/> Rapid or pounding heartbeat <input type="checkbox"/> Chest Pain	Total _____	Other	<input type="checkbox"/> Frequent illness <input type="checkbox"/> Frequent or urgent urination <input type="checkbox"/> Genital itch or discharge	Total _____
Joints & Muscles	<input type="checkbox"/> Pain or aches in joints <input type="checkbox"/> Arthritis <input type="checkbox"/> Stiffness or limitation of movement <input type="checkbox"/> Pain or aches in muscles <input type="checkbox"/> Feeling of weakness or tiredness	Total _____		<i>Grand Total</i>	_____



CAAB-25

Chronic Ailment Assessment Booklet

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

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

PART I

Section A

- 1) Have you taken a broad spectrum antibiotic drug:
 - A) in the last 6 months N Y (10)
 - B) If the response to A is no, have you ever taken antibiotics? N Y (5)
- 2) Have you had recurrent infections requiring prolonged antibiotic use? N Y (20)
- 3) Have you taken birth control pills? N Y (5)
- 4) Have you taken prednisone? N Y (5)
- 5) Have you had athlete's foot, ringworm, jock itch, or other chronic fungus infections of the skin or nails? N Y (5)
- 6) Do you crave sugar? N Y (5)
- 7) Do you crave breads? N Y (5)
- 8) Do you crave alcoholic beverages? N Y (5)
- 9) Have you ever had candida/yeast? N Y (10)
- 10) Endometriosis or infertility N Y (5)
- 11) Symptoms worse on damp, muggy days or in moldy places 0 1 2 3
- 12) Fatigue or lethargy 0 1 2 3
- 13) Poor memory 0 1 2 3
- 14) Depression 0 1 2 3
- 15) Muscle and or joint aches or weakness 0 1 2 3
- 16) Abdominal pain 0 1 2 3
- 17) Constipation 0 1 2 3
- 18) Diarrhea 0 1 2 3
- 19) Bloating, belching, or intestinal gas 0 1 2 3
- 20) Vaginal burning, itching, or discharge 0 1 2 3
- 21) Premenstrual tension 0 1 2 3
- 22) Irritability 0 1 2 3
- 23) Inability to concentrate 0 1 2 3
- 24) Frequent mood swings 0 1 2 3
- 25) Recurrent rashes or itching 0 1 2 3
- 26) Rectal itching 0 1 2 3
- 27) Urgency or urinary frequency 0 1 2 3
- 28) Burning while urinating 0 1 2 3

Total Points _____

Section B

- 1) Have you traveled outside the USA? N Y (5)
- 2) Since traveling abroad, have you had an elevated white blood count, intestinal problems, night sweats, or unexplained fever? N Y (5)
- 3) Do you drink untested or unfiltered water? N Y (5)
- 4) Do you use a microwave oven for cooking (instead of reheating) beef, fish, or pork? N Y (5)
- 5) Do you prefer fish or meat that is undercooked, i.e., rare or medium rare? N Y (5)
- 6) At home, do you use the same cutting board for chicken, fish, and meat as you do for vegetables? N Y (5)
- 7) Have you lived with, or do you currently live with or handle pets? N Y (5)
- 8) Do you work or have children in a daycare center? N Y (5)
- 9) Do you garden or work in a yard to which cats and dogs have access? N Y (5)
- 10) Have you ever had parasites? N Y (10)
- 11) Red blood in stool 0 1 2 3
- 12) Abdominal pain and cramps 0 1 2 3
- 13) Lower back pain 0 1 2 3
- 14) Gas, bloating 0 1 2 3
- 15) Fever 0 1 2 3
- 16) Chronic Fatigue 0 1 2 3
- 17) Constipation 0 1 2 3
- 18) Diarrhea 0 1 2 3
- 19) Foul smelling stools 0 1 2 3
- 20) Anal itching 0 1 2 3
- 21) Bad breath 0 1 2 3
- 22) Grind teeth 0 1 2 3
- 23) Lethargic 0 1 2 3
- 24) Mucus in stool 0 1 2 3
- 25) Lack of stamina 0 1 2 3

Total Points _____

PART II**Section A**

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

Total Points _____

Section B

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

Total Points _____

Section C

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

Total Points _____

Section D

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

Total Points _____

PART III**Section A**

- | | | | | |
|--|---|---|---|---|
| 1) Moderate to severe pain under right side of rib cage | 0 | 1 | 2 | 3 |
| 2) Abdominal pain worsens with deep breathing | 0 | 1 | 2 | 3 |
| 3) Regurgitate bitter fluid | 0 | 1 | 2 | 3 |
| 4) Bloating, full feeling | 0 | 1 | 2 | 3 |
| 5) Belching, heartburn, gas | 0 | 1 | 2 | 3 |
| 6) Fatty foods cause indigestion | 0 | 1 | 2 | 3 |
| 7) Nausea or vomiting | 0 | 1 | 2 | 3 |
| 8) Feel restless, agitated | 0 | 1 | 2 | 3 |
| 9) Unexplained itchy skin worse at night | 0 | 1 | 2 | 3 |
| 10) Stool color alternates from clay colored to normal brown | 0 | 1 | 2 | 3 |

Total Points _____

- | | | | | |
|--|---|---|-------|---|
| 11) Feeling of poor health | 0 | 1 | 2 | 3 |
| 12) Fatigue, weakness, exhaustion | 0 | 1 | 2 | 3 |
| 13) Unable to concentrate, irritable, confused | 0 | 1 | 2 | 3 |
| 14) Swollen feet and/or legs | 0 | 1 | 2 | 3 |
| 15) Easy bruising | 0 | 1 | 2 | 3 |
| 16) Feeling of extreme dryness | 0 | 1 | 2 | 3 |
| 17) Reddened skin, especially palms | 0 | 1 | 2 | 3 |
| 18) Dark urine, diminished flow | 0 | 1 | 2 | 3 |
| 19) Dry, flaky skin, hair | N | | Y (3) | |
| 20) Yellowish cast to skin, eyes | N | | Y (3) | |