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

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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)	Bloated	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)	Bloated, 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
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)

Total Points _____