Functional Imbalance Appraisal

This Functional Imbalance Appraisal is designed to help your healthcare provider better evaluate your overall health and effectively determine the course of testing and therapeutic action needed to help you achieve optimal health. CHECK the answer which best applies to your lifestyle and symptoms. When you are finished, add the number of "YES" responses in each section and enter the total on the line provided. Please return this form to your healthcare provider upon completing.

NUTRITION & DIGESTION

Do you include fast foods in your diet? ❑ Yes ❑ No
Are you on a vegan diet (vegetarian, with no eggs or dairy)? ❑ Yes ❑ No
Do you have more than 3 alcoholic drinks per week? ❑ Yes ❑ No
Do you experience belching, bloating, or persistent fullness after eating? ❑ Yes ❑ No
Do you have a poor appetite? ❑ Yes ❑ No
Do you have a bad taste in your mouth? ❑ Yes ❑ No
Have you had a partial or complete loss of taste? ❑ Yes ❑ No
Do you have an intolerance to specific foods? ❑ Yes ❑ No
Do you have trouble swallowing? ❑ Yes ❑ No
Do you have a history of anemia? ❑ Yes ❑ No
Do you see undigested food in your stool or a greasy film on the toilet water? ❑ Yes ❑ No
Do you have difficulty gaining weight? ❑ Yes ❑ No
Do you experience acid reflux/heartburn? ❑ Yes ❑ No
Do you use acid blocking drugs (e.g. Pepcid AC) or antacids? ❑ Yes ❑ No
Do you use digestive aids (enzymes)? ❑ Yes ❑ No
Are your fingernails soft, brittle, or dotted with white spots? ❑ Yes ❑ No
Are you prone to muscle cramps? ❑ Yes ❑ No
Do you have poor night vision? ❑ Yes ❑ No
Is your skin dry, easily bruised, or slow to heal when injured? ❑ Yes ❑ No

Scoring:
0-3 - "yes" responses – little problems associated with this category
4-6 - needs some attention
7-9 - initiate evaluation
>9 - will need immediate attention

TOTAL Yes: _____

ENDOCRINE BALANCE

Do you suffer from chronic stress? ❑ Yes ❑ No
Do you feel worse from skipping a meal or after eating sweets? ❑ Yes ❑ No
Do you suddenly feel dizzy upon standing? ❑ Yes ❑ No
Do you have difficulty sleeping, or wake not feeling refreshed? ❑ Yes ❑ No
Do you feel more tired or depressed during the winter months? ❑ Yes ❑ No
Have you had a loss of body hair (men and women) and/or scalp hair (women)? ❑ Yes ❑ No
Are you sensitive to minor weather changes? ❑ Yes ❑ No
Does your skin tan without sun exposure? ❑ Yes ❑ No
Do you crave salt? ❑ Yes ❑ No
Have you noted labile emotions or mood swings? ❑ Yes ❑ No
Have you been told you have high blood pressure? ❑ Yes ❑ No
Have you been told you have high cholesterol or triglycerides in your blood? ❑ Yes ❑ No
Is there a family history of osteoporosis? ❑ Yes ❑ No
Has there been a decline in your sex drive? ❑ Yes ❑ No
Do you suffer from fatigue, constipation, weight gain, dry skin, or chilliness? ❑ Yes ❑ No
Do you have excess weight around your middle? ❑ Yes ❑ No
Have you experienced an increase in thirst or urination? ❑ Yes ❑ No
Do you feel worse during your pre-menstrual time? (woman) ❑ Yes ❑ No
Do you have a history of infertility or miscarriage? (woman) ❑ Yes ❑ No
Have you experienced changes in your menstrual periods? (woman) ❑ Yes ❑ No
Have you felt worse since menopause? (woman) ❑ Yes ❑ No
Have you felt tired or less motivated since turning age 50 or so? (man) ❑ Yes ❑ No

Scoring:
0-3 "yes" responses – little problems associated with this category
4-6 - needs some attention
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TOTAL Yes: _____

DETOXIFICATION & ELIMINATION

DETOXIFICATION:

Do you have a history of exposure to chemical or toxic metals in your work or home environment? ❑ Yes ❑ No
Do you have amalgam (silver) fillings? ❑ Yes ❑ No
Do you include large fish in your diet (e.g. tuna, swordfish, halibut)? ❑ Yes ❑ No
Are you sensitive to smells such as car exhaust, perfumes, household cleaners, and cigarette smoke? ❑ Yes ❑ No
Do you currently take more than one regular medication? ❑ Yes ❑ No
Are you prone to side effects from medications? ❑ Yes ❑ No
Do you experience difficulty with thinking or memory? ❑ Yes ❑ No
Have you become more sensitive to alcohol? ❑ Yes ❑ No
Do you have a history of liver disease, hepatitis, or mononucleosis? ❑ Yes ❑ No
Are your muscles stiff or sore, or do they fatigue quickly? ❑ Yes ❑ No
Do you have frequent headaches? ❑ Yes ❑ No
Do you have oral sores, dental caries, or gingivitis? ❑ Yes ❑ No

Scoring:
0-3 "yes" responses – little problems associated with this category
4-6 - needs some attention
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TOTAL Yes: _____

ELIMINATION:

Do you suffer from constipation and/or diarrhea? ❑ Yes ❑ No
Do you have dry, hard, or small stool? ❑ Yes ❑ No
Do you ever see mucus or blood in your stool? ❑ Yes ❑ No
Do you experience frequent gas or bloating? ❑ Yes ❑ No
Do you suffer from abdominal discomfort or cramping? ❑ Yes ❑ No
Have you had 2 or more courses of antibiotics in the past year? ❑ Yes ❑ No
Has there been any foreign travel? ❑ Yes ❑ No
Have you ever had water from a well or stream? ❑ Yes ❑ No

Scoring:
0-2 - "yes" responses – little problems associated with this category
3-5 - needs some attention
>5 - will need immediate attention

TOTAL Yes: _____

IMMUNE BALANCE

Do you catch colds or flu bugs easily? ❑ Yes ❑ No
Are you slow to recover from infections? ❑ Yes ❑ No
Do you have swollen lymph nodes in neck, armpit, or groin? ❑ Yes ❑ No
Do you have seasonal allergies? ❑ Yes ❑ No
Do you experience chronic sinus congestion or post-nasal drip? ❑ Yes ❑ No
Do you feel worse (within a few hours to two days) after eating certain foods? ❑ Yes ❑ No
Do you have dark circles under your eyes? ❑ Yes ❑ No
Do you experience asthma? ❑ Yes ❑ No
Have you ever been diagnosed with an auto-immune disease? ❑ Yes ❑ No
Do you experience joint pain? ❑ Yes ❑ No
Do you suffer from itching of eyes, nose, palate, throat, or skin? ❑ Yes ❑ No
Are you sensitive to molds, dust, pets, or other parts of the environment? ❑ Yes ❑ No
Is there a history of cancer in your family? ❑ Yes ❑ No
Does your diet consist of daily or almost daily intake of <u>any</u> wheat product (breads, pastas, cereals)? ❑ Yes ❑ No
Do you crave sugar? ❑ Yes ❑ No
Have you had prolonged or repeated courses of antibiotics at any time in your life? ❑ Yes ❑ No
Are you having diminished energy or "foggy thinking" processes? ❑ Yes ❑ No

Scoring:
0-3 - "yes" responses – little problems associated with this category
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TOTAL Yes: _____