



Health Appraisal Questionnaire Short Form with Graph

Client Name:

Date:

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Health Appraisal Questionnaire



YOU ARE WHAT YOU EAT

1. Do you shop less frequently than every four days?
 Yes (1) No (0)
2. Do you eat more packaged (frozen or canned) fruits and vegetables than fresh?
 Yes (3) No (0)
3. Do you eat more cooked vegetables than raw?
 Yes (3) No (0)
4. Do you eat vegetables with less than two meals daily?
 Yes (5) No (0)
5. Do you buy more non-organic vegetables than organic vegetables?
 Yes (5) No (0)
6. Do you use a microwave oven?
Yes (check option below) No (0)
 1-2 times per week (2)
 3-4 times per week (5)
 more than 4 times per week (10)
7. Do you eat quick cook grains such as Rice-aroni, Quaker Oats or Minute rice more often than slow cooked organic whole grains?
 Yes (5) No (0)
8. Do you eat white bread more often than whole grain breads?
 Yes (5) No (0)

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Health Appraisal Questionnaire



9. Do you drink pasteurized/homogenized milk, or eat cheeses frequently?

- Yes (check option below) _____ No (0)
____ 1-2 times per week (1)
____ 3 times per week (3)
____ more than 3 times per week (5)

10. Do you eat non-organic yogurts that are low fat, presweetened or have fruit added?

- Yes (check option below) _____ No (0)
____ 1-2 times per week (1)
____ 3 times per week (3)
____ more than 3 times per week (5)

11. Do you eat typical store bought eggs from cage raised chickens (as apposed to free range, grain fed eggs)?

- ____ Yes (5) _____ No (0)

12. Do you eat red meat more than once every four days?

- ____ Yes (3) _____ No (0)

13. Do you commonly eat meats (beef, chicken, turkey) from sources other than a free-range and hormone-free source?

- ____ Yes (3) _____ No (0)

14. Do you eat canned f sh more frequently than fresh f sh?

- ____ Yes (3) _____ No (0)

15. Do you use commercial salad dressings?

- Yes (check option below) _____ No (0)
____ once a week (1)
____ twice per week (2)
____ more than 2 times per week (3)



Health Appraisal Questionnaire



16. Do you use Mayonnaise or products containing hydrogenated oils?

- Yes (check option below) ___ No (0)
___ once a week (1)
___ twice per week (2)
___ more than 2 times per week (5)

17. Do you eat nuts and/or seeds that are roasted and/or salted?

- ___ Yes (1) ___ No (0)

18. Do you use white table sugar as a sweetener?

- Yes (check option below) ___ No (0)
___ once a week (1)
___ 2-3 times per week (3)
___ more than 3 times per week (5)

19. Do you use artificial sweeteners such as Sweet-n-Low, Equal or Nurtasweet?

- Yes (check option below) ___ No (0)
___ once a week (1)
___ 2-3 times per week (5)
___ more than 3 times per week (10)

20. Do you use standard white table salt?

- ___ Yes (5) ___ No (0)

21. Do you eat TV dinners or other highly processed foods more than three times a week?

- ___ Yes (5) ___ No (0)

22. Do you eat from fast food restaurants like McDonald's, Arby's, Wendy's, etc...?

- Yes (check option below) ___ No (0)
___ 1-2 times per week (2)
___ 3 times per week (5)
___ more than 3 times per week (10)

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Health Appraisal Questionnaire



23. Do you eat from vending machines?

- Yes (check option below) _____ No (0)
- ___ 1-2 times per week (2)
- ___ 3 times per week (5)
- ___ more than 3 times per week (10)

24. Do you drink tap water?

- ___ Yes (10) _____ No (0)

25. Do you eat some form of store bought dessert, such as ice cream, cookies, donuts, cakes or pies after dinner most nights?

- ___ Yes (check option below) _____ No (0)
- ___ once a week (1)
- ___ 2-3 times per week (3)
- ___ more than 3 times per week (5)

Total Score: _____ / 130



Health Appraisal Questionnaire



STRESS

1. Do you eat more or less when stressed than when not stressed?
 Yes (10) No (0)
2. Do you worry over job, income or money problems?
 Yes (10) No (0)
3. Are any of your relationships causing you stress?
 Yes (10) No (0)
4. Do you often feel anxious?
 Yes (5) No (0)
5. Do you often feel upset when things go wrong or feel that things go wrong often?
 Yes (5) No (0)
6. Do you lash out at others?
 Yes (5) No (0)
7. Do you feel your sex drive is lower than normal for you?
 Yes (5) No (0)
8. Do you feel stressed due to lack of intimacy in one or more relationships?
 Yes (5) No (0)
9. Have you had reduced contact with friends (feeling antisocial) or an increase in contact because you feel you need to vent your frustrations or stresses to others?
 Yes (3) No (0)

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10. Do you feel isolated or suffer from loneliness?

Yes (3)

No (0)

11. Do you take any form of medication prescribed by a physician directly or indirectly related to stress in your life or a psychological disorder?

Yes (15)

No (0)

12. Do you lose more than two days of work a year due to illness?

Yes (5)

No (0)

Total Score: _____ / **81**

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Health Appraisal Questionnaire



CIRCADIAN HEALTH

1. Do you live in the same time zone you were born in?
 Yes (0) No (5)
2. Do you travel across time zones more than once a month?
 Yes (10) No (0)
3. Do you wake up feeling un-rested and in need of more sleep?
Yes (check option below) No (0)
 once a week (1)
 3 times per week (5)
 more than 3 times per week (10)
4. Do you commonly go to bed after 10:30 PM?
 Yes (10) No (0)
5. Are the times you have bowel movements consistent and predictable on a daily basis?
 Yes (0) No (5)
6. Do you suffer from reduced memory since moving to a new time zone or since traveling across time zones?
 Yes (10) No (0)
7. Has your sense of hunger changed from being hungry at breakfast (upon rising), lunch (mid-day) and dinner times (sunset) since moving to a new time zone or traveling across time zones frequently (> 1 x Mo.)?
 Yes (10) No (0)

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8. Do you wake up at night between 1:00 am and 4:00 am and have a hard time falling back to sleep?

- Yes (check option below) _____ No (0)
- ___ once a week (1)
- ___ 3 times per week (5)
- ___ more than 3 times per week (10)

9. Do you tend to have a hard time staying awake in the afternoon after eating lunch?

- Yes (check option below) _____ No (0)
- ___ once a week (1)
- ___ 3 times per week (5)
- ___ more than 3 times per week (10)

10. Do you do shift work that requires you to stay up late at night?

- ___ Yes (10) _____ No (0)

Total Score: _____ / 90



Health Appraisal Questionnaire



YOU ARE WHEN YOU EAT

1. Do you frequently skip meals?

Yes (3)

No (0)

2. Do you typically go more than four hours without eating?

Yes (check option below)

No (0)

1-2 times per week (1)

3 times per week (2)

more than 3 times per week (3)

3. Do you sometimes skip breakfast?

Yes (check option below)

No (0)

2 times per week (1)

3 times per week (5)

more than 3 times per week (10)

4. Do you avoid fats when eating?

Yes (5)

No (0)

5. Do you frequently eat carbohydrates (i.e. breads, bagels, cookies, pasta, fruit, cereals, muffins, crackers, chocolate, or candy) by themselves?

Yes (5)

No (0)

6. Do you get hungry or crave sweets within two hours after eating a meal?

Yes (5)

No (0)

7. Do you use caffeine and/or sugar containing drinks (i.e. coffee, tea, sodas, fruit juices with sucrose, corn syrup or added sugar)?

Yes (check option below)

No (0)

1 cup a day (1)

2 cups per day (3)

more than 2 cups per day (5)

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Health Appraisal Questionnaire



8. Have you tried diets to lose weight?

- Yes (check option below) _____ No (0)
- ____ once (1)
 - ____ twice (2)
 - ____ three-f ve times (5)
 - ____ more thãve times (10)

9. Do you have difficulty burning fat around your belly, hips or thighs even with regular exercise?

- ____ Yes (3) _____ No (0)

10. Do you eat your largest meal at night?

- ____ Yes (1) _____ No (0)

Total Score: _____ / 50



Health Appraisal Questionnaire



DIGESTIVE SYSTEM HEALTH

1. Do you experience lower abdominal bloating?

- Yes (check option below) _____ No (0)
____ 1-2 times per week (3)
____ 3 times per week (5)
____ more than 3 times per week (10)

2. Do you frequently have loose stools or diarrhea?

- Yes (check option below) _____ No (0)
____ once a week (1)
____ 3 or more times per week (5)

3. Do you experience constipation or stools that are compact/hard to pass?

- Yes (check option below) _____ No (0)
____ 1-2 times per week (3)
____ 3 or more times per week (5)

4. Do you find that you often burp/belch after meals?

- ____ Yes (3) _____ No (0)

5. Do you frequently have gas?

- ____ Yes (3) _____ No (0)

6. Do you crave certain foods, such as bread, chocolate, certain fruit, and red meat, if you have not eaten them in a day or two?

- ____ Yes (5) _____ No (0)

7. Do you have a poor appetite and/or feel worse after eating?

- Yes (check option below) _____ No (0)
____ 1-2 times per week (3)
____ 3 times per week (5)
____ more 3 times per week (10)

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8. Do you have an excessive appetite and/or sweet cravings?

Yes (5)

No (0)

9. Do you frequently (more than twice a week) experience abdominal pain, cramps or general abdominal discomfort?

Yes (20)

No (0)

10. Do you have indigestion, heartburn or upset stomach?

Yes (check option below)

No (0)

1-2 times per week (3)

3 times per week (5)

more 3 times per week (10)

11. Do you get a headache after eating?

Yes (check option below)

No (0)

1-2 times per week (3)

more than 3 times per week (5)

Total Score: _____ / 81



Health Appraisal Questionnaire



DETOXIFICATION SYSTEM HEALTH

1. Are your eyes sensitive to bright light?
 Yes (3) No (0)
2. Do you suffer from irritability and have difficulty relaxing?
 Yes (10) No (0)
3. Do you often feel fatigued and sluggish?
 Yes (10) No (0)
4. Do you suffer from frequent headaches?
Yes (check option below) No (0)
 once a week (1)
 3 or more per week (5)
5. Do you have dark circles and/or puffiness under eyes?
Yes (check option below) No (0)
 once a week (3)
 2-3 times per week (5)
 more than 3 times per week (10)
6. Are you sensitive to perfumes, paint fumes, traffic fumes, detergents or cigarette smoke?
Yes (check option below) No (0)
 mildly (3)
 moderately (5)
 very (10)
7. Have you been unable to lose cellulite with diet and/or exercise?
 Yes (10) No (0)

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8. Are you currently, or have you in the past, been frequently exposed to industrial or agricultural chemicals, such as solvents, cleaning fluids, paint fumes, plant sprays and fertilizers?

Yes (check option below) _____ No (0)
____ brief exposure (3)
____ more than once a week (5)
____ daily (10)

9. Do you experience mental sluggishness, poor memory or poor concentration?

Yes (check option below) _____ No (0)
____ 1-2 times per week (3)
____ 3 times per week (5)
____ more than 3 times per week (10)

10. Do you suffer from skin reactions such as rashes, itching or burning, for which the cause is unknown?

Yes (check option below) _____ No (0)
____ 1-2 times per month (3)
____ 3 times per month (5)
____ more than 3 times per month (10)

Total Score: _____ / 88



Client Name:

Date:



	You Are What You Eat Zone 1 - 2 - 3	Stress Zone 4	Circadian Health	You Are When You Eat	Digestive System Health Zone 1 - 2 - 3	Detoxification System Health Zone 2 - 3	Total Score
Max Score/ % Score	130	81	90	50	81	88	520
100%							
90							
80							
70							
60							
50							
40							
30							
20							
10							
0%							
Score 1							
Score 2							
Score 3							

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