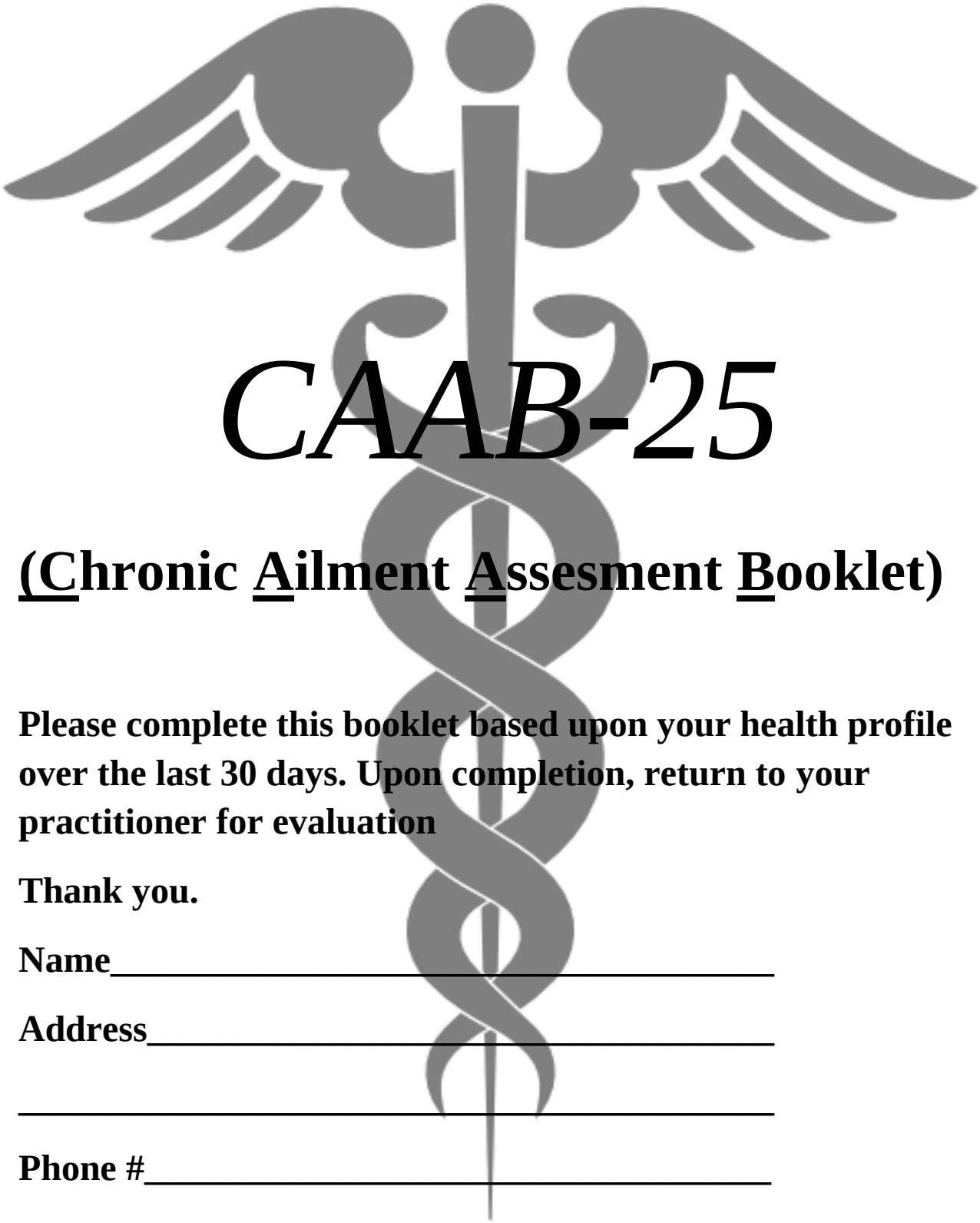

CAAB-25

(Chronic Ailment Assesment 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_____

Medical Symptoms Questionnaire

Name _____ **Date** _____

Rate each of the following symptoms based upon your typical health profile for:

☐ *Past 30 days* ☐ *Past 48 hours*

Point Scale

0 - *Never* or *almost never* have the symptom
1 - *Occasionally* have it, effect is *not severe*
2 - *Occasionally* have it, effect is *severe*
3 - *Frequently* have it, effect is *not severe*
4 - *Frequently* have it, effect is *severe*

HEAD	_____	Headaches	
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	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 _____
EARS	_____	Itchy ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	Total _____
NOSE	_____	Stuffy nose	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	Total _____
MOUTH/THROAT	_____	Chronic coughing	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or discolored tongue, gums, lips	
	_____	Canker sores	Total _____
SKIN	_____	Acne	
	_____	Hives, rashes, dry skin	
	_____	Hair loss	
	_____	Flushing, hot flashes	
	_____	Excessive sweating	Total _____
HEART	_____	Irregular or skipped heartbeat	
	_____	Rapid or pounding heartbeat	
	_____	Chest pain	Total _____

LUNGS	_____	Chest congestion	
	_____	Asthma, bronchitis	
	_____	Shortness of breath	
	_____	Difficulty breathing	Total _____
DIGESTIVE TRACT	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching, passing gas	
	_____	Heartburn	
	_____	Intestinal/stomach pain	Total _____
JOINTS/MUSCLE	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Pain or aches in muscles	
	_____	Feeling of weakness or tiredness	Total _____
WEIGHT	_____	Binge eating/drinking	
	_____	Craving certain foods	
	_____	Excessive weight	
	_____	Compulsive eating	
	_____	Water retention	
	_____	Underweight	Total _____
ENERGY/ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	Total _____
MIND	_____	Poor memory	
	_____	Confusion, poor comprehension	
	_____	Poor concentration	
	_____	Poor physical coordination	
	_____	Difficulty in making decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	Total _____
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear, nervousness	
	_____	Anger, irritability, aggressiveness	
	_____	Depression	Total _____
OTHER	_____	Frequent illness	
	_____	Frequent or urgent urination	
	_____	Genital itch or discharge	
			Total _____

GRAND TOTAL *TOTAL* _____

This form was created by The Institute for Functional Medicine. www.functionalmedicine.org.

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)	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 _____