CAAB – 25

Chronic Ailment Assessment Booklet

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

Name: ____________________ Phone: ____________________

Address: ____________________ Reassess Date: ____________________

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City: ____________________

State: __________ Zip: ____________________

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 symptoms
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

Category	Score	Symptom
Digestive Tract		Nausea or vomiting
		Diarrhea
		Constipation
		Bloated Feeling
		Belching or passing gas
		Heartburn
		Total
Ears		Itchy ears
		Ear aches, infections
		Drainage from ears
		Ringing in the ears, hearing loss
		Total
Emotions		Mood swings
		Anxiety, fear or nervousness
		Anger, irritability or aggressiveness
		Depression
		Total
Energy - Activity		Fatigue, sluggishness
		Apathy, lethargy
		Hyperactivity
		Restlessness
		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
Head		Headaches
		Faintness
		Dizziness
		Insomnia
		Total
Heart		Irregular or skipped heartbeat
		Rapid or pounding heart
		Chest pain
		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
Lungs		Chest Congestion
		Asthma, bronchitis
		Shortness of breath
		Difficulty breathing
		Total
Mind		Poor memory
		Confusion, poor comprehension
		Difficulty in making decisions
		Stuttering or stammering
		Slurred speech
		Learning disabilities
		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
Nose		Stuffy nose
		Sinus problems
		Hay fever
		Sneezing attacks
		Excessive mucus formation
		Total
Skin		Acne
		Hives, rashes, or dry skin
		Flushing or hot flashes
		Excessive sweating
		Total
Weight		Binge Eating
		Craving certain foods
		Excessive weight
		Compulsive eating
		Water retention
		Underweight
		Total
Other		Frequent illness
		Frequent or urgent urination
		Genital itch or discharge
		Total

Grand Total __________

CAAB – Chronic Ailment Assessment

SELECT 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 points in each section and enter the number in the "Total Point" box. Score a "Yes" answer with the points that are listed for the 'Yes / No' questions.

0= Never or rarely   1= Twice a week or less   2= Three to six times per week   3= Daily or several times a day

The first ten questions in sections A & B are Yes / No answers. Points for 'yes' vary per question. No=0 for all.

	PART 1 – Section A	**Electronic users:** Select the number from the drop down box	**Paper users:** Write the number in this column
1	Have you taken a broad spectrum antibiotic drug: In the last 6 months?		
	If not within the last 6 months, have you ever taken antibiotics?		
2	Have you had recurrent infections requiring prolonged antibiotic use?		
3	Have you taken birth control pills?		
4	Have you taken prednisone?		
5	Have you had athlete's foot, ringworm, jock itch or other fungus infections of the skin or nails?		
6	Do you crave sugar?		
7	Do you crave breads?		
8	Do you crave alcoholic beverages?		
9	Have you ever had candida - yeast?		
10	Edometriosis or infertility?		
11	Symptoms worse on damp, muggy days or in moldy places		
12	Fatigue or lethargy		
13	Poor memory		
14	Depression		
15	Muscle and/or joint aches, or weakness		
16	Abdominal pain		
17	Constipation		
18	Diarrhea		
19	Bloating, belching, or intestinal gas		
20	Vaginal burning, itching, or discharge		
21	Premenstrual tension		
22	Irritability		
23	Inability to concentrate		
24	Frequent mood swings		
25	Recurrent rash or itching		
26	Rectal itching		
27	Urgency or urinary frequency		
28	Burning while urinating		
	Section A Total Points		

	PART 1 – Section B	**Electronic users:** Select the number from the drop down box	**Paper users:** Write the number in this column
1	Have you traveled outside the USA?		
2	Since traveling abroad, have you had an elevated white blood count, intestinal issues, night sweats, or unexplained fever?		
3	Do you drink untested or unfiltered water?		
4	Do you use a microwave oven for cooking (not reheating) beef, fish, or pork?		
5	Do you prefer fish or meat that is cooked rare or medium rare?		
6	At home, do you use the same cutting board for meats and fish as you do for vegetables?		
7	Have you lived with, or currently live with or handle pets?		
8	Do you work or have children in a day care center?		
9	Do you garden or work in a yard to which cats /dogs have access?		
10	Have you ever had parasites?		
11	Red blood in stool		
12	Abdominal pain / cramps		
13	Lower back pain		
14	Gas, bloating		
15	Fever		
16	Chronic Fatigue		
17	Constipation		
18	Diarrhea		
19	Foul smelling stools		
20	Anal itching		
21	Bad breath		
22	Grind teeth		
23	Lethargic		
24	Mucus in stool		
25	Lack of stamina		
	Section B Total Points		

0= Never or rarely 1= Twice a week or less 2= Three to six times per week 3= Daily or several times a day

PART 2 Section A	Electronic users: Select the number from the drop down box	Paper users: Write the number in this column
1 Indigestion		
2 Belching, burping		
3 Gas immediately following a meal		
4 Sense of fullness during meals		
5 Poor appetite, picky eater		
6 Difficult bowel movements		
7 Difficulty swallowing		
8 History of anemia, unresponsive to iron		
9 Vegetarian (no eggs, dairy)		
10 Spoon shaped nails		
11 Unintentional weight loss		
12 Partial loss of taste or smell		
Total Points		
Section - B		
1 Indigestion and fullness lasts 2-4 hours after eating		
2 Pain, tenderness, soreness on left side under rib cage		
3 Bloated		
4 Excessive passage of gas		
5 Abdominal cramps, aches		
6 Nausea and / or vomiting		
7 Specific foods / beverages aggravate indigestion		
8 Roughage, fiber cause constipation		
9 Three or more large bowel movements daily		
10 Alternation constipation & diarrhea		
11 Undigested food in stool		
12 Mucus in stool		
13 Dry, flaky skin, dry brittle hair		
14 Difficulty gaining weight		
Total Points		

PART 2 Section C	Electronic users: Select the number from the drop down box	Paper users: Write the number in this column
1 Lower abdominal pain, cramping and / or spasms		
2 Lower abdominal pain relief by passing stool or gas		
3 Raw fruits, vegetables, and stress aggravate bowel pain		
4 Diarrhea (loose watery stool)		
5 Three plus bowel movements daily		
6 Excessive gas and bloating		
7 Painful, difficult, straining during bowel movements		
8 Hard, dry or small stools		
9 Alternating diarrhea/constipation		
10 Mucus, pus in stool		
11 Feeling that bowels do not empty completely		
12 Red blood after bowel movement		
13 Anal itching		
Total Points		
Section D		
1 Stomach pain, burning, aching 1-4 hours after eating		
2 Feeling hungry 1-2 hrs after eating		
3 Stomach discomfort, pain in response to strong emotions, thoughts, smell of food		
4 Heartburn, especially when lying down, bending forward		
5 Heartburn due to spicy and fatty foods, chocolate, peppers, citrus, alcohol, caffeine		
6 Difficulty or pain when swallowing		
7 Chest pain or infections, difficulty breathing		
8 For relief from carbonated drinks, cream / milk / food		
9 Constipation		
10 Black, tarry stool		
Total Points		

PART 3		
1 Moderate to severe pain under right side of rib cage		
2 Abdominal pain worsens with deep breathing		
3 Regurgitate bitter fluid		
4 Bloated, full feeling		
5 Belching, heartburn, gas		
6 Fatty foods cause indigestion		
7 Nausea or vomiting		
8 Feel restless, agitated		
9 Itchy skin worse at night		
10 Alternating stool color: clay - brown		
11 Feeling of poor health		
12 Fatigue, weakness, exhaustion		
13 Poor concentration, irritable, confusion		
14 Swollen feet and / or legs		
15 Easy bruising		
16 Feeling of extreme dryness		
17 Reddened skin, especially palms		
18 Dark urine, diminished flow		
19 Dry, flaky skin, hair		
20 Yellowish cast to skin, eyes		
Total points		