

A Lebro Center for Well Being

Today's Date _____

Name: _____ Age _____ Sex _____

Address: _____ City: _____ State: _____ Zip _____

Marital Status: _____

Occupation: _____

Directions: Circle the answer (YES) if you can answer YES to the question asked. Circle the answer (NO) if you have to answer No to the question asked. Read the questions carefully, pay particular attention to the adverbs such as... "often", "sometimes", "never", "always", etc. this will help you decide on your answer. Answer all questions. if you are in doubt, guess

GI

- | | | | |
|---|--|-----|----|
| 1 | Have you ever had a bad accident? | YES | NO |
| 2 | Do you frequently suffer from constipation? | YES | NO |
| 3 | Does your stomach often get upset? | YES | NO |
| 4 | Do you often belch and feel uncomfortable after meals? | YES | NO |
| 5 | Do you often have stomach or bowel cramps? | YES | NO |
| 6 | Do you feel you have halitosis most of the time? | YES | NO |

CV

- | | | | |
|----|---|-----|----|
| 7 | Are you the first to get out of breath when you exert yourself? | YES | NO |
| 8 | Do you find yourself worrying about pains in your heart or chest? | YES | NO |
| 9 | Does your heart race rapidly at times without apparent reason? | YES | NO |
| 10 | Does your heart thump or seem to stop momentarily at times? | YES | NO |

EF

- | | | | |
|----|---|-----|----|
| 11 | Do you experience periods of fatigue or exhaustion? | YES | NO |
| 12 | Do sore or painful feet bother you every day? | YES | NO |
| 13 | Does a feeling of fullness in your head make it difficult to do your work properly? | YES | NO |
| 14 | Do you awaken tired and worn out in the morning? | YES | NO |

- | | | | |
|----|---|-----|----|
| 15 | Do you have much eyestrain? | YES | NO |
| 16 | Do you feel your body is in poor condition? | YES | NO |
| 17 | Do you worry a lot about your health? | YES | NO |
| 18 | Have you ever had a symptom or physical weakness for which doctors could find no cause? | YES | NO |
| 19 | Do you believe you are more fatigued than you should be? | YES | NO |

PP

- | | | | |
|----|---|-----|----|
| 20 | Do you lose out on work or fun because of pain in the back? | YES | NO |
| 21 | Does the top of your head often feel tender? | YES | NO |
| 22 | Do you sweat a great deal regardless of weather? | YES | NO |
| 23 | Do muscles of your head, face or shoulders twitch a great deal? | YES | NO |
| 24 | Do you have spells of severe itching? | YES | NO |

O

- | | | | |
|----|---|-----|----|
| 25 | Do sudden thoughts pop into your mind and frighten you? | YES | NO |
| 26 | Are you too fearful of some ordinary object or situation? | YES | NO |
| 27 | Are you tense and nervous most of the time? | YES | NO |
| 28 | Do you have periods of such restlessness which prevents your sitting comfortably? | YES | NO |
| 29 | Do you tremble or feel shaky "inside"? | YES | NO |
| 30 | Do you find it hard to keep your mind on a task or job? | YES | NO |

