

# Clinical Appraisal Indicator

## Instructions:

Indicate the symptoms that apply to you (LEAVE BLANK THE BOXES THAT DO NOT APPLY)

(1) = **Mild** symptoms (Occurs 1-2 times/year)

(2) = **Moderate** symptoms (Occurs several times/month)

(3) = **Severe** symptoms (aware of it constantly)

### Group One

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> 1. Nervous Stomach         | <input type="checkbox"/> 5. Mentally Alert, Quick       | <input type="checkbox"/> 9. Cold Sweats Often        |
| <input type="checkbox"/> 2. Dry Mouth/Eyes/Nose     | <input type="checkbox"/> 6. Extremities Cold, Clammy    | <input type="checkbox"/> 10. Fever Easily Raised     |
| <input type="checkbox"/> 3. Pulse Speeds After Meal | <input type="checkbox"/> 7. Heart Pounds After Retiring | <input type="checkbox"/> 11. Neuralgia-like Symptoms |
| <input type="checkbox"/> 4. Keyed Up, Fail to Calm  | <input type="checkbox"/> 8. Acid Foods Upset            |  |

**Are Your Symptoms Made Worse By Emotional Stress?**

### Group Two

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> 12. Perspire Easily                | <input type="checkbox"/> 16. Digestion Rapid                    | <input type="checkbox"/> 20. Joint Stiffness After Rising         |
| <input type="checkbox"/> 13. Muscle/Leg/Toe Cramps At Night | <input type="checkbox"/> 17. Frequent Vomiting                  | <input type="checkbox"/> 21. Circulation Poor, Sensitive to Cold  |
| <input type="checkbox"/> 14. Eyelids Swollen, Puffy         | <input type="checkbox"/> 18. Difficulty Swallowing              | <input type="checkbox"/> 22. Subject to Colds, Asthma, Bronchitis |
| <input type="checkbox"/> 15. Indigestion Soon After Meals   | <input type="checkbox"/> 19. Constipation, Diarrhea Alternating |   |

**Are Your Symptoms Made Worse By Physical Stress?**

### Group Three

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> 23. Afternoon Headaches        | <input type="checkbox"/> 26. Heart Palpitates if Meals Missed or Delayed                  | <input type="checkbox"/> 29. Crave Candy or Coffee in Afternoons   |
| <input type="checkbox"/> 24. Get "Shaky" if Hungry      | <input type="checkbox"/> 27. Eat When Nervous   | <input type="checkbox"/> 30. Abnormal Craving for Sweets or Snacks |
| <input type="checkbox"/> 25. Faintness if Meals Delayed | <input type="checkbox"/> 28. Awaken After a Few Hours of Sleep/ Hard to Get Back to Sleep |  |

### Group Four

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> 31. Bruise Easily, "Black and Blue" Spots | <input type="checkbox"/> 35. Susceptible to Colds and Fevers                                  | <input type="checkbox"/> 40. Hands and Feet go to Sleep Easily, Numbness                     |
| <input type="checkbox"/> 32. Sigh Frequently, "Air Hunger"         | <input type="checkbox"/> 36. Swollen Ankles, Worse at Night                                   | <input type="checkbox"/> 41. Tendency to Anemia  |
| <input type="checkbox"/> 33. Aware of "Breathing heavily"          | <input type="checkbox"/> 37. Muscle Cramps, Worse During Night                                | <input type="checkbox"/> 42. Tension under Breast bone, Feeling Tightness, Worse on Exertion |
| <input type="checkbox"/> 34. Open Windows in Closed Rooms          | <input type="checkbox"/> 38. Dull Pain in Chest or Radiating into Left Arm, Worse on Exertion |  |

### Group Five

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> 43. Dry Skin                                  | <input type="checkbox"/> 47. Biliousness                  | <input type="checkbox"/> 51. Laxatives Used Often                          |
| <input type="checkbox"/> 44. Skin Rashes Frequently                    | <input type="checkbox"/> 48. Greasy Foods Upset           | <input type="checkbox"/> 52. History of Gall-Bladder Attacks or Gallstones |
| <input type="checkbox"/> 45. Bitter Metallic Taste in Mouth In Morning | <input type="checkbox"/> 49. Stools Light-Colored         | <input type="checkbox"/> 53. Sneezing Attacks                              |
| <input type="checkbox"/> 46. Bowel Movements Painful or Difficult      | <input type="checkbox"/> 50. Pain Between Shoulder Blades |  |

**Group Six**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> 54. Lower Bowel Gas Several Hours After Eating   | <input type="checkbox"/> 56. Coated Tongue  | <input type="checkbox"/> 58. Gas Shortly After Eating        |
| <input type="checkbox"/> 55. Burning Stomach Sensation Relieved by Eating | <input type="checkbox"/> 57. Indigestion ½ to 1 Hour After Eating: May be up to 3-4 Hours | <input type="checkbox"/> 59. Stomach "Bloating" After Eating |

**Group Seven****A.**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> 60. Pulse Fast At Rest  | <input type="checkbox"/> 64. Highly Emotional | <input type="checkbox"/> 68. Heart Palpitates |
| <input type="checkbox"/> 61. Nervousness         | <input type="checkbox"/> 65. Flush Easily     | <input type="checkbox"/> 69. Insomnia         |
| <input type="checkbox"/> 62. Can't Gain weight   | <input type="checkbox"/> 66. Night Sweats     |   |
| <input type="checkbox"/> 63. Intolerance to Heat | <input type="checkbox"/> 67. Inward Trembling |   |

**B.**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> 70. Impaired Hearing     | <input type="checkbox"/> 73. Constipation                                | <input type="checkbox"/> 76. Slow Pulse, Below 65 |
| <input type="checkbox"/> 71. Decrease in Appetite | <input type="checkbox"/> 74. Mental Sluggishness                         | <input type="checkbox"/> 77. Increase in Weight   |
| <input type="checkbox"/> 72. Ringing in Ears      | <input type="checkbox"/> 75. Headaches Upon Arising Wears off During Day |   |

**C.**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> 78. Low Blood Pressure | <input type="checkbox"/> 80. Increased Sex Drive          | <input type="checkbox"/> 82. Decreased Sugar Tolerance |
| <input type="checkbox"/> 79. Failing Memory     | <input type="checkbox"/> 81. Headaches, Splitting/Rending |  |

**D.**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> 83. Bloating of Intestines        | <input type="checkbox"/> 86. Sex Desire Reduced/Lacking  | <input type="checkbox"/> 89. Women: Menstrual Disorders              |
| <input type="checkbox"/> 84. Abnormal Thirst               | <input type="checkbox"/> 87. Tendency to Ulcers, Colitis |  |
| <input type="checkbox"/> 85. Weight Gain Around Hips/Waist | <input type="checkbox"/> 88. Increased Sugar Tolerance   | <input type="checkbox"/> 90. Young Girls: Lack of Menstrual Function |

**E.**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> 91. Hot Flashes | <input type="checkbox"/> 93. Dizziness                | <input type="checkbox"/> 95. Sugar in Urine (Not Diabetes) |
| <input type="checkbox"/> 92. Headaches   | <input type="checkbox"/> 94. Increased Blood Pressure | <input type="checkbox"/> 96. Masculine Tendencies (Female) |

**F.**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> 97. Low Blood Pressure  | <input type="checkbox"/> 101. Arthritic Tendencies            | <input type="checkbox"/> 105. Allergies: Tendency to Asthma      |
| <input type="checkbox"/> 98. Chronic Fatigue     | <input type="checkbox"/> 102. Perspiration Increases          | <input type="checkbox"/> 106. Exhaustion: Muscular & Nervousness |
| <input type="checkbox"/> 99. Weakness, Dizziness | <input type="checkbox"/> 103. Crave Salt                      | <input type="checkbox"/> 107. Respiratory Disorders              |
| <input type="checkbox"/> 100. Tendency to Hives  | <input type="checkbox"/> 104. Brown Spots/Discoloring of Skin |  |

**Group Eight****Female Only**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> 108. Painful Menses                   | <input type="checkbox"/> 112. Menstruation Excessive & Prolonged | <input type="checkbox"/> 116. Menopause, Hot Flashes |
| <input type="checkbox"/> 109. Premenstrual Tension             | <input type="checkbox"/> 113. Painful Breasts                    | <input type="checkbox"/> 117. Menses Scanty          |
| <input type="checkbox"/> 110. Very Easily Fatigued             | <input type="checkbox"/> 114. Menstruate Too Frequently          | <input type="checkbox"/> 118. Acne, Worse at Menses  |
| <input type="checkbox"/> 111. Depressed Feeling Before Periods | <input type="checkbox"/> 115. Vaginal Discharge                  |  |

**Male Only**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> 119. Tire Too Easily          | <input type="checkbox"/> 122. Pain on Inside Legs or Heel            | <input type="checkbox"/> 125. Leg Nervousness at Night |
| <input type="checkbox"/> 120. Urination Difficult      | <input type="checkbox"/> 123. Feeling of Incomplete Bowel Evacuation | <input type="checkbox"/> 126. Diminished Sex Drive     |
| <input type="checkbox"/> 121. Night urination Frequent | <input type="checkbox"/> 124. Prostate Trouble                       |  |

**Group Nine**

- |                              |                                |                                     |
|------------------------------|--------------------------------|-------------------------------------|
| ___ 127. Chronic Cough       | ___ 131. Difficulty Breathing  | ___ 135. Infections Settle in Lungs |
| ___ 128. Pain Around Ribs    | ___ 132. Coughing Up Phlegm    | ___ 136. Sensitive to Smog          |
| ___ 129. Shortness of Breath | ___ 133. Coughing Up Blood     |                                     |
| ___ 130. Chest Pain          | ___ 134. Bronchitis (Frequent) |                                     |

**Group Ten**

- |                                    |                                      |   |
|------------------------------------|--------------------------------------|---|
| ___ 137. Frequent Urination        | ___ 141. Cloudy Urine                | ___ 144. Painful/Burning When Passing Urine |
| ___ 138. Rose-Colored/Bloody Urine | ___ 142. Rarely Need to Urinate      | ___ 145. Urination When You Cough/Sneeze    |
| ___ 139. Dripping After Urination  | ___ 143. Frequent Bladder Infections | ___ 146. Strong-Smelling Urine              |
| ___ 140. Difficulty Passing Urine  |                                      |   |

**Group Eleven**

**Section A**

- |  |                                     |                                   |
|--|-------------------------------------|-----------------------------------|
| ___ 147. Throat Infections             | ___ 150. Gets Boils/Cysts           | ___ 153. Bumpy Skin, Back of Arms |
| ___ 148. Poor Wound Healing            | ___ 151. Swollen Lymph Nodes        | ___ 154. Inflamed/Bleeding Gums   |
| ___ 149. Slow to Recover from Cold/Flu | ___ 152. Catch Colds/Flu too Easily |                                   |

**Section B**

- |                                  |                                |                        |
|----------------------------------|--------------------------------|------------------------|
| ___ 155. Chronic Lung Congestion | ___ 157. Breathe Through Mouth | ___ 159. Hyperactivity |
| ___ 156. Post-Nasal Drip         | ___ 158. Swollen Tongue        |                        |

**IMPORTANT:** Please list your four main health complaints, in order of importance

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_\_  
\_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ SEX - M/F

OCCUPATION \_\_\_\_\_

NOTES

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_