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# Health Appraisal Questionnaire - Patient Symptom Analysis

Name: _____ Date: _____

**Scoring**... Circle the score in the column that best suits your symptoms, in either Severity or Frequency. Circle all questions, including when the answer is zero. Answer for how you are currently feeling, and for past 6 months.

Severity Frequency
Column **A** = Never
Column **B** = Mild ——— **or** - Infrequent Symptoms (twice per week or less)
Column **C** = Moderate — **or -** Frequent Symptoms (3 to 6 times a weekly)
Column **D** = Severe ——- or - Daily Symptoms

| **Section 1.** | **A** | **B** | **C** | **D** |
|---|---|---|---|---|
| 1. Curved spine, height loss, stooped base of neck hump (dowager's hump) | 0 | 2 | 5 | 10 |
| 2. Bone pain - back, hip or knee pain | 0 | 2 | 5 | 10 |
| 3. Sciatic pain | 0 | 2 | 5 | 10 |
| 4. Osteoporosis | 0 | 2 | 5 | 10 |
| 5. Recent broken bones, fractures | 0 | 2 | 5 | 10 |
| 6. Arthritis - Osteo/Rheumatoid | 0 | 2 | 5 | 10 |
| 7. Joints - swelling painful, deformity, injury, stiffness | 0 | 2 | 5 | 10 |
| 8. Noisy joints (creak, grind etc.) | 0 | 1 | 3 | 5 |
| 9. Nodules on fingers | 0 | 2 | 5 | 10 |
| 10. History of gout | 0 | 2 | 5 | 10 |
| 11. Damaged disc, slipped disc | 0 | 2 | 5 | 10 |
| 12. Bursitis or tendonitis | 0 | 1 | 3 | 5 |

1. Total .....

| **Section 2.** | | | | |
|---|---|---|---|---|
| 1. Tightness or pain in back, neck or shoulder muscles | 0 | 2 | 5 | 10 |
| 2. Muscular spasms, cramping | 0 | 2 | 5 | 10 |
| 4. Stiffness in muscles | 0 | 2 | 5 | 10 |
| 5. Tenderness, pain in muscles | 0 | 2 | 5 | 10 |
| 6. Weakness in muscles | 0 | 2 | 5 | 10 |
| 7. Trembling of muscles | 0 | 2 | 5 | 10 |

2. Total .....

| **Section 3.** | | | | |
|---|---|---|---|---|
| 2. Chest tightness on stress or exertion | 0 | 2 | 5 | 10 |
| 3. Palpitations, irregular heartbeat | 0 | 2 | 5 | 10 |
| 4. Swelling of the ankles | 0 | 2 | 5 | 7 |
| 5. Shortness of breath on exertion/rest | 0 | 1 | 3 | 5 |
| 6. Calf pain on exercise | 0 | 2 | 5 | 7 |
| 7. Dizziness on exertion | 0 | 2 | 5 | 7 |
| 8. Previous angina attacks, heart attack or stroke | **No** | | **Yes** | (10) |

| *Section 3 continued ...* | **A** | **B** | **C** | **D** |
|---|---|---|---|---|
| 9. Known cardiac murmur or condition | **No** | | **Yes** | (10) |
| 10. High blood cholesterol, triglycerides | **No** | | **Yes** | (10) |
| 11. Blood clotting problems | **No** | | **Yes** | (10) |
| 11. Blood Pressure or Heart medication | **No** | | **Yes** | (15) |

3. Total .....

| **Section 4.** | | | | |
|---|---|---|---|---|
| 1. Blue, numb, cold fingers or toes | **No** | | **Yes** | (10) |
| 2. Ulcers or sores on legs and feet | **No** | | **Yes** | (10) |
| 3. Shiny, hairless skin on arms or legs | No | | Yes | (5) |
| 4. Varicose veins | **No** | | **Yes** | (10) |
| 4. Cramps or pain in legs when walking | 0 | 2 | 5 | 10 |
| 6. Pins and needles or numbness in Hands and feet | 0 | 1 | 3 | 5 |
| 7. Fluid retention feet, legs, body | 0 | 2 | 5 | 10 |
| 8. Difficulty with written or spoken words or concentration | 0 | 1 | 3 | 5 |
| 9. Hearing loss | 0 | 1 | 3 | 5 |
| 10. Ringing in the ears | 0 | 1 | 3 | 5 |
| 11. Fleeting nausea or dizziness | 0 | 1 | 3 | 5 |
| 12. Previous deep vein thrombosis | 0 | 2 | 5 | 10 |
| 13. Take Anti-clotting medication | **No** | | **Yes** | (18) |

4. Total .....

| **Section 5.** | | | | |
|---|---|---|---|---|
| 1. Morning headaches | 0 | 1 | 2 | 3 |
| 2. Feel tired, nervy, weak | 0 | 1 | 2 | 3 |
| 3. Ringing in ears | 0 | 1 | 2 | 3 |
| 4. High Blood Pressure | **No** | | **Yes** | (15) |
| 5. Flushing of cheeks easily | 0 | 1 | 2 | 3 |
| 6. Tingling and numb hands and feet | 0 | 1 | 2 | 3 |
| 7. Blurry vision | 0 | 1 | 2 | 3 |
| 8. Sleepy or dizzy in daytime | 0 | 1 | 2 | 3 |

5. Total .....

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| **Section 6.** | **A** | **B** | **C** | **D** |
|---|---|---|---|---|
| 1. Smoker | **No** | | **Yes** | (10) |
| 2. Cough | 0 | 2 | 5 | 10 |
| 3. Asthma, Wheezing | 0 | 2 | 5 | 10 |
| 4. Repeated chest infections | 0 | 2 | 5 | 10 |
| 5. Shortness of breath on effort or at rest | 0 | 2 | 5 | 7 |
| 6. Chest pain on breathing or coughing | 0 | 2 | 5 | 10 |
| 7. Pneumponia in past | 0 | 2 | 5 | 10 |
| 8. Coughing up mucus/phlegm | 0 | 2 | 5 | 10 |
| 9. Take asthma medication | **No** | | **Yes** | (10) |

6. Total .....

| **Section 7.** | | | | |
|---|---|---|---|---|
| 1. Burping up gas | 0 | 2 | 5 | 10 |
| 2. Bloating or fullness after meals | 0 | 2 | 5 | 10 |
| 3. Abdominal distention, swelling | 0 | 1 | 3 | 5 |
| 4. Less than 1 bowel movement per day | 0 | 1 | 2 | 3 |
| 5. Food intolerances, allergies | 0 | 1 | 2 | 3 |
| 6. Foul smelling breath | 0 | 1 | 3 | 5 |
| 7. Low vitamin B12 levels | **No** | | **Yes** | (10) |
| 8. Acne or Acne Rosacea | 0 | 2 | 5 | 8 |
| 9. Eczema | 0 | 1 | 3 | 5 |
| 10. Flaking, peeling or brittle nails | 0 | 1 | 3 | 5 |

7. Total .....

| **Section 8.** | | | | |
|---|---|---|---|---|
| 1. Past duodenal or stomach ulcers | **No** | | **Yes** | (8) |
| 2. Do you have an ulcer now? | **No** | | **Yes** | (10) |
| 3. Do you use antacids? | **No** | | **Yes** | (8) |
| 4. Stomach pains after a meal | **No** | | **Yes** | (8) |
| 5. Stomach pains in the night | 0 | 1 | 3 | 5 |
| 6. Heartburn or reflux | 0 | 2 | 5 | 8 |
| 7. Food, drink makes stomach feel better | 0 | 2 | 5 | 8 |
| 8. Black stools (blood) | 0 | 2 | 5 | 10 |
| 9. Helicobacter breath test positive | **No** | | **Yes** | (10) |

8. Total .....

| **Section 9.** | | | | |
|---|---|---|---|---|
| 1. Abdominal cramps after eating meals | 0 | 1 | 2 | 3 |
| 2. Abdominal cramps opening bowels | 0 | 1 | 2 | 3 |
| 3. Loose stools, constipation | 0 | 2 | 5 | 10 |
| 4. Tiredness after meals | 0 | 1 | 3 | 5 |
| 5. Smelly stools | 0 | 2 | 5 | 7 |
| 6. Acne, Food allergies | 0 | 2 | 5 | 7 |
| 7. Inflammation of the small bowel | 0 | 2 | 5 | 7 |
| 8. Mucous in stools | 0 | 2 | 5 | 7 |
| 9. Fullness, indigestion for 2-4 hrs after meals | 0 | 1 | 3 | 5 |
| 10. Bowel gas, flatulence, wind | 0 | 1 | 3 | 5 |

9. Total .....

| **Section 10.** | | | | |
|---|---|---|---|---|
| 1. Chronic fungal infections, thrush, parasites abnormal bacteria | 0 | 1 | 3 | 5 |

| *Section 10 cont.* | **A** | **B** | **C** | **D** |
|---|---|---|---|---|
| 2. Low fibre diet | 0 | 1 | 3 | 5 |
| 3. Constipation or diarrhoea | 0 | 2 | 5 | 10 |
| 4. Antibiotic use (note frequency) | 0 | 2 | 5 | 10 |
| 5. High meat intake | 0 | 1 | 3 | 5 |
| 6. Abdominal bloating / distention | 0 | 2 | 5 | 7 |
| 7. Bowel gas, flatulence, wind | 0 | 2 | 5 | 7 |
| 8. Diverticulitis | 0 | 1 | 3 | 5 |
| 9. Ulcerative Colitis or Crohns disease | **No** | | **Yes** | **(10)** |
| 10. Changeable bowel habits | 0 | 2 | 5 | 7 |
| 11. Blood in stool | 0 | 2 | 5 | 10 |
| 12. Foul smelling stool or wind | 0 | 1 | 3 | 5 |

10. Total .....

| **Section 11.** | | | | |
|---|---|---|---|---|
| 1. Indigestion - pain / nausea after eating | 0 | 2 | 5 | 10 |
| 2. Previous or current hepatitis or abnormal liver function tests | **No** | | **Yes** | (10) |
| 3. Pain under front right side of rib cage, or right side of back | 0 | 2 | 5 | 8 |
| 4. Yellowness of sclera (whites of eyes) | 0 | 2 | 5 | 10 |
| 5. Indigestion or pains after fatty food | 0 | 1 | 5 | 10 |
| 6. Light coloured stools | 0 | 1 | 5 | 10 |
| 7. High cholesterol or triglycerides | 0 | 1 | 5 | 10 |
| 8. Gallstones, or pain under right hand side of rib cage | 0 | 1 | 5 | 10 |
| 9. Fatigue, tired all the time | 0 | 1 | 2 | 3 |
| 10. Irritability, depression, foggy thinking | 0 | 1 | 2 | 3 |
| 11. Hot at night after alcohol | 0 | 1 | 5 | 10 |
| 12. Past or present exposure to toxins | 0 | 1 | 3 | 5 |
| 13. Poor tolerance to pharmaceuticals | 0 | 1 | 3 | 5 |
| 14. Easily irritated or angered | 0 | 1 | 3 | 5 |

11. Total .....

| **Section 12.** | | | | |
|---|---|---|---|---|
| 1. Poor sense of smell and taste | 0 | 1 | 2 | 3 |
| 2. Dark under the eyes, on cheeks | 0 | 1 | 2 | 3 |
| 3. Catch colds and flu easily | **No** | | **Yes** | (10) |
| 4. Nasal blockage, mucus, post nasal drip, sore throat | 0 | 2 | 5 | 7 |
| 5. Frequent antibiotic use | 0 | 2 | 5 | 7 |
| 6. Cold sores, herpes, HPV or HIV | **No** | | **Yes** | (10) |
| 7. Infections anywhere in body | 0 | 2 | 5 | 10 |
| 8. Discharge from ears | 0 | 2 | 5 | 10 |
| 9. Slow healing wounds | 0 | 2 | 5 | 10 |
| 10. Swelling in groin, armpits or neck | 0 | 2 | 5 | 10 |
| 11. Had cancer in the past | 0 | 2 | 5 | 10 |

12. Total .....

| **Section 13.** | | | | |
|---|---|---|---|---|
| 1. Hayfever, sinusitis | 0 | 2 | 5 | 10 |
| 2. Eczema, psoriasis, dermatitis | **No** | | **Yes** | (10) |
| 3. Urticaria (hives) | **No** | | **Yes** | (10) |
| 4. Arthritis (osteo, rheumatoid) | 0 | 1 | 3 | 5 |
| 5. Headaches & Migraine | 0 | 2 | 5 | 10 |
| 6. Itching or red eyes | 0 | 2 | 5 | 10 |
| 7. Mouth ulcers | 0 | 2 | 5 | 10 |

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| *Section 13. cont ..* | **A** | **B** | **C** | **D** |
|---|---|---|---|---|
| 8. Hyperactive, ADD, ADHD | **No** | | **Yes** | (10) |
| 9. Asthma, wheezing | **No** | | **Yes** | (10) |
| 10. Chronic cough/hoarseness | 0 | 1 | 3 | 5 |
| 11. MS, RA – any autoimmune disease | **No** | | **Yes** | (10) |

13. Total .....

**Section 14.**

| | | | | |
|---|---|---|---|---|
| 1. Fatigue, tired all the time | 0 | 2 | 5 | 10 |
| 2. Poor tolerance to stress | 0 | 2 | 5 | 10 |
| 3. Salt cravings | 0 | 2 | 5 | 7 |
| 4. Poor exercise tolerance | 0 | 2 | 5 | 7 |
| 5. Food sensitivities | 0 | 1 | 3 | 5 |
| 6. Environmental pollutant sensitivity | 0 | 1 | 3 | 5 |
| 7. Dizziness or blurry vision when rising or standing up | 0 | 1 | 2 | 3 |
| 8. Irritability, rapid mood swings | 0 | 1 | 2 | 3 |
| 9. Slow recovery from infections | 0 | 1 | 2 | 3 |
| 10. Wakes early in morning - 3-4 am | 0 | 1 | 2 | 3 |
| 11. Prolonged periods of stress in past | 0 | 1 | 2 | 5 |
| 12. Sensitive to perfumes & odours | 0 | 1 | 2 | 5 |

14. Total .....

**Section 15.**

| | | | | |
|---|---|---|---|---|
| 1. Sensitive to cold | 0 | 2 | 5 | 10 |
| 2. Irregular menstruation | 0 | 1 | 3 | 5 |
| 3. History of infertility | **No** | | **Yes** | (10) |
| 4. Depression | 0 | 1 | 3 | 5 |
| 5. Fatigue | 0 | 1 | 3 | 5 |
| 6. Constipation | 0 | 1 | 3 | 5 |
| 7. Dry skin | 0 | 1 | 2 | 3 |
| 8. Fluid retention | 0 | 1 | 3 | 5 |
| 9. Loss of hair anywhere on the body | 0 | 2 | 5 | 10 |
| 10. Difficulty in losing weight | 0 | 1 | 3 | 5 |
| 11. Goitre now or in past | **No** | | **Yes** | (10) |

15. Total .....

**Section 16.**

| | | | | |
|---|---|---|---|---|
| 1. Sweating if food is delayed, | 0 | 2 | 5 | 10 |
| 2.Irritability if meals are missed | 0 | 2 | 5 | 10 |
| 3. Frequent copious urination/thirst | 0 | 1 | 3 | 6 |
| 4. Tremors or shakiness if meals missed | 0 | 2 | 5 | 9 |
| 5. Dizziness after sugary food or drink | 0 | 1 | 3 | 5 |
| 6. Craving coffee or stimulants | 0 | 1 | 2 | 3 |
| 7. Shaky if too much coffee | 0 | 1 | 3 | 5 |
| 8. Headaches if meals are missed | 0 | 2 | 5 | 10 |
| 9. Poor memory or concentration | 0 | 1 | 2 | 3 |
| 10. Eating relieves symptoms | 0 | 2 | 5 | 10 |
| 11. Difficulty in losing weight | 0 | 2 | 5 | 8 |
| 12. Weight gain around middle | 0 | 2 | 5 | 10 |
| 13. Immediate family member has diabetes. | **No** | | **Yes** | (10) |

16. Total .....

**Section 17.**

| | **A** | **B** | **C** | **D** |
|---|---|---|---|---|
| 1. Bed wetting | 0 | 2 | 5 | 10 |
| 2. Frequent urination | 0 | 2 | 5 | 10 |
| 3. Frequent infections | 0 | 2 | 5 | 10 |
| 4. Blood or protein in urine | 0 | 2 | 5 | 10 |
| 5. Puffy eyelids | 0 | 1 | 3 | 5 |
| 6. Antibiotics for urinary infections | 0 | 2 | 5 | 10 |
| 7. Polyps in urethra or bladder | 0 | 2 | 5 | 10 |
| 8. Strong smelling urine | 0 | 2 | 5 | 10 |
| 9. Dripping after or poor urine stream | 0 | 1 | 3 | 5 |
| 10. Incontinence on exertion, sneezing etc. | 0 | 2 | 5 | 10 |
| 11. Wake at night to pee. | 0 | 2 | 5 | 10 |

17. Total .....

**Section 18.** ***FEMALE ONLY***

*Symptoms that occur **before** periods*

| | | | | |
|---|---|---|---|---|
| 1. Gains weight before and with periods | 0 | 2 | 5 | 10 |
| 2. Bloating before periods | 0 | 2 | 5 | 10 |
| 3. Irritability before periods | 0 | 2 | 5 | 10 |
| 4. Anxiety | 0 | 1 | 3 | 5 |
| 5. Depression | 0 | 1 | 3 | 5 |
| 6. Skin eruptions | 0 | 1 | 3 | 5 |
| 7. Craving carbohydrates, sugar, bread | 0 | 1 | 3 | 5 |
| 8. Leg pains, heaviness, cramping | 0 | 2 | 5 | 10 |
| 9. Headaches | 0 | 2 | 5 | 10 |
| 10. Breast tenderness | 0 | 2 | 5 | 10 |

18. Total .....

**Section 19.** ***FEMALE***

| | | | | |
|---|---|---|---|---|
| 1. Irregular, delayed periods | 0 | 2 | 5 | 10 |
| 4. Miscarriages | **No** | | **Yes** | (10) |
| 5. Pregnancy complications | 0 | 2 | 5 | 10 |
| 6. Ectopic pregnancies | **No** | | **Yes** | (10) |
| 7. Vaginal infections | 0 | 2 | 5 | 7 |
| 8. Known sexually transmitted disease | **No** | | **Yes** | (10) |
| 9. Unable to fall pregnant at all | **No** | | **Yes** | (10) |
| 10. Unable to fall pregnant 2nd/3rd time | **No** | | **Yes** | (10) |
| 11. Polycystic ovarian syndrome | **No** | | **Yes** | (10) |
| 12. Endometriosis | **No** | | **Yes** | (10) |

19. Total .....

**Section 20.** ***FEMALE***

*Symptoms that occur **during** periods*

| | | | | |
|---|---|---|---|---|
| 1. Abdominal pain or cramping | 0 | 2 | 5 | 10 |
| 2. Very light blood flow | 0 | 2 | 5 | 10 |
| 3. Heavy flow/severe blood loss | 0 | 2 | 5 | 10 |
| 4. Blood clots lost with period | 0 | 2 | 5 | 10 |
| 5. Diarrhoea/ constipation with periods | 0 | 1 | 3 | 5 |
| 6. Pain or ache in low back or legs | 0 | 2 | 5 | 10 |
| 7. Nausea with periods | 0 | 2 | 5 | 10 |
| 8. Fatigue with periods | 0 | 1 | 3 | 5 |
| 9. Headaches, migraines with periods | 0 | 2 | 5 | 10 |

20. Total .....

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| **Section 21. *FEMALE*** | **A** | **B** | **C** | **D** |
|---|---|---|---|---|
| 1. Breast lumps | 0 | 2 | 5 | 10 |
| 2. Breast tenderness | 0 | 1 | 3 | 5 |
| 3. Ovarian cysts, Fibroids | **No** | | **Yes** | (10) |
| 4. Endometriosis | **No** | | **Yes** | (10) |
| 5. Family history of uterine, cervical or breast cancer | **No** | | **Yes** | (10) |
| 6. Abnormal pap smears | **No** | | **Yes** | (10) |
| 7. Cervical erosions | **No** | | **Yes** | (10) |
| 8. Mid-cycle pain | 0 | 1 | 3 | 5 |
| 9. On hormonal birth control or HRT | **No** | | **Yes** | (10) |

21. Total .....

| **Section 22. - *FEMALE*** | | | | |
|---|---|---|---|---|
| 1. Insomnia | 0 | 1 | 3 | 5 |
| 2. Joint pain | 0 | 1 | 3 | 5 |
| 3. Fatigue | 0 | 1 | 3 | 5 |
| 4. Low libido | 0 | 1 | 3 | 5 |
| 5. Mood changes or anxiety | 0 | 1 | 3 | 5 |
| 6. Menstrual irregularity | 0 | 2 | 5 | 7 |
| 7. Cessation of periods | 0 | 2 | 5 | 10 |
| 7. Hair loss | 0 | 2 | 5 | 7 |
| 8. Menorrhagia (heavy periods) | 0 | 2 | 5 | 7 |
| 9. Dry vagina | 0 | 2 | 5 | 7 |
| 10. Night sweats, Hot flushing | 0 | 2 | 5 | 10 |

22. Total .....

| **Section 23. - *MALE ONLY Section*** | | | | |
|---|---|---|---|---|
| 1. Low libido | 0 | 2 | 5 | 7 |
| 2. Premature ejaculation | 0 | 2 | 5 | 7 |
| 3. Aching at back of legs, rectal area | 0 | 1 | 3 | 5 |
| 4. Burning on urination | 0 | 2 | 5 | 10 |
| 5. Genital warts / lesions | **No** | | **Yes** | **(10)** |
| 6. Difficulty in urinating or dripping after urination | 0 | 2 | 5 | 10 |
| 7. Low sperm number and / or motility | **No** | | **Yes** | (10) |
| 8. Previous sexually transmitted disease | **No** | | **Yes** | (10) |
| 9. Varicocele | **No** | | **Yes** | (10) |
| 10. Blood or other discharge from penis | **No** | | **Yes** | (10) |

23. Total .....

**Both Males and Females from now on**

| **Section 24.** | | | | |
|---|---|---|---|---|
| 1. Light headedness/vertigo | 0 | 2 | 5 | 7 |
| 2. Walking difficulties | 0 | 2 | 5 | 7 |
| 3. Poor bowel / bladder control | 0 | 2 | 5 | 7 |
| 4. Speech difficulties | 0 | 2 | 5 | 7 |
| 5. Weakness of limbs | 0 | 2 | 5 | 7 |
| 6. Paralysis, spasticity | **No** | | **Yes** | (10) |
| 7. Poor co-ordination / balance | 0 | 2 | 5 | 7 |
| 8. Muscle twitching | 0 | 2 | 5 | 7 |
| 9. Sensory, perception changes | 0 | 2 | 5 | 10 |
| 10. Short / long-term memory loss | 0 | 2 | 5 | 10 |

24. Total .....

| **Section 25.** | **A** | **B** | **C** | **D** |
|---|---|---|---|---|
| 1. - Stroke, TIA, brain haemorrhage | **No** | | **Yes** | (15) |
| 2. Alzheimer's or dementia | **No** | | **Yes** | (15) |
| 3. Tremor | **No** | | **Yes** | (15) |
| 4. Parkinson's disease | **No** | | **Yes** | (15) |
| 5. Motor neurone disease | **No** | | **Yes** | (15) |
| 6. Epilepsy | **No** | | **Yes** | (15) |
| 7. Multiple sclerosis | **No** | | **Yes** | (15) |

25. Total .....

| **Section 26.** | | | | |
|---|---|---|---|---|
| 1. Chronic pain at any site | 0 | 2 | 5 | 10 |
| 2. Headaches, migraines, cluster headaches | 0 | 2 | 5 | 10 |
| 3. Trigeminal Neuralgia or pain following herpes/shingles infection | 0 | 2 | 5 | 10 |
| 4. Addiction to recreational drugs | **No** | | **Yes** | (15) |
| 5. Difficulty giving up smoking | **No** | | **Yes** | (15) |
| 6. Need to have at least one alcoholic drink each day | **No** | | **Yes** | (15) |
| 7. Gambling addiction | **No** | | **Yes** | (10) |
| 8. Food addiction/ anorexia/ bulimia | **No** | | **Yes** | (15) |
| 9. Depends on medication for pain | **No** | | **Yes** | (15) |

26. Total .....

| **Section 27.** | | | | |
|---|---|---|---|---|
| 1. Forgetful | 0 | 2 | 5 | 10 |
| 2. Difficult concentration | 0 | 2 | 5 | 10 |
| 3. Treated for schizophrenia | **No** | | **Yes** | (15) |
| 4. Depression | **No** | | **Yes** | (15) |
| 5. Obsessive compulsive disorder | **No** | | **Yes** | (15) |
| 6. Easily distracted, learning problems | 0 | 2 | 5 | 10 |
| 7. Suicidal thoughts | **No** | | **Yes** | (15) |
| 8. Anxiety, Waking with anxiety | 0 | 2 | 5 | 10 |
| 9. Panic Attacks | **No** | | **Yes** | (15) |
| 10. Mood swings | 0 | 2 | 5 | 10 |
| 11. Bipolar disorder | **No** | | **Yes** | (15) |

27. Total **.....**

| **Section 28.** | | | | |
|---|---|---|---|---|
| 1. Vivid dreams | 0 | 1 | 3 | 5 |
| 2. Light sleep | 0 | 1 | 3 | 5 |
| 3. Sleep talking or walking | 0 | 1 | 3 | 5 |
| 4. Snoring | 0 | 1 | 3 | 5 |
| 5. Sleep apnoea | 0 | 1 | 3 | 5 |
| 6. Difficulty falling asleep | 0 | 1 | 3 | 5 |
| 7. Early morning waking | 0 | 1 | 3 | 5 |
| 8. Frequent waking | 0 | 1 | 3 | 5 |
| 9. Wake during night with difficulty getting back to sleep | 0 | 1 | 3 | 5 |
| 10. Waking up exhausted | 0 | 1 | 3 | 5 |

28. Total .....