HEALTH QUESTIONNAIRE (NTAF)

Name:_____**Age:**_____**Sex:**_____**Date:**_____

Please circle the appropriate number on all questions below:

0 – you never had it 1 - you had it but you don't have it now 2 - you have it sometimes 3 -you have it most of the time or always

SECTION A	0 1 2 3
Is your memory noticeable declining	0 1 2 3
Are you having a hard time remembering names or phone numbers	0 1 2 3
Is your ability to focus noticeably declining	0 1 2 3
Has it become harder for you to learn thing	0 1 2 3
How often do you have a hard time remembering your appointments	0 1 2 3
Is your temperament getting worse in general	0 1 2 3
Are you losing your attention span endurance	0 1 2 3
How often do you find yourself down or sad	0 1 2 3
How often do you fatigue when reading compared to the past	0 1 2 3
How often do you fatigue when reading compared to the past	0 1 2 3
How often do you walk into rooms and forget why	0 1 2 3
How often do you pick up your cell and forget why	0 1 2 3
	0 1 2 3
SECTION B	
How high is your stress level	0 1 2 3
How often do you feel that you have something that must be done	0 1 2 3
Do you feel you never have time for yourself	0 1 2 3
How often do you feel you are not getting enough sleep or rest	0 1 2 3
Do you find it difficult to get regular exercise	0 1 2 3
Do you feel uncared for by the people in your life	0 1 2 3
Do you feel you are not accomplishing your life's purpose	0 1 2 3
Is sharing your problems with someone difficult for you	0 1 2 3
SECTION C	
SECTION C-1	
How often do you get irritable, shaky or have lightheadness between meals	0 1 2 3
How often do you feel energized after eating	0 1 2 3
How often do you have difficulty eating large meals in the morning	0 1 2 3
How often does your energy level drop in the afternoon	0 1 2 3
How often do you crave sugar and sweets in the afternoon	0 1 2 3
How often do you wake up in the middle of the night	0 1 2 3
How often do you have difficulty concentrating before eating	0 1 2 3
How often do you depend on coffee to keep yourself going	0 1 2 3
How often do you feel agitated, easily upset, and nervous between meals	0 1 2 3
SECTION C-2	
Do you get fatigued after meals	0 1 2 3
Do you crave sugar and sweets after meals	0 1 2 3
Do you feel you need stimulants such as coffee after meals	0 1 2 3
Do you have difficulty losing weight	0 1 2 3
How much larger is your waist girth compared to your hip girth	0 1 2 3
How often do you urinate	0 1 2 3
Have your thirst and appetite been increased	0 1 2 3
Do you have weight gain when under stress	0 1 2 3
Do you have difficulty falling asleep	0 1 2 3
SECTION 1- S	
Are you losing your pleasure in hobbies and interests	0 1 2 3
How often do you feel overwhelmed with ideas to manage	0 1 2 3
How often do you have feelings of inner rage (anger)	0 1 2 3
How often do you have feelings of paranoia	0 1 2 3
How often do you feel sad or down for no reason	0 1 2 3
How often do you feel like you are not enjoying life	0 1 2 3

How often do you feel you lack artistic appreciation	0 1 2 3
How often do you feel depressed in overcast weather	0 1 2 3
How much are you losing your enthusiasm for your favorite activities	0 1 2 3
How much are you losing enjoyment for your favorite foods	0 1 2 3
how often do you have feelings of dependency on others	0 1 2 3
How much are you losing your enjoyment of friendships and relationships	0 1 2 3
How often do you feel more susceptible to pain	0 1 2 3
How often do you have feelings of unprovoked anger	0 1 2 3
How much are you losing interest in life	0 1 2 3
How often do you have difficulty falling into deep restful sleep	0 1 2 3
SECTION 2-D	
How often do you have feelings of hopelessness	0 1 2 3
How often do you have self destructive thoughts	0 1 2 3
How often do you have an inability to handle stress	0 1 2 3
How often do you have anger and aggression while under stress	0 1 2 3
How often do you prefer to isolate yourself from others	0 1 2 3
How often do you feel you are not rested even after long hours of sleep	0 1 2 3
How easily are you distracted from your tasks	0 1 2 3
How often do you have unexplained lack of concern for family and friends	0 1 2 3
How often do you have an inability to finish tasks	0 1 2 3
How often do you feel the need to consume caffeine to stay alert	0 1 2 3
How often do you feel your libido decreased	0 1 2 3
How often do you lose your temper for minor reasons	0 1 2 3
How often do you have feelings of worthlessness	0 1 2 3
SECTION 3-G	
How often do you have feelings of guilt about everyday decisions	0 1 2 3
How often do you feel anxious or panic for no reason	0 1 2 3
How often do you have feelings of being overwhelmed for no reason	0 1 2 3
How often do you feel knots in your stomach	0 1 2 3
How often does your mind feel restless	0 1 2 3
How often do you have feelings of dread or impending doom	0 1 2 3
How often do you worry about things you were not worried before	0 1 2 3
How often do you have disorganized attention	0 1 2 3
How often do you have feelings off inner tension and inner excitability	0 1 2 3
How difficult is to turn your mind off when you want to relax	0 1 2 3
SECTION 4-ACH	
Do you feel your verbal memory is decreased	0 1 2 3
Do you have memory lapses	0 1 2 3
Has your creativity been decreased	0 1 2 3
Do you feel your visual memory (shapes and images)is decreased	0 1 2 3
Has your comprehension been diminished	0 1 2 3
Do you have difficulty calculating numbers	0 1 2 3
Do you have difficulty recognizing objects and faces	0 1 2 3
Do you feel like your opinion about yourself has changed	0 1 2 3
Are you experiencing excessive urination	0 1 2 3
Are you experiencing slower mental response	0 1 2 3

***Symptom groups in this flyer are not intended to be used as a diagnosis of any disease condition.**
For nutritional purposes only

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