# Christine Slonetsky, MSW, ND
# Health Questionnaire

**Welcome. It is our hope that we can assist you with your current and future health concerns. Our focus is: health improvement, maintenance, prevention and education. Any current health problems may be indicators of underlying imbalances. Part of our job will be to explore your overall health status and to advise you on measures to ensure optimal well being.**

**During the course of you examination and treatments, please feel free to comment, ask questions, and provide us with feedback. We feel that the more you know about yourself, the more active a role you can play in restoring and maintaining your own health. Together, we can form a team on the side of a healthy future.**

## PATIENT INFORMATION

Name: _____

Phone H: (____)_____ B: (____)_____

Address: _____ Apt:_____

City: _____ Postal Code:_____

Age:_____ Birthdate: Day:____ Mo:____Yr:_____ Sex: M F

How did you hear about Dr Christine? **Please check all that apply;**

____ Current Client of DHC ___ Building Sign ___ Business Cards/Flyer ___Yellow Pages

Internet: _____Canada 411 ____Yellow Pages.ca _____ Google _____Yahoo ____ Bing

____ Referral (Who?) _____ Other (Explain) _____

Place of Birth:_____ Marital Status: S M Sep Wid

Number of Children:_____ Ages: _____

If the patient is a child, give the parents name: Mother: _____ Father:_____

Occupation: _____ Employer: _____

Have you received naturopathic care previously? Yes No If yes, when? _____

Name of Practitioner(s): _____For what reasons? _____

Medical Doctor _____ (phone) _____

Are you under the care of any other health care practitioner? Yes No

Name(s)_____ For What Reason? _____

# Confidential Health and Lifestyle Questionnaire

**Dear Patient:**
**Please complete this questionnaire with care. Your answers will help us to determine the most effective health care for you. Please print throughout. Thank you.**

What are your chief reasons for being here in order of importance to you?

_____

_____

_____

How long have these problems occurred?

_____

Have you had similar problems before? Yes No Explain:

_____

_____

Do you have any relatives with similar problems? Yes No Who?

_____

List any practitioners seen for the above conditions:

_____

List diagnosis, type of treatments, for these conditions:

_____

_____

List any medications you are presently taking & doses:

_____

What do you feel is causing any health problems you may have?_____

_____

When did you last feel well?

_____

What do you hope to achieve from participating in naturopathic care?

_____

_____

**Please indicate the occurrence of the following and give details and dates:**

Surgery: _____ Hospitalization: _____

_____ _____

Accidents: _____ Major Illnesses: _____

_____ _____

Loss of Consciousness: _____ Seizures: _____

_____ _____

Weight: _____ Height:_____ Blood Type: _____

Are you satisfied with your current weight? Yes No Have you ever had a weight problem? Yes No

Are you constipated: Yes No Number of bowel movements per day? _____

Do you exercise regularly? Yes No How often? _____

What type of program? _____

What type of things do you find stressful? _____

Do you meditate or use any type of relaxation exercise? Yes No

Do you have regular sleep habits? Yes No How many Hours? _____

Early riser? Yes No Difficulty falling asleep? Yes No Nightmares? Yes No

Do you drink coffee? Yes No No./day: _____ Black tea: Yes No No./day: _____

Do you smoke? Yes No If yes, how long? _____ No./day?

Do you drink alcohol? Yes No Daily Am't? _____Weekly Am't? _____ Special Occasions?_____

What types? _____

Do you have any hobbies? Yes No If yes, please list: _____

**Is there a history of any of the following in your <u>family</u>? (Please circle and state relationship of <u>family</u> member):**

| | | | |
|---|---|---|---|
| Alcoholism | Cancer | Heart Disease | Schizophrenia |
| Allergies | Cataracts | Hyperactivity | Stomach Ulcers |
| Arteriosclerosis | Celiac | Kidney Disease | Stroke |
| Arthritis | Colitis | Learning Disability | Tuberculosis |
| Asthma | Depression | Mental Disease | Yeast Infections |
| Bed Wetting | Diabetes | Muscular Dystrophy | Venereal Disease |
| Candida Albicans | Epilepsy | Multiple Sclerosis | |

## Circle any of the following medications you are taking:

| | | | |
|---|---|---|---|
| Antacids | Antibiotic/Antifungal | Antidepressants | Antidiabetic/Insulin |
| Aspirin/Tylenol | Chemotherapy | Cortisone/Anti-Inflammatory | Heart Medications |
| High Blood Pressure | Hormones | Laxatives | Lithium |
| Oral Contraceptives | Radiation | Relaxants/Sleeping Pills | Thyroid |
| Ulcer Medication | | | |

Recreational Drugs: specify: _____

Other specific: _____

## Circle if you eat, drink, or use:

| | | | |
|---|---|---|---|
| Alcohol | Candy | Carbonated beverages | Cigarettes |
| Fast Foods (regularly) | Fried Foods | Margarine | Luncheon Meats |
| Refined Sugars | Saccharine (Sweet & Low) | Chew Tobacco | Coffee |
| Distilled Water | Aspartame (Nutrasweet) | Relaxants/Sleeping Pills | |

Vitamins and/or Minerals: specify; _____

## Circle if you:

| | | |
|---|---|---|
| Diet Often | Do Not Exercise Regularly | Salt Food without Tasting |
| Are Under Excessive Stress | Are Exposed To Chemicals at Work | Are Exposed to Cigarette Smoke |

# INFORMED CONSENT STATEMENT

**THIS FORM MUST BE SIGNED BEFORE ANY TREAMENT WILL BE RENDERED**

Naturopathic medicine uses non–invasive methods of assessing the bodily functions and the use of natural therapeutic for correction. The methods used by Christine Slonetsky, N.D. include homeopathy, clinical nutrition, botanical medicine, traditional Chinese medicine and acupuncture, counselling, and various modes of physical therapy.

The current health care system in Ontario is under scrutiny. In order to clarify my position as your health care practitioner, and our mutual responsibilities in your health care, I, Christine Slonetsky, N.D., ask for your cooperation in signing this statement of acknowledgement, in so doing:

1. That you understand that I am a Naturopathic Doctor, and not a conventional medical doctor, that I use non-invasive, natural methods as assessment and treatment of body dysfunctions. That any treatment you receive is not mutually exclusive from any treatment or advice you may now be receiving or may receive in the future from another licensed health care provider.

2. That you understand the methods that I may use have proven clinical foundation, yet may not be accepted by standard (allopathic) medicine.

3. That you understand that I am required by my licensing board to perform a physical examination on each new patient. This will be adhered to unless a full report is sent by the referring practitioner and that report is deemed acceptable.

4. That you understand that treatment and/or referral to other health practitioners is based on the assessment of your health revealed through personal history, physical examination, laboratory testing and other appropriate methods of evaluation. You are at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario.

5. That you understand I reserve the right to determine which cases fall outside my scope of practice, in which event the appropriate referral will be recommended.

6. That you are not an agent of any private or government agency attempting to gather information without so stating your intentions.

7. That while changes in dietary habits are not an absolute pre-requisite for treatment, that you understand that failure to follow sound nutritional, exercise, and lifestyle programs could undermine the expected results.

8. That you are accepting or rejecting this care of your own free will.

9. That you understand that the ultimate responsibility for your health care is your own, and that I am here to support you in this. I reserve the right to discontinue my services where it is apparent that your expectation and what I can provide are not in agreement.

10. That you understand that all fees for services and supplements are payable at the time of the appointment by the patient or the guardian. That there is a fee for telephone consultations of greater than 10 minutes. Notice of 24 hours is require for appointment cancellation, otherwise you will be charged an administrative fee for $35. Any special financial arrangements may be made clear in advance.

I, _____ have read, understood and acknowledge the above statements.

Signature: _____ Date: _____

# *FirstLine Therapy* ™ Health Profile

NAME _____ DATE _____ WEEK _____

Rate each of the following symptoms based upon your typical health profile for: ☒ *Past 30 days* ☐ *Past 48 hours*

| *Point Scale* | | | |
|---|---|---|---|
| | 0 | *Never* or *almost never* have the symptom | 3 *Frequently* have it, effect is *not severe* |
| | 1 | *Occasionally* have it, effect is *not severe* | 4 *Frequently* have it, effect is *severe* |
| | 2 | *Ocasionally* have it, effect is *severe* | |

***HEAD***
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
_____ 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

***EARS***
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
_____ TOTAL

***NOSE***
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
_____ TOTAL

***MOUTH/ THROAT***
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums or lips
_____ Canker sores
_____ TOTAL

***SKIN***
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
_____ TOTAL

***HEART***
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
_____ TOTAL

***LUNGS***
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
_____ TOTAL

***DIGESTIVE TRACT***
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
_____ TOTAL

***JOINTS/ MUSCLE***
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
_____ TOTAL

***WEIGHT***
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
_____ TOTAL

***ENERGY/ ACTIVITY***
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
_____ TOTAL

***MIND***
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ TOTAL

***EMOTIONS***
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
_____ TOTAL

***OTHER***
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____ TOTAL

GRAND TOTAL _____

# *HEALTH APPRAISAL - BRIEF*

NAME_____ DATE_____

CIRCLE 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 number of points in each section and enter the number in the **Total Point** box. The score for YES is the number inside the parenthesis ( ).

**(0) never or rarely (1) twice a week or less (2) three to six times a week (3) daily or several times a day**

## PART I

### Section A

| | | | | |
|---|---|---|---|---|
| 1. Indigestion | 0 | 1 | 2 | 3 |
| 2. Belching, burping | 0 | 1 | 2 | 3 |
| 3. Gas immediately following a meal | 0 | 1 | 2 | 3 |
| 4. Sense of fullness during meals | 0 | 1 | 2 | 3 |
| 5. Poor appetite, picky eater | 0 | 1 | 2 | 3 |
| 6. Difficult bowel movements | 0 | 1 | 2 | 3 |
| 7. Difficulty swallowing | 0 | 1 | 2 | 3 |
| 8. History of anemia, unresponsive to iron | N | | | Y (10) |
| 9. Vegetarian (no eggs, dairy) | N | | | Y (5) |
| 10. Spoon shaped nails | N | | | Y (3) |
| 11. Unintentional weight loss | N | | | Y (3) |
| 12. Partial loss of taste or smell | N | | | Y (3) |

**Total Points**_____

### Section B

| | | | | |
|---|---|---|---|---|
| 1. Indigestion and fullness lasts 2-4 hours after eating | 0 | 1 | 2 | 3 |
| 2. Pain, tenderness, soreness on left side under rib cage | 0 | 1 | 2 | 3 |
| 3. Bloated | 0 | 1 | 2 | 3 |
| 4. Excessive passage of gas | 0 | 1 | 2 | 3 |
| 5. Abdominal cramps, aches | 0 | 1 | 2 | 3 |
| 6. Nausea and/or vomiting | 0 | 1 | 2 | 3 |
| 7. Specific foods/beverages aggravate indigestion | 0 | 1 | 2 | 3 |
| 8. Roughage and fiber causes constipation | 0 | 1 | 2 | 3 |
| 9. Three or more large bowel movements daily | 0 | 1 | 2 | 3 |
| 10. Alternating constipation and diarrhea | 0 | 1 | 2 | 3 |
| 11. Undigested food in stool | 0 | 1 | 2 | 3 |
| 12. Mucus in stool | 0 | 1 | 2 | 3 |
| 13. Dry, flaky skin, dry brittle hair | N | | | Y (3) |
| 14. Difficulty gaining weight | N | | | Y (3) |

**Total Points**_____

### Section C

| | | | | |
|---|---|---|---|---|
| 1. Stomach pain, burning, aching 1-4 hours after eating | 0 | 1 | 2 | 3 |
| 2. Feeling hungry an hour or two after eating | 0 | 1 | 2 | 3 |
| 3. Stomach discomfort, pain in response to strong emotions, thoughts, smell of food | 0 | 1 | 2 | 3 |
| 4. Heartburn, especially when lying down, bending forward | 0 | 1 | 2 | 3 |
| 5. Heartburn due to spicy and fatty foods, chocolate, peppers, citrus, alcohol, caffeine | 0 | 1 | 2 | 3 |
| 6. Difficulty or pain when swallowing | 0 | 1 | 2 | 3 |
| 7. Chest pain or infections, difficulty breathing | 0 | 1 | 2 | 3 |
| 8. Experience relief from carbonated beverages, cream/milk/food | 0 | 1 | 2 | 3 |
| 9. Constipation | 0 | 1 | 2 | 3 |
| 10. Black, tarry stool | 0 | 1 | 2 | 3 |

**Total Points**_____

### Section D

| | | | | |
|---|---|---|---|---|
| 1. Lower abdominal pain, cramping and/or spasms | 0 | 1 | 2 | 3 |
| 2. Lower abdominal pain relief by passing stool or gas | 0 | 1 | 2 | 3 |
| 3. Raw fruits, vegetables and stress aggravate bowel pain | 0 | 1 | 2 | 3 |
| 4. Diarrhea (loose watery stool) | 0 | 1 | 2 | 3 |
| 5. More than three bowel movements daily | 0 | 1 | 2 | 3 |
| 6. Excessive gas and bloating | 0 | 1 | 2 | 3 |
| 7. Painful, difficult,straining during bowel movements | 0 | 1 | 2 | 3 |
| 8. Hard, dry or small stool | 0 | 1 | 2 | 3 |
| 9. Extremely narrow stools | 0 | 1 | 2 | 3 |
| 10. Alternating diarrhea/constipation | 0 | 1 | 2 | 3 |
| 11. Mucus, pus in stool | 0 | 1 | 2 | 3 |
| 12. Feeling that bowels do not empty completely | 0 | 1 | 2 | 3 |
| 13. Bright red blood following bowel movement | 0 | 1 | 2 | 3 |
| 14. Anal itching | 0 | 1 | 2 | 3 |

**Total Points**_____

## PART II

### Section A

| | | | | |
|---|---|---|---|---|
| 1. Moderate to severe pain under right side of rib cage | 0 | 1 | 2 | 3 |
| 2. Abdominal pain worsens with deep breathing | 0 | 1 | 2 | 3 |
| 3. Regurgitate bitter fluid | 0 | 1 | 2 | 3 |
| 4. Bloated, full feeling | 0 | 1 | 2 | 3 |
| 5. Belching, heartburn, gas | 0 | 1 | 2 | 3 |
| 6. Fatty foods cause indigestion | 0 | 1 | 2 | 3 |
| 7. Nausea or vomiting | 0 | 1 | 2 | 3 |
| 8. Feel restless, agitated | 0 | 1 | 2 | 3 |
| 9. Unexplained itchy skin worse at night | 0 | 1 | 2 | 3 |
| 10. Stool color alternates from clay colored to normal brown | 0 | 1 | 2 | 3 |
| 11. Feeling of poor health | 0 | 1 | 2 | 3 |
| 12. Fatigue, weakness, exhaustion | 0 | 1 | 2 | 3 |
| 13. Unable to concentrate, irritable, confused | 0 | 1 | 2 | 3 |
| 14. Swollen feet and/or legs | 0 | 1 | 2 | 3 |
| 15. Easy bruising | 0 | 1 | 2 | 3 |
| 16. Feeling of extreme dryness | 0 | 1 | 2 | 3 |
| 17. Reddened skin, especially palms | 0 | 1 | 2 | 3 |
| 18. Dark urine, diminished flow | 0 | 1 | 2 | 3 |
| 19. Dry, flaky skin, hair | N | | | Y (3) |
| 20. Yellowish cast to skin, eyes | N | | | Y (3) |

**Total Points**_____

### Section B

| | | | | |
|---|---|---|---|---|
| 1. Fatigue, sluggish | 0 | 1 | 2 | 3 |
| 2. Feel cold, (i.e. hands and feet) | 0 | 1 | 2 | 3 |

**Section B** (continued)

| | | | | |
|---|---|---|---|---|
| 3. Difficult, infrequent bowel movements | 0 | 1 | 2 | 3 |
| 4. Dryness - skin, hair | 0 | 1 | 2 | 3 |
| 5. Thick, brittle nails | 0 | 1 | 2 | 3 |
| 6. Outer third of eyebrow thins | 0 | 1 | 2 | 3 |
| 7. Puffy face, hands and feet | 0 | 1 | 2 | 3 |
| 8. Swollen upper eyelids | 0 | 1 | 2 | 3 |
| 9. Eyeballs move involuntarily | 0 | 1 | 2 | 3 |
| 10. Muscles weak, cramp and/or tremble | 0 | 1 | 2 | 3 |
| 11. Slow mental processes, forgetfulness | 0 | 1 | 2 | 3 |
| 12. Slow heart beats | 0 | 1 | 2 | 3 |
| 13. Loss of appetite | 0 | 1 | 2 | 3 |
| 14. Abdominal swelling | 0 | 1 | 2 | 3 |
| 15. Unsteady gait, movements | 0 | 1 | 2 | 3 |
| 16. Lack of interest in sex | 0 | 1 | 2 | 3 |
| 17. Premenstrual tension | N | | | Y (3) |
| 18. Infertility | N | | | Y (3) |
| 19. Heavy menstrual bleeding | N | | | Y (3) |
| 20. Gain weight easily | N | | | Y (10) |
| 21. Swelling of the neck | N | | | Y (10) |
| 22. Thinning hair on scalp, face and genitals | N | | | Y (3) |

**Total Points**_____

## PART III

| | | | | |
|---|---|---|---|---|
| 1. Progressive, mild fatigue after exertion or stress | 0 | 1 | 2 | 3 |
| 2. General weakness | 0 | 1 | 2 | 3 |
| 3. Blurred vision, dizzy when rising | 0 | 1 | 2 | 3 |
| 4. Depression | 0 | 1 | 2 | 3 |
| 5. Rapid mood swings | 0 | 1 | 2 | 3 |
| 6. Irritable, nervous | 0 | 1 | 2 | 3 |
| 7. Dark circles under the eyes | 0 | 1 | 2 | 3 |
| 8. Disinterest in food | 0 | 1 | 2 | 3 |
| 9. Abdominal pain | 0 | 1 | 2 | 3 |
| 10. Indigestion | 0 | 1 | 2 | 3 |
| 11. Blotchy skin (white patches) | 0 | 1 | 2 | 3 |
| 12. Tan skin, no sun | 0 | 1 | 2 | 3 |
| 13. Black freckles on upper forehead, face, neck | 0 | 1 | 2 | 3 |
| 14. Craving for salty foods | 0 | 1 | 2 | 3 |
| 15. Gradual loss of body hair | N | | | Y (3) |
| 16. Sensitive to subtle changes in surroundings, weather | N | | | Y (5) |

**Total Points**_____

## PART IV

**Section A**

| | | | | |
|---|---|---|---|---|
| 1. Generalized bone tenderness and achiness | 0 | 1 | 2 | 3 |
| 2. Localized bone pain | 0 | 1 | 2 | 3 |
| 3. Bone deformity or swelling | 0 | 1 | 2 | 3 |
| 4. Shins hurt during or after exercises | 0 | 1 | 2 | 3 |
| 5. Low back or hip pain | 0 | 1 | 2 | 3 |
| 6. Limp, walking difficulties | 0 | 1 | 2 | 3 |
| 7. Crunching or creaking sounds when move joints | 0 | 1 | 2 | 3 |
| 8. Hands, feet, throat spasm, feel numb | 0 | 1 | 2 | 3 |
| 9. Joint pain and stiffness - especially in spine, hips, knees | 0 | 1 | 2 | 3 |
| 10. Hearing loss, headaches, ringing in ears | 0 | 1 | 2 | 3 |
| 11. Established bone loss | N | | | Y (10) |
| 12. Calcium deposits | N | | | Y (5) |
| 13. Spinal curvature | N | | | Y (10) |
| 14. Recent loss of height | N | | | Y (10) |
| 15. Bow legs | N | | | Y (5) |
| 16. Stooped posture | N | | | Y (5) |
| 17. Hump at base of neck | N | | | Y (5) |
| 18. Unexplained bone fracture | N | | | Y (10) |
| 19. Tooth loss, gum disease | N | | | Y (3) |

**Total Points**_____

**Section B**

| | | | | |
|---|---|---|---|---|
| 1. General muscle ache, pains | 0 | 1 | 2 | 3 |
| 2. Localized muscle stiffness, tension, pain | 0 | 1 | 2 | 3 |
| 3. Specific points on body feel sore when presses | 0 | 1 | 2 | 3 |
| 4. Headaches | 0 | 1 | 2 | 3 |
| 5. Fatigue, tired, sluggish | 0 | 1 | 2 | 3 |
| 6. Difficulty sleeping | 0 | 1 | 2 | 3 |
| 7. Feel unrefreshed upon awakening | 0 | 1 | 2 | 3 |
| 8. Muscle weakness or loss | 0 | 1 | 2 | 3 |
| 9. Difficulty speaking swallowing | 0 | 1 | 2 | 3 |
| 10. Muscle cramps or spasm | 0 | 1 | 2 | 3 |
| 11. Muscles twitch or tremble - eyelids, thumb, calf muscle | 0 | 1 | 2 | 3 |
| 12. Irresistible urge to move legs | 0 | 1 | 2 | 3 |

**Section B** (continued)

| | | | | |
|---|---|---|---|---|
| 13. Legs move during sleep | 0 | 1 | 2 | 3 |
| 14. Numbing, tingling sensation | 0 | 1 | 2 | 3 |
| 15. Excessive joint mobility | 0 | 1 | 2 | 3 |
| 16. Unable to fully straighten or extend legs and/or arms | 0 | 1 | 2 | 3 |
| 17. Upper or lower back pain | 0 | 1 | 2 | 3 |

**Total Points**_____

**Section C**

| | | | | |
|---|---|---|---|---|
| 1. Joint stiffness, soreness | 0 | 1 | 2 | 3 |
| 2. Red, swollen painful joints | 0 | 1 | 2 | 3 |
| 3. Joint stiffness worsens with rest, improves with moving | 0 | 1 | 2 | 3 |
| 4. Cracking joints | 0 | 1 | 2 | 3 |
| 5. Shooting, aching, tingling pain down the back of leg | 0 | 1 | 2 | 3 |
| 6. Joint pain involves one or a few joints | 0 | 1 | 2 | 3 |
| 7. Joints hurt when moving or when carrying weight | 0 | 1 | 2 | 3 |
| 8. Limited range of motion | 0 | 1 | 2 | 3 |
| 9. Difficulty standing up from sitting position | 0 | 1 | 2 | 3 |
| 10. Joint stiffness improves with rest, worsens with moving | 0 | 1 | 2 | 3 |
| 11. Headache | 0 | 1 | 2 | 3 |
| 12. Difficulty chewing food or opening mouth | 0 | 1 | 2 | 3 |
| 13. Numbness, prickling, tingling sensation in the neck, shoulder and arms | 0 | 1 | 2 | 3 |
| 14. Involuntary muscle spasms | 0 | 1 | 2 | 3 |
| 15. Deliberate movement with hands is difficult | 0 | 1 | 2 | 3 |
| 16. Injure, strain, sprain easily | 0 | 1 | 2 | 3 |
| 17. Discomfort or pain in neck, shoulder or arm | 0 | 1 | 2 | 3 |
| 18. Knobby overgrowths on the joints closest to the fingertips | N | | | Y (5) |
| 19. Double jointed | N | | | Y (5) |
| 20. One leg shorter than the other | N | | | Y (5) |

**Total Points**_____