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Thank you for choosing St George Naturopathic Clinic to assist you in improving your health. In order to plan the best course of treatment for you, I need to know as much as possible about your current health and lifestyle.

This download contains 5 questionnaires in a total of 11 pages (includes this cover page):

- Your Health Goals (1 page)
- Your Lifestyle and Family History (1 page)
- Health Appraisal Questionnaire (4 pages)
- DASS for emotional health (3 pages)
- Food Intake Summary (1 page)

It is most important that you complete all the questions, even if most of it does not seem to apply to you. It is just as important for me to know what is not a health issue for you as it is for me to know what is a health issue for you.

Please give as much information as possible, and feel free to write comments or add a page of notes.

In the Health Appraisal Questionnaire, please circle words in the questions that most apply to you, as well as rating the severity by A, B, C or D. Make sure you include a list of all medications you are taking.

All questionnaires are strictly confidential. If you prefer not to include your name, contact me and I can give you an ID number.

Your first appointment is on .....

Peter Kelly

## YOUR HEALTH GOALS

Name or ID number \_\_\_\_\_

Date \_\_\_\_\_

1. What are your health and lifestyle goals?

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2. How do you rate your present level of health? Rate 1-10, 10 being excellent \_\_\_\_\_

3. How do you rate your present level of vitality? Rate 1-10, 10 being excellent \_\_\_\_\_

4. How do you rate your present level of lifestyle? Rate 1-10, 10 being excellent \_\_\_\_\_

5. How confident are you in your ability to persevere with the healthy diet, lifestyle and exercise programs required for you to achieve health and wellbeing? Rate 1-10, 10 being highly confident \_\_\_\_\_

6. How committed are you to improving your health status? Rate 1-10, 10 being highly committed \_\_\_\_\_

7. Are you willing to change your diet? Yes ( ) No ( ) Maybe ( ) Explain \_\_\_\_\_

\_\_\_\_\_

8. Are you willing to change your lifestyle habits? ? Yes ( ) No ( ) Maybe ( ) Explain \_\_\_\_\_

\_\_\_\_\_

9. Are you willing to increase your aerobic capacity with an exercise program? Yes ( ) No ( ) Maybe ( )

Explain \_\_\_\_\_

10. Are you willing to increase your strength and stamina with a strength resistance program? Yes ( )

No ( ) Maybe ( ) Explain \_\_\_\_\_

11. How long to your feel it would take you to achieve your health and lifestyle goals?

Days ( ) Weeks ( ) Months ( ) Years ( )

12. What do you think could stop you from achieving your health goals?

Time ( ) Commitment ( ) Resources ( ) Support ( ) Money ( ) Interest ( ) Health ( )

Other \_\_\_\_\_

13. What do you want to achieve by coming to St George Naturopathic Clinic?

\_\_\_\_\_

\_\_\_\_\_

**YOUR LIFESTYLE**

Name or ID number \_\_\_\_\_

Date \_\_\_\_\_

1. What is your occupation? \_\_\_\_\_
2. How long have you been in this occupation? \_\_\_\_\_
3. How would you rate your job satisfaction? Rate 1-10, 10 being excellent \_\_\_\_\_
4. How would you rate your stress levels at work? Rate 1-10, 10 being extreme \_\_\_\_\_
5. How would you rate your stress levels at home? Rate 1-10, 10 being extreme \_\_\_\_\_
6. When did you have your last holiday of more than one week? \_\_\_\_\_
7. How often do you exercise for more than 30 minutes? Never ( ) Once weekly ( ) Twice weekly ( )  
Three or more times weekly ( )
8. Do you play a sport? If so what? \_\_\_\_\_

**YOUR FAMILY HISTORY**

Any family history of these diseases?	Yes	No	If "Yes" what relatives – eg. Father, Sister, Uncle etc.
Diabetes			
Dermatitis or Eczema			
Asthma			
Hayfever or allergic rhinitis			
Auto-immune e.g. rheumatoid arthritis, Lupus, Multiple sclerosis, Crohn's disease, etc.			
Cancer			
Heart Disease or Stroke			

ID .....

Date form filled in.....

**Patient Symptom Analysis**

- ❖ Please circle the words in the question most applicable to you so that I can get a clear picture of your symptoms.
- ❖ Add comments if it will better describe your symptoms
- ❖ Make sure you fill in the "Main Reason for Visit", and "Medications" boxes.
- ❖ Please return form by fax or mail before your initial visit.

<b>Age</b> .....	<b>Scoring</b> - Circle the score in the column that best suits your current symptoms, in either Severity or Frequency.	Column	A = Not a problem in the last 4 weeks		
		Column	B = Mild	or - Infrequent Symptoms (twice per week or less)	
<b>M / F</b>		Column	C = Moderate	or - Frequent Symptoms (3 to 6 times a weekly)	
		Column	D = Severe	or - Daily Symptoms	

**Main Reason for Visit :**

**Medications & Supplements:**

**Operations:**

<b>Section 1.</b>	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>
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. Spinal problems, pain, 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. High uric acid level	0	2	5	10
11. Damaged disc, slipped disc	0	2	5	10
12. Bursitis or tendonitis	0	1	3	5
1. Total .....				
<b>Section 2.</b>				
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 (fasciculation)	0	2	5	10
2. Total .....				
<b>Section 3.</b>				
2. Chest tightness on stress or exertion	0	2	5	10
3. Palpitations, arrhythmias, extra beats	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	<b>No</b>	<b>Yes</b>	(10)	

<i>Section 3 continued ...</i>	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>
9. Known cardiac murmur or condition	<b>No</b>	<b>Yes</b>	(10)	
10. High blood cholesterol, triglycerides or blood clotting problems	<b>No</b>	<b>Yes</b>	(10)	
11. Blood Pressure or Heart medication	<b>No</b>	<b>Yes</b>	(15)	
3. Total .....				
<b>Section 4.</b>				
1. Blue, numb, cold fingers or toes	<b>No</b>	<b>Yes</b>	(10)	
2. Ulcers, sores on legs and feet	<b>No</b>	<b>Yes</b>	(10)	
3. Shiny, discoloured, hairless skin on arms or legs / Varicose veins	<b>No</b>	<b>Yes</b>	(10)	
4. Cramps, pain in legs when walking	0	2	5	10
6. Pins and needles, numbness - hands, 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. Dizziness, ringing in the ears	0	1	3	5
10. Fleeting nausea / Hearing loss	0	1	3	5
11. Previous deep vein thrombosis	0	2	5	10
12. Take Anti-clotting medication	<b>No</b>	<b>Yes</b>	(18)	
4. Total .....				
<b>Section 5.</b>				
1. Morning headaches	0	1	2	3
2. Feel tired, nervy, weak	0	1	2	3
3. Ringing in ears / Sleepy, dizzy	0	1	2	3
4. Hi Blood Pressure / Heart medication	<b>No</b>	<b>Yes</b>	(15)	
5. Flushing with no known cause	0	1	2	3
6. Tingling and numb hands and feet	0	1	2	3
7. Blurry vision	0	1	2	3
5. Total .....				

<b>Section 6.</b>	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>
1. Smoker	<b>No</b>	<b>Yes</b>	(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. Gets chest infections easily	0	2	5	10
8. Coughing up mucus/phlegm	0	2	5	10
9. Takes asthma medication	<b>No</b>	<b>Yes</b>	(10)	
6. Total .....				
<b>Section 7.</b>				
1. Burping up gas	0	2	5	10
2. Bloating 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	<b>No</b>	<b>Yes</b>	(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 .....				
<b>Section 8.</b>				
1. Past duodenal ulcers, stomach problems	<b>No</b>	<b>Yes</b>	(8)	
2. Do you have an ulcer now ?	<b>No</b>	<b>Yes</b>	(10)	
3. Do you use antacids ?	<b>No</b>	<b>Yes</b>	(8)	
4. Stomach pains on lying down or bending after a meal	0	1	3	5
5. Stomach symptoms, heartburn, pain	0	2	5	8
6. Food, drink makes stomach feel better	0	2	5	8
7. Black stools (blood)	0	2	5	10
8. Helicobacter breath test positive	<b>No</b>	<b>Yes</b>	(10)	
8. Total .....				
<b>Section 9.</b>				
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 .....				
<b>Section 10.</b>				
1. Chronic fungal infections, thrush, parasites abnormal bacteria	0	1	3	5

<i>Section 10 cont...</i>	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>
2. Low fibre diet	0	1	3	5
3. Constipation, diarrhoea, colitis	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. Abdominal pain, Diverticulitis	0	1	3	5
9. Changeable bowel habits	0	2	5	7
10. Red blood in stool (or blood found in stool on testing)	0	2	5	10
10. Total .....				
<b>Section 11.</b>				
1. Indigestion, pain or nausea after eating or nausea after drinking alcohol	0	2	5	10
2. Previous hepatitis, glandular fever or abnormal liver function tests	<b>No</b>	<b>Yes</b>	(10)	
3. Pain under front right side of rib cage, 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	3	5
6. Light coloured stools, dark urine	0	1	3	5
7. High cholesterol or triglycerides	0	1	3	5
8. Gallstones, pain under right hand side of rib cage	0	1	2	3
9. Fatigue, tired all the time	0	1	2	3
10. Irritability, depression, foggy thinking	0	1	2	3
11. Reddened palms or skin	0	1	3	5
12. Generally feels unwell	0	1	3	5
11. Total .....				
<b>Section 12.</b>				
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	<b>No</b>	<b>Yes</b>	(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, HIV	<b>No</b>	<b>Yes</b>	(10)	
7. Ear, nose, throat, eyes, lung, skin infections	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, neck	0	2	5	10
12. Total .....				
<b>Section 13.</b>				
1. Hayfever, sinusitis	0	2	5	10
2. Eczema, psoriasis, dermatitis	<b>No</b>	<b>Yes</b>	(10)	
3. Urticaria (hives)	<b>No</b>	<b>Yes</b>	(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

Section 13. cont ..	A	B	C	D
8. Hyperactive, ADD, ADHD, Learning difficulties	No	Yes	(10)	
9. Asthma, wheezing	No	Yes	(10)	
10. Chronic cough/hoarseness	0	1	3	5
11. MS, SLE, other autoimmune diseases	No	Yes	(10)	
13. Total .....				
<b>Section 14.</b>				
1. Fatigue, tired all the time	0	2	5	7
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. Feels dizzy, 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. Changes in skin pigmentation, colour	0	1	2	3
14. Total .....				
<b>Section 15.</b>				
1. Sensitive to cold	0	2	5	10
2. Irregular menstruation	0	1	3	5
3. History of infertility	0	2	5	7
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
15. Total .....				
<b>Section 16.</b>				
1. Sweating if food is delayed, irritability if meals are missed	0	2	5	10
2. Frequent copious urination and increased thirst	0	1	3	6
3. Tremors or shakiness if meals missed	0	2	5	9
4. Dizziness after sugary food or drink	0	1	3	5
5. Craving coffee or stimulants	0	1	2	3
6. Headaches if meals are missed	0	2	5	10
7. Poor memory	0	1	2	3
8. Eating relieves symptoms	0	2	5	10
9. Difficulty in losing weight or slow recovery from infections	0	2	5	8
10. Immediate family member has a history of diabetes	No	Yes	(10)	
16. Total .....				
<b>Section 17.</b>				
1. Bed wetting	0	2	5	10

Section 17. cont ...	A	B	C	D
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
17. Total .....				
<b>Section 18. FEMALE ONLY</b>				
<i>Symptoms that occur before periods</i>				
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 .....				
<b>Section 19. FEMALE</b>				
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. Primary infertility (has not had a child)	No	Yes	(10)	
10. Secondary infertility (has had at least one child)	No	Yes	(10)	
11. Polycystic ovary syndrome	No	Yes	(10)	
12. Endometriosis	No	Yes	(10)	
19. Total .....				
<b>Section 20. FEMALE</b>				
<i>Symptoms that occur during periods</i>				
1. Abdominal pain or cramping	0	2	5	10
2. Light or heavy blood flow/clots	0	2	5	10
3. Diarrhoea, constipation with periods	0	1	3	5
4. Pain or ache in low back or legs	0	2	5	10
5. Nausea with periods	0	2	5	10
6. Fatigue with periods	0	1	3	5
7. Headaches, migraines with periods	0	2	5	10
20. Total .....				

<b>Section 21. FEMALE</b>	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>
1. Breast lumps	0	2	5	10
2. Breast tenderness	0	1	3	5
3. Ovarian cysts, Fibroids	<b>No</b>	<b>Yes</b>		(10)
4. Endometriosis	<b>No</b>	<b>Yes</b>		(10)
5. Family history of cysts / cancer	<b>No</b>	<b>Yes</b>		(10)
6. Abnormal pap smears	<b>No</b>	<b>Yes</b>		(10)
7. Cervical erosions	<b>No</b>	<b>Yes</b>		(10)
8. Mid-cycle pain	0	1	3	5
9. Hormonal birth control	<b>No</b>	<b>Yes</b>		(10)
21. Total .....				
<b>Section 22. - FEMALE</b>				
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	0	1	3	5
6. Menstrual irregularity	0	2	5	7
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 .....				
<b>Section 23. - MALE ONLY Section</b>				
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	<b>No</b>	<b>Yes</b>		10
6. Difficulty in urinating, dripping after urination	0	2	5	10
7. Low sperm number and / or motility	<b>No</b>	<b>Yes</b>		(10)
8. Previous sexually transmitted disease	<b>No</b>	<b>Yes</b>		(10)
9. Varicocele	<b>No</b>	<b>Yes</b>		(10)
10. Blood or other discharge from penis	<b>No</b>	<b>Yes</b>		(10)
23. Total .....				
<b>Section 24. - FEMALE AND MALE sections</b>				
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	<b>No</b>	<b>Yes</b>		(10)
7. Poor co-ordination / balance	0	2	5	7
8. Muscle twitching	0	2	5	7
9. Sensory, perception changes - temperature, numbness, tingling	0	2	5	10
10. Short / long-term memory loss	0	2	5	10
24. Total .....				

<b>Section 25.</b>	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>
1. Cerebravascular - Stroke, transient ischaemic attacks, haemorrhage	<b>No</b>	<b>Yes</b>		(15)
2. Alzheimer's disease senile dementia	<b>No</b>	<b>Yes</b>		(15)
3. Tremor	0	2	5	10
4. Parkinson's disease	<b>No</b>	<b>Yes</b>		(15)
5. Motor neurone disease	<b>No</b>	<b>Yes</b>		(15)
6. Epilepsy	<b>No</b>	<b>Yes</b>		(15)
25. Total .....				
<b>Section 26.</b>				
1. Chronic pain at any site	0	2	5	10
2. Headaches, migraines, cluster headaches	0	2	5	10
3. Neuralgia - Trigeminal following herpes/shingles infection	0	2	5	10
4. Addiction to recreational drugs	<b>No</b>	<b>Yes</b>		(15)
5. Difficulty giving up smoking	<b>No</b>	<b>Yes</b>		(15)
6. Need to have at least one alcoholic drink each day	<b>No</b>	<b>Yes</b>		(15)
7. Reflex sympathetic dystrophy	<b>No</b>	<b>Yes</b>		(15)
8. Chronic arthritis	0	2	5	10
9. Food addiction/ anorexia/ bulimia	<b>No</b>	<b>Yes</b>		(15)
10. Depends on medication for pain	<b>No</b>	<b>Yes</b>		(15)
26. Total .....				
<b>Section 27.</b>				
1. Forgetful	0	2	5	10
2. Difficult concentration	0	2	5	10
3. Treated for schizophrenia	<b>No</b>	<b>Yes</b>		(15)
4. Depression	<b>No</b>	<b>Yes</b>		(15)
5. Obsessive compulsive disorder	<b>No</b>	<b>Yes</b>		(15)
6. Easily distracted, learning problems	0	2	5	10
7. Suicidal thoughts	<b>No</b>	<b>Yes</b>		(15)
8. Anxiety, Waking with anxiety	<b>No</b>	<b>Yes</b>		(15)
9. Panic Attacks	<b>No</b>	<b>Yes</b>		(15)
10. Mood swings	0	2	5	10
27. Total .....				
<b>Section 28.</b>				
1. Vivid dreams	0	1	3	5
2. Light sleep	0	1	3	5
3. Sleep talking	0	1	3	5
4. Sleep walking	0	1	3	5
5. Snoring (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	<b>No</b>	<b>Yes</b>		(5)
10. Waking up exhausted	0	1	3	5
28. Total .....				

Please indicate the total number of times you eat the following foods in a week. Include all meals – breakfast, lunch dinner, and all snacks. I want to get an idea of your total nutritional intake for the week. Add anything not listed.

	Weekly serves		Weekly serves
Tofu or soy beans		Vegemite	
Fish		Jam or honey	
Seafood (oysters, prawns, calamari etc)		Tea – cups per week	
Pork		Coffee – cups per week	
Red meat		Breakfast cereal – name it .....	
Sausages		Oats	
Chicken		Bread – slices per week	
Eggs		Tomatoes	
Meat pies or sausage rolls		Potato	
Hamburgers		Orange vegetables – e.g. sweet potato, carrot, pumpkin	
Hot chips, French fries		Peas	
Dried beans (lentils, baked beans etc)		Dark green, leafy vegetables	
Vegetarian meals		Salad greens	
Pasta, Spaghetti		Cauliflower, broccoli, cabbage, Brussels sprouts	
Rice		Citrus fruits – orange, grapefruit etc.	
Take away foods – total per week		Stone fruit – peach, plum, nectarine etc.	
Pizza		Tropical fruits – banana, mango, paw paw etc.	
Mc Donalds		Apple or pear	
Kentucky Chicken		Berries – strawberry, blueberry etc.	
Fried fish		Fruit juice	
Yoghurt		Vegetable juice	
Cheese		Desserts	
Dairy desserts eg. fruche, fromais		Cakes	
Ice Cream		Sweet Biscuits	
Milk – include milk on cereal		Soft drinks	
Nuts – roasted, salted		Cordial	
Nuts – raw, unsalted		Beer – glasses per week	
Peanut butter		Wine – glasses per week	
Chocolate		Spirits – nips per week	

Please read each statement and circle a number 0, 1, 2, or 3 which indicates how much the statement applied to you over the PAST WEEK. There are no right or wrong answers. Do not spend too much time on any one statement.

*The rating scale is as follows:*

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me a considerable degree, or a good part of the time
- 3 Applied to me very much, or most of the time

When you have finished you can transfer the scores to the columns in the score sheet on the next page.

1	I found myself getting upset by quite trivial things	0	1	2	3
2	I was aware of dryness in my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I just couldn't seem to get going	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I had a feeling of shakiness (eg. legs going to give way)	0	1	2	3
8	I found it difficult to relax	0	1	2	3
9	I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting upset rather easily	0	1	2	3
12	I felt that I was using a lot of nervous energy	0	1	2	3
13	I felt sad and depressed	0	1	2	3
14	I found myself getting impatient when I was delayed in any way (eg. lifts, traffic lights, being kept waiting)	0	1	2	3
15	I had a feeling of faintness	0	1	2	3
16	I felt that I had lost interest in just about everything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I perspired noticeably (e.g. hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life wasn't worthwhile	0	1	2	3

22	I found it hard to wind down	0	1	2	3
23	I had difficulty in swallowing	0	1	2	3
24	I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat, heart pounding)	0	1	2	3
26	I felt down-hearted and blue	0	1	2	3
27	I found that I was very irritable	0	1	2	3
28	I felt I was close to panic.	0	1	2	3
29	I found it hard to calm down after something upset me	0	1	2	3
30	I feared that I would be "thrown" by some trivial but unfamiliar task	0	1	2	3
31	I was unable to become enthusiastic about anything	0	1	2	3
32	I found it difficult to tolerate interruptions wothat I was doing	0	1	2	3
33	I was in a state of nervous tension	0	1	2	3
34	I felt I was pretty worthless	0	1	2	3
35	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
36	I felt terrified	0	1	2	3
37	I could see nothing in the future to be hopeful about	0	1	2	3
38	I felt that life was meaningless	0	1	2	3
39	I found myself getting agitated	0	1	2	3
40	I was worried about situations in which I might panic & make a fool of myself	0	1	2	3
41	I experienced trembling (e.g. in the hands)	0	1	2	3
42	I found it difficult to work up the initiative to do things	0	1	2	3

DASS is a standard questionnaire published in 1995

Lovibond, S.H. & Lovibond, P.F. (1995). Manual for the Depression Anxiety Stress Scales (2<sup>nd</sup>. Ed). Sydney: Psychology Foundation.

DASS 42 Score Sheet

Enter each score from the questionnaire into the first two columns.

Add up each row and enter the score into the available total box.

Add up each of the columns

Question	Score	Question	Score	Total	Total	Total
1		22		XXXXXXXXXX	XXXXXXXXXX	
2		23		XXXXXXXXXX		XXXXXXXXXX
3		24			XXXXXXXXXX	XXXXXXXXXX
4		25		XXXXXXXXXX		XXXXXXXXXX
5		26			XXXXXXXXXX	XXXXXXXXXX
6		27		XXXXXXXXXX	XXXXXXXXXX	
7		28		XXXXXXXXXX		XXXXXXXXXX
8		29		XXXXXXXXXX	XXXXXXXXXX	
9		30		XXXXXXXXXX		XXXXXXXXXX
10		31			XXXXXXXXXX	XXXXXXXXXX
11		32		XXXXXXXXXX	XXXXXXXXXX	
12		33		XXXXXXXXXX	XXXXXXXXXX	
13		34			XXXXXXXXXX	XXXXXXXXXX
14		35		XXXXXXXXXX	XXXXXXXXXX	
15		36		XXXXXXXXXX		XXXXXXXXXX
16		37			XXXXXXXXXX	XXXXXXXXXX
17		38			XXXXXXXXXX	XXXXXXXXXX
18		39		XXXXXXXXXX	XXXXXXXXXX	
19		40		XXXXXXXXXX		XXXXXXXXXX
20		41		XXXXXXXXXX		XXXXXXXXXX
21		42			XXXXXXXXXX	XXXXXXXXXX
			TOTALS:			
				<b>Total for D</b>	<b>Total for A</b>	<b>Total for S</b>