HEALTH QUESTIONNAIRE (NTAF)

Name:_________________________________ Age:________ Sex: _______ Date: ___________________

***Please circle the appropriate number "0-3" on all questions below. 0 as the least / never to 3 as the most / always.**

SECTION A

Question				
● Is your memory noticeably declining?	0	1	2	3
● Are you having a hard time remembering names & 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 things?	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 fatigue when driving compared to the past?	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 walk into rooms and forget	0	1	2	3
● How often do you pick up your cell phone and forget why?	0	1	2	3

SECTION B

Question				
● 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	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 C1

Question				
● How often do you get irritable, shaky, or have lightheadedness 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 C2

Question				
● 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

Question				
● 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 fell 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 much are you losing your enjoyment of friendships and relationships?	0	1	2	3
● How often do you have difficulty falling into deep restful sleep?	0	1	2	3
● How often do you have feelings of dependency on others?	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

SECTION 2 - D

Question				
● 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 feel you are not rested even after long hours of sleep?	0	1	2	3
● How often do you prefer to isolate yourself from others?	0	1	2	3
● How often do you have unexplained lack of concern for family and friends?	0	1	2	3
● How easily are you distracted from your tasks?	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 has been 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

Question				
● How often do you feel anxious or panic for no reason?	0	1	2	3
● How often do you have feelings of dread or impending doom?	0	1	2	3
● How often do you feel knots in your stomach?	0	1	2	3
● How often do you have feelings of being overwhelmed for no reason?	0	1	2	3
● How often do you have feelings of guilt about everyday decisions?	0	1	2	3
● How often does your mind feel restless?	0	1	2	3
● How difficult is it to turn your mind off when you want to relax?	0	1	2	3
● How often do you have disorganized attention?	0	1	2	3
● How often do you worry about things you were not worried about before?	0	1	2	3
● How often do you have feelings of inner tension and inner excitability?	0	1	2	3

SECTION 4 - ACH

Question				
● Do you feel your visual memory (shapes & images) is decreased?	0	1	2	3
● 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
● 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 & 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 responses?	0	1	2	3

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

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