HEALTH APPRAISAL QUESTIONNAIRE SHORT FORM WITH GRAPH

You Are What You Eat

1. Do you shop less frequently than every four days?

   ___ Yes (1) ___ No (0)

2. Do you eat more packaged (frozen or canned) fruits and vegetables than fresh?

   ___ Yes (3) ___ No (0)

3. Do you eat more cooked vegetables than raw?

   ___ Yes (3) ___ No (0)

4. Do you eat vegetables with less than two meals daily?

   ___ Yes (5) ___ No (0)

5. Do you buy more non-organic vegetables than organic vegetables?

   ___ Yes (5) ___ No (0)

6. Do you use a microwave oven?

   Yes (check option below) ___ No (0)
   ___ 1-2 times per week (2)
   ___ 3-4 times per week (5)
   ___ more than 4 times per week (10)

7. Do you eat quick cook grains such as Rice-aroni, Quaker Oats or Minute rice more often than slow cooked organic whole grains?

   ___ Yes (5) ___ No (0)

8. Do you eat white bread more often than whole grain breads?

   ___ Yes (5) ___ No (0)

9. Do you drink pasteurized/homogenized milk, or eat cheeses frequently?

   Yes (check option below) ___ No (0)
   ___ 1-2 times per week (1)
   ___ 3 times per week (3)
   ___ more than 3 times per week (5)

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10. Do you eat non-organic yogurts that are low fat, presweetened or have fruit added?

Yes (check option below) ___ No (0)
___ 1-2 times per week (1)
___ 3 times per week (3)
___ more than 3 times per week (5)

11. Do you eat typical store bought eggs from cage raised chickens (as apposed to free range, grain fed eggs)?

___ Yes (5) ___ No (0)

12. Do you eat red meat more than once every four days?

___ Yes (3) ___ No (0)

13. Do you commonly eat meats (beef, chicken, turkey) from sources other than a free-range and hormone-free source?

___ Yes (3) ___ No (0)

14. Do you eat canned fish more frequently than fresh fish?

___ Yes (3) ___ No (0)

15. Do you use commercial salad dressings?

Yes (check option below) ___ No (0)
___ once a week (1)
___ twice per week (2)
___ more than 2 times per week (3)

16. Do you use Mayonnaise or products containing hydrogenated oils?

Yes (check option below) ___ No (0)
___ once a week (1)
___ twice per week (2)
___ more than 2 times per week (5)

17. Do you eat nuts and/or seeds that are roasted and/or salted?

___ Yes (1) ___ No (0)

18. Do you use white table sugar as a sweetener?

Yes (check option below) ___ No (0)
___ once a week (1)
___ 2-3 times per week (3)
___ more than 3 times per week (5)

19. Do you use artificial sweeteners such as Sweet-n-Low, Equal or Nurtasweet?

Yes (check option below) ___ No (0)
___ once a week (1)
___ 2-3 times per week (5)
___ more than 3 times per week (10)

20. Do you use standard white table salt?

___ Yes (5) ___ No (0)

21. Do you eat TV dinners or other highly processed foods more than three times a week?

___ Yes (5) ___ No (0)

22. Do you eat from fast food restaurants like McDonald's, Arbey's, Wendy's, etc…?

Yes (check option below) ___ No (0)
___ 1-2 times per week (2)
___ 3 times per week (5)
___ more than 3 times per week (10)

23. Do you eat from vending machines?

Yes (check option below) ___ No (0)
___ 1-2 times per week (2)
___ 3 times per week (5)
___ more than 3 times per week (10)

24. Do you drink tap water?

___ Yes (10) ___ No (0)

25. Do you eat some form of store bought dessert, such as ice cream, cookies, donuts, cakes or pies after dinner most nights?

___Yes (check option below) ___ No (0)
___ once a week (1)
___ 2-3 times per week (3)
___ more than 3 times per week (5)

Total Score: _____

Stress

1. Do you eat more or less when stressed than when not stressed?

___ Yes (10) ___ No (0)

2. Do you worry over job, income or money problems?

___ Yes (10) ___ No (0)

3. Are any of your relationships causing you stress?

___ Yes (10) ___ No (0)

4. Do you often feel anxious?

___ Yes (5) ___ No (0)

5. Do you often feel upset when things go wrong or feel that things go wrong often?

___ Yes (5) ___ No (0)

6. Do you lash out at others?

___ Yes (5) ___ No (0)

7. Do you feel your sex drive is lower than normal for you?

___ Yes (5) ___ No (0)

8. Do you feel stressed due to lack of intimacy in one or more relationships?

___ Yes (5) ___ No (0)

9. Have you had reduced contact with friends (feeling antisocial) or an increase in contact because you feel you need to vent your frustrations or stresses to others?

___ Yes (3) ___ No (0)

10. Do you feel isolated or suffer from loneliness?

___ Yes (3) ___ No (0)

11. Do you take any form of medication prescribed by a physician directly or indirectly related to stress in your life or a psychological disorder?

___ Yes (15) ___ No (0)

12. Do you lose more than two days of work a year due to illness?

___ Yes (5) ___ No (0)

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Circadian Health

1. Do you live in the same time zone you were born in?

___ Yes (0) ___ No (5)

2. Do you travel across time zones more than once a month?

___ Yes (10) ___ No (0)

3. Do you wake up feeling un-rested and in need of more sleep?

Yes (check option below) ___ No (0)
___ once a week (1)
___ 3 times per week (5)
___ more than 3 times per week (10)

4. Do you commonly go to bed after 10:30 PM?

___ Yes (10) ___ No (0)

5. Are the times you have bowel movements consistent and predictable on a daily basis?

___ Yes (0) ___ No (5)

6. Do you suffer from reduced memory since moving to a new time zone or since traveling across time zones?

___ Yes (10) ___ No (0)

7. Has your sense of hunger changed from being hungry at breakfast (upon rising), lunch (mid-day) and dinner times (sunset) since moving to a new time zone or traveling across time zones frequently (> 1 x Mo.)?

___ Yes (10) ___ No (0)

8. Do you wake up at night between 1:00 am and 4:00 am and have a hard time falling back to sleep?

Yes (check option below) ___ No (0)
___ once a week (1)
___ 3 times per week (5)
___ more than 3 times per week (10)

9. Do you tend to have a hard time staying awake in the afternoon after eating lunch?

Yes (check option below) ___ No (0)
___ once a week (1)
___ 3 times per week (5)
___ more than 3 times per week (10)

10. Do you do shift work that requires you to stay up late at night?

___Yes (10) ___ No (0)

Total Score: _____

You Are When You Eat

1. Do you frequently skip meals?

   ___ Yes (3) ___ No (0)

2. Do you typically go more than four hours without eating?

   Yes (check option below) ___ No (0)
   ___ 1-2 times per week (1)
   ___ 3 times per week (2)
   ___ more than 3 times per week (3)

3. Do you sometimes skip breakfast?

   Yes (check option below) ___ No (0)
   ___ 2 times per week (1)
   ___ 3 times per week (5)
   ___ more than 3 times per week (10)

4. Do you avoid fats when eating?

   ___ Yes (5) ___ No (0)

5. Do you frequently eat carbohydrates (i.e. breads, bagels, cookies, pasta, fruit, cereals, muffins, crackers, chocolate, or candy) by themselves?

   ___ Yes (5) ___ No (0)

6. Do you get hungry or crave sweets within two hours after eating a meal?

   ___ Yes (5) ___ No (0)

7. Do you use caffeine and/or sugar containing drinks (i.e. coffee, tea, sodas, fruit juices with sucrose, corn syrup or added sugar)?

   Yes (check option below) ___ No (0)
   ___ 1 cup a day (1)
   ___ 2 cups per day (3)
   ___ more than 2 cups per day (5)

8. Have you tried diets to lose weight?

Yes (check option below) ___ No (0)
___ once (1)
___ twice (2)
___ three-five times (5)
___ more than five times (10)

9. Do you have difficulty burning fat around your belly, hips or thighs even with regular exercise?

___ Yes (3) ___ No (0)

10. Do you eat your largest meal at night?

___ Yes (1) ___ No (0)

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Digestive System Health

1. Do you experience lower abdominal bloating?

   Yes (check option below) ___ No (0)
   ___ 1-2 times per week (3)
   ___ 3 times per week (5)
   ___ more than 3 times per week (10)

2. Do you frequently have loose stools or diarrhea?

   Yes (check option below) ___ No (0)
   ___ once a week (1)
   ___ 3 or more times per week (5)

3. Do you experience constipation or stools that are compact/hard to pass?

   Yes (check option below) ___ No (0)
   ___ 1-2 times per week (3)
   ___ 3 or more times per week (5)

4. Do you find that you often burp/belch after meals?

   ___ Yes (3) ___ No (0)

5. Do you frequently have gas?

   ___ Yes (3) ___ No (0)

6. Do you crave certain foods, such as bread, chocolate, certain fruit, and red meat, if you have not eaten them in a day or two?

   ___ Yes (5) ___ No (0)

7. Do you have a poor appetite and/or feel worse after eating?

   Yes (check option below) ___ No (0)
   ___ 1-2 times per week (3)
   ___ 3 times per week (5)
   ___ more 3 times per week (10)

8. Do you have an excessive appetite and/or sweet cravings?

   ___ Yes (5) ___ No (0)

9. Do you frequently (more than twice a week) experience abdominal pain, cramps or general abdominal discomfort?

___ Yes (20) ___ No (0)

10. Do you have indigestion, heartburn or upset stomach?

Yes (check option below) ___ No (0)
___ 1-2 times per week (3)
___ 3 times per week (5)
___ more than 3 times per week (10)

11. Do you get a headache after eating?

Yes (check option below) ___ No (0)
___ 1-2 times per week (3)
___ more than 3 times per week (5)

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Detoxification System Health

1. Are your eyes sensitive to bright light?

   ___ Yes (3) ___ No (0)

2. Do you suffer from irritability and have difficulty relaxing?

   ___ Yes (10) ___ No (0)

3. Do you often feel fatigued and sluggish?

   ___ Yes (10) ___ No (0)

4. Do you suffer from frequent headaches?

   Yes (check option below) ___ No (0)
   ___ once a week (1)
   ___ 3 or more per week (5)

5. Do you have dark circles and/or puffiness under eyes?

   Yes (check option below) ___ No (0)
   ___ once a week (3)
   ___ 2-3 times per week (5)
   ___ more than 3 times per week (10)

6. Are you sensitive to perfumes, paint fumes, traffic fumes, detergents or cigarette smoke?

   Yes (check option below) ___ No (0)
   ___ mildly (3)
   ___ moderately (5)
   ___ very (10)

7. Have you been unable to lose cellulite with diet and/or exercise?

   ___ Yes (10) ___ No (0)

8. Are you currently, or have you in the past, been frequently exposed to industrial or agricultural chemicals, such as solvents, cleaning fluids, paint fumes, plant sprays and fertilizers?

   Yes (check option below) ___ No (0)
   ___ brief exposure (3)
   ___ more than once a week (5)
   ___ daily (10)

9. Do you experience mental sluggishness, poor memory or poor concentration?

Yes (check option below) ___ No (0)
___ 1-2 times per week (3)
___ 3 times per week (5)
___ more than 3 times per week (10)

10. Do you suffer from skin reactions such as rashes, itching or burning, for which the cause is unknown?

Yes (check option below) ___ No (0)
___ 1-2 times per month (3)
___ 3 times per month (5)
___ more than 3 times per month (10)

Total Score: _____

HAQ Short Form Score Sheet

	You Are What You Eat Zones 1, 2 & 3	Stress Zone 4	Circadian Health	You Are When You Eat Zone 3	Digestive System Health Zones 1, 2 & 3	Detoxification System Health Zones 3 & 4	Total Score
	130	81	90	50	81	88	520
	___	___	___	___	___	___	___
High Priority	60	60	70	35	60	60	☹
	___	___	___	___	___	___	___
	40	40	50	20	40	40	215
	___	___	___	___	___	___	___
Moderate Priority	30	30	40	15	30	30	😐
	___	___	___	___	___	___	___
	20	20	30	10	20	20	125
	___	___	___	___	___	___	___
Low Priority	15	10	15	5	10	10	☺
	___	___	___	___	___	___	___
Score 1							
Score 2							

Name: _____ **Date:** _____

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