HOPEWELL
NATUROPATHIC
FAMILY MEDICINE
YOUR PARTNER IN GOOD HEALTH

**Kasia Hopewell, ND**
**1601 El Camino Real, Suite 101**
**Belmont, CA 94002**
**TEL: 650-591-9355**

# Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

**Name:**_____ ☐ **M** ☐ **F** **Date:**_____ **DOB:**_____ **Age:**_____

**Please list your primary care physician (PCP) and any other healthcare providers you consult with**.

| Healthcare Provider: | Type of Practice: | Phone Number: |
|---|---|---|
| *Dr. Anna Smith (PCP)* | *DO* | *425.555.1212* |
| | | |
| | | |
| | | |
| | | |

Date of last physical exam: _____

Date of last pap/prostate exam: _____

Date of last fasting blood draw: _____

**Please list your present health concerns in order of their importance.**

| Concern: | Date of Onset: |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**What are your goals for this visit?**

_____

_____

**Traumas, car accidents, injuries:**

_____

_____

**Please list prior hospitalizations:**

| Reason: | Date/Where: |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

HOPEWELL
NATUROPATHIC
FAMILY MEDICINE
YOUR PARTNER IN GOOD HEALTH

**Kasia Hopewell, ND**
**1601 El Camino Real, Suite 101**
**Belmont, CA 94002**
**TEL: 650-591-9355**

**Please list your previous medical diagnoses:**

**1. Diagnosis**_____ Date of Onset:_____ Doctor Involved:_____

Current symptoms: Current treatments: Treatments received in the past:

What aggravates your condition? What helps your condition? In your mind, what caused this problem?

What do you hope for as we work together to treat this problem naturopathically?

**2. Diagnosis**_____ Date of Onset:_____ Doctor Involved:_____

Current symptoms: Current treatments: Treatments received in the past:

What aggravates your condition? What helps your condition? In your mind, what caused this problem?

What do you hope for as we work together to treat this problem naturopathically?

**3. Diagnosis**_____ Date of Onset:_____ Doctor Involved:_____

Current symptoms: Current treatments: Treatments received in the past:

What aggravates your condition? What helps your condition? In your mind, what caused this problem?

What do you hope for as we work together to treat this problem naturopathically?

**4. Diagnosis**_____ Date of Onset:_____ Doctor Involved:_____

Current symptoms: Current treatments: Treatments received in the past:

HOPEWELL
NATUROPATHIC
FAMILY MEDICINE
YOUR PARTNER IN GOOD HEALTH

**Kasia Hopewell, ND**
**1601 El Camino Real, Suite 101**
**Belmont, CA 94002**
**TEL: 650-591-9355**

What aggravates your condition? _____

What helps your condition? _____

In your mind, what caused this problem? _____

What do you hope for as we work together to treat this problem naturopathically?

_____

**Please list any prescription medication you are currently taking..**

| Medication: *Eg. Lipitor* | Reason: *High cholesterol* | Year Started: *2000* | Dosage: *10mg once daily* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Please list any over the counter medication you are currently taking.**

| Medication: *Eg. Advil* | Reason: *Pain relief* | Frequency: *3 times/week* | Dosage: *250mg twice daily* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Please list any nutritional supplements, herbs, or homeopathics you are taking.**

| Supplement/Manufacturer/Form: *Eg. Quercetin/Natural Factors/capsules* | Reason: *Allergies* | Date Started: *May 10, 2004* | Dosage: *235mg 3x/daily* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

HOPEWELL
NATUROPATHIC
FAMILY MEDICINE
YOUR PARTNER IN GOOD HEALTH

**Kasia Hopewell, ND**
**1601 El Camino Real, Suite 101**
**Belmont, CA 94002**
**TEL: 650-591-9355**

**Please list any known allergies.**

| Drug Allergy: | Food Allergy: | Environmental Allergy: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## Family Health History

Are you adopted? ☐ Yes ☐ No

Please check if you have any of the following family history:

| | | | | |
|---|---|---|---|---|
| ☐ Alcoholism | ☐ Autoimmune dz | ☐ Epilepsy | ☐ Kidney disease | ☐ Thyroid disorder |
| ☐ Allergies | ☐ Cancer | ☐ Heart attack | ☐ Obesity | ☐ Other – |
| ☐ Anxiety | ☐ Depression | ☐ Heart disease | ☐ Osteoporosis | Please list: |
| ☐ Arthritis | ☐ Diabetes | ☐ Hypertension | ☐ Stroke | |

| | Current Age | Age of Death | Significant health problem or cause of death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brothers/Sisters (list) | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| Children (list) | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| Maternal Grandmother | | | |
| Maternal Grandfather | | | |
| Paternal Grandmother | | | |
| Paternal Grandfather | | | |

*Please leave this space blank for doctor use*

HOPEWELL
NATUROPATHIC
FAMILY MEDICINE
YOUR PARTNER IN GOOD HEALTH

**Kasia Hopewell, ND**
**1601 El Camino Real, Suite 101**
**Belmont, CA 94002**
**TEL: 650-591-9355**

## Childhood Medical History

**Any complications during your mother's pregnancy with you?** ☐ Yes ☐ No
If so, please describe: _____
Please check the box that describes how you were born:
☐ Vaginal ☐ C-section ☐ Forceps ☐ Vacuum ☐ Trauma?
Any newborn problems?
☐ Jaundice ☐ Extended hospitalization ☐ Other, please describe:

**As a baby, were you fed:**
☐ Breastmilk ☐ Formula ☐ Mixed
Do you know at what age you were first given solid foods? _____
Please describe your diet as a child: _____

**Please indicate if you had any of the following childhood illnesses**.
☐ Acne ☐ Chicken pox ☐ Mono pox ☐ Pertussis ☐ Rubella ☐ Scarlet Fever
☐ ADD ☐ Measles ☐ Mumps ☐ Polio ☐ Rheumatic Fever ☐ Other: _____
How often did you get sick as a child? _____
What kind of illnesses did you usually experience? *Eg. Ear infections, sore throat, cough, allergies, asthma…*
_____
How often did you take antibiotics? _____
Please list any other medications taken regularly as a child._____
_____

**Please describe your vaccination history**.
☐ I was fully vaccinated ☐ I was selectively vaccinated ☐ I was not vaccinated
Check the vaccinations that you've had:
☐ Chicken pox ☐ Hepatitis B ☐ MMR ☐ Polio ☐ Other: _____
☐ DPT ☐ HIB ☐ Pneumonia ☐ PPD _____
Last tetanus booster: _____
Do you get the flu vaccine? _____
Have you ever had an adverse reaction to a vaccine? ☐ Yes ☐ No

**Please describe your childhood home environment.**
As a child, what adults lived with you?_____
Your birth order? *Eg. 3 of 5 kids* _____
Was your home safe? _____
Did you have any traumas or losses as a child? _____
Did you grow up in the city, suburbs or in a rural area? _____
Any difficulties in school? _____
Did anyone in your home smoke or use drugs regularly? _____

HOPEWELL
NATUROPATHIC
FAMILY MEDICINE
YOUR PARTNER IN GOOD HEALTH

**Kasia Hopewell, ND**
**1601 El Camino Real, Suite 101**
**Belmont, CA 94002**
**TEL: 650-591-9355**

## Other Lifestyle Factors

**Please describe your physical activity level**:

- ☐ Sedentary *Eg. No exercise*
- ☐ Mild exercise *Eg. Climb stairs, walk 3 blocks, golf*
- ☐ Occasional exercise *Eg. Work or recreation for 30 minutes duration less than 4 times weekly*
- ☐ Regular vigorous exercise *Eg. Work or recreation for 30 minutes more than 4 times weekly*

After moderate or vigorous exercise, how do you feel? ☐ Great ☐ Drained

**Please list your current body weight: _____** Desired body weight: _____
What is the most _____ and least _____ that you have weighed as an adult (excluding pregnancy)?
Do you diet to lose weight? ☐ Yes ☐ No
Do you take medications, herbs, or supplements to lose weight? ☐ Yes ☐ No
Do you have, or have you ever had, an eating disorder? ☐ No ☐ Binging ☐ Purging ☐ Avoidance of food

**BMI** *Please leave blank for doctor use*

**Please list who you currently live with.** *Eg. Spouse, children, roommates, pets*

| Name | Age | Relationship | Name | Age | Relationship |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

Is your home a sanctuary for you? ☐ Yes ☐ No
Is your home safe? ☐ Yes ☐ No
Does your home have lead paint? ☐ Yes ☐ No
Is there a gun in your home? ☐ Yes ☐ No
Is your home moldy? ☐ Yes ☐ No

**Do you work primarily ☐ inside or ☐ outside the home?**
Please list your present occupation. _____
How many hours a week do you work? _____
How many days a week do you work? _____
Do you spend more than half of your day at a desk or computer? ☐ Yes ☐ No
Do you take vacations? ☐ Yes ☐ No
Are you happy in your work? ☐ Yes ☐ No

**Please check off any potential toxic exposures**

- ☐ Anesthesia
- ☐ Asbestos
- ☐ Cleaning chemicals
- ☐ Electric power lines
- ☐ Frequent air travel
- ☐ Glassblowing
- ☐ Lead paint
- ☐ Mercury fillings
- ☐ Model building
- ☐ Nuclear power plant
- ☐ Painting
- ☐ Pesticides
- ☐ Pottery
- ☐ Second-hand smoke
- ☐ Other heavy metals
- ☐ Other mercury exposure
- ☐ Other solvents

**Patient Name** _____ **DOB** _____ **Date** _____

HOPEWELL
NATUROPATHIC
FAMILY MEDICINE
YOUR PARTNER IN GOOD HEALTH

**Kasia Hopewell, ND**
**1601 El Camino Real, Suite 101**
**Belmont, CA 94002**
**TEL: 650-591-9355**

## Dietary Assessment and Habits

How many servings of red meat (beef, lamb, pork, etc.) do you eat each week?

How many servings of fish do you eat each week?

How many servings of poultry (chicken, turkey, duck, etc) do you eat each week?

How many servings of beans do you eat each week?

How many servings of soy (tofu, soy milk, tempeh, etc) do you eat each week?

How many servings of dairy products (milk, ice cream, yogurt, etc) do you eat each week?

How many servings of fruit do you eat each day? *Eg. 1 serving = 1 small piece of fruit, ½ cup juice, ¼ cup dried fruit*

How many servings of vegetables do you eat each day? *Eg. 1 serving = ½ cup raw or cooked vegetables, 1 cup fresh green leafy vegetables*

How many sweets or desserts do you eat each day? What types?

How many times do you eat out each week?

How many times to you eat 'fast food' each week?

How many glasses of water do you drink each day?

How many glasses of other drinks do you have each day? What types?

Please list any foods that you crave.

HOPEWELL
NATUROPATHIC
FAMILY MEDICINE
YOUR PARTNER IN GOOD HEALTH

**Kasia Hopewell, ND**
**1601 El Camino Real, Suite 101**
**Belmont, CA 94002**
**TEL: 650-591-9355**

## Recall of Dietary Intake

Please list all foods and drinks you have consumed in the previous 48 hours. Include meals, snacks, beverages and condiments.

**Breakfast**

| | Food Item | Preparation *Eg. Baked, fried* | Amount |
|---|---|---|---|
| Day 1 | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Day 2 | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Lunch**

| | Food Item | Preparation *Eg. Baked, fried* | Amount |
|---|---|---|---|
| Day 1 | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Day 2 | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Dinner**

| | Food Item | Preparation *Eg. Baked, fried* | Amount |
|---|---|---|---|
| Day 1 | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Day 2 | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Patient Name** _____ **DOB** _____ **Date** _____

HOPEWELL NATUROPATHIC FAMILY MEDICINE
YOUR PARTNER IN GOOD HEALTH

Kasia Hopewell, ND
1601 El Camino Real, Suite 101
Belmont, CA 94002
TEL: 650-591-9355

**Snacks**

| | Food Item | Preparation *Eg. Baked, fried* | Amount |
|---|---|---|---|
| Day 1 | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Day 2 | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Alcohol Intake**

Do you drink alcohol? ☐ Yes ☐ No
Do you feel you drink too much? ☐ Yes ☐ No
Are you prone to binge drinking? ☐ Yes ☐ No
Do you drive after drinking? ☐ Yes ☐ No

What kind? _____ How many drinks/week? ____
Have you ever experienced blackouts? ☐ Yes ☐ No
Do you feel guilty about your drinking? ☐ Yes ☐ No
Are you sensitive to criticism of your drinking? ☐ Yes ☐ No

**Tobacco**

Do you currently, or have you in the past, used tobacco? ☐ Yes ☐ No
Please check the box that applies to you.

| ☐ Cigarettes | ☐ Chew | ☐ Pipe | ☐ Cigars |
|---|---|---|---|
| ___ packs/day | ___ times/day | ___ times/day | ___ times/day |

For how many years have you used tobacco products? _____
In what year did you quit using tobacco products? _____

**Drug Use**

Do you currently use recreational or street drugs? ☐ Yes ☐ No
Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

**Caffeine**

Do you drink coffee? ☐ Yes ☐ No Amount: _____
Do you drink soda? ☐ Yes ☐ No Amount: _____
Do you drink caffeinated tea? ☐ Yes ☐ No Amount: _____
Other: _____ Amount: _____

HOPEWELL NATUROPATHIC FAMILY MEDICINE
YOUR PARTNER IN GOOD HEALTH

Kasia Hopewell, ND
1601 El Camino Real, Suite 101
Belmont, CA 94002
TEL: 650-591-9355

## Elimination

### Gut

How often do you have a bowel movement? _____

Does your stool have any of the following qualities?

| | | | | |
|---|---|---|---|---|
| ☐ Undigested food | ☐ Formed | ☐ Dry | ☐ Tan | ☐ Yellow |
| ☐ Bright red blood | ☐ Loose | ☐ Greasy | ☐ Black | ☐ Other: |
| ☐ Mucus | ☐ Hard | ☐ Brown | ☐ Green | |

Do you strain to pass stool? ☐ Yes ☐ No

Do you experience gas bloating, belching? ☐ Yes ☐ No

Do you have hemorrhoids? ☐ Yes ☐ No

Do you even unintentionally pass stool? ☐ Yes ☐ No

Please check any box that applies to you.

| | | | |
|---|---|---|---|
| ☐ Abdominal pain | ☐ Nausea/vomiting | ☐ Diarrhea | ☐ Recent change in bowel habits |
| ☐ Heartburn/Indigestion | ☐ Constipation | ☐ None | |

### Kidneys

How often do you urinate? _____

Please check any box that applies to you.

| | | |
|---|---|---|
| ☐ Pain with urination | ☐ Must get up at night to urinate | ☐ Kidney stones |
| ☐ Urinate too frequently | ☐ Leaking urine when coughing or laughing | ☐ Recurrent urinary tract infection |
| ☐ Urgency to urinate | | ☐ Other |
| ☐ Urinary flow obstruction | ☐ Leaking urine at other times | ☐ None |
| ☐ Dribbling at end of urination | | |

### Skin

Do you sweat easily? ☐ Yes ☐ No

Do you use antiperspirant? ☐ Yes ☐ No

Do you apply lotions or oils to you skin? ☐ Yes ☐ No

Do you scrub or dry brush your skin? ☐ Yes ☐ No

What type? _____

Please note if you have any of the following:

| | | | |
|---|---|---|---|
| ☐ Acne | ☐ Dry skin | ☐ Skin cancer | ☐ Pigment changes |
| ☐ Eczema | ☐ Contact dermatitis | ☐ Hair loss or unusual growth | ☐ None |
| ☐ Rash | ☐ Moles | | |
| ☐ Chronic itching | ☐ Hives | ☐ Yellowing of the skin | |

### Liver

Please note if you have any of the following.

| | | | |
|---|---|---|---|
| ☐ Yellowing of the skin | ☐ Nausea/vomiting | ☐ PMS | ☐ None |
| ☐ Chronic itching | ☐ Abdominal pain | ☐ Menstrual irregularity | |

Are you unable to tolerate any of the following.

| | | | |
|---|---|---|---|
| ☐ Cigarette smoke | ☐ Perfume | ☐ Alcohol | ☐ Caffeine |

HOPEWELL NATUROPATHIC FAMILY MEDICINE
YOUR PARTNER IN GOOD HEALTH

**Kasia Hopewell, ND**
**1601 El Camino Real, Suite 101**
**Belmont, CA 94002**
**TEL: 650-591-9355**

## Review of Systems

Please check of you have, or have had, concerns in the following areas to a significant degree. Also note any recent changes in the areas listed below.

### Constitutional

☐ Weight
☐ Energy level
☐ Sleep
☐ Appetite
☐ Strength
☐ Night sweats
☐ Sense of wellbeing
☐ Ability to sleep
☐ Libido
☐ None

### Eyes, ears, nose, mouth, throat

☐ Vision loss
☐ Double vision
☐ Excessive tearing
☐ Dry eyes
☐ Blind spots
☐ Eye pain
☐ Eye discharge
☐ Hearing loss
☐ Ringing in the ears
☐ Vertigo/dizziness
☐ Nose bleeds
☐ Chronic stuffy nose
☐ Post nasal drip
☐ Recurrent sinus infection
☐ Headaches
☐ Missing teeth
☐ Gingivitis
☐ Bad breath
☐ Neck stiffness or swelling
☐ None

### Heart and blood vessels

☐ Chest wall pain
☐ Palpitations
☐ Short of breath w/ mild exercise
☐ Short of breath lying flat
☐ Heart murmur
☐ Varicose veins
☐ Clotting disorder
☐ Vessel inflammation
☐ Fainting
☐ Swelling
☐ Leg pain when walking
☐ Anemia
☐ None

### Lungs

☐ Painful breathing
☐ Shortness of breath
☐ Wheezing
☐ Cough
☐ Chronic bronchitis
☐ Coughing sputum
☐ Coughing blood
☐ None

### Musculoskeletal

☐ Back pain
☐ Scoliosis
☐ Bone loss/fractures
☐ Muscle weakness
☐ Muscle cramps
☐ Muscle pain
☐ Joint pain
☐ Morning stiffness
☐ Hot/red muscles or joints
☐ Limited range of motion
☐ None

### Neurologic and psychological

☐ Seizures/convulsions
☐ Paralysis
☐ Numbness/tingling
☐ Tremor
☐ Incoordination
☐ Speech difficulties
☐ Anxiety
☐ Depression
☐ Bipolar disorder
☐ Suicidal history
☐ None

### Endocrine

☐ Breast enlargement – men
☐ Thyroid problems
☐ Heat or cold intolerance
☐ Excessive urination
☐ Excessive thirst
☐ Spacey feeling after food
☐ Waking at night
☐ Fainting
☐ Swelling
☐ None

HOPEWELL
NATUROPATHIC
FAMILY MEDICINE
YOUR PARTNER IN GOOD HEALTH

**Kasia Hopewell, ND**
**1601 El Camino Real, Suite 101**
**Belmont, CA 94002**
**TEL: 650-591-9355**

# Women's Health

## Menstrual History

Age menses began: _____ Date of last menstrual period: _____
Length of cycle: _____ Duration of flow: _____
Date of last PAP: _____ Any history of irregular PAPs? ☐ Yes ☐ No
What best describes your current menstrual cycle:
☐ Regular ☐ Irregular ☐ Stopped ☐ Heavy ☐ Painful ☐ Other
Please describe any PMS symptoms you experience: _____
_____
_____

## Sexual History

Are you sexually active? ☐ Yes ☐ No Are you in a monogamous relationship? ☐ Yes ☐ No
Have you ever had an STD screen? ☐ Yes ☐ No Have you ever had an STD? ☐ Yes ☐ No
If yes, please list: _____
Please check the box if you have, or have had, any of the following.
☐ Pain with sex ☐ Vaginal discharge ☐ Any sores, warts, or lesions
☐ Concerns about libido ☐ Hysterectomy ☐ Recurrent urinary tract infections
☐ Recurrent yeast infections

## Fertility and Contraception

Number of pregnancies: _____ Any problems with pregnancies? ☐ Yes ☐ No
Number of births: _____ Any concerns regarding fertility? ☐ Yes ☐ No
Are you currently trying to get pregnant? ☐ Yes ☐ No If no, please describe your current method of birth control: _____

## Breast Health

Please check the box that applies to you.
☐ Breast implants ☐ Rash ☐ Self breast exams
☐ Lumps or nodules ☐ Fibrocystic changes ☐ Clinical breast exams
☐ Nipple discharge ☐ None ☐ Annual mammograms Date last test:_____

## Perimenopause/Menopause

Age menopause began: _____
Please check the box that applies to you.
☐ Hot flashes ☐ Low libido ☐ Fatigue ☐ Joint/body pain ☐ Change in memory/cognition
☐ Insomnia ☐ Irregular bleeding ☐ Palpitations ☐ Mood changes ☐ None
☐ Vaginal dryness ☐ Heavy bleeding ☐ Urinary Tract Infections ☐ Depression
☐ Pain with sex ☐ Incontinence ☐ Anxiety
Please describe any current treatment: _____

## Bone Health

Please check the box that applies to you.
☐ Bone fracture ☐ Limited physical activity ☐ History of eating disorders ☐ Weigh < 127lbs
☐ Smoker ☐ No menses for > 1yr

**Patient Name** _____ **DOB** _____ **Date** _____

HOPEWELL
NATUROPATHIC
FAMILY MEDICINE
YOUR PARTNER IN GOOD HEALTH

**Kasia Hopewell, ND**
**1601 El Camino Real, Suite 101**
**Belmont, CA 94002**
**TEL: 650-591-9355**

## Personal Biographical Review

**I**n the course of our hurried lives, we often rush past significant lessons. Patterns in our biographies, if reflected upon, can yield important lessons that can motivate us to make overdue changes and fortify us as we move toward a healthier future.

**T**ake a few pieces of regular 8" x 11" lined paper and number every OTHER space with the numbers 0 up to your age. (Therefore, a 40 year old person needs 82 lined spaces). Each year of your life (starting with year 0 which you spent in your mother's womb) is budgeted two lines.

**T**he therapeutic exercise is designed for you to reflect upon your life and record in brief anything significant in the limited spaces. For example, consider formative events of an interpersonal nature, such as births of siblings, deaths of important people in your life, divorces, marriages, lessons learned, traumatic events or positive peak experiences. Note all events you are proud of as well as events you regret. Write down the defining events of your life. Be sure to include any symptoms, illnesses, hospitalizations and surgeries as well. For men with military history, if traumatic episodes are too painful (PTSD) to discuss in detail, simply note that you do not wish to go into detail.

**F**illing in this chronological history form may take up to one hour. Do not be discouraged by this challenge. This will be time well invested, for by considering the patterns and defining moments of your life, you and Dr. Hopewell can discern important formative connections. This mutual detective work should uncover clues that will lead you in the direction of improved health and well-being. As is the case with every other part of this health questionnaire, your biographical review will be held in strict confidence.

## Mood Inventory

Please take a few deep breaths and slow down before answering the following eleven (11) questions. Read the questions carefully before answering honestly. Your answers should reflect your general feeling over the past week.

1) I do not feel sad.
I feel sad.
I am so sad all the time and I can't snap out of it.
I am so sad and or unhappy that I can't stand it.

2) I am not particularly discouraged about the future.
I feel discouraged about the future.
I feel I have nothing to look forward to.
I feel that the future is hopeless and that things cannot improve.

3) I do not feel like a failure.
I feel I have failed more than the average person.
As I look back on my life, all I can see are a lot of failures.
I feel I am a complete failure as a person.

**Kasia Hopewell, ND**
**1601 El Camino Real, Suite 101**
**Belmont, CA 94002**
**TEL: 650-591-9355**

4) I get as much satisfaction out of things as I used to.
I don't enjoy things the way I used to
I don't get real satisfaction out of anything anymore.
I am dissatisfied or bored with everything.

5) I don't feel particularly guilty.
I feel guilty a good part of the time.
I feel guilty most of the time.
I feel guilty all of the time.

6) I don't feel like I am being punished.
I feel I may be punished.
I expect to be punished.
I feel I am being punished.

7) I don't feel disappointed in myself.
I am disappointed in myself.
I am disgusted with myself.
I hate myself.

8) I don't feel I am any worse than anyone else.
I am critical of myself for my weaknesses and mistakes.
I blame myself all the time for my failures.
I blame myself for everything that happens.

9) I don't have any thoughts of killing myself.
I have thoughts of killing myself, but I would not carry them out.
I would like to kill myself.
I would kill myself if I had the chance.

10) I don't cry any more than usual.
I cry more than I used to.
I cry all the time.
I used to be able to cry, but now I can't cry even though I want to.

11) I am not more irritated by things than I ever am.
I am slightly more irritated now than usual.
I am quite annoyed or irritated a good deal of the time.
I am irritated all the time now.