Name _____

Date ____/____/____

The **MULTI-FACTORIAL INFLAMMATION Questionnaire: YOUR KEY TO PAIN RELIEF**

DESCRIPTION OF _____ (your chronic condition)

When did it first begin? _____

When did it last occur? _____

About how often does it occur? ___ time(s) per week/month

About how long does it last? _____ minutes/hours/days

What helps cause it? _____

What(if any) is the sensation you notice before it begins?_____

The Original Incident

The last time(date) I can remember feeling really well for more than just a few days was _____

During the six-month period before the date I have just written down, I experienced (**check ("√") all that apply**):

A period of great stress
- at home.....
- at work or school .....
- in an important relationship.....

A major loss.....
A major triumph.....
An emotional trauma.....
An emotional breakthrough.....
A financial setback.....
An addition to my family.....
A new relationship.....
An acute medical illness (for ex. an infection)
Hospitalization.....
Surgery.....
An accident or injury.....
"Food poisoning" or an "intestinal flu" .....
A dental problem or major dental work
A new medication (example, taking an antibiotic)
A change of diet.....
A crash or fad diet.....
A change in exercise or activity level.....
A change in sleeping habits.....
A change in location of my home, school, or workplace.....
A change in my use of
- nutritional supplements.....
- medication.....
- my soap, shampoo, or detergent.....

Renovation / construction at home, work, school.....
A leak or flood at home, work, or school.....
Foreign travel.....
Wilderness activities .....

If any of these events closely preceded a noticeable change in your health status, it may be seen as a precipitating event.

Choose the answers that are closest to your own personal experience. Answer each question with a number, as follows:

0 = Never/Rare – Insignificant AND Monthly or less often

1 = Occasionally or Slight – Average 1x /wk OR Mildly affects

2 = Often or Moderate – 2-3 per week OR Moderately affects you

3 = Frequent or Severe – Most days [or EVERY month like a cycle] OR Mild affects you

? = Unknown – I don't understand or know; NA – Not Apply

Hypoacidity

Food repeats on you after you eat……0 1 2 3
Excessive burping and belching following meals…...0 1 2 3
Stomach spasms and cramping during or after eating.0 1 2 3
A sensation that food just sits in your stomach, creating uncomfortable fullness, pressure and bloating during or after a meal……0 1 2 3
Bad taste in your mouth……..…0 1 2 3
Small amounts of food fill you up immediately……. 0 1 2 3
Skip meals or eat erratically because you have no appetite……..… 0 1 2 3

Total _____

GI Inflammation

Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt……...0 1 2 3
Feel hungry an hour or two after eating a good-sized meal……...…0 1 2 3
Stomach pain, burning and/or aching over a period of 1-4 hours after eating……...…0 1 2 3
Stomach pain, burning and/or aching relieved by eating food, drinking carbonated beverage, cream or milk, or taking antacids…….. 0 1 2 3
Burning sensation in the lower part of your chest, especially when lying down or bending forward… 0 1 2 3
Painful indigestion even when relaxed or on vacation.0 1 2 3
Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache…….. 0 1 2 3
Feel a sense of nausea when you eat……0 1 2 3
Difficulty or pain when swallowing food or beverage.0 1 2 3

Total _____

Small Intestine, Pancreas

When massaging under your rib cage *on your left* side, there is pain, tenderness or soreness…….. **0 1 2 3**
Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal… **0 1 2 3**
Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement……. **0 1 2 3**
Specific foods/beverages aggravate indigestion…..… **0 1 2 3**
The consistency or form of your stool changes (e.g., from narrow to loose) during one day……0 1 2 3
Stool odor is embarrassing……...0 1 2 3
Undigested food in your stool…… 0 1 2 3
Three or more large bowel movements daily…….. 0 1 2 3
Diarrhea (frequent loose, watery stool)……... 0 1 2 3
Bowel movement shortly after eating (within 1 hour).0 1 2 3

Total _____

Colon

Discomfort, pain or cramps in your colon (lower abdominal area)…… 0 1 2 3
Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas……0 1 2 3
Generally constipated (or straining during bowel movements)……...0 1 2 3

Stool is small, hard and dry……..0 1 2 3
Pass mucous in your stool……**0 1 2 3**
Alternate between constipation and diarrhea…….. **0 1 2 3**
Rectal pain, itching or cramping…… **0 1 2 3**
No urge to have a bowel movement…….0 1 2 3
An almost continual need to have a bowel movement.0 1 2 3
Total _____

LIVER/GALLBLDDER (related to intestines)

When massaging under your rib cage on your right side, there is pain, tenderness or soreness….0 1 2 3
Abdominal pain worsens with deep breathing……0 1 2 3
Pain at night that may move to your back or right shoulder……0 1 2 3
Bitter fluid repeat after eating…… 0 1 2 3
Feel abdominal discomfort or nausea when eating rich, fatty or fried foods ……...0 1 2 3
Throbbing temples and/or-dull pain in forehead associated with overeating……0 1 2 3
Unexplained itchy skin worse at night …….. 0 1 2 3
Stool color alternates from clay colored and normal brown…… 0 1 2 3
General feeling of poor health……....0 1 2 3
Total _____

Do you suffer from toxic overload?

I look older than my age……0 1 2 3
I feel more tired than I should …….……...0 1 2 3
My whole body aches …….…….. 0 1 2 3
I have trouble concentrating…….……...0 1 2 3
My body retains excess fluid…….. 0 1 2 3
I seem to be less healthy every year…….. 0 1 2 3
Smells and odors make me sick……0 1 2 3
I get every cold or flu that comes by……..0 1 2 3
I take pain relievers or antacids……..0 1 2 3
People think I drink(alcohol) too much……..0 1 2 3
I feel ashamed of my drinking(alcohol)……0 1 2 3
I need a drink of alcohol to feel well……..0 1 2 3
I smoke cigarettes……..…… 0 1 2 3
I use street drugs…….……0 1 2 3
I take prescription medication for a chronic health condition……0 1 2 3
I don't like vegetables……0 1 2 3
How often are strong chemicals used in your home?.0 1 2 3
How often are pesticides used in your home?……0 1 2 3
How often is your home treated for pesticides?…….0 1 2 3
How often are you exposed to nail polish/hair spray?…...0 1 2 3
How often are you exposed to gas/paint/exhaust fumes?..0 1 2 3
Total _____

If your total score is 10 or more, you may need help detoxifying.

Do you have food allergies? List:_____

My ears turn red for no apparent reason…… 0 1 2 3
My tongue looks like a map, with irregular flattened patches……..……. 0 1 2 3
I have dark circles under my eyes……..0 1 2 3
I have to clear my throat frequently…….. 0 1 2 3
My lips or throat itch after eating……...0 1 2 3
My skin itches for no apparent reason…….. 0 1 2 3
The inner corners of my eyes itch……. 0 1 2 3
I feel sleepy after eating……0 1 2 3
I feel my best if I don't eat at all……0 1 2 3
I feel more hungry after eating than before I ate… 0 1 2 3
I have irresistible cravings for specific foods……. 0 1 2 3 (milk, for example)_____
Eating gives me diarrhea, headaches, or skin rashes….. 0 1 2 3
Total _____

If your total score is 5 or more, food allergy or food intolerance may be a trigger for symptoms.

ANXIETY

Does worrying get you down?……..**0 1 2 3**
Does every little thing get on your nerves and wear you out?……**0 1 2 3**
Would you consider yourself a nervous person?…. **0 1 2 3**
Do you feel easily agitated?……**0 1 2 3**
Do you shake and tremble?……. 0 1 2 3
Are you keyed up and jittery?…….. 0 1 2 3
Do you tremble or feel weak when someone shouts at you?…….. 0 1 2 3
Do you become scared at sudden movements or noises at night?……0 1 2 3
Do you find yourself sighing a lot?……...…0 1 2 3
Are you awakened out of your sleep by frightening dreams?……..0 1 2 3
Do frightening thoughts keep coming back in your mind?...0 1 2 3
Do you become suddenly scared for no good reason?…0 1 2 3
Do you break out in a cold sweat?……... 0 1 2 3
Total _____

ANGER

Do you feel pent up and ready to explode?…… 0 1 2 3
Are you prone to noisy and emotional outbursts?…. 0 1 2 3
Do you do things on impulse?…… 0 1 2 3
Are you easily upset or irritated?……0 1 2 3
Do you go to pieces if you don't control yourself….. 0 1 2 3
Do little annoyances get on your nerves and make you angry?…….. 0 1 2 3
Does it make you angry to have anyone tell you what to do?……..0 1 2 3
Do you flare up in anger if you can't have what you want?.0 1 2 3
Total _____

Section 5. Is it the company of others?

I am subject to harassment
at home ……..…. 0 1 2 3
at work or school …… 0 1 2 3
I feel worse in the company of
my spouse or partner…… 0 1 2 3
my boss ……...0 1 2 3
one or more of my coworkers…….. 0 1 2 3
one or more of my friends …….. 0 1 2 3
one or more of my relatives…… 0 1 2 3
I feel worse at gatherings or parties…….. 0 1 2 3
Total _____

The total score is not important. A positive response to any question indicates that interpersonal or social distress may be a trigger for symptoms. Also ask yourself:
Are there any thoughts, memories, smells, or sounds that trigger (or relieve) my symptoms? If so, what are they?

DYSGLYCEMIA - L

When you miss meals or go without food for extended periods of time do you experience any of the following symptoms?

A sense of weakness…… **0 1 2 3**
A sudden sense of anxiety when you get hungry….0 1 2 3
Tingling sensation in your hands…….0 1 2 3
A sensation of your heart beating too quickly or forcefully…….0 1 2 3
Shaky, jittery, hands trembling…….0 1 2 3
Sudden profuse sweating and/or your skin feels clammy?……..0 1 2 3
Nightmares possibly associated with going to bed on an empty stomach……..0 1 2 3
Wake up at night feeling restless……. 0 1 2 3
Agitation, easily upset, nervous…….0 1 2 3
Poor memory, forgetful……0 1 2 3
Confused or disoriented……... 0 1 2 3
Dizzy, faint……...0 1 2 3
Cold or numb…….0 1 2 3
Headaches or head pounding……... 0 1 2 3
Blurred vision or double vision……...0 1 2 3

Total _____

DYSGLYCEMIA - E

Frequent urination day and night……..**0 1 2 3**
Unusual thirst -- feeling like you can't drink enough water…….0 1 2 3
Unusual hunger -- eating all the time……... 0 1 2 3
Vision blurs……...0 1 2 3
Feel itchy all over……0 1 2 3
Tingling or numbness in your feet……0 1 2 3
Sores heal slowly……..0 1 2 3
Sense of drowsiness, lethargy during the day, not associated with missing meals or not sleeping 0 1 2 3
Eating starchy foods, even if they are healthy and unprocessed (like rice, corn, beans, whole wheat, or oats) causes you to gain weight or prevents you from losing weight… 0 1 2 3
Loss of hair on your legs……. 0 1 2 3

Total _____

How often do you miss meals? ……. 0 1 2 3

MQ (Magnesium Quotient)?

I experience:

Leg or foot cramps……0 1 2 3
Sensitivity to loud noises……..0 1 2 3
Muscle twitches, spasms, tension…… 0 1 2 3
Palpitations……...0 1 2 3
Trouble falling asleep…….. 0 1 2 3
Restless legs …… 0 1 2 3
Sighing…….. 0 1 2 3
Irritability…… 0 1 2 3
Migraine headaches…… 0 1 2 3
Stress…… 0 1 2 3

Total _____

If your total score is 7 or more, you may be lacking in magnesium.

Do you need an oil change?

I experience:

Soft, fraying, or brittle nails..... 0 1 2 3
Dry, scaly, or flaky skin 0 1 2 3
Chicken skin (tiny bumps on my arms..... 0 1 2 3
Dandruff..... 0 1 2 3
Pain or stiffness in my joints..... 0 1 2 3
Dry, lackluster, or unruly hair..... 0 1 2 3
Excessive thirst..... 0 1 2 3
Menstrual cramps..... 0 1 2 3
Premenstrual breast pain..... 0 1 2 3

Total _____

If your total score is 5 or more, you may be lacking essential fatty acids.

How's your rhythm?

I wake up in the morning without an alarm clock 0 1 2 3
I feel well-rested after a night's sleep..... 0 1 2 3
I go to bed & wake up at about the same time each day... 0 1 2 3
On weekends, I get up at about the same time as on weekdays..... 0 1 2 3
I am able to sleep through the night……...0 1 2 3

Total (____)

If your total score is less than 10, you may have an imbalance in your daily rhythm. **(It may be d/t significant noise or pain.)**

IMMUNE

Eyes water or tear……**0 1 2 3**
Mucous discharge from the eyes…….0 1 2 3
Ears ache, itch, feel congested or sore…… 0 1 2 3
Discharge from ears…… 0 1 2 3
Hoarse voice……0 1 2 3
Do you have to clear your throat frequently?……..0 1 2 3
Do you often feel a choking lump in your throat?….. 0 1 2 3
Is your nose continually congested?……0 1 2 3
Are you prone to loud snoring?……0 1 2 3
Does your nose run constantly?……...0 1 2 3
Nosebleeds……...0 1 2 3
Do you suffer from severe colds?……0 1 2 3
Do frequent colds keep you miserable all winter?…..0 1 2 3
Flu symptoms last longer than 5 days……0 1 2 3
Do infections settle in your lungs?……..0 1 2 3
Chest discomfort or pain……..0 1 2 3
Do you experience sudden breathing difficulties?…. 0 1 2 3
Do you struggle with shortness of breath?……..... 0 1 2 3
Difficulty exhaling (breathing out)……....0 1 2 3
Breathlessness followed by coughing during exertion, no matter how slight…….. 0 1 2 3
Inability to breathe comfortably while lying down... 0 1 2 3
Do you cough up lots of phlegm?…….. 0 1 2 3
Hear noisy rattling sounds when breathing in and out?…0 1 2 3
Are you troubled with coughing?…….. 0 1 2 3
Do you wheeze?…… 0 1 2 3
Do you have severe soaking sweats at night?…… 0 1 2 3
Do your lips and/or nails have a bluish hue?……. 0 1 2 3
Are you sleepy during the day?……..0 1 2 3
Do you have difficulty concentrating?……... 0 1 2 3
Eyes, ears, nose, throat, and lung symptoms seem associated with specific foods like dairy or wheat products...0 1 2 3
Eyes, ears, nose, throat, and lung symptoms seem associated with seasonal change…….0 1 2 3

Total _____

The most obvious **EFFECTS OF ILLNESS** are the specific symptoms we experience.

Because of my symptoms, I have…

missed time from work or school…….. 0 1 2 3
found it harder to perform my work ……. 0 1 2 3
limited the kind of work I can do…….. 0 1 2 3
given up a hobby I enjoy……0 1 2 3
been unable to read for enjoyment ……. 0 1 2 3
stayed home from a gathering or party……. 0 1 2 3
canceled a visit to a friend or relative…… 0 1 2 3
canceled a visit from a friend or relative……0 1 2 3
not even bothered to schedule visits…….. 0 1 2 3
cut down on going to church……..0 1 2 3
decreased involvement in a community group..0 1 2 3
limited my driving……. 0 1 2 3
limited my use of public transportation……. 0 1 2 3
limited my travel …….. 0 1 2 3
decreased my housework…….. 0 1 2 3
decreased my exercise or sports…… 0 1 2 3
had difficulty walking, climbing stairs,
bending, or stooping…….. 0 1 2 3
become more dependent on others…… 0 1 2 3
been less able to care for others……. 0 1 2 3
had difficulty shopping, carrying groceries,
preparing meals, dressing myself, or
bathing myself…..……..0 1 2 3
become depressed, irritable, anxious……. 0 1 2 3
had trouble sleeping……0 1 2 3
had trouble staying awake ……0 1 2 3
started worrying about my health……0 1 2 3
lost interest in sex……0 1 2 3

Total _____

DISCIPLINE and ASSERTION

I believe I can do well in the following activities:

Following a prescribed diet for six months……. 0 1 2 3
Following an exercise routine……..0 1 2 3
Taking a daily relaxation break……0 1 2 3
Spending more time with loved ones…….. 0 1 2 3
Overcoming a bad habit……...0 1 2 3
Distracting myself from problems……... 0 1 2 3
Seeking information about problems……..0 1 2 3
Solving problems……0 1 2 3
Taking prescribed medication …… 0 1 2 3
Asserting my needs with my spouse or partner... 0 1 2 3
Asserting my needs with my children…… 0 1 2 3
Asserting my needs with my parents……... 0 1 2 3
Asserting my needs with my coworkers…….. 0 1 2 3
Asserting my needs with my boss……0 1 2 3
Asserting my needs with my doctor…… 0 1 2 3

Total (_____)

If your total score is <u>less than</u> 20, you may need help in creating a positive self-image that boosts your feelings of self-efficacy.

STRESS REDUCERS

I spend time each day in quiet reflection, prayer,
relaxation, or journaling..... 0 1 2 3
I spend most of the day on my feet.....0 1 2 3
I exercise briskly for thirty minutes or more.....0 1 2 3
I engage in sports activities.....0 1 2 3
I get fresh air and sunshine.....0 1 2 3
I eat leisurely, enjoying my meals.....0 1 2 3
I engage in physically strenuous work.....0 1 2 3

Total (_____)

<u>Menstruating</u> Women Only – Other Girls and Males, *skip to* "OVERALL TOTAL".

(<u>Menopausal</u> women should skip to "Section E")

SECTION A

Do you experience(MORE OFTEN or WORSE) any of these symptoms within three days to two weeks <u>prior to menstruation</u>?

[A]

Anxious, irritable or restless…….0 1 2 3
Numbness, tingling in hands and feet…….. 0 1 2 3
Easy to anger, resentful…… 0 1 2 3
Aggressive or hostile toward family/friends…… 0 1 2 3

[B]

Abdominal bloating, feeling swollen (e.g., feet)……..0 1 2 3
Temporary weight gain…… 0 1 2 3
Breast tenderness, swelling……... 0 1 2 3
Appearance of breast lumps……0 1 2 3
Discharge from nipples…… 0 1 2 3
Nausea and/or vomiting……... 0 1 2 3
Diarrhea or constipation……...0 1 2 3
Aches and pains (back, joints, etc.)…… 0 1 2 3

[C]

Craving for sweets……0 1 2 3
Increased appetite or binge eating……0 1 2 3
Headaches…… 0 1 2 3
Being easily overwhelmed, shaky or clumsy……...0 1 2 3
Heart pounding……0 1 2 3
Dizziness or fainting…… 0 1 2 3

[Dl

Confused and forgetful to the point that work suffers. 0 1 2 3
Overwhelmed with feelings of sadness and worthlessness 0 1 2 3
Difficulty sleeping or falling asleep……0 1 2 3
Engaging in self destructive behavior……..0 1 2 3

Total _____

SECTION B

Do you experience(MORE OFTEN or WORSE) any of these symptoms <u>during your period</u>?

Cramping in lower abdomen or pelvic area…… 0 1 2 3
Pain is sharp and/or dull or intermittent……..0 1 2 3
Bloating and sense of abdominal fullness……0 1 2 3
Diarrhea or constipation ……0 1 2 3
Nausea and/or vomiting……..…… 0 1 2 3
Low back and/or legs ache…….. 0 1 2 3
Headaches……0 1 2 3
Unusual fatigue (take naps) resulting in missed work 0 1 2 3
Painful and/or swollen breasts……0 1 2 3
Scanty blood flow……0 1 2 3

Total _____

SECTION C

Painful or difficult sexual intercourse…… 0 1 2 3
Low abdominal pain throughout the month……0 1 2 3
Low back ache or pain throughout the month……0 1 2 3
Pelvic pressure or pain while sitting down or
standing up, relieved by lying down……..…..0 1 2 3
Painful bowel movements……0 1 2 3
Constipated or difficult bowel movements……..0 1 2 3
Rectal pain……0 1 2 3
Painful or difficult (straining) urination…….. 0 1 2 3
Abnormal vaginal discharge……0 1 2 3
Offensive vaginal discharge…… 0 1 2 3
Vaginal itching or burning with or without intercourse.. 0 1 2 3
Pain during periods is getting progressively worse….0 1 2 3

Total _____

SECTION D

Absence of periods for six months or longer…….……0 1 2 3
Periods occur irregularly (e.g., 3 to 6 times a year).. 0 1 2 3
Profuse heavy bleeding during periods……. 0 1 2 3
Menstrual blood contains clots and tissue……..0 1 2 3
Bleeding between periods can occur anytime……0 1 2 3
Menstrual bleeding at cycles greater than every 35 days 0 1 2 3
Intense upper stomach pain, lasting several hours at the time you ovulate (approximately day 14 of your cycle)…….0 1 2 3
Bleeding occurs at ovulation (approximately day 14 of your cycle)……0 1 2 3
Monthly abdominal pain without bleeding……... 0 1 2 3
Abundant cervical mucous……0 1 2 3
Acne and/or oily skin…… 0 1 2 3
Overwhelming urges for sexual intercourse……..0 1 2 3
Aggressive feelings……0 1 2 3
Increased growth of dark facial and/or body hair…. 0 1 2 3
Poor sense of smell……0 1 2 3
Voice is becoming deeper……. 0 1 2 3
Breasts seem to be getting smaller……0 1 2 3
Pain during periods is getting progressively worse.. 0 1 2 3

Total _____

SECTION E

Urinary problems…….. 0 1 2 3
Vaginal discharge……..0 1 2 3
Vaginal secretions are watery and thin……..0 1 2 3
Vaginal dryness……0 1 2 3
Sexual intercourse is uncomfortable……. 0 1 2 3
Interest in having sex is low……..0 1 2 3
Engorged breasts……0 1 2 3
Breast tenderness, soreness……0 1 2 3
Difficulty with orgasm……...0 1 2 3
Vaginal bleeding after sexual intercourse……. 0 1 2 3
I occasionally skip periods…… 0 1 2 3
The length (number of days) of your period varies month to month, with the number of days of bleeding getting less…….0 1 2 3

Total _____

Totals without parentheses _____
Totals with parentheses (minus) -_____
Overall Total =_____

CoQ10 – www.aan.com (April 28, 2004) – 34% fewer migraines than placebo