

# Histadelia, Histapenia, Kryptopyrrolurea Assessment Form

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

## Section 1:

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|--|-----|----|
| 1. Good tolerance of cold?   | Yes | No |
| 2. Poor tolerance of heat?   | Yes | No |
| 3. Unexplained nausea?   | Yes | No |
| 4. Poor pain tolerance?  | Yes | No |
| 5. Excessive salivation?   | Yes | No |
| 6. A tendency towards hyperactivity?   | Yes | No |
| 7. Frequent cold/flu symptoms?   | Yes | No |
| 8. Phobias?  | Yes | No |
| 9. Highly motivated and hard-driving personality?  | Yes | No |
| 10. Good creativity/imagination?   | Yes | No |
| 11. High libido?   | Yes | No |
| 12. Joint pain?  | Yes | No |
| 13. Swelling/stiffness?  | Yes | No |
| 14. Excessive perspiration?  | Yes | No |
| 15. Warm skin?   | Yes | No |
| 16. Do you sneeze in bright sunlight?  | Yes | No |
| 17. Where you shy and oversensitive as a teenager?   | Yes | No |
| 18. Can you make tears easily, and are never bothered by a lack of saliva or a dry mouth?          | Yes | No |
| 19. Do you hear a pulse in your head on the pillow at night ?                                      | Yes | No |
| 20. Do you have frequent muscle cramps ?   | Yes | No |
| 21. Do you have a high sensitivity to pain ?   | Yes | No |
| 22. Do you find it easy to have orgasms with sex, and do you have a high libido?                   | Yes | No |
| 23. Do you get headaches regularly   | Yes | No |
| 24. Does your mind go blank at times ?   | Yes | No |
| 25. Do you have seasonal allergies, such as hayfever?  | Yes | No |
| 26. Do you tend to be a light sleeper  | Yes | No |
| 27. Do you only need 5 to 7 hours of sleep each night ?  | Yes | No |
| 28. Do you burn up foods rapidly ?   | Yes | No |
| 29. Have you thought seriously about suicide ?   | Yes | No |
| 30. Can you tolerate high doses of medication or drugs ?   | Yes | No |
| 31. Do you have large ears and long fingers or toes (Is your second toe longer than your big toe)? | Yes | No |
| 32. Are you addicted to drugs, alcohol, or sugar?  | Yes | No |
| 33. Are you a perfectionist or an obsessive, Type-A personality?                                   | Yes | No |
| 34. Are you impulsive?   | Yes | No |

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| 35. Do boys predominate among your siblings? | Yes | No |
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## Section 2:

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|---|-----|----|
| 1. Canker sores?  | Yes | No |
| 2. Difficult orgasms with sex?  | Yes | No |
| 3. No headaches or allergies?   | Yes | No |
| 4. Ideas of grandeur?   | Yes | No |
| 5. Undue suspicion of people?   | Yes | No |
| 6. Racing thoughts?   | Yes | No |
| 7. The feeling that someone or something is controlling your mind?  | Yes | No |
| 8. Have you ever had visual hallucinations?   | Yes | No |
| 9. Have you ever heard voices inside your head?   | Yes | No |
| 10. Ringing in the ears?  | Yes | No |
| 11. High anxiety?   | Yes | No |
| 12. Food sensitivities?   | Yes | No |
| 13. Good pain tolerance?  | Yes | No |
| 14. Few or no colds?  | Yes | No |
| 15. Is your mouth usually dry?  | Yes | No |
| 16. Are your eyes usually dry?  | Yes | No |
| 17. Do you have bouts of despair or bouts of crying?  | Yes | No |
| 18. Unusual sensitivity to chemicals, perfumes, gasoline, plastics, etc.?   | Yes | No |
| 19. Severe PMS?   | Yes | No |
| 20. Do you have slow sexual responsiveness and/or a low libido?   | Yes | No |
| 21. Do you have tension headaches?  | Yes | No |
| 22. Do you have heavy growth of body hair?  | Yes | No |
| 23. Do you tend to carry any excess fat in your lower extremities rather than evenly distributed around your body (pear shaped figure)? | Yes | No |
| 24. Do you have a lot of dental fillings?   | Yes | No |
| 25. Do you have a head full of grand plans but are easily frustrated?   |     |    |
| 26. Do you ever feel paranoid   | Yes | No |
| 27. Do you get few or no colds?   | Yes | No |
| 28. Do you have low tolerance for medications or drugs?   | Yes | No |
| 29. Do you tire easily?   | Yes | No |
| 30. Do you need at least 8 hours of sleep or are you a slow riser in the morning?   | Yes | No |
| 31. Do you experience frequent Irritability?  | Yes | No |

### Section 3:

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|--|-----|----|--|-----|----|
| 1. When you were young, did you sunburn easily?  | Yes | No | 21. Have you noticed a sweet smell (fruity odor) to your breath or sweat when ill or stressed?                           | Yes | No |
| 2. Do you have pale or fair skin?  | Yes | No | 22. Do you have, or did you have before braces, crowded upper front teeth?   | Yes | No |
| 3. Do you have a reduced amount of head hair, eyebrows, eyelashes, or do you have prematurely grey hair?                           | Yes | No | 23. Do you prefer to not eat breakfast, or even experience light nausea in the morning?                                  | Yes | No |
| 4. Do you have poor dream recall or Nightmares?  | Yes | No | 24. Does your face sometimes look swollen while under a lot of stress?   | Yes | No |
| 5. Are you becoming more of a "loaner" as you age?   | Yes | No | 25. Do you have a poor appetite, or a poor sense of smell or taste?  | Yes | No |
| 6. Do you avoid outside stress because it upsets your emotional balance?   | Yes | No | 26. Do you have any upper abdominal, splenic pain?   | Yes | No |
| 7. Have you been anxious, fearful or felt a lot of inner tension since childhood but mostly hide these inner feelings from others? | Yes | No | 27. As a child did you ever get a "stitch" in your side as you ran?  | Yes | No |
| 8. Is it hard to clearly recall past events and people in your life?   | Yes | No | 28. Do you tend to focus internally (on yourself) rather than on the external world?                                     | Yes | No |
| 9. Do you have bouts of depression and/or exhaustion?  | Yes | No | 29. Do you frequently experience fatigue?  | Yes | No |
| 10. Do you have cluster headaches  | Yes | No | 30. Do you feel uncomfortable with Strangers?  | Yes | No |
| 11. Are your eyes sensitive to sunlight  | Yes | No | 31. Do your knees ever crack or ache?  | Yes | No |
| 12. Do you belong to an all-girl family, or have look-alike sisters?   | Yes | No | 32. Do you overreact to tranquilizers, barbiturates, alcohol or other drugs (does a little produce a powerful response)? | Yes | No |
| 13. Do you get frequent colds and/or infections, or unexplained chills or fevers?  | Yes | No | 33. Does it bother you to be seated in the middle of a room?   | Yes | No |
| 14. Do you dislike eating protein?   | Yes | No | 34. Are you anemic?  | Yes | No |
| 15. Have you ever been a vegetarian?   | Yes | No | 35. Do you have cold hands/feet?   | Yes | No |
| 16. Did you reach puberty later than normal?   | Yes | No | 36. Are you easily upset (internally) by criticism?  | Yes | No |
| 17. Are there white spots/flecks on your fingernails, or do you have opaquely white or paper-thin nails?                           | Yes | No | 37. Do you have a tendency towards morning constipation?   | Yes | No |
| 18. Are you prone to acne, eczema or psoriasis?  | Yes | No | 38. Do you have a tingling sensation or muscle spasms in your legs or arms?  | Yes | No |
| 19. Do you prefer the company of one or two close friends rather than a gathering of friends?                                      | Yes | No | 39. Do changes in your routine (traveling, new situations) provoke stress?   | Yes | No |
| 20. Do you have stretch marks on your skin?  | Yes | No | 40. Do you tend to become dependent on one person whom you build your life around?                                       | Yes | No |