

Sickness Syndrome Depression SSIBD Questionnaire

Name: _____

Section I: Depression/Sadness

Below is a list of the ways that people have used to describe how they feel or behave. There are no right or wrong answers.. Please indicate how often you have felt this way during the past week (7 days).

Please use the following scale to score the statements below:
 0= Rarely or none of the time (less than 1 day)
 1= Some or a little of the time (1-2 days)
 2= Occasionally or a moderate amount of time (3-4 days)
 3= Most or all of the time (5-7 days)

I was bothered by things that usually don't bother me.	
I did not feel like eating; my appetite was poor.	
I felt that I could not shake off the blues even with help from my family or friends.	
I had trouble keeping my mind on what I was doing.	
I felt depressed.	
I felt that everything I did was an effort.	
I thought my life had been a failure.	
I felt fearful.	
My sleep was restless.	
I talked less than usual.	
I felt lonely.	
People were unfriendly.	
I had crying spells.	
I felt sad.	
I felt that people dislike me.	
I could not get "going."	

Please use the following scale to score the statements below:
 3= Rarely or none of the time (less than 1 day)
 2= Some or a little of the time (1-2 days)
 1= Occasionally or a moderate amount of time (3-4 days)
 0= Most or all of the time (5-7 days)

I felt I was just as good as other people.	
I felt hopeful about the future.	
I was happy.	
I enjoyed life.	

Section II: Stressful Events (The Holmes/Rahe Scale)

Many “life changing” events can be stressful, both in terms of the way in which we perceive them and in terms of the increased incidence of physical illness that occur during the following 12 months. This scale offers valuable information in terms of the stressful events that have occurred in your life (including those events that you perceive as positive events) over the past 12 months and offer one important piece of the larger Sickness Syndrome/Inflammation in the Brain and Depression picture.

Events	Indicate Y or N
Death of spouse	
Divorce	
Marital separation	
Jail term	
Death of a close family member	
Personal injury or illness	
Marriage	
Dismissal from work	
Marital reconciliation	
Retirement	
Change in health of family member	
Pregnancy	
Sex difficulties	
Gain of new family member	
Business readjustment	
Change in financial state	
Death of close friend	
Change to different line of work	
Change in no. of arguments with spouse	
Major mortgage	
Foreclosure of mortgage or loan	
Change in responsibilities at work	
Son or daughter leaving home	
Trouble with in-laws	
Outstanding personal achievement	
Partner begins or stops work	
Begin or end school	
Change in living conditions	
Revision of personal habits	
Trouble with boss	
Change in work hours or conditions	
Change in residence/schools/recreation	
Change in social activities	
Small mortgage or loan	
Change in sleeping/eating habits	
Change in no. of family get-togethers	
Vacation	
Major religious/family holiday	
Minor violations of the law (e.g. traffic or speeding tickets, etc.)	

Section III: Adrenal Function

Rate each of the following symptoms based upon your health profile for the past 6 months.

- 0 = Rarely or Never Experience the Symptom
- 1 = Occasionally Experience the Symptom, Effect is not Severe
- 2 = Occasionally Experience the Symptom, Effect is Severe
- 3 = Frequently Experience the Symptom, Effect is not Severe
- 4 = Frequently Experience the Symptom, Effect is Severe

Acne	
Dizziness	
Headaches	
Hot flashes	
Female: hair growth on face	
Chronic fatigue	
High OR low blood pressure	
Arthritis	
Poor circulation	
Swollen ankles	
Crave salt	
Allergies or Asthma	
Respiratory disorder	

Section IV: Female Hormonal Balance

Rate each of the following symptoms based upon your health profile for the past 6 months.

- 0 = Rarely or Never Experience the Symptom
- 1 = Occasionally Experience the Symptom, Effect is not Severe
- 2 = Occasionally Experience the Symptom, Effect is Severe
- 3 = Frequently Experience the Symptom, Effect is not Severe
- 4 = Frequently Experience the Symptom, Effect is Severe

Menopausal hot flashes	
Scanty or missed periods	
Menstrual cycle greater then 40 days	
Acne	
Hysterectomy/ovaries removed	
Swollen painful breasts	
Pain during intercourse	
Low sex drive	
Depressed before menses	
Missed periods	
Increased fat around midsection	

Section V: Male Hormonal Balance

Rate each of the following symptoms based upon your health profile for the past 6 months.

- 0 = Rarely or Never Experience the Symptom
- 1 = Occasionally Experience the Symptom, Effect is not Severe
- 2 = Occasionally Experience the Symptom, Effect is Severe
- 3 = Frequently Experience the Symptom, Effect is not Severe
- 4 = Frequently Experience the Symptom, Effect is Severe

Painful urination	
Low sex drive	
Low energy	
Depressed	
Prostate challenges	
Easily fatigued	
Increased fat around mid section	

Section VI: Vagal output

Rate each of the following symptoms based upon your health profile for the past 6 months.

- 0 = Rarely or Never Experience the Symptom
- 1 = Occasionally Experience the Symptom, Effect is not Severe
- 2 = Occasionally Experience the Symptom, Effect is Severe
- 3 = Frequently Experience the Symptom, Effect is not Severe
- 4 = Frequently Experience the Symptom, Effect is Severe

Muscle cramps in the evening	
Swollen/puffy eyes	
Insatiable appetite	
Feel lightheaded	
Frequent constipation and/or diarrhea	
Easily perspire	
Reduced Appetite	
Cold extremities	
Cannot relax; gets startled	
Dry mouth, eyes or nose	
Watery eyes or nose	
Heart pounds when going to sleep	

Section VII: Blood Sugar/Fat imbalance

Rate each of the following symptoms based upon your health profile for the past 6 months.

- 0 = Rarely or Never Experience the Symptom
- 1 = Occasionally Experience the Symptom, Effect is not Severe
- 2 = Occasionally Experience the Symptom, Effect is Severe
- 3 = Frequently Experience the Symptom, Effect is not Severe
- 4 = Frequently Experience the Symptom, Effect is Severe

Have diabetes and/or metabolic syndrome	
Hungry between meals	
Get "shaky" if hungry	
Get "lightheaded" if miss a meal	
Crave high sugar or high fat foods	
Eat when stressed or nervous	

Body Mass Index

Weight (pounds)	Height (Inches)
<input type="text"/>	<input type="text"/>

Section VIII: Immune/Infection

Please answer Y for yes and N for no based on your exposure to infection anytime over the course of your life.

	Indicate Y or N
Mother diagnosed with Cytomegalovirus while carrying you	
Mother diagnosed with Flu while carrying you	
Diagnosed with Lyme disease	
Herpes infection	
HIV infection	
Cancer	
<i>Strep pneumoniae</i> infection (e.g. Strep throat)	
Any diagnosed viral or bacterial infection not listed above	

Section IX: Exposure to Toxins

Rate each of the following situations based upon your environmental profile for the past 120 days

- 0 = Never
- 1 = Rarely
- 2 = Monthly
- 3 = Weekly
- 4 = Daily

How often are strong chemicals used in your home ? (disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.)	<input type="text"/>
How often are pesticides used in your home?	<input type="text"/>
How often do you have your home treated for insects?	<input type="text"/>
How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense or varnish in your home or office?	<input type="text"/>
How often are you exposed to nail polish, perfume, hair spray and other cosmetics?	<input type="text"/>
How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?	<input type="text"/>

Rate each of the following situations based upon your environmental profile for the past 120 days

- 0 = No
- 1 = Mild Change
- 2 = Moderate Change
- 3 = Drastic Change

Have you noticed any negative change in your health since you moved into your home or apartment?	<input type="text"/>
Have you noticed any negative change in your health since you started your new job?	<input type="text"/>

Indicate Y or N

Do you have a water purification system in your home?	<input type="text"/>
Do you have any indoor pets?	<input type="text"/>
Do you have an air purification system in your home?	<input type="text"/>
Are you a dentist, painter, farm worker or construction worker?	<input type="text"/>

Questionnaire Submission Instructions

This questionnaire and the results are to be used by a healthcare professional in determining the proper care and treatment for the patient. To have this questionnaire scored and analyzed please fill out all appropriate fields below and either mail or fax using the information at the bottom of this page. The completed report will be sent to the physician's address. Additional copies can be downloaded from www.sicksyndrome.com

Cost for questionnaire analysis: \$122

Physician Name _____

Physician Practice _____

Practice Phone #: _____

Physician Address: _____

Physician City, State, Zip: _____

Patient Name _____

Payment Information

Check Enclosed M/C Visa Discover

Credit Card #	Expiration Date (MM/YY)

Credit Card Holders Last Name Credit Card Holders First Name

CC Billing Address

CC Billing City CC Billing State CC Billing Zip

Credit Card Holder's Signature Date

Fax or Mail the completed questionnaire:

Fax: (800) 439-1382

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