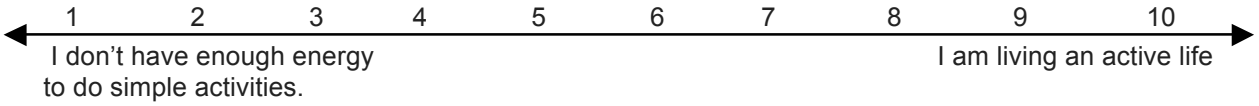
Functional Awareness Questionnaire

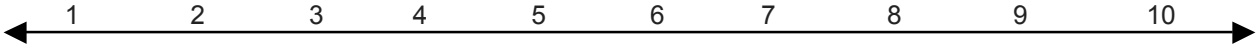
This information will be used to provide a clearer picture of your health. There are no correct answers, so honestly, rate each question. Please read and mark the score for each question on the scale. (Check box if taking medication for topic of question.)

Name: _____ Date: _____

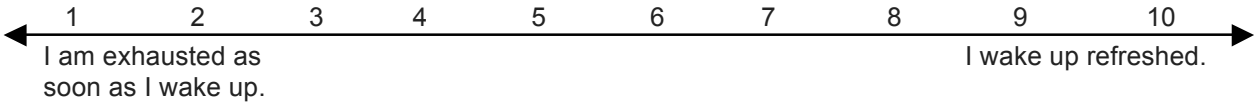
1) Energy Level: Taking medications; ☐



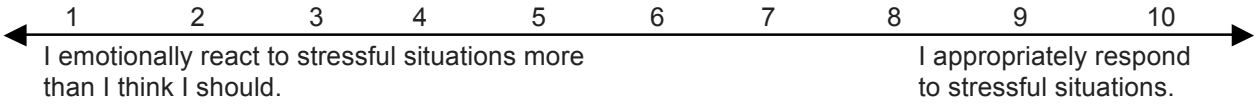
2) Sleep Quality: Taking Medications; ☐
(Hours)



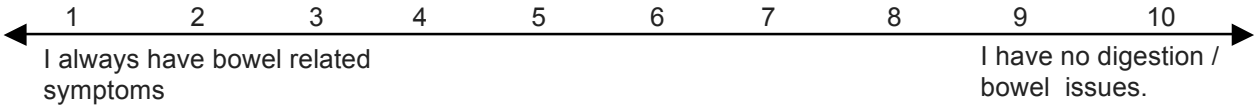
3) Restful Sleep ; Taking Medications; ☐



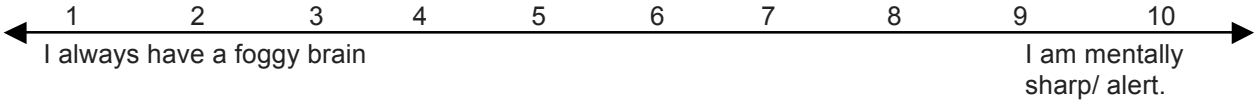
4) Irritable /Moodiness: Taking Medications; ☐



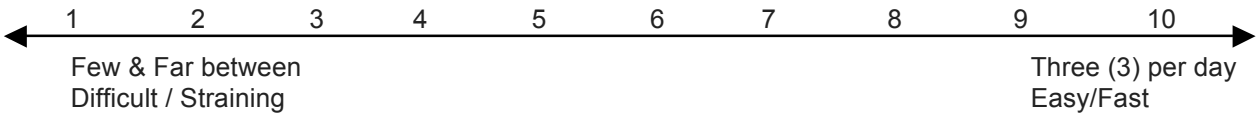
5) Digestions/ Acid Reflux; Taking Medication; ☐



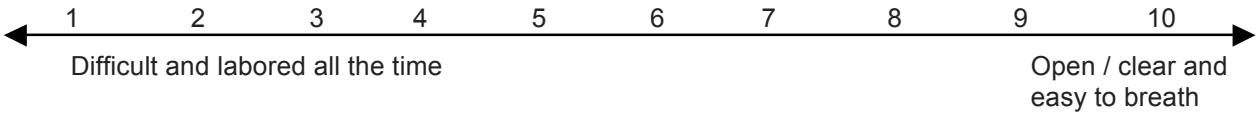
6) Mental Alertness Taking Medication; ☐



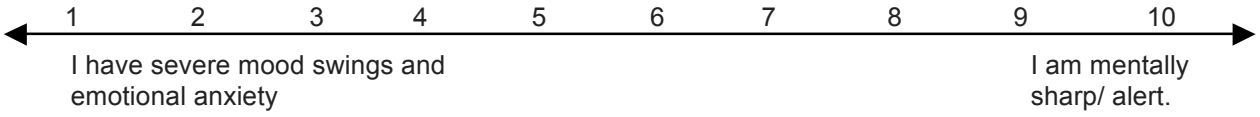
7) Bowel Movements: Taking Medication; ☐



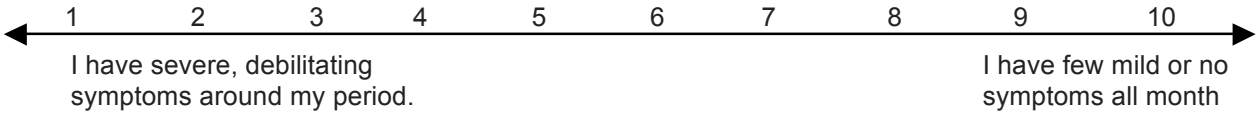
8) Breathing: Taking Medication; ☐



9) Emotional Stability: Taking Medication; ☐



10) Menstrual Challenges: Taking Medication; ☐



Other Comments:

_____

_____

_____

For Clinical Use Only:

Weight: _____ Height: _____ Frame: _____ Age: _____

Res: _____ Reac: _____ % BF: _____ PA: _____ BMI: _____