

Name _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Email _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: Single Partner Married Separated Divorced Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit _____ Date began _____

List current health problems for which you are being treated: _____

What types of therapies have you tried for these problem(s) or to improve your health overall:

- Diet modification
- Fasting
- Vitamins/minerals
- Herbs
- Homeopathy
- Chiropractic
- Acupuncture
- Conventional drugs
- Other _____

Do you experience any of these general symptoms on a regular basis?

- Debilitating fatigue
- Shortness of breath
- Insomnia
- Constipation
- Chronic pain/inflammation
- Depression
- Panic attacks
- Nausea
- Fecal incontinence
- Bleeding
- Disinterest in sex
- Headaches
- Vomiting
- Urinary incontinence
- Discharge
- Disinterest in eating
- Dizziness
- Diarrhea
- Low grade fever
- Itching/rash

Current medications (prescription or over-the-counter): _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

Outcome: _____

Major hospitalization, surgeries, injuries. Please list all procedures, complications (if any), and dates:

Year	Surgery, illness, or injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, residence or finances): _____

Do you consider yourself: Underweight Overweight Healthy weight Your weight today: _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) and/or life threatening activities (e.g., firefighter, police officer, etc.)? _____

What are your current health goals: _____

Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other _____

Medical (Men)

- Benign prostatic hyperplasia
- Prostate cancer
- Decreased sex drive

- Infertility
- Sexually transmitted disease
- Other _____

Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other _____
- Date of last GYN exam _____
- Mammogram + -
- PAP + -
- Form of birth control _____
- # of children _____
- # of pregnancies _____
- C-section _____
- Age of first period _____
- Date of last menstrual cycle _____
- Length of cycle _____ days
- Interval of time between cycles _____ days

- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____
- Surgical menopause
- Menopause

Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other _____

Health Habits

- Tobacco:
- Cigarettes: # /day _____
- Cigars: # /day _____
- Alcohol:
- Wine: # glasses/d or wk _____
- Liquor: # ounces/d or wk _____
- Beer: # glasses/d or wk _____
- Caffeine:
- Coffee: # 6 oz cups/d _____
- Tea: # 6 oz cups/d _____
- Soda w/caffeine: # cans/d _____
- Other sources _____
- Water: # glasses/d _____
- Exercise
- 5-7 days/wk
- 3-4 days/wk
- 1-2 days/wk
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk: #days/wk _____
- Run, jog, other aerobic - #days/wk _____

- Weight lift: #days/wk _____
- Stretch: #days/wk _____
- Other _____

Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction

Specific food restrictions:

- dairy wheat eggs
- soy corn all gluten
- Other _____

Food Frequency

- Number of servings per day: _____
- Fruits (citrus, melons, etc.) _____
- Dark green or deep yellow/orange vegetables _____
- Grains (unprocessed) _____
- Beans, peas, legumes _____
- Dairy, eggs _____
- Meat, poultry, fish _____

Eating Habits

- Skip meals (which ones) _____
- One meal/day
- Two meals/day
- Three meals/day
- Graze (small frequent meals)
- Generally eat on the run
- Eat constantly whether hungry or not

Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening primrose/GLA
- Calcium, source _____
- Magnesium
- Zinc
- Minerals (describe) _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol)
- Herbs
- Homeopathy
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Other _____

I Would Like to:

- Energy, Vitality
- Feel more vital
- Have more energy
- Have more endurance
- Be less tired after lunch
- Sleep better
- Be free of pain
- Get less colds and flu
- Get rid of allergies
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, etc.
- Stop using laxatives and stool softeners
- Improve sex drive

Body Composition

- Lose weight
- Burn more body fat
- Be stronger
- Have better muscle tone
- Be more flexible

Stress: Mental and Emotional

- Learn how to reduce stress
- Think more clearly and be more focused
- Improve memory
- Be less depressed
- Be less moody
- Be less indecisive
- Feel more motivated

Life Enrichment

- Reduce my risk of degenerative disease
- Slow down accelerated aging
- Maintain a healthier life longer
- Change from a "treating-illness" orientation to creating a wellness lifestyle

NEW CLIENT JOURNAL - Past Three Days or Daily

Name _____

Date _____

Wake)Up Time: _____

Breakfast: _____

Meal Description:

Dinner Time: _____

Meal Description:

Mid)Morning Snack Time: _____

Snack Description:

After Dinner Snack Time: _____

Snack Description:

Lunch Time: _____

Meal Description

Beverages:

Mid)Afternoon Snack Time: _____

Snack Description:

Exercise/Sleep (detail type and duration)

ACNEM Nutritional Assessment Prompt Sheet

1. Past History
 - a. All illness, time requiring medication, time admitted to hospital
2. Home and work History
 - a. Any exposure to environmental toxins – lead, asbestos, pesticides etc.
 - b. Any exposure to mould or water damaged building
3. Childhood history
 - a. Illness
 - b. Recurrent infections
 - c. ENT/ eczema / EBV
4. Immune System
 - a. Type of infections – colds/flu/tonsillitis/cough/pneumonia/UTI/thrush/cold sores
 - b. Hayfever – frequency/duration/onset
 - c. History of antibiotics
 - d. Do you get colds /viruses often?
5. Travel History
 - a. Countries visited
 - b. Any illness during or after travelling
6. Diet
 - a. Food allergies or intolerances
 - b. Do you have any dietary restrictions, special diet followed? (vegetarian, paleo, gluten free etc.)
 - c. Cravings/aversions
 - d. I ask for a typical breakfast lunch dinner snacks and sweets or treats – some clinicians will get a food diary
 - e. Apps available: lifesum/my fitness pal – very helpful

7. Digestion/ GIT /Gut Microbiome

- a. Appetite, pain/discomfort, burping, reflux, bloating/fullness, nausea, flatulence
- b. Bowel motions – regularity, consistency (Bristol Chart), colour, diarrhoea, constipation, pain, mucous, blood in stool, undigested food
- c. past antibiotics
- d. Pesticide exposure
- e. Amalgams
- f. Severe gut infections
- g. Appendicitis? Ruptured
- h. Ever had a scope??

8. Nervous System

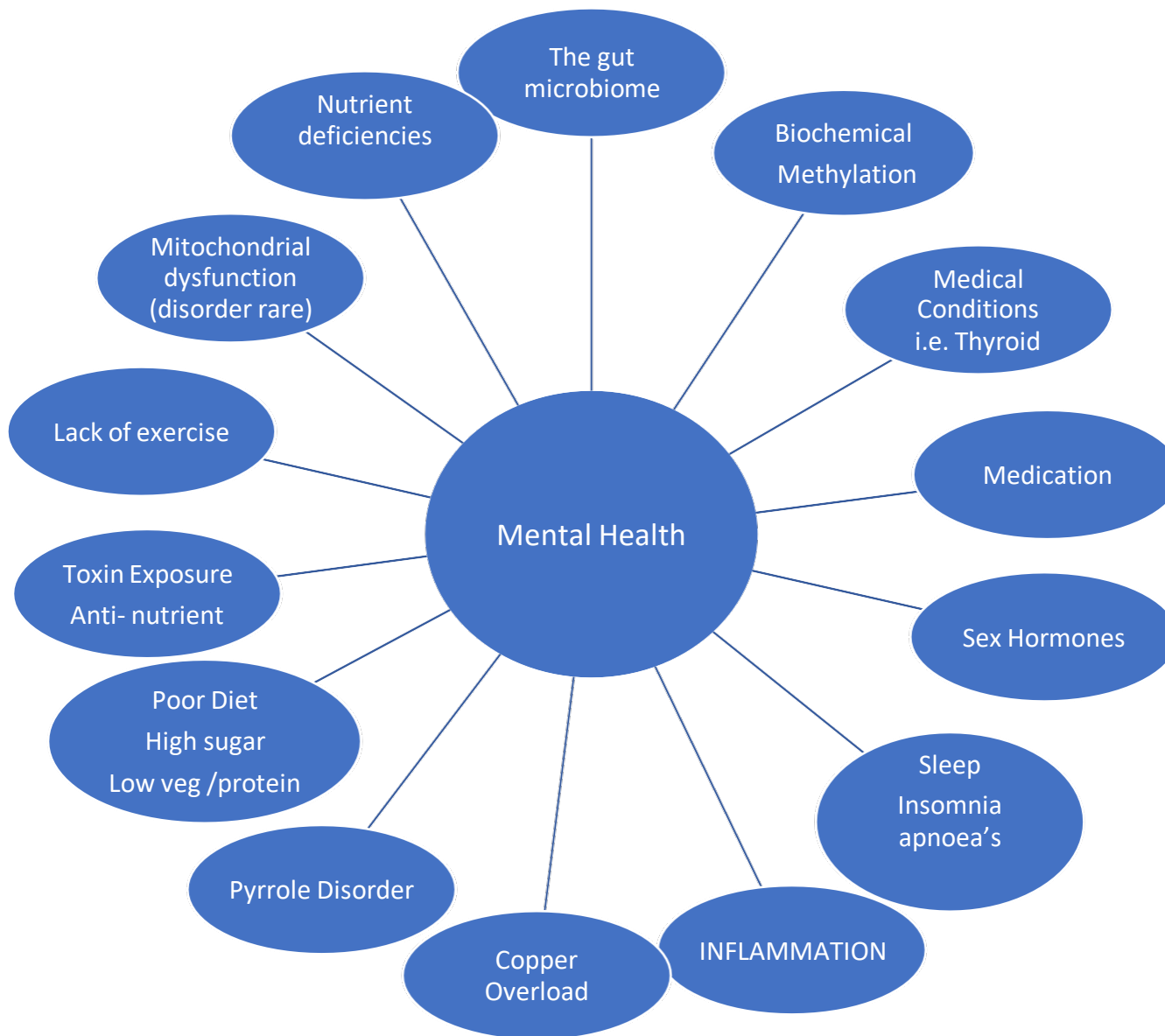
- a. Mood, concentration/memory/recall, anxiety
- b. Have you been anxious since you were a child or did this start after an event
- c. Past trauma

9. Cardiometabolic

- a. Hypoglycaemia – dizziness, craving sweets (especially after meals), mid-afternoon slump
- b. Hyperglycaemia – floaters in eyes, skin tags, central obesity, increased urination, increased thirst, sleepiness after eating
- c. Fluid retention

10. Lifestyle

- a. Stress out of 10 (causes)
- b. Energy out of 10
- c. Relaxation – frequency, duration, type
- d. Exercise – frequency, duration, type
- e. Sleep – quality, quantity, wake refreshed, snoring, do they wake refreshed? Sleep apnoea



Mental Health – Lifestyle Apps Recommended

Meditation

- Buddhify – mindfulness mediation on the go
- Hearts App – Heartfulness Institute (also has CDs etc. on website)
- Insight Timer – free meditation app
- TED Talk by Jim Donovan – Trick your brain to sleep
- Michael Sealey hypnotherapy (via YouTube)








Sleep and Activity

- Sleep Cycle App – sleep analysis & smart alarm clock
- Bellabeat App
- Oura rings – sleep and activity trackers
- Smart phones – sleep and activity trackers
- Yoga/ Down Dog – great yoga anywhere

Patient Handout – Sleep

1. Avoid stimulants that may interfere with sleep – caffeine, alcohol, nicotine
2. Turn your bedroom into a sleep-inducing environment – dark, cool and quiet
3. Establish a soothing pre-sleep routine – relax before bed, bath, no phone/tablets etc.
4. Go to sleep when you are truly tired
5. Don't watch the clock
6. Use light to your advantage – natural light first thing in the morning
7. Keep a consistent sleep schedule to regulate circadian rhythms
8. Nap early or not at all
9. Lighten up on evening meals – finish dinner several hours before bedtime
10. Balance fluid intake – drink during the day not just before bed
11. Exercise early as it can stimulate cortisol – finish at least 3 hours before bed
12. Follow through with the changes

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid

CONSTIPATION

- Constipation is very common - one in seven people report symptoms of constipation.
- If you struggle to empty your bowels or you open your bowels infrequently, you may be constipated. Dry, hard and small pellet-shaped stools are another sign of constipation.
- Constipation can lead to stomach discomfort, nausea and fatigue.

All tied up?

Constipation can be caused by...

- **A lack of dietary fibre.** A special type of fibre called insoluble fibre absorbs water in your bowel and adds bulk to your stool. This is what keeps you regular – without enough insoluble fibre, you may become constipated.
- **Insufficient water intake.** You may be constipated if you don't drink enough water, even if your diet is high in fibre. Fibre draws water into your digestive tract and softens the stool. Without enough water, the bulk in your digestive tract will be hard and difficult to move.
- **Inactivity.** Exercise strengthens the muscles of your digestive system and gets them working, speeding up the transit time of the contents in your bowel.



1. Hard to pass pellets
2. Lumpy, snake-like
3. Snake-like with cracks
4. Smooth, soft, snake-like
5. Soft pellets, easy passed
6. Fluffy, mushy pieces
7. Liquid, watery

Bristol Stool Chart
Stool types 3 and 4 are ideal.

Six tips to get things moving



1. Switch to wholegrains.

Rolled oats, brown rice and wholemeal pasta are higher in fibre than their refined white counterparts. Choose wholegrain options wherever possible.



2. Aim for two and five.

Fruit and vegetables are particularly rich in fibre, especially the skins – so throw away your veggie peeler! Your target is two fruits and five veg a day.



3. Try psyllium.

With more than 80% fibre, a little bit of psyllium goes a long way. Sprinkle a small amount over your cereal, add it to a smoothie or fold it through banana bread batter.



4. Opt for legumes.

Beans, chickpeas and lentils are high in fibre and super economical, so they're a win-win. Try baked beans for breakfast, a chickpea salad for lunch or dhal made from lentils for dinner.



5. Drink enough water.

Females should aim for eight cups a day, and for men, that quota is bumped up to ten.



6. Work on your fitness.

Your target is 30 minutes every single day. The more, the better.

Anti-inflammatory Diet – Patient Handout

	Foods to Enjoy	Foods to Avoid
Carbohydrates	Wholegrains – oats, quinoa, millet, buckwheat, brown & wild rice	Highly refined/ High Glycaemic Index (GL) - white bread, white rice, pasta, cereals, crackers
	Fresh fruits & vegetables – ideally 800g p/day	High sugar – sweets, biscuits, cakes
Fats & oils	Low mercury fish (Salmon, Snapper, Whiting, Blue Grenadier)	High trans and saturated fats – margarine, packaged foods, fried foods, high quantity of red meat, processed red meat
	*Raw nuts	*High mercury fish (shark (Flake), swordfish, barramundi, gemfish, ling, Southern blue tuna, Orange Roughy)
	*Olive oil, coconut oil, flaxseed oil	High omega 6 fats – corn & vegetable oils
Protein	Plant based protein – legumes, chickpeas, soy	Processed meats – salami, sausage, bacon, ham
	*Lean meat – beef, lamb, chicken, kangaroo,	Fatty red meat
	Low mercury fish (Salmon, Snapper, Whiting, Blue Grenadier)	
Herbs & spices	Tumeric, ginger, chilli, cinnamon, oregano, basil, thyme, rosemary, *cocoa	

*Moderate amounts are recommended – 2-3 serves p/week



FIBRE YOUR HEALTH HERO


Fast facts

- Fibre is the indigestible part of plant foods that works to keep your digestive system happy and healthy.
- There are three types of fibre:
 1. **Soluble fibre** – dissolves in water, creating a thick gel in your gut. This slows down digestion and keeps you feeling full. Soluble fibre also helps to lower cholesterol and manage blood sugars.
 2. **Insoluble fibre** – absorbs water which adds bulk to your stool and keeps you regular.
 3. **Resistant starch** – resists digestion in the small bowel and ferments in the large bowel, producing substances which keep your bowel lining healthy.
- Eating enough fibre reduces your risk of heart disease, some cancers and diabetes.

How much fibre do you do?

Males should aim to have 38 grams of fibre per day, while women should aim for 28g per day. These dietary targets have been set in order to reduce your risk of chronic disease.





GRAINS

			
Whole wheat breakfast cereal (1akes) 6.4g fibre per 30g (2/3 cup)	Popcorn 2g fibre per 13g snack pack	Rolled oats 5.8g fibre per half cup (60g)	Wholemeal bread with added grains and seeds 3.5g fibre per slice




FRUIT

			
Passionfruit 7g passionfruit per 50g pulp	Raspberries 7g fibre per punnet (125g)	Pear 5.4g fibre per pear	Grapes 4g fibre per cup (150g)

VEGGIES

			
Carrot 4g fibre per carrot (100g)	Broccoli 3.7g fibre per cup (raw) (75g)	Parsnip 3.6g fibre per parsnip (100g)	Beetroot 5.3g fibre per small beetroot (150g)





LEGUMES

			
Split peas 6.3g fibre per half cup cooked (75g)	Green peas 5g fibre per half cup (frozen) (75g)	Red kidney bean 4.9g fibre per half cup (canned) (75g)	Baked beans 11.4g fibre per 220g can

NUTS/SEEDS

			
Chia seeds 3.4g fibre per tbs (10g)	Linseeds 2.7g fibre per tbs (10g)	Pistachios 2.7g fibre per 30g	Almonds 2.2g fibre per 30g


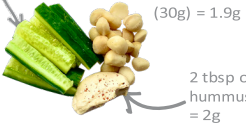



OTHER

			
Psyllium 4.2g fibre per tsp (5g)	Natural crunchy peanut butter 1.3g fibre per tbs (20g)	Hummus 1g fibre per tbs (20g)	Avocado 2.5 g fibre per quarter (50g)

Drinking enough water is key when increasing your fibre intake. Without enough, you could become constipated and experience stomach discomfort.

Your high-fibre day on a plate...

Here's what 30 grams of fibre per day could look like:

<p>1/2 cup natural muesli (with nuts and seeds) = 7g</p>  <p>Muesli, yogurt and fruit</p>	<p>1 banana = 3.6g</p> <p>1 small sliced cucumber (100g) = 1g</p> <p>1 small handful of raw macadamias (30g) = 1.9g</p>  <p>Cucumber, dip and nuts</p>
<p>1 grainy wrap = 4.3g</p>  <p>Tuna wrap</p>	<p>2 tbs of hummus = 2g</p> <p>1 apple = 3.5g</p>  <p>Apple and coffee</p>
<p>2 cups of garden salad = 3.2g</p>  <p>Beef stir fry</p>	<p>1 cup cooked brown rice (100g) = 1.5g</p> <p>1 1/2 cups stir fried mixed veg = 3g</p>

ADULT METHYLATION QUESTIONNAIRE

NAME: _____

DATE: _____

* To be completed by patient

Please indicate by circling which response best describes you, **particularly in an un-medicated and un-supplemented state.**

Mental			
Academic accomplishment in traditional subjects at school e.g. maths, science, literacy	High	Medium	Low
Artistic & musical abilities		No	Strong
Learning difficulties in school including dyslexia	No		Yes
Perfectionistic traits either in past or now	Yes	No	
Motivation	High	Medium	Low
Competitiveness in any area – may be with others or <u>self</u>	High	Medium	Low
May be described as talkative	No		Yes
May be described as hyperactive at times		No	Yes
Religious beliefs		No	Yes
Emotional			
Anxiety or inner turmoil	Outwardly calm with marked inner anxiety	None	Anxiety which is evident to all and can become panic
Phobias	Yes	No	
Obsessive compulsive or ritualised behaviours	Yes	No	
Strong sense of routine, order & control e.g. diet, cleaning, work	Yes		No – but try to keep routine doesn't often work out that way
Tendency to collecting things → hoarding	Yes	No	
Insomnia – generally difficult to wind down → severe insomnia	Yes	No	
Previous or current diagnoses of	OCD or Anorexia or Bulimia or Addictions of any sort		Panic Attacks or ADHD or Psychoses including schizophrenia

Physical features			
Allergies & sensitivities	Inhalant e.g. hayfever, dust mite	Neither	Chemical e.g. perfumes OR food intolerances such as salicylates
Metabolic rate	Fast – tendency to slimness	Average	Slow – tendency to overweight
Athleticism	Strong	Neither	Poor
Libido when in relationship	High	Average	Low
Response to Previous Medications & Nutrients			
Response to anti-histamines	Positive	NA or Unknown	Negative
Mood response to antidepressants e.g. any medications use to increase serotonin levels	Positive	NA or Unknown	Negative
Mood response to Valium, Xanax, Temazepam, Lorazepam	Minor benefit, No effect or Negative	NA or Unknown	Strong Positive
Oestrogen e.g. contraceptive pill, HRT	Positive	NA or Unknown	Negative
Mood response to SAMe	Positive or nil	NA or Unknown	Negative
Mood response to folic acid	Negative	NA or Unknown	Positive or nil
Pathology Test Results (to be filled in by clinician when available)			
Whole Blood Histamine	> 0.55umol/L	0.4-0.55 umol/L	<0.4 umol/L
Basophils	Tend to be > 0.02	NA or Unknown	Tend to be < 0.02
Homocysteine	Tends to be low < 7	NA or Unknown	Tends to be high > 9
Elevated Copper		No	Yes
<p>How to Calculate Column Totals</p> <ul style="list-style-type: none"> • Award 0 points to each 'NA or Unknown' • Award 1 point per answer in unshaded rows <p>Award 2 points per answer in green shaded rows</p>			
Marked dominance of 1 column total suggestive of	Under	Neither	Over

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** ...
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____
2. Did a parent or other adult in the household **often** ...
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____
3. Did an adult or person at least 5 years older than you **ever**...
Touch or fondle you or have you touch their body in a sexual way?
or
Try to or actually have oral, anal, or vaginal sex with you?
Yes No If yes enter 1 _____
4. Did you **often** feel that ...
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____
5. Did you **often** feel that ...
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____
6. Were your parents **ever** separated or divorced?
Yes No If yes enter 1 _____
7. Was your mother or stepmother:
Often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 _____
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
Yes No If yes enter 1 _____
10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

DASS 21 NAME _____ DATE _____

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all – NEVER
- 1 Applied to me to some degree, or some of the time – SOMETIMES
- 2 Applied to me to a considerable degree, or a good part of time – OFTEN
- 3 Applied to me very much, or most of the time – ALMOST ALWAYS

FOR OFFICE USE

		N	S	O	AA	D	A	S
1	I found it hard to wind down	0	1	2	3			
2	I was aware of dryness of my mouth	0	1	2	3			
3	I couldn't seem to experience any positive feeling at all	0	1	2	3			
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3			
5	I found it difficult to work up the initiative to do things	0	1	2	3			
6	I tended to over-react to situations	0	1	2	3			
7	I experienced trembling (eg, in the hands)	0	1	2	3			
8	I felt that I was using a lot of nervous energy	0	1	2	3			
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3			
10	I felt that I had nothing to look forward to	0	1	2	3			
11	I found myself getting agitated	0	1	2	3			
12	I found it difficult to relax	0	1	2	3			
13	I felt down-hearted and blue	0	1	2	3			
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3			
15	I felt I was close to panic	0	1	2	3			
16	I was unable to become enthusiastic about anything	0	1	2	3			
17	I felt I wasn't worth much as a person	0	1	2	3			
18	I felt that I was rather touchy	0	1	2	3			
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3			
20	I felt scared without any good reason	0	1	2	3			
21	I felt that life was meaningless	0	1	2	3			

DASS Severity Ratings

The DASS is a **quantitative** measure of distress along the 3 axes of depression, anxiety¹ and stress². It is not a categorical measure of clinical diagnoses.

Emotional syndromes like depression and anxiety are intrinsically dimensional – they vary along a continuum of severity (independent of the specific diagnosis). Hence the selection of a single cut-off score to represent clinical severity is necessarily arbitrary. A scale such as the DASS can lead to a useful assessment of **disturbance**, for example individuals who may fall short of a clinical cut-off for a specific diagnosis can be correctly recognised as experiencing considerable symptoms and as being at high risk of further problems.

However for clinical purposes it can be helpful to have ‘labels’ to characterise degree of severity relative to the population. Thus the following cut-off scores have been developed for defining mild/moderate/severe/extremely severe scores for each DASS scale.

Note: the severity labels are used to describe the full range of scores in the population, so ‘mild’ for example means that the person is above the population mean but probably still way below the typical severity of someone seeking help (ie it does not mean a mild level of disorder).

The individual DASS scores do not define appropriate interventions. They should be used in conjunction with all clinical information available to you in determining appropriate treatment for any individual.

¹Symptoms of psychological arousal

²The more cognitive, subjective symptoms of anxiety

DASS 21 SCORE

DEPRESSION SCORE ANXIETY SCORE STRESS SCORE

--	--	--

	Depression	Anxiety	Stress
Normal	0 – 4	0 – 3	0 – 7
Mild	5 – 6	4 – 5	8 – 9
Moderate	7 – 10	6 – 7	10 – 12
Severe	11 – 13	8 – 9	13 – 16
Extremely Severe	14 +	10 +	17 +