



McLaughlin Health Risk Assessment

The following questions along with your other exam findings, will help us determine the cause of your health issues. Inflammation is the underlying cause of all disease and these symptoms may indicate inflammation in your body. The answers will help us identify potential threats to your health and areas we need to work on to prevent chronic pain and disease. Please be as honest as possible with your answers and tell us what we “need” to hear and not necessarily what we “want” to hear.

1. Do you have a family history of early cardiovascular disease (Heart attack, Bypass, transplant or stroke (a male relative affected before age 55 or a female relative affected before age 65)?

- a. No
- b. No but I do have a family member with later onset heart disease
- c. Yes, on one side of the family
- d. Yes on both sides of the family
- e. Yes, and it is present in multiple generations

2. Do you have bleeding gums or gum disease? (Check all answers that apply)

- a. Never
- b. I usually don't floss but my gums never bleed or hurt:
- c. I usually don't floss my teeth but my gums are sensitive:
- d. Yes, when I brush or floss
- e. My gums bleed without even having to floss my teeth

3. Which of the following best describes your sleep patterns?

- a. I sleep soundly 7-8 hours a night
- b. I sleep but restlessly for 6-8 hours a night
- c. I sleep less than 7 hours or more than 9
- d. I sleep less than 5 hours of poor quality sleep per night
- e. I sleep less than 4 hours a night

4. Do you snore?

- a. No
- b. Yes, occasionally
- c. Yes, frequently and loudly
- d. Yes, and I have sleep apnea
- e. Yes and I have sleep apnea and so does at least one family member

5. Do you have rheumatoid arthritis, Celiac's disease, a thyroid condition, psoriasis, lupus or any other inflammatory/autoimmune disease?

- a. No
- b. Yes, but it is controlled by medication
- c. Yes, even though I am taking medication I still have consistent symptoms
- d. Yes and symptoms are consistent and debilitating with or without medication
- e. Yes and so does at least one family member

6. Have you been checked for vitamin D deficiency?

- a. My vitamin D level is between 60-80
- b. My vitamin D level is between 40-60
- c. My vitamin D level is between 30-40
- d. My vitamin D level is lower than 30
- e. I do not know my vitamin D level

7. Do you have a history of migraine headaches?

- a. No
- b. Occasionally, but with no migraine aura
- c. Yes on a regular basis, with no migraine aura
- d. Yes on a regular basis, with a migraine aura
- e. My headaches are debilitating, are all consuming and I have lost the ability to function

8. How would you characterize your ability to cope with stress?

- a. I'm usually pretty laid back
- b. I have stress but I have healthy ways to cope with stress
- c. Sometimes people say that I seem stressed
- d. I feel stressed and anxious most of the time
- e. I feel stress all of the time and it is interfering with my life and my relationships

9. How much *TOTAL* time do you spend sitting (job, driving, home, TV, computer etc.)?

- a. Less than 5 hours:
- b. Less than 7 hours:
- c. More than 9 hours:
- d. More than 11 hours:
- e. More than 13 hours:

10. How much formal exercise (cardio, mobility and strength training) do you get?

- a. At least 30 minutes, 5 to 7 days per week
- b. At least 30 minutes 2 to 4 times per week
- c. At least 30 minutes 1 to 2 times per week
- d. 30 minutes, once a week or less
- e. I do not exercise

11. Do you smoke or use tobacco products?

- a. No
- b. I used to smoke, but have quit for at least 5 years
- c. I used to smoke, but quit less than 5 years ago
- d. I am exposed to second hand smoke regularly
- e. I smoke/use smokeless tobacco products infrequently (1-3 times per day)
- f. I smoke/use smokeless tobacco products on a regular basis? (More than 3 times per day)

12. Do you drink regular or diet soft drinks?

- a. Never
- b. Rarely drink soda (diet or regular)
- c. Once a week (diet or regular)
- d. 2-3 per week:
- e. Once or more a day

13. (Women only): Did you experience high blood pressure or gestational diabetes during pregnancy?

- a. No
- b. Yes

13. (Men only): Do have erectile dysfunction?

- a. No
- b. Yes

14. Do you take supplements daily that were recommended or prescribed by your health care provider?

- a. Yes, every day
- b. Yes, but only 5 days per week
- c. Yes, when I remember
- d. Not that were recommended by a health care provider but I do take supplements
- e. No, I don't take any supplements

15. Do you have diabetes or high blood sugar?

- a. No
- B. No but I have a family member that does
- b. Yes, I'm pre-diabetic
- c. Yes, I'm insulin resistant
- d. Yes, I'm diabetic
- e. I haven't had my blood sugar tested

16. Do you have pain of any kind?

- a. No
- b. Yes, 1-2 times per month
- c. Yes, 1-2 times per week
- d. Yes, more than 1-2 times per week
- e. Yes, every day and constant

17. Do you have healthy relationships and a rich social network of friends and activities?

- a. Absolutely, totally agree
- b. Somewhat agree
- c. I wouldn't call it "rich" but I have friends and see them from time to time
- d. I really don't have a lot of friends and see them occasionally
- e. I don't have any friends and I really like it that way

18. Do you drink alcohol?

- a. No
- b. Yes, 1-2 glasses 3x or less per week (3-6 glasses total)
- c. Yes, 1-2 glasses 7x per week (7-13 glasses total)
- d. Yes, more than 2 glasses 7x per week (14+ glasses total)
- e. Yes, every day and more than 3 drinks in a day

19. Do you eat meals or snacks that contain sugar in any form like cookies, cakes, candy, pastas, sugar-laden sauces such as ketchup, breads, etc.?

- a. No, never
- b. Yes, monthly 1-4 meals or snacks contain sugar
- c. Yes, weekly 2-3 meals or snacks contain sugar
- d. Yes, daily 2-3 meals or snacks contain sugar
- e. Yes, daily 4+ meals or snacks contain sugar

20. Are you taking medication for chronic medical problems such as digestive disorders; cardiovascular problems; high cholesterol; headaches; chronic pain; blood sugar problems; chronic fatigue; immune problems or chronic infections; or any other chronic conditions?

- a. No
- b. 1 medication
- c. 2 medications
- d. 3 medications
- e. 4 + medications

Scoring The McLaughlin Health Risk Assessment

Add the number of a. answers: _____ Multiply by 5 and place here: _____

Add the number of b. answers: _____ Multiply by 4 and place here: _____

Add the number of c. answers: _____ Multiply by 3 and place here: _____

Add the number of d. answers: _____ Multiply by 2 and place here: _____

Add the number of e. answers: _____ Multiply by 1 and place here: _____

Add your total score for the test: _____

