**HARPER HEALTH INDICATOR TEST**

**Instructions**

Check off each symptom that you have according to its severity.

1. Means you ***never*** have the symptom
2. Means it is ***mild*** when it occurs or it occurs occasionally
3. Means ***moderate*** or occurs at least once a week
4. Means ***severe*** or occurring frequently

Multiply the number of check in each column by the number at the top of the column and then add the numbers in the three columns to get your total score.

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| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **0** | **1** | **2** | **3** |  | |  |  |  |  | Tired all the time | |  |  |  |  | Hungry between meals or at night | |  |  |  |  | Depressed | |  |  |  |  | Insomnia | |  |  |  |  | Wake up after few hours of sleep | |  |  |  |  | Fearful (overwhelmed by people, places, or things) | |  |  |  |  | Can’t really decide easily | |  |  |  |  | Can’t concentrate | |  |  |  |  | Poor memory | |  |  |  |  | Worry frequently | |  |  |  |  | Feel insecure or low self-image | |  |  |  |  | Highly emotional | |  |  |  |  | Moody | |  |  |  |  | Cry easily, or feel like crying inside | |  |  |  |  | Fits of anger | |  |  |  |  | Magnify insignificant details (make mountains out of mole-hills) | |  |  |  |  | Eat candy, cake, cookies, or drink soda pop | |  |  |  |  | Eat bread, pasta, potatoes, rice, or beans | |  |  |  |  | Consume alcohol | |  |  |  |  | Drink more than 3 cups of coffee or cola drinks a day | |  |  |  |  | Crave candy, soda, or coffee between meals or mid-afternoon | |  |  |  |  | Can’t work well under pressure | |  |  |  |  | Headaches | |  |  |  |  | Sleepy or drowsy after meals | |  |  |  |  | Lack of energy | |  |  |  |  | Reduced initiative | | |  |  |  |  |  | | --- | --- | --- | --- | --- | | **0** | **1** | **2** | **3** |  | |  |  |  |  | Eat when nervous | |  |  |  |  | Stomach cramps or “nervous stomach” | |  |  |  |  | Allergies: asthma, hay fever, skin, sinus trouble, etc. | |  |  |  |  | Fatigue relieved by eating | |  |  |  |  | Suicidal thoughts or tendencies, feelings of hopelessness | |  |  |  |  | Bored | |  |  |  |  | Bad dreams | |  |  |  |  | Irritable before meals | |  |  |  |  | Heart beats fast (palpitations) | |  |  |  |  | Get shaky inside if hungry | |  |  |  |  | Feel faint if meal is delayed | |  |  |  |  | Ulcers, gastritis, chronic indigestion, abdominal bloating | |  |  |  |  | Cold hands or feet | |  |  |  |  | Trembling (shaking) of the hands | |  |  |  |  | Blurred vision | |  |  |  |  | Bleeding gums | |  |  |  |  | Dizziness, giddiness, or light-headedness | |  |  |  |  | Aware of breathing heavily | |  |  |  |  | Bruise easily | |  |  |  |  | Reduced sex drive | |  |  |  |  | Incoordination (drop or bump into things) | |  |  |  |  | Swearing excessively | |  |  |  |  | Unsocial or anti-social behavior | |  |  |  |  | Muscle twitching or cramps | |  |  |  |  | Excessive thirst | |  |  |  |  | Phobias | |  |  |  |  | Weight change | |

**Patient’s Name**: Click here to enter your name

**Date**: Click for Date

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| --- | --- | --- | --- | --- |
| **Total Boxes ticked in the “0 Column”** | Enter number | | **X 0 =** | **0** |
| **Total Boxes ticked in the “1 Column”** | Enter number | | **X 1 =** | Value of Boxes ticked X 1 |
| **Total Boxes ticked in the “2 Column”** | Enter number | | **X 2 =** | Value of Boxes ticked X 2 |
| **Total Boxes ticked in the “3 Column”** | Enter number | | **X 3 =** | Value of Boxes ticked X 3 |
| **Total Score** | | Value of Numbers Added Above |