

HRISMIMT-QUESTIONNAIRE: IMMUNE HEALTH

PART 1: PATIENT TO FILL OUT

Name : _____ Date: _____

Please fill in the following questionnaire to assist your Practitioner in gaining information about your current symptoms and health concerns. Please answer all questions in each section.

GENERAL ASSESSMENT:

Please review the list below and tick the answer that best describes your experience over the past month.

How many hours do you sleep most nights?	<5	5-7	7-8	9+
How stressed do you usually feel on a scale of 0 to 10? (0 = least amount, 10 = highest amount)	0-2	3-5	6-7	8-10
How much time do you spend exercising?	minutes per week		times per week	
Are you a smoker?	Yes		No	
How much alcohol do you drink on weekdays?	standard drink/s			
How much alcohol do you drink on weekends?	standard drink/s			
Have you ever received a vaccine? If so, how often?	Never	Once or Twice	Annually	
Have you ever experienced an adverse reaction to the influenza vaccine or any other vaccination?	Yes		No	
Please list any vaccination/s you have received and detail any adverse reactions:				
How many serves of fruit and vegetables do you consume daily? (i.e. 1 serve = ½ cup)	0-3	4-6	7-8	9+
How many glasses of water do you drink per day? (i.e. 1 glass = 1 cup of water = 250 mL)	0-3	4-6	7-8	9+

TREATMENT PRIORITISATION:

This section assists your Practitioner in streamlining your prescription to select the most appropriate treatment/s for your needs. Please review the list below and tick the answer that best represents your current health. Please tally your score for each section.

SECTION 1	0	1	2	3
How often have you experienced cold and flu symptoms (e.g. fever, sore throat, runny nose, coughing and/or lethargy) in the last 12 months?	<1	1-2	3-4	5+
Do you feel like you catch a cold or the flu more frequently than people around you (e.g. family members or co-workers)?	No			Yes
On average, how many days does a cold or flu limit you from your regular activities, such as work or exercise?	<1	1-2	3-4	5+
Total				
Section 1 Total				

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SECTION 2	0	1	2	3
Do you struggle with lingering symptoms that persist following cold and flu recovery, such as nasal congestion or post nasal drip?	No			Yes
In the last year, how often have you experienced recurring episodes of the same infection/symptoms of relapsing infections (i.e. sinusitis, tonsillitis, bronchitis, cold sores or skin infections e.g. Staphylococcus)?	0	1-2	3-4	5+
Do you experience prolonged fatigue or struggle to 'feel well' in the weeks following a cold or flu?	No			Yes
Total				
Section 2 Total				

SECTION 3	0	3
Do you have a history of chronic infections (e.g. Epstein-Barr virus, shingles, hepatitis, tick-borne infections, sexually transmitted infections [STIs] etc.)?	No	Yes
Have you ever experienced persistent fatigue for longer than 3 months following an infection? Do you experience ongoing relapses of chronic fatigue syndrome (CFS)?	No	Yes
Are you considered to be immunosuppressed (i.e. diagnosed with immune deficiency illness or autoimmune disease), or have you received immunosuppressive treatments in the last two years (i.e. treatments for organ transplant, corticosteroids treatments, chemotherapy etc.)?	No	Yes
Total		
Section 3 Total		

SECTION 4	0	1	2	3
Do you experience allergy symptoms (e.g. itchy skin or eyes, swelling, or asthmatic cough) that worsen seasonally or when you are exposed to animal dander, pollen or particular foods (i.e. wheat, dairy, soy or nuts)?	No			Yes
How often do you use treatments such as steroid creams, antihistamines or steroid inhalers to manage allergy symptoms (i.e. eczema, hay fever or asthma)?	Rarely	Once a month	Once a week	Daily
How much do your allergies impact your daily life?	None	A little	Moderate	Severe
Total				
Section 4 Total				

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SECTION 5					
5a		0		3	
Have you been diagnosed with a chronic inflammatory or autoimmune disease that is difficult to manage (i.e. difficult to control symptom flares or maintain remission from pain)?		No		Yes	
		Section 5a Total			
5b		0	1	2	3
How often do you use treatments to manage chronic inflammatory symptoms (i.e. joint pain, back pain, pain caused by past injuries)?		Rarely	Once a month	Once a week	Daily
How much do your symptoms impact your daily life?		None	A little	Moderate	Severe
Total					
		Section 5a + 5b Total			
5c		0		3	
Do you suffer from loss of cartilage that makes joint mobility painful?		No		Yes	
Have you experienced a progressive worsening in pain symptoms (e.g. muscle, joint or nerve pain) over the last 12 months?		No		Yes	
Total					
		Section 5a + 5c Total			

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PREVENTATIVE NUTRITION

SECTION 6		0	1	2	3
Have you followed a vegan or vegetarian diet over the last 12 months?		No			Yes
In the last six months, have you taken prescribed medicines such as the oral contraceptive pill, antacids (reflux medication), diuretics, or have required the ongoing use of non-steroidal anti-inflammatories (NSAIDs)?		No			Yes
Have you ever been diagnosed with coeliac disease or inflammatory bowel disease (IBD) or any condition that reduces nutrient absorption?		No		Yes	
Total					
Section 6 Total					

SECTION 7		0	1	2	3
From spring to autumn, how much time per day do you spend in direct sunlight with arms exposed between 10 am and 2 pm? *Please tick one answer depending on current season.	Spring -Autumn	>30 minutes	<15 minutes	<5 minutes	0 minutes
	Winter	>40 minutes	15-30 minutes	7-15 minutes	<7 minutes
Do you have naturally dark brown skin (i.e. Fitzpatrick skin phototype V-VI)?		No		Yes	
Do you live in a southern region below a latitude of 35° (i.e. Canberra, Adelaide, Melbourne, Hobart or New Zealand) during the winter months of the year?		No			Yes
In the last three months, have you had your vitamin D levels assessed and determined to be insufficient (i.e. <40-50 nmol/L)? (Leave blank if unsure)		No			Yes
Total					
Section 7 Total					

* During summer, individuals with pale to moderate brown skin require 6 to 7 minutes of sun exposure (i.e. full arm exposure or equivalent area). In individuals with dark brown skin, 15 to 50 minutes is recommended. In winter, individuals with pale to moderate brown skin require between 7 to 40 minutes of sun exposure daily. In individuals with dark brown skin, it may not be possible to maintain vitamin D levels through sun exposure alone in southern states

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PART 2: PRACTITIONER TO FILL OUT

Herbal Formula

Add the scores of sections one to five in Part 1 and enter the total into the 'score' column below:

- Rank each section based on the score in descending order (i.e. 1 is the top score, 2 is the second highest etc).
- Rank 1 indicates the most relevant prescription for your patient.
- If the top scores are close, check the questions relevant to the section and ascertain which formula is most indicated for your patient's needs or contact Clinical Support on +1-304-914-4772

SECTION	FORMULA	SCORE	RANK
1			
2			
3			
4			
5a + 5b			
5a + 5c			

** The [IMT Wellness Product - Four Phase Program](#) is designed to address the core drivers of allergy and reactivity by managing the effects of dietary allergens, digestive enzymes, gut microbiota, intestinal barrier function and immune reactivity. The program outlines key evidence-based strategies to minimise symptom severity in addition to outlining specialised diets to promote the reduction of allergy symptoms.

Probiotic Formula

Choose the most appropriate probiotic formula for the patient's presentation below:

To <i>stimulate</i> the immune response during acute, recurrent and chronic infections.	
To <i>regulate</i> the immune response in patients with allergic conditions (i.e. eczema, hay fever and asthma) or inflammatory conditions (i.e. autoimmune disease).	

Preventative Nutritional Support

Add the scores of sections six to seven in Part 1 and enter the total into the 'score' column below:

- Rank each section based on the score in descending order (i.e. 1 is the top score, 2 is the second highest etc.).
- Rank 1 indicates the most relevant prescription for your patient to enhance nutritional status, however both products may be indicated.

SECTION	FORMULA	SCORE	RANK
6			
7			