

Thyroid Appraisal Indicator (TAI)

INSTRUCTIONS: IF YOU HAVE ANY OF THE FOLLOWING PROBLEMS, INDICATE "YES" WITH A CHECK MARK, ADD THEM UP AND ENTER YOUR SCORE BELOW ALONG WITH YOUR NAME (PRINTED) AND DATE

INTERPRETATION: ONE OR MORE SYMPTOMS/PROBLEMS MAY BE SEEN IN HYPOTHYROIDISM

TAI SCORE: _____ **NAME:** _____ **DATE:** _____

- | | |
|--|--|
| <input type="checkbox"/> Low energy, excessive fatigue | <input type="checkbox"/> Low motivation and ambition |
| <input type="checkbox"/> Repetitive infections, e.g. colds, sore throats, sinus, ears, urinary tract, yeast, skin-acne | <input type="checkbox"/> Low self-esteem |
| <input type="checkbox"/> Circulatory disturbances | <input type="checkbox"/> Dizziness, lightheadedness |
| <input type="checkbox"/> Chronic skin condition | <input type="checkbox"/> Food intolerances |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Increased susceptibility to substance abuse-caffeine, nicotine/smoking |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Anxiety/panic attacks |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Myxedema (drooping, swollen eyes) |
| <input type="checkbox"/> Coarse Hair | <input type="checkbox"/> Dry eyes/blurred vision |
| <input type="checkbox"/> Brittle nails | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Extreme sensitivity to cold in hands/feet | <input type="checkbox"/> Elevated cholesterol |
| <input type="checkbox"/> Chronic boils | <input type="checkbox"/> Digestive problems-irritable bowel syndrome, acid, indigestion, constipation, leaky gut syndrome, toxic bowel, etc. |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Poor coordination |
| <input type="checkbox"/> "Winter" itch | <input type="checkbox"/> Diminished sex drive |
| <input type="checkbox"/> Fish Skin | <input type="checkbox"/> Inhibited sexual development |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Food cravings |
| <input type="checkbox"/> Headaches- chronic, migraine, tension | <input type="checkbox"/> Yellow-orange coloration on skin (particularly palms) |
| <input type="checkbox"/> Menstrual problems- irregular, painful, excessive periods; PMS | <input type="checkbox"/> Slow speech |
| <input type="checkbox"/> Infertility problem (male or female) | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Neurotic tendency | <input type="checkbox"/> Arthritis, joint aches |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Inappropriate weight gain |
| <input type="checkbox"/> Emotionally explosive | <input type="checkbox"/> Carpal Tunnel Syndrome |
| <input type="checkbox"/> Cold Skin | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Sensitivity of cold at temperatures comfortable to others | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Skin pallor | <input type="checkbox"/> Skin-flushing, pigment changes |
| <input type="checkbox"/> Hair loss | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Labored or difficult breathing | <input type="checkbox"/> Very tired after eating |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Consume aspartame, e.g. Nutrasweet, Equal, sugarless foods and products |
| <input type="checkbox"/> Swelling-feet, eyelids; fluid retention | <input type="checkbox"/> Consume fluoride, e.g. water, beverages, drugs, dental treatments, prescription medications |
| <input type="checkbox"/> Decreased/increased sweating | <input type="checkbox"/> Consume soy products |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Teeth missing, root canal, crown, upper |
| <input type="checkbox"/> Palpitations | |
| <input type="checkbox"/> Poor equilibrium, coordination | |
| <input type="checkbox"/> Muscle aches and weakness | |
| <input type="checkbox"/> Hearing disturbances | |
| <input type="checkbox"/> Burning and pricking sensitivity | |
| <input type="checkbox"/> Have or have had silver amalgam fillings in teeth | |
| <input type="checkbox"/> Loss of outer 1/3 of eyebrows | |
| <input type="checkbox"/> Low body temperature | |
| <input type="checkbox"/> Dry skin/hair | |
| <input type="checkbox"/> Insomnia, narcolepsy, falling asleep uncontrollably during day | |

#3, 14: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

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