HEALTH ASSESSMENT

Name_____

Address_____

_____

Home Phone_____

Cell Phone_____

Business Phone_____

Fax_____

E-Mail Address_____

Preferred Method of Contact: Home_____ Cell_____ Business_____ E-mail_____
(mark all that apply)

Date of Birth_____ **Age**_____

Family Status: Single_____ Married_____ Significant Other_____

Partner's Name_____

Number of Children Living at Home and Ages:_____

Occupation:_____

Employer:_____

Ethnicity:_____ **Last Grade Completed:**_____

Date_____

When was the last time you saw a doctor for a check-up or illness?_____

In the past 12 months, how many times did you see a doctor about your health?_____

During the past year, how many days did you miss from work or have to curtail your regular activities due to illness?_____

In the past 12 months, how many days were you in the hospital?_____

Comparing your health to others of your age, how would you rate your health?

____Excellent
____Good
____Fair
____Poor

List Allergies to Medicine and describe allergic reaction:

_____
_____
_____

List all medications, both prescription and over-the-counter:

Medication	Condition	Dosage

List all supplements, vitamins, nutraceuticals: (You may copy labels and submit them)

Supplement	Condition	Dosage

List any diagnostic or surgical procedures you have had, including inpatient and outpatient procedures. List year of occurrence.

_____
_____
_____

List hospitalizations, reason, and year.

_____
_____
_____

List injuries, car accidents, fractures and year.

_____
_____

List environmental exposures and year.

Asbestos_____ Coal Dust_____
Chemicals_____ Sun exposure, tanning_____
Fumes, gases_____ Radon exposure_____
X-ray treatments_____

Check the column that applies to you and your family:

Condition	Myself	Sibling	Mother	Father	Grandparents
1. Heart Disease					
2. Cancer (list type)					
3. Diabetes					
4. Arthritis					
5. Liver Disease					
6. Psychiatric Disease					
7. Autoimmune Disease					
8. Thyroid Disease					
9. Stroke					
10. Parkinsons					
11. Alzheimers					
12. Pulmonary Disease					
13. Sleep apnea, snoring					
14. Kidney Disease					
15. Stomach Disorders					
16. Bowel Disease					
17. Bladder Disease					
18. Obesity					
19. Osteoporosis					

Condition	Myself	Sibling	Mother	Father	Grandparents
20. Migraine Headache					
21. Anemia					
22. HIV/AIDS					
23. Allergies, environmental					
24. Allergies, food					

Please note the number and give an explanation for checked items:

_____
_____
_____
_____
_____
_____

REVIEW OF SYMPTOMS

SKIN AND HAIR	**Mild**	**Moderate**	**Severe**	**N/A**
Dry, brittle hair				
Dry skin				
Brittle nails				
Acne				
Age spots				
Puffy, wrinkled skin				
Dark circles under eyes				
Hair thinning or falling out				
Bumpy skin on face or back of arms				
Spider veins on nose or face				
Persistent skin rash				
Slow or poor wound healing				
Bruise easily				
Excess hair growth				
Skin tags				

CARDIOPULMONARY **Mild Moderate Severe N/A**

Chest pain at rest_____
Chest pain during exercise_____
Other pain in chest or sides_____
Frequent upper respiratory infections(colds)_____
Fluid retention (swollen ankles)_____
Difficulty exercising_____
Wheezing_____
Leg cramps or pain while walking_____
Palpitations, irregular heart beat_____
Rapid heart beat_____
Shortness of breath_____
Sleep apnea_____
Anemia or history of anemia_____
High cholesterol or lipids?_____
On medication for cholesterol? ____yes ____no
High blood pressure_____
On medication for blood pressure? ____yes ____no

METABOLIC AND IMMUNE SYSTEMS

Loss of outer portion of eyebrow_____
Cold intolerance_____
Heat intolerance_____
Cold hands and feet_____
Overweight problems_____
Difficulty gaining or maintaining weight_____
Diabetes_____
Overactive thyroid (hyperthyroid)_____
Underactive thyroid (hypothyroid)_____
Sweet cravings_____
Feel weak if missed meal_____
Feel irritable or shaky if missed meal_____
Increased thirst_____
Need to drink caffeine to "get going"_____
Increased abdominal fat_____
Decreased muscle tone or mass_____
Fatigue/low energy_____

URINARY SYSTEM **Mild Moderate Severe N/A**

Frequent urinary infections_____
Frequent urination_____
Night time urination_____
Slow stream with urination_____
Urinary urgency (feeling need to void)_____
Loss of bladder control with urge_____
Loss of bladder control with cough, laugh, sneeze_____
Burning or pain with urination_____
Blood in urine_____
Diagnosed with overactive bladder or interstitial cystitis? ____yes ____no
History of kidney infection (pyelonephritis)? ____yes ____no

GASTROINTESTINAL SYSTEM **Mild Moderate Severe N/A**

Abdominal pain_____
Nausea and/or vomiting_____
Heartburn, indigestion_____
Chronic constipation_____
Chronic diarrhea_____
Alternating diarrhea and constipation_____
Flatulence (gas) or bloating_____
Blood in stool? ____yes ____no Annual exam for blood in stool? ____yes ____no
Mucous in stool? ____yes ____no Annual rectal exam? ____yes ____no
Gallstones/gall bladder pain? ____yes ____no
Liver disease? ____yes ____no Colonoscopy date_____
Inflammatory bowel disease (Crohn's or Ulcerative Colitis)? ____yes ____no

NEUROLOGICAL SYSTEM **Mild Moderate Severe N/A**

Migraine headaches_____
Severe headaches weekly or more often_____
Feel faint or weak_____
Seizures (convulsions)_____
Tremors_____
Dizziness_____
Tingling or numbness_____
Balance problems_____
Memory problems_____
Lack of mental focus_____
Problems with attention and concentration_____
Lack of mental alertness_____

PSYCHO-PHYSIOLOGIC **Mild Moderate Severe N/A**

Insomnia_____
Hypersomnia (sleeping too much)_____
Rapid Mood Swings_____
Impatient, moody, nervous_____
Depression_____
Anxiety_____
Personality changes_____
Excessive stress_____
Difficulty getting out of bed_____
Currently in psychotherapy? ____yes ____no
History of psychiatric disease? ____yes ____no
History of hospitalization for psychiatric disease? ____yes ____no

EYES, EARS, NOSE, THROAT **Mild Moderate Severe N/A**

Change in vision_____
Blurry vision or tunnel vision_____
Hearing loss_____
Tinnitus (ringing in ears)_____
Nosebleeds_____
Sore throat/hoarseness_____
Sore or bleeding gums_____
Sores in the mouth or lips_____
Annual dental check ups? ____yes ____no
Annual teeth cleaning? ____yes ____no
Brush teeth twice a day? ____yes ____no
Use dental floss daily? ____yes ____no

MUSCULOSKELETAL **Mild Moderate Severe N/A**

Joint pain/swelling/stiffness_____
Arthritis_____
Back pain_____
Limited range of motion of joint_____
Muscle spasms_____
Fibromyalgia_____
Carpal tunnel syndrome_____

FOR MEN ONLY **YES** **NO**

SYMPTOM:

Difficulty maintaining/attaining an erection?_____
Painful ejaculation?_____
Underactive sex drive?_____
Overactive sex drive?_____
Premature ejaculation?_____
Pain in genital area?_____
Infertility?_____
Varicose veins on scrotum?_____
Low sperm count?_____
Penile discharge?_____
Early morning erections?_____
Penile rash, fungal infection (Jock Itch)?_____
Swollen genitals?_____
Swelling in groin?_____
Genital sores?_____
Lump or mass in scrotum?_____
History of sexually transmitted disease?_____
Prostatic hypertrophy (enlarged prostate)?_____
Prostate cancer?_____
Vasectomy? When?_____
History of sexual abuse?_____

MEDICATION

Have you used medication for erectile dysfunction? Which medications and how often?

Do you use anything else to enhance sexual function?

Have you used hormones such as testosterone, DHEA, or Human Growth Hormone? Which ones and when?

LABORATORY

When was your last PSA test?_____ Was it normal_____ or abnormal____

FOR WOMEN ONLY

Pregnancy History-List Number of:

Pregnancies	____
Miscarriages	____
Abortions	____
Ectopic preg	____
Live births	____
Living children	____

History of Infertility? ____yes ____no

Treatment for infertility?_____
_____

History of Sexually Transmitted Disease?	____yes	____no
History of Uterine Fibroids?	____yes	____no
History of Endometriosis?	____yes	____no
History of Ovarian Cysts?	____yes	____no
Pelvic pain	____yes	____no
PCOS (polycystic ovarian syndrome)	____yes	____no

Menstrual History:

Last Normal Menstrual Period _____

Skipped Periods?	____yes	____no
Heavy Periods?	____yes	____no
Irregular Periods?	____yes	____no
Painful Periods?	____yes	____no
Premenstrual Symptoms:		
Bloating	____yes	____no
Water retentions	____yes	____no
Sweets cravings	____yes	____no
Weight gain	____yes	____no
Moodiness	____yes	____no
Irritability	____yes	____no
Depression	____yes	____no
Breast Tenderness	____yes	____no
Headaches	____yes	____no

Contraception History (Circle any that apply):

Intrauterine Device Oral Contraceptives Vasectomy Condoms Diaphragm Sponge Tubal Ligation

Gynecologic Symptoms	**Mild**	**Moderate**	**Severe**	**N/A**
Hot flashes				
Night sweats				
Vaginal dryness				
Lack of lubrication				
Painful sex				
Aversion to sex				
Overactive sex drive				
Underactive sex drive				
Longer to orgasm				
Weak or muffled orgasm				
History of sexual abuse				

Hormone Use

Have you used hormones such as estrogen, progesterone, testosterone, DHEA, other?
List names and types :

_____
_____
_____
_____

Laboratory Testing

When was your last mammogram?_____ Normal?____ Abnormal?____
When was your last pap test? _____ Normal?____ Abnormal?____

WHAT ARE THE SYMPTOMS OR PROBLEMS YOU WANT ME TO HELP YOU WITH?

_____

_____

_____

_____

_____

_____

FOR YOUR CARE TO BE A WIN, WHAT WOULD YOU LIKE TO ACHIEVE?

_____

_____

_____

_____

_____

_____

Life Style Assessment Questionnaire

Name: _____ Date_____

Primary cook in home_____

Numbers of hours worked daily_____weekly_____

Please list the foods that you typically eat and the times you eat them

Breakfast:_____

_____

Lunch:_____

_____

Dinner:_____

_____

Snacks:_____

_____

Beverages / Quantities_____

_____

How many times a week do you:

Use tobacco/ quantity_____

Drink alcohol / quantity_____

Drink soda / quantity_____

Drink caffeinated beverages what and how much_____

Have dessert after a meal?_____

Eat at restaurants_____drive thrus_____take out_____

Prepare breakfast at home_____ lunch_____ dinner_____

Skip meals/ which one_____eat after 7:00 pm_____

Do you use recreational drugs / type_____

What type of regular exercise do you do? Type and length of time

Monday:_____

Tuesday:_____

Wednesday:_____

Thursday:_____

Friday:_____

Saturday:_____

Sunday:_____

How many hours of uninterrupted sleep to you get nightly?_____

How much time do you spend outdoors during the week? _____

And on the weekends? _____

How much time do you spend driving?_____

Do you use a seatbelt? ____yes ____no

What are your hobbies?_____

_____

Do you travel outside the country? ____yes ____no

List the countries you have visited in the past 5 years:_____

_____

Do you consider yourself to be under excessive stress? What are the sources of your stress?_____

_____

_____

***Exercise Readiness Questionnaire* (ERQ)**

Regular exercise is associated with many health benefits. Increasing physical activity is safe for most people. However, some individuals should check with a physician before they become more physically active. Completion of this questionnaire is a first step when planning to increase the amount of physical activity in your life. Please read each question carefully and answer every question honestly:

Yes	No	1) Has a physician ever diagnosed you with a heart condition **and** indicated you should restrict your physical activity?
Yes	No	2) When you perform physical activity, do you feel pain in your chest?
Yes	No	3) When you were not engaging in physical activity, have you experienced chest pain in the past month?
Yes	No	4) Do you ever faint or get dizzy and lose your balance?
Yes	No	5) Do you have an injury or orthopedic condition (such as a back, hip, or knee problem) that may worsen due to a change in your physical activity?
Yes	No	6) Do you have high blood pressure or a heart condition in which a physician is currently prescribing a medication?
Yes	No	7) Are you pregnant?
Yes	No	8) Do you have insulin dependent diabetes?
Yes	No	9) Are you 69 years of age or older **and** not used to being very active?
Yes	No	10) Do you know of any other reason you should not exercise or increase your physical activity?

If you answered yes to any of the above questions, talk with your doctor **before** you become more physically active. Tell your doctor your plan to exercise and to which questions you answer yes.

If you honestly answered no to all questions you can be reasonably certain you can safely increase your level of physical activity **gradually**.

If your health changes so you then answer **yes** to any of the above questions, seek guidance from a physician.

Participant signature	Date

LIFE BALANCE SURVEY **Name:**

1) My health is a low priority	**T**	**F**
2) I shop to relieve stress	**T**	**F**
3) I exercise excessively	**T**	**F**
4) I watch TV excessively	**T**	**F**
5) I am addicted to the computer	**T**	**F**
6) I am a workaholic	**T**	**F**
7) I am a hoarder	**T**	**F**
8) I am sexually compulsive	**T**	**F**
9) I eat compulsively	**T**	**F**
10) I am disorganized at home	**T**	**F**
11) I smoke	**T**	**F**
12) I drink excessive alcohol	**T**	**F**
13) I use illicit drugs	**T**	**F**
14) My spending is out of control	**T**	**F**
15) I eat out frequently	**T**	**F**
16) I eat fast food frequently	**T**	**F**
17) I drink coffee excessively	**T**	**F**
18) I am addicted to Starbucks drinks	**T**	**F**
19) I am addicted to internet porn	**T**	**F**
20) I drive aggressively or recklessly	**T**	**F**

HORMONE HEALTH ASSESSMENT Name:

OVERALL HEALTH		
Do you have reduced energy or are easily fatigued?	Y	N
Do you have insomnia or poor sleep quality?	Y	N
Do you lack a "sense of well-being?"	Y	N
HEALING AND IMMUNITY		
Do you have increased healing time?	Y	N
Do you have decreased joint flexibility?	Y	N
Do you have chronic pain (e.g. arthritis)?	Y	N
Do you have increased susceptibility to illness?	Y	N
BODY COMPOSITION		
Do you have increased body fat?	Y	N
Do you have reduced muscle mass or muscle strength?	Y	N
Do you have reduced exercise performance?	Y	N
HAIR, SKIN, AND BONE		
Do you have decreased hair and nail growth?	Y	N
Do you have thinning skin or hair?	Y	N
Do you have dry hair or skin or brittle nails?	Y	N
Do you have wrinkles or redundant, loose skin?	Y	N
Do you have reduced bone density?	Y	N
METABOLISM		
Do you have elevated blood sugar abnormalities (too high or too low)?	Y	N
Do you have high cholesterol levels?	Y	N
Do you have cold intolerance?	Y	N
Do you have heat intolerance?	Y	N
Have you been diagnosed with a thyroid problem?	Y	N
MENTAL HEALTH		
Do you have reduced memory or concentration?	Y	N
Do you have mood swings?	Y	N
Do you have depression or anxiety?	Y	N
SEXUAL AND REPRODUCTIVE FUNCTION		
Do you have low sex drive (libido)?	Y	N
Do you have low sexual arousal or orgasmic difficulty?	Y	N
Do you have vaginal dryness, or painful sexual intercourse?	Y	N
Do you have PMS?	Y	N
Do you have heavy menses?	Y	N
Do you have painful menses?	Y	N
Do you have hot flashes or night sweats?	Y	N

TOTAL "YES" ANSWERS_____ X 3.3 = TOTAL SCORE_____%

The higher your score, the greater the likelihood that hormone deficiencies are an underlying cause of your problems.

ADRENAL HEALTH ASSESSMENT Name:

Do you frequently have low body temperature? (Less than 98 degrees F)	Y	N
Do you frequently get irritable?	Y	N
Do you have poor memory or concentration?	Y	N
Do you notice palpitations?	Y	N
Do you suffer from allergies or asthma?	Y	N
Do you bruise easily or find your wounds heal slowly?	Y	N
Do you get frequent, chronic infections?	Y	N
Do you have dry, thinning skin?	Y	N
Do you get headaches?	Y	N
Do you have unexplained hair loss?	Y	N
Do you skip meals?	Y	N
Do you have thyroid problems?	Y	N
Is low energy a problem?	Y	N
Do you need caffeine in the morning or after lunch?	Y	N
Do you get cravings for sugar, fat, or salt?	Y	N

Total Points for This Section_____ x 2 = _____%

Are you emotionally overstressed?	Y	N
Do you get tenderness across your lower back?	Y	N
Do you suffer from depression or down moods?	Y	N
Do you have low blood pressure?	Y	N
Do you experience a "second wind" (high energy) at bedtime?	Y	N
Do you get light-headed when sitting or standing from lying down?	Y	N

Total Points for This Section_____ x 5 =_____%

Do you suffer from chronic pain?	Y	N
Do you have hypoglycemia (low blood sugar) symptoms such as headaches, sleepiness, mood swings, or shakiness if skipping meals?	Y	N
Do you suffer from insomnia?	Y	N
Do you have PMS (premenstrual syndrome)?	Y	N
Are you menopausal or peri-menopausal?	Y	N

Total Points for This Section_____ x 8 = _____%

Add the totals for each section to get your GRAND TOTAL:

TOTAL SCORE _____%

The higher your score, the higher your likelihood of having Adrenal Fatigue as a cause of your problems.

BRAIN HEALTH ASSESSMENT Name:

LOW SEROTONIN SYMPTOMS

Do you have loss of pleasure in hobbies and interests?	Y	N
Do you feel overwhelmed with ideas to manage?	Y	N
Do you have feelings of depression?	Y	N
Do you feel like you are not enjoying life?	Y	N
Do you get depressed when it is cloudy or when there is lack of sunlight?	Y	N
Do you have decreased enjoyment of your favorite foods?	Y	N
Do you have decreased enjoyment of friendships and relationships?	Y	N
Are you unable to fall into deep restful sleep?	Y	N
Do you feel more susceptible to pain?	Y	N
Do you have feelings of unprovoked anger?	Y	N

SCORE_____

LOW DOPAMINE SYMPTOMS

Do you have feelings of worthlessness?	Y	N
Do you have feelings of hopelessness?	Y	N
Do you have anger and aggression while under stress?	Y	N
Do you not feel rested even after long hours of sleep?	Y	N
Do you want to isolate yourself from others?	Y	N
Are you distracted easily?	Y	N
Do you have an inability to finish tasks?	Y	N
Do you feel the need to get alert by consuming caffeine?	Y	N
Do you have low libido?	Y	N
Do you lose your temper for minor reasons?	Y	N

SCORE_____

LOW GABA SYMPTOMS

Do you have feelings of anxiousness or panic for no reason?	Y	N
Do you have feelings of dread?	Y	N
Do you have feelings of a "knot" in your stomach?	Y	N
Do you have feelings of being overwhelmed for no reason?	Y	N
Do you have feelings of guilt about decisions?	Y	N
Do you have a restless mind?	Y	N
Do you have a hard time turning your mind off when you want to relax?	Y	N
Do you have disorganized attention?	Y	N
Do you worry about things you never had thought about before?	Y	N
Do you have feelings of inner tension and inner excitability?	Y	N

SCORE_____

LOW ACETYLCHOLINE SYMPTOMS

Do you have decreased visual memory?	Y	N
Do you have decreased verbal memory?	Y	N
Do you have memory lapses?	Y	N
Do you have impaired creativity?	Y	N
Do you have diminished comprehension?	Y	N
Do you have difficulty calculating numbers?	Y	N
Do you have difficulty recognizing objects and faces?	Y	N
Do you have an altered awareness of self?	Y	N
Do you have excessive urination?	Y	N
Do you have slower mental responsiveness?	Y	N

SCORE_____

TOTAL SCORE_____ X 2.5 = TOTAL_____%

The higher your score, the more likely that you have neurotransmitter deficiency as a cause of your problems.

HEART HEALTH ASSESSMENT Name:

Do you have a personal history of heart attack or stroke?	Y	N
Have you had bypass surgery or artery stenting procedures?	Y	N
Do you have hypertension (high blood pressure)?	Y	N
Do you have high serum cholesterol or triglycerides?	Y	N
Do you have a diet high in meat, dairy, and saturated fats?	Y	N
Do you have a diet high in carbohydrates (starches and sugar) or high in processed foods?	Y	N
Do you have a family history of premature (prior to age 50) heart disease?	Y	N
Do you have a personal history of diabetes?	Y	N
Do you have a family history of diabetes?	Y	N
Are you overweight?	Y	N
Is your waist measurement 35 inches or greater (for females)?	Y	N
Is your waist measurement 40 inches or greater (for males)?		
Is your fasting blood sugar greater than 110?	Y	N
Are you a smoker?	Y	N
Do you have high inflammatory blood markers such as CRP or homocysteine?	Y	N

SCORE_____ x 7 = TOTAL_____ %

The higher your score, the higher your risk of cardiovascular disease.

GASTROINTESTINAL AND LIVER HEALTH ASSESSMENT Name:

Circle the question number if your answer is YES:

1) Do you have GERD (Gastroesophageal Reflux) or Indigestion?
2) Do you have chronic Constipation?
3) Do you have chronic Diarrhea?
4) Do you have alternating Diarrhea and Constipation?
5) Do you have Abdominal Bloating?
6) Do you have Abdominal Gas?
7) Do you suffer from Abdominal Pain or Discomfort?
8) Have you had rashes such as Psoriasis, Hives, or Eczema?
9) Do you have Bloating or Belching after meals?
10) Do you have a feeling of uncomfortable fullness after meals, even if only eating a small amount of food?
11) Do you have Inflammatory Bowel Disease such as Crohn's or Colitis?
12) Do you have Bad Breath?
13) Do you have Brain Fog?
14) Do you have Fatigue or Low Energy?
15) Do you have Food Allergies?
16) Have you been diagnosed with Celiac Disease?
17) Have you used antacids such as Protonix, Pepcid, Zantac, Aciphex, or Nexium for longer than 6 months?
18) Have you been told you have Irritable Bowel Syndrome (IBS)?
19) Do you eat a diet high in refined and processed foods?
20) Do you have food allergies?
21) Do you avoid certain foods because you know they will cause discomfort?
22) Do you have a history of any type of hepatitis?
23) Has your gallbladder been removed?
24) Have you been diagnosed with a stomach ulcer?
25) Have you been diagnosed with an Autoimmune Disorder such as: Multiple Sclerosis, Lupus Erythematosis, Sjogren's Syndrome, Hashimotos's Thyroiditis, Rheumatoid Arthritis, Myasthenia Gravis, Scleroderma

Add the number of circles to obtain your score: _____

Total "YES" answers x 4=TOTAL_____%

The higher your score, the higher the likelihood that Gastrointestinal Problems are an important underlying cause of your health problems.

TOXICITY ASSESSMENT

Point Scale:
0 = Never or almost never have the symptom
I = Occasionally have it, effect is not severe
2 = Occasionally have it, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

HEAD
___Headaches
___Dizziness
___Insomnia
___Faintness
TOTAL_____

EARS
___Itchy ears
___Ringing in ears/ loss of hearing
___Earaches/ ear infections
___Drainage from ear
TOTAL_____

EYES
___Bags or dark circles under eyes
___Watery or itchy eyes
___Swollen, reddened, or sticky eyelids
___Blurred or tunnel vision
TOTAL_____

NOSE
___Stuffy nose
___Sinus congestion, sinus infection
___Constant sneezing Hay fever/allergies
___Excess mucus formation
TOTAL_____

MOUTH/THROAT
___Chronic coughing
___Sore throat, hoarseness, loss of voice
___Gagging, frequent need to clear throat
___Swollen tongue, gums, or lips
___Swollen lymph nodes
___Canker sores, mouth ulcers
TOTAL_____

ENERGY LEVEL
___Fatigue/low energy
___Restlessness
___Hyperactivity
___Feeling of weakness
TOTAL_____

HEART
___Chest pain
___Irregular or skipped heartbeat
___Rapid or pounding heartbeat
TOTAL_____

LUNGS
___Asthma, bronchitis
___Chest congestion
___Shortness of breath
___Difficulty breathing
TOTAL_____

SKIN
___Acne or brown "age/liver spots"
___Hives, rashes, cysts, boils
___Eczema or psoriasis
___Itchy skin/dermatitis
___Hair loss, hair thinning
___Body odor
___Excessive sweating
TOTAL_____

JOINTS/MUSCLES
___Pain or aches in joints or lower back
___Stiffness or limitation of movement ___Arthritis
___Pain or aches in muscles
TOTAL_____

MENTAL/EMOTIONAL
___Poor memory
___Difficulty concentrating
___Mood swings
___Depression
___Anxiety, fear, or nervousness
___Anger, irritability, or aggressiveness
___Insomnia
TOTAL_____

WEIGHT
___Underweight
___Overweight
___Difficulty losing weight
___Crave certain foods
TOTAL_____

OTHER
___PMS
___Frequent colds, flus
___Chemical or environmental sensitivities
___Food allergies/sensitivities
TOTAL_____

Please add the numbers from each section and write the section total in the spaces provided. Then add all the section totals together and put that total in the space below:

GRAND TOTAL_____

INTERPRETATION OF RESULTS:
15 or lower: You have a low level of toxicity.
16 to 49: You have a moderate level of toxicity.
50 or higher: You have a high level of toxicity.