

[Print Assessment Forms](#)

Name:	Phone:	
Email:	Birthdate:	Gender:

General Health Assessment

Note: Some questions may repeat on each page, yet the questions are specific to that area we are testing.

0 = Never

1 = Seldom (Less than 30% of the time)

2 = Occasionally (Between 30% - 70% of the time)

3 = Frequent (More than 70% of the time)

Do you feel tired most of the time?	0	1	2	3
Does the fatigue alter your lifestyle?	0	1	2	3
Intestinal gas	0	1	2	3
Abdominal bloating	0	1	2	3
Crave sugar	0	1	2	3
Crave beer or bread	0	1	2	3
Constipation or diarrhea	0	1	2	3
Irritable or easily angered	0	1	2	3
Trouble thinking clearly and/or short term memory loss	0	1	2	3
Faint, dizzy, or lightheaded	0	1	2	3
Muscle aches	0	1	2	3
Weight gain	0	1	2	3
Itching or burning of vagina, rectum, or prostate	0	1	2	3
Loss of sexual desire	0	1	2	3
White thrush or yellow fuzzy tongue	0	1	2	3
Athlete's foot, ringworm, or jock itch	0	1	2	3
Fungus of toenails or fingernails	0	1	2	3
Bothered by exposure to perfumes, insecticides, or other chemical smells	0	1	2	3

Ever take antibiotics	0	1	2	3
Using birth control	0	1	2	3
On synthetic hormones	0	1	2	3
Ever taken steroid drugs for allergies, asthma, or injuries	0	1	2	3

Thyroid Function Assessment

Note: Some questions may repeat on each page, yet the questions are specific to that area we are testing.

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2 = Occasionally (Between 30% - 70% of the time)

3 = Frequent (More than 70% of the time)

Do you have severe fatigue and find it hard to get up in the morning?	0	1	2	3
Do you have generalized low energy?	0	1	2	3
Do you need caffeine and/or other stimulants to get you going?	0	1	2	3
Do you have a family history of thyroid disease?	0	1	2	3
Do you to gain weight easily?	0	1	2	3
Have you had difficulty losing weight in the last 2 years?	0	1	2	3
Do you have dry skin?	0	1	2	3
Do you have constipation?	0	1	2	3
Are your menstrual cycles irregular?	0	1	2	3
Do you suffer from mood swings?	0	1	2	3
Is your hair thinning?	0	1	2	3
Are the outer third of your eyebrows missing or thinning?	0	1	2	3
Is your hair dry/brittle?	0	1	2	3
Do you have low sex drive?	0	1	2	3
Do you have any problems remembering things?	0	1	2	3
Do you have high cholesterol?	0	1	2	3
Do you have low blood pressure?	0	1	2	3
Do you suffer from depression?	0	1	2	3
Is your skin yellow?	0	1	2	3

Stress Assessment

Note: Some questions may repeat on each page, yet the questions are specific to that area

we are testing.

0 = Never

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2 = Occasionally (Between 30% - 70% of the time)

3 = Frequent (More than 70% of the time)

Do you have a close support network of family and friends?	0	1	2	3
Are you happy with your current job/profession?	0	1	2	3
Do you exercise regularly (3 or more times per week)?	0	1	2	3
Do you eat 3 meals and 0-2 snacks per day?	0	1	2	3
Do you consume caffeine, sugar or refined carbohydrates?	0	1	2	3
Do you take downtime to recharge you batteries (trips and small daily amounts)?	0	1	2	3
Do you take a multivitamin/mineral complex daily?	0	1	2	3
Are you comfortable financially?	0	1	2	3
Are you satisfied with your life and its direction?	0	1	2	3
Do you keep your weight within normal range easily?	0	1	2	3
Do you get 8 hours of uninterrupted sleep per night?	0	1	2	3
Are you frequently anxious, depressed, or have panic attacks?	0	1	2	3
Would you rate yourself as stressed?	0	1	2	3
Do you suffer from allergies, arthritis, fibromyalgia, or asthma?	0	1	2	3
Do you have trouble falling asleep?	0	1	2	3
Are you sensitive to smells?	0	1	2	3
Are you more tired after exercise?	0	1	2	3
Are you frequently irritable, angry, or upset?	0	1	2	3
Have you experienced any major life stresses in the past year?	0	1	2	3
Do you have trouble getting up, or making it through the day without caffeine?	0	1	2	3
Do you catch colds or flu more than 3 times a year?	0	1	2	3
Do you crave carbohydrates and sugar?	0	1	2	3

Hormone Balance Assessment (Female)

Vaginal dryness	No	Yes
Anxiety, mood swings	No	Yes
Sagging skin	No	Yes

sagging skin	No	Yes
Poor sleep quality	No	Yes
Memory problems	No	Yes
Fatigue	No	Yes
Lethargic depression	No	Yes
Night sweats	No	Yes
Hot flashes	No	Yes
Painful intercourse	No	Yes
Bladder infections	No	Yes
Low blood sugar	No	Yes
Salt and fluid retention	No	Yes
Foggy thought process	No	Yes
Migrane/tension headaches	No	Yes
Heavy blood flow	No	Yes
Puffy/bloated	No	Yes
Rapid weight gain	No	Yes
Depression/anxiety	No	Yes
Insomnia	No	Yes
Infertility	No	Yes
Sleep disorders	No	Yes
Weight gain	No	Yes
Miscarriages	No	Yes
PMS symptoms	No	Yes
Mood swings	No	Yes
Anxiety/depression	No	Yes
Painful or lumpy breasts	No	Yes
Endometriosis	No	Yes
Tumors	No	Yes
Osteoporosis	No	Yes
Water retention	No	Yes

Depressed libido	No	Yes
Thinning hair	No	Yes
Unusual facial/arm/leg hair	No	Yes
Acne breakouts	No	Yes
Hypoglycemia	No	Yes
Blood sugar highs and lows	No	Yes
Painful ovaries	No	Yes
Fatigue	No	Yes
Blood sugar highs and lows	No	Yes
Thin dry skin	No	Yes
Brown age spots	No	Yes
Inability to exercise	No	Yes

Toxic Burden Assessment

<p>How many fast food meals do you eat each week?</p> <p>None 1-2 meals 3 or more meals</p>	
<p>Do you consume 'diet foods' sweetened with aspartame, Splenda, or saccharin?</p> <p>Yes No</p>	
<p>Do you tend to overeat?</p> <p>Yes No</p>	
<p>Do you consume damaged fats (hydrogenated oils or oxidized/rancid fats)?</p> <p>Yes No</p>	
<p>Do you regularly consume foods preserved with MSG (monosodium glutamate)?</p> <p>Yes No</p>	
<p>Do you eat foods that are artificially colored?</p>	

Yes No	
Do you chew your food completely? Yes No	
How many refined carbs or sugar servings do you eat per day? None One 2-3 4 or more	
Do you eat only organic produce? (Grown with no pesticides) Always Sometimes Never	
How many different colors of vegetables & fruits do you eat in a day? 0-1 different colors 2-4 different colors 5 or more different colors	
Do you have an excessive consumption of sodas, coffee (more than two cups a day)? Yes No	
Is your coffee and/or tea certified organic? Always Sometimes Never	
Do you use freshly ground flaxseed meal? Yes No	
Is your oil organic and in a dark bottle? Yes No	
Do you drink alkaline-type green drinks or chlorella beverages? Yes No	
Do you drink 8-10 glasses of filtered, spring or mineral water every	

day? Yes No	
Do you use fresh dark green herbs like cilantro, in your cooking? Yes No	
About how many grams of fiber do you eat each day? 0 - 10 grams 10 - 15 grams 15 - 20 grams 20 - 25 grams 25+ grams	1 med Avocado : 12 grams 2 slices Whole Wheat Bread : 6 grams 3/4 cup Broccoli : 7 grams 6 Wheat Thins : 2.2 grams 20 Grapes : 1 gram 1 cup Cooked Beans : 19 grams 1 tbsp Peanut Butter : 1.1 gram 1 cup Bran Cereal : 20 gram <u>Low Fiber Foods (1-2 grams):</u> Cereal, Whitebread, Meats, Pancake, Eggs, Dairy, Pasta, Cheese
Do you cook or re-heat foods in plastic containers in the microwave? Yes No	
Do you consistently take high quality antioxidants? Yes No	
Do you use whey protein? Yes No	
Do you use probiotics or prebiotics? Yes No	
Do you exercise 2 or more times per week for 30 minutes or more to induce a hard sweat? Yes No	
Do you experience GI distress? Yes No	
Do you consume alcohol? No	

<p>Yes 1-4 drinks per week</p> <p>Yes 5 or more drinks per week</p>	
<p>Do you regularly use prescription or over the counter (OTC) medication?</p> <p>Yes</p> <p>No</p>	
<p>Do you use nicotine?</p> <p>Yes</p> <p>No</p>	
<p>Do you use a sauna 1-2 times a week?</p> <p>Yes</p> <p>No</p>	
<p>For women, is your body fat 30% or greater? Or for men, is your body fat 20% or greater?</p> <p>Yes</p> <p>No</p>	
<p>Do you use a cell phone with a headset or hands free?</p> <p>Yes</p> <p>No</p>	
<p>Do you live or work in an environment that recirculates the indoor air?</p> <p>Yes</p> <p>No</p>	
<p>Do you use pesticides on your property?</p> <p>Yes</p> <p>No</p>	
<p>How often do you travel by plane?</p> <p>Never</p> <p>1-3 times a year</p> <p>4-6 times a year</p> <p>6 or more times a year</p>	
<p>Do you use a computer?</p> <p>Yes</p> <p>No</p>	
<p>How many hours a day do you spend in front of a computer?</p> <p>Less than a 1/2 hour</p>	

1-2 hours 3-6 hours 7 or more hours	
Do you live with someone who uses nicotine? Yes No	
Do you have green plants in your house? Yes No	
Do you expose yourself to toxins like household cleaners? Yes No	
Do you consistently use air purifiers? Yes No	
Do you use water filters? Never Sometimes Always	

Frequency of Purchase

Please select the average number of times Daily OR Weekly you purchased and/or consumed these items.

<----- **Daily** ----->
 <-----
Weekly ----->

Can of soda	
0 1 2 3 4 5 6	1 2 3 4 5 6 7 8 9
Cup of Brewed Coffee	
0 1 2 3 4 5 6	1 2 3 4 5 6 7 8 9
Cup of Specialty Coffee	
0 1 2 3 4 5 6	1 2 3 4 5 6 7 8 9
Small Bag of Chips	
0 1 2 3 4 5 6	1 2 3 4 5 6 7 8 9
Candy Bar	
0 1 2 3 4 5 6	1 2 3 4 5 6 7 8 9
Pack of Gum	
0 1 2 3 4 5 6	1 2 3 4 5 6 7 8 9

Alcoholic Beverage	
0 1 2 3 4 5 6	1 2 3 4 5 6 7 8 9
Eating Lunch Out	
0 1 2 3 4 5 6	1 2 3 4 5 6 7 8 9
Eating Dinner Out	
0 1 2 3 4 5 6	1 2 3 4 5 6 7 8 9

**The Top Three Reasons Why I Filled This Form Out
Notes:**

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