Bridge To Higher Health Personal Evaluation Profile

Name: _____ Date: _____
Address: _____ Phone: work _____
_____ home _____
_____ cell _____
Birth date: _____ e-mail: _____

Circle the answer that best reflects the <u>intensity of each symptom at this time</u>.

0=never 1=seldom 2=occasionally 3=often

Digestion: Low Acidity

1. **Indigestion** 0 1 2 3
2. **Abdominal bloating** 0 1 2 3
3. **Feel too full after eating** 0 1 2 3
4. **Constipation** 0 1 2 3
5. **Belching/Burping** 0 1 2 3
6. **Diminished appetite** 0 1 2 3
7. **Stomach growls/gurgles** 0 1 2 3
8. **Any known food allergies** ..... No Yes

Notes:

Assimilation: Small Intestine

1. **Stomach cramps** 0 1 2 3
2. **Indigestion immediately after eating** 0 1 2 3
3. **Feel tired after meals** 0 1 2 3
4. **Flatulence (gas)** 0 1 2 3
5. **Constipation/diarrhea (alternating)** 0 1 2 3
6. **Fiber rich diet won't stop constipation** 0 1 2 3
7. **Loose stool** 0 1 2 3
8. **Presence of mucus in stool** 0 1 2 3
9. **Stool poorly formed** 0 1 2 3
10. **Four or more large stools daily** 0 1 2 3
11. **Stools have foul odor** 0 1 2 3
12. **Forgetful, poor memory** 0 1 2 3
13. **History of pimples, skin eruption** ..... No Yes
14. **Any known food allergies** ..... No Yes

Notes:

Pancreas: Low Blood Sugar (Hypoglycemia)

1. **Dizziness/dimmed vision when standing Suddenly** 0 1 2 3
2. **Stong desire/craving for sweets** 0 1 2 3
3. **Sweets/alcohol promptly relieve headaches** 0 1 2 3
4. **Irritable if meal is missed or delayed** 0 1 2 3
5. **Hungry most of the time** 0 1 2 3
6. **Constantly anxious, nervous, worrisome** 0 1 2 3
7. **Frequently drowsy, impatient, moody** 0 1 2 3
8. **Need for caffeine to get going** 0 1 2 3
9. **Rapid heart beat after eating sweets** 0 1 2 3
10. **Four or more large stools daily** 0 1 2 3
11. **Restless, poor concentration** 0 1 2 3
12. **Forgetful; poor memory** 0 1 2 3
13. **Feel shakey; weak or fatigued** 0 1 2 3
14. **Feel better/calmer after eating?** ..... No Yes
15. **Low Protein/high carbohydrate diet** ..... No Yes

High Acidity

1. **Stomach pains just before or after meals** 0 1 2 3
2. **Stomach pains with no apparent reason** 0 1 2 3
3. **Stomach pain relieved by carbonated Drinks** 0 1 2 3
4. **Stomach pain relieved by milk/cream** 0 1 2 3
5. **Emotional upset causes stomach pain** 0 1 2 3
6. **Heartburn immediately after meals** 0 1 2 3
7. **Constant need for antacids** 0 1 2 3
8. **"Butterfly feeling" in stomach** 0 1 2 3
9. **Family history of ulcer/gastritis** ..... No Yes
10. **Ulcer in the past year** ..... No Yes
11. **Current Ulcer** ..... No Yes
12. **Very dark or black stool** ..... No Yes
13. **Hot/spicy foods cause stomach Irritation** ..... No Yes

Large Intestine (Colon)

1. **Diarrhea** 0 1 2 3
2. **Recurrent infections/colds** 0 1 2 3
3. **History of kidney and/or bladder Infections** 0 1 2 3
4. **Yeast infection (including vaginal)** 0 1 2 3
5. **Frequent abdominal cramps** 0 1 2 3
6. **Fingernail and/or toenail fungus** 0 1 2 3
7. **Diarrhea and constipation (alternating)** 0 1 2 3
8. **Chronic constipation** 0 1 2 3
9. **Use of antibiotics in past year** ..... No Yes
10. **Meat eater** ..... No Yes
11. **Vision deteriorating rapidly** ..... No Yes

Notes:

High Blood Sugar (Diabetes)

1. **Decreased resistance to infection** 0 1 2 3
2. **Slow healing cuts, wounds, etc.** 0 1 2 3
3. **Night sweats** 0 1 2 3
4. **Heightened thirst** 0 1 2 3
5. **Increased appetite** 0 1 2 3
6. **Eating sweets does not alleviate cravings** 0 1 2 3
7. **Fatigue, mental confusion** 0 1 2 3
8. **Poor, deteriorating eyesight** 0 1 2 3
9. **Itchy skin, boils and/or leg sores** 0 1 2 3
10. **History of diabetes in the family** ..... No Yes
11. **Sugar(glucose) detected in urine** ..... No Yes
12. **Low Protein/high carbohydrate diet** ..... No Yes
13. **Overweight** ..... No Yes

Notes:

Bridge To Higher Health

2. Personal Evaluation Profile

Liver/Gallbladder

1. Abdominal pain after eating fatty foods....0 1 2 3
2. Pain in the right side under rib cage 0 1 2 3
3. Painful or tender big toe 0 1 2 3
4. Hard/dry stool (painful to pass).....0 1 2 3
5. Stool color is grayish (light in color) 0 1 2 3
6. Stool has foul odor 0 1 2 3
7. Gray colored skin.....0 1 2 3
8. History of constipation.....0 1 2 3
9. Headaches following meals.....0 1 2 3
10. Recurring sour, bitter taste in mouth.....0 1 2 3
11. Red blood in stool.....No Yes

Liver/Gallbladder

13. Yellow sclera (white of the eyes).....0 1 2 3
14. Bad Breath or body odor 0 1 2 3
15. Tired/sleepy after meals 0 1 2 3
16. Dandruff 0 1 2 3
17. Retain Water 0 1 2 3
18. Dry skin and/or oily skin 0 1 2 3
19. Eat at fast food restaurants.....0 1 2 3
20. Impatient, impulsive, easy to anger.....0 1 2 3
21. Vision problems/red or dry eyes .....No Yes
22. Have had jaundice or hepatitis.....No Yes
23. High blood cholesterol and/or low HDL ....No Yes

Notes:

Kidney/Bladder

1. Constant feeling of a full bladder 0 1 2 3
2. Loss of control holding urine.....0 1 2 3
3. Drip/Dribble after urination 0 1 2 3
4. Blood or pus in urine (any amount) 0 1 2 3
5. Hazy or cloudy urine.....0 1 2 3
6. Urine has odor/strong smell 0 1 2 3
7. Long intervals between urination 0 1 2 3
8. Straining to urinate with scant passage....0 1 2 3
9. Awake in the middle of the night to Urinate 0 1 2 3
10. Feeling of fear/Insecurity 0 1 2 3
11. Dark circles under eyes 0 1 2 3
12. Pain or pressure in middle of back 0 1 2 3
13. Intermittent pain in urethra.....0 1 2 3
14. History of bladder infection/cystitis .....No Yes
15. Recent use of antibiotics – Kidney/ Bladder infections .....No Yes
16. Recent bladder surgery .....No Yes

Please list all current medications:

Thyroid

1. Sensitivity to cold/wet weather 0 1 2 3
2. Hands and feet are cold.....0 1 2 3
3. Constantly tired/fatigued.....0 1 2 3
4. Lack of Stamina for daily chores 0 1 2 3
5. Diagnosis of ADD 0 1 2 3
6. Eyes appear bulging or swollen.....0 1 2 3
7. Skin is dry (lacks moisture).....0 1 2 3
8. Difficulty waking up in the morning 0 1 2 3
9. Depressed, apathetic, lethargic.....0 1 2 3
10. Lack of or diminished sex drive 0 1 2 3
11. Irritability/mood swings when eating Sweets.....0 1 2 3

Notes:

Thyroid

12. Constipation 0 1 2 3
13. Gain weight easily .....No Yes
14. Basal/armpit temperature less than Normal.....No Yes
15. Slow reflexes/reaction time .....No Yes
16. Infertility/impotency.....No Yes

For women only:

17. Heavy/profuse menstrual bleeding 0 1 2 3
18. Premenstrual tension/stress.....0 1 2 3

Notes:

Adrenal

1. Unable to tolerate much exercise.....0 1 2 3
2. Catch colds or get sick easily.....0 1 2 3
3. Sensitive to air pollutants, chemicals, Stroke 0 1 2 3
4. Breathing is labored/difficult 0 1 2 3
5. Feelings of weakness/shakiness 0 1 2 3
6. Moments of depression 0 1 2 3
7. Rapid mood swings 0 1 2 3
8. Energy lag in morning to mid-afternoon ...0 1 2 3
9. Need for caffeine to get going.....0 1 2 3
10. Intermittent constipation.....0 1 2 3
11. Dark circles beneath the eyes.....0 1 2 3
12. Dizzy/light headed upon standing 0 1 2 3
13. Lack of mental alertness (mental fog) 0 1 2 3
14. Retain water.....0 1 2 3
15. Insomnia 0 1 2 3
16. Eyes sensitive to bright/direct light 0 1 2 3
17. Use cortisone, prednisone, steroids.....0 1 2 3

Dietary Questions:

1. Use of the microwave oven 0 1 2 3
2. Drink Alcohol 0 1 2 3
3. Drink Coffee.....0 1 2 3
4. Smoke cigarettes, etc.. .....No Yes
5. Use Recreational drugs.....No Yes
6. Eat vegetables 0 1 2 3
7. Drink Sodas 0 1 2 3

How much water do you drink per day?_____

What is your health goal?_____

Bridge To Higher Health
3. Personal Evaluation Profile

Circulatory System: Heart

1. Nervous/jittery for no apparent reason 0 1 2 3
2. Calf muscles cramp when walking 0 1 2 3
3. Arrhythmia/chest pain when walking 0 1 2 3
4. Shortness of breath during minor activity 0 1 2 3
5. Rapid heart beat during minor activity 0 1 2 3
6. Palpitations/erratic heart beat 0 1 2 3
7. Numbness/pain in left arm 0 1 2 3
8. Heaviness in legs 0 1 2 3
9. Edema/swelling of feet and ankles 0 1 2 3
10. Regular exercise 0 1 2 3
11. Frequent aerobic exercise ..... No Yes
12. Red, swollen nose ..... No Yes
13. Usual resting heart rate . . . .Slow Normal Fast

(Note: slow-less than 70bpm, Fast-over 110bpm)

High Blood Pressure

1. Pain in back of head upon awakening AM . 0 1 2 3
2. Headaches/migraines for no apparent Reason 0 1 2 3
3. Rapid pulse/shortness of breath 0 1 2 3
4. Easily tired by minor exertion 0 1 2 3
5. Visual disturbance 0 1 2 3
6. Exercise regularly ..... No Yes
7. Systolic and diastolic pressure close To each other ..... No Yes

Respiratory System

1. Shortness of breath/labored breathing 0 1 2 3
2. Chest tightness/pain 0 1 2 3
3. Recurring/chronic cough 0 1 2 3
4. Coughing up phlegm or blood 0 1 2 3
5. Chest colds 0 1 2 3
6. Sensitive to smog/perfumes, etc. 0 1 2 3
7. Live/work with people who smoke 0 1 2 3
8. Hair thinning/falling out/slow growing 0 1 2 3
9. Lymph glands swell 0 1 2 3
10. Ear infection/congestion 0 1 2 3
11. Slow recover from cold or flu 0 1 2 3
12. Catch colds/flu easily, despite Precautions 0 1 2 3
13. Skin on back of arms is rough/bumpy 0 1 2 3

Circulation

1. Get angry/excited easily 0 1 2 3
2. Headaches/migraines for no apparent Reason 0 1 2 3
3. Poor concentration/foggy brain 0 1 2 3
4. Ringing in ears 0 1 2 3
5. Cold extremities (hands/feet) 0 1 2 3
6. Numbness in extremities (hands/feet) 0 1 2 3
7. Blushing for no apparent reason 0 1 2 3
8. Speech slurred/sloppy 0 1 2 3
9. Calf muscles cramp when walking 0 1 2 3
10. Poor circulation 0 1 2 3
11. Systolic and diastolic pressures Widely separated ..... No Yes
12. Lower ear lobe has vertical crease ..... No Yes
13. History of stroke ..... No Yes
14. Resting blood pressure . . . . . .Low Normal High

Notes:

Lymphatic

1. Need to clear throat, particularly in AM 0 1 2 3
2. Swelling in throat/neck 0 1 2 3
3. Skin Irritation/rash 0 1 2 3
4. Pressure/congestion in or behind ears 0 1 2 3
5. Do you exercise regularly ..... No Yes

For Women Only:

6. Nodules or tenderness in breasts 0 1 2 3
7. Swelling in feet/ankles upon rising in AM . 0 1 2 3
8. Puffiness beneath eyes in the morning 0 1 2 3

Excessive Function (Hyper Immunity)

1. Known food sensitivity/allergy 0 1 2 3
2. Some foods cause illness/anxiety/ Depression 0 1 2 3
3. Stomach pain/G.I. tract discomfort 0 1 2 3
4. Swallowing tablets is difficult 0 1 2 3
5. Skin disorder/rashes ..... No Yes
6. Bronchitis/asthma/chronic Lung problems ..... No Yes
7. Recurring migraine headaches ..... No Yes
8. Mucus in throat/chest 0 1 2 3
9. Low grade fever from time to time 0 1 2 3
10. Swollen/inflamed joints, body aches 0 1 2 3
11. Swollen or sore tongue 0 1 2 3
12. Eye Itch/puffiness/discharge 0 1 2 3
13. Ear stuffy/congested 0 1 2 3
14. Sinus infection 0 1 2 3

Part Two: Excessive Function

15. Runny nose/post nasal drip 0 1 2 3
16. Alternating diarrhea and constipation 0 1 2 3
17. Bed wetting ..... No Yes
18. Attention deficit/Hyperactivity ..... No Yes
19. Use aspirin, Tylenol, ibuprofen ..... No Yes
20. Use cortisone, prednisone, and steroids .... No Yes
21. Mouth breather ..... No Yes

Bone

1. Cavities/dental weaknesses 0 1 2 3
2. Bones sore/painful 0 1 2 3
3. Pain in joints/extremities 0 1 2 3
4. Eat meat at most meals ..... No Yes
5. 3+ cups a day of carbonated beverages .... No Yes
6. Gingivitis/gum sensitivity ..... No Yes
7. Use antacids at least once a day ..... No Yes
8. Presently wear dentures ..... No Yes
9. Any known bone deformities ..... No Yes
10. Diagnosed with arthritis/rheumatism ..... No Yes
11. Diagnosed with osteoporosis ..... No Yes
12. Recent bone fracture (past 2 years) ..... No Yes

For Women Only:

13. Post Menopausal ..... No Yes

Notes: