Professional Health Assessment

Each symptom/question equals one point unless otherwise noted

Please circle the number of any symptom or question that pertains to you. Add up the number of symptoms/questions that you have circled and place the number where it says "Your Score". If you're unsure of a symptom or question, skip it and move on.

Section 1

1. mood swings
2. depression
3. anxiety and/or panic attacks
4. chronic fatigue
5. insomnia
6. weight loss
7. digestive disturbances
8. muscular weakness
9. chronic pain
10. impaired wound healing
11. heightened susceptibility to infection
12. diminished resistance to stress
13. nervousness and/or agitation
14. hair loss
15. slow growing hair and/or nails
16. brittle hair and/or nails
17. dry skin and/or hair
18. split ends
19. do you drink one or more alcoholic beverages per day?
20. were you a heavy drinker in the past?
21. do you drink four or more cups of coffee per day?
22. do you consume beverages or foods sweetened with Nutrasweet on a daily basis?
23. do you have a history of pancreatitis?
24. do you have hypochlorhydria (low stomach acid)?
25. have you had a portion of your stomach or intestines removed?
26. do you have chronic anemia?
27. do you have a history of panic disorder?
28. do you fail to remember your dreams?
29. do cuts or burns heal slowly?
30. do you have reduced levels of protein in your blood (low BUN, albumin, globulin, creatine, etc.)?

Your Score _____

Section 2

1. eczema or psoriasis
2. heart rhythm disturbances
3. chronic fatigue
4. gum disease
5. muscles tear or injure easily
6. muscle twitching and/or cramps
7. spastic neck muscles
8. sluggish mental function
9. rapid aging
10. low HDL (good cholesterol)
11. heart flutter and/or palpitations
12. depression
13. heel spurs
14. calcium deposits in the joints
15. chronic arthritis
16. headaches during or prior to menses
17. high carbohydrate diet
18. eat mostly starches such as corn, wheat, pasta, bread, muffins, chips, potatoes, rice, etc.
19. difficulty losing weight
20. epilepsy
21. leg cramps
22. muscle tension or tight spastic muscles
23. heart pounds uncontrollably
24. get sick from exposure to cold damp weather or cold drafts
25. poor concentration
26. memory loss
27. poor endurance
28. exhaustion after minor exertion
29. high triglycerides
30. high cholesterol
31. slow recovery from exercise
32. dry skin
33. cholesterol deposits on the face (xanthomas)
34. rapid heartbeat without exercise (above 79 per minute)
35. muscular soreness, fatigue/exhaustion
36. muscular atrophy (loss of muscle tissue)
37. persistent abdominal distension
38. pale coloration of the face
39. chronic fatigue syndrome
40. highly intolerant to cold weather
41. gain weight rapidly/easily
42. Do you eat mostly processed or junk foods?
43. Do white flour products, such as bread, pasta, rolls, noodles/macaroni, cookies, cakes, doughnuts, buns, muffins, lasagna, spaghetti, etc., constitute a large portion of your diet?
44. Do you have a history of angina and/or coronary artery disease?
45. Have you had a heart attack recently (within the past 5 years)?
46. Is your cholesterol level above 250?
47. Have you been diagnosed with an enlarged heart or cardiomyopathy?
48. Do you suffer from congestive heart failure?
49. Do you have a blood sugar level in excess of 200?
50. Are you currently taking anti-anxiety medications such as Prozac, Xanax, Zoloft, etc.?
51. Do you exercise vigorously on a regular basis?
52. Are you easily weakened by stress or physically intolerant to stress?
53. Is your blood pressure higher than 150/110?
54. Are you a binge drinker?
55. Do you have a history of kidney stones?

56. Have you had more than 3 kidney stones in your lifetime?
57. Do you consume candy on a daily basis?
58. Are you a soda pop addict?
59. Do you eat pastries on a daily basis?
60. Do you suffer from diabetes?
61. Have you been diagnosed with ALS, multiple sclerosis, or myasthenia gravis?
62. Are you involved in competitive or combative sports?
63. Do you suffer from Alzheimer's disease?
64. Do you suffer from Parkinson's disease?
65. Are you morbidly obese (over 30 pounds overweight)?

Your Score _____

Section 3

1. easy bruising
2. bleeding gums
3. nosebleeds
4. inflammation and/or swelling of the joints
5. swollen extremities
6. varicose and/or spider veins
7. heavy menstrual bleeding
8. retinal hemorrhages
9. repeated miscarriages
10. tendency to form blood clots
11. blood in the urine
12. hemorrhoids
13. glaucoma
14. fragile blood vessels (blood vessels which burst easily)
15. arthritis
16. fever blisters
17. petechiae (tiny red blood spots on the skin)
18. failing vision
19. blood in the stool
20. do you have a history of coronary artery disease or hardening of the arteries?
21. have you had blood clots in the veins?
22. have you suffered a stroke, or do you have a significant family history of stroke?
23. do you have a history of stomach and/or duodenal ulcers?
24. do you avoid consuming fresh fruits and/or vegetables?
25. do you consume aspirin, motrin or other anti-inflammatory drugs on a daily or weekly basis?
26. do you suffer from shingles or genital herpes outbreaks?

Your Score _____

Section 4

1. excessive gas
2. fullness and/or bloating after meals
3. poorly formed stools
4. constipation
5. greasy, pale or gray stools that float
6. chronic heartburn
7. undigested food particles in stool
8. chronic diarrhea
9. colitis and/or irritable bowel syndrome
10. eczema and/or psoriasis
11. hives and/or other severe allergic reactions
12. lack of appetite
13. white spots on fingernails
14. ridges on the fingernails
15. slow growing hair and/or nails
16. hair loss
17. stomach or bowel pain after eating
18. fatigue after eating
19. rectal burning
20. do you have low stomach acid?
21. do you have a significant family history of diabetes or do you suffer from diabetes?
22. do you have a history of pancreatitis?
23. do you consume on a daily basis one or more servings of foods/beverages containing artificial sweeteners?
24. do you have a history of stomach or intestinal cancer?
25. do you smoke and/or use chewing tobacco?
26. is your diet high in refined sugar?
27. do you consume alcoholic beverages on a daily basis?
28. do you eat processed foods or fast foods on a daily basis?
29. do you eat mostly cooked foods?
30. do you avoid eating raw fruits and vegetables?
31. are you a ravenous eater or do you eat excessively fast?
32. do you drink five or more cups of coffee per day?
33. do you have mucous in your stool?

Your Score _____

Section 5

1. muscular weakness
2. heart rhythm disturbances
3. delayed wound healing
4. enlarged heart
5. morbid obesity
6. chronic unrelenting fatigue
7. bleeding gums
8. receding gums
9. high blood pressure

10. chronic kidney disease
11. increased susceptibility to infections
12. chronic gum infections
13. foul breath
14. muscular atrophy
15. accelerated aging of the skin
16. do you avoid eating fatty fish?
17. do you have a difficult time initiating weight loss?
18. do you have an aversion/intolerance to exercise or do you feel ill after exercising?
19. do you have an immune deficiency disorder?
20. do you have a history of angina and/or coronary artery disease?
21. do you have a history of congestive heart failure?
22. do you have asthma?
23. do you avoid eating red meats and poultry?
24. do you have chronic lung infections?
25. do you smoke one half pack or more cigarettes a day?
26. do you have shortness of breath after exertion?
27. do you experience severe muscle pain, particularly after exercising?

Your Score _____

Section 6

1. easy bruising
2. bleeding and/or purple-appearing gums
3. lower back pain
4. arthritis and/or joint pain
5. delayed wound healing
6. loose teeth
7. chronic fatigue
8. sensitivity to extremes in temperature
9. thinning of the bones
10. nosebleeds
11. thinning and/or premature aging of the skin
12. liver spots
13. petechiae (tiny red blood spots on skin)
14. heightened susceptibility to infections
15. hemorrhoids
16. insomnia
17. dryness of the mouth
18. dry, itching skin
19. swollen joints
20. loss of appetite
21. listlessness and/or apathy
22. depression
23. tendency to plaque and/or tartar
24. Do you regularly consume aspirin?
25. Do you regularly take non-steroidal anti-inflammatory agents such as Motrin, Indocin, Clinoril, or Butazolidin?
26. Do you regularly consume birth control pills?
27. Do you take antibiotics on a daily or weekly basis?
28. Are you exposed to excessive quantities of chemical or exhaust fumes while on the job or during your travels?
29. Do you eat limited quantity of fruits and vegetables?
30. Do you currently use cocaine, crack, or heroin, or have you used such drugs for prolonged periods in the past?
31. Do you currently consume marijuana, or have you consumed it for prolonged periods in the past?
32. Are you a cigarette smoker?
33. Are you exposed to passive (second-hand) smoke on a regular basis?
34. Do you easily injure your joints, muscles, or tendons?
35. Do you take cortisone or apply cortisone cream on a daily or weekly basis?
36. Do you suffer from learning or reading impairment?
37. Do you have a history of hardening of the arteries?
38. Do you work in or near a nuclear facility/power plant, or are you exposed on a monthly basis to x-rays?
39. Do you see spots (“floaters”) in your eyes?
40. Do you have a history of degenerative joint disease?
41. Do you suffer from growing pains (children/adolescents)?
42. Do you have deep pain in the bones and/or joints?

Your Score _____

Section 7

1. insomnia
2. irritability
3. rapid heartbeat and/or irregular heartbeat
4. nearsightedness
5. nosebleeds
6. chronic diarrhea
7. bone pain, especially in the legs
8. chronic upper or lower back pain
9. aching in the teeth
10. frequent fractures
11. cataracts
12. premature graying of the hair
13. scoliosis
14. muscular rigidity
15. muscle twitching
16. muscle cramps and/or spasms
17. convulsions and/or seizures
18. vague or migrating joint pain
19. easy bruising
20. soft teeth and/or tooth decay
21. thinning of bones (osteoporosis)
22. chipping and/or cracking teeth

23. arthritis
24. delayed wound healing
25. bruxism (grinding of the teeth)
26. Do you have psoriasis and/or eczema?
27. Are you bedridden, or were you bedridden for prolonged periods in the past?
28. Do you have fair skin?
29. Do you avoid eating fatty fish such as salmon, halibut, mackerel, sardines and herring?
30. Are you a vegetarian? **(if vegan, add 3 additional points)**
31. Do you avoid milk products because of allergies or other reasons?
32. Do you have a mitral valve prolapse and/or heart arrhythmia?
33. Do you have colon or prostate cancer?
34. Do you have high blood pressure?
35. Do you have acne or rosacea?
36. Do you get little or no exposure to sunlight?
37. Do you have liver or pancreatic disease?
38. Do you take Dilantin or phenobarbitol (epilepsy drug) on a daily basis?
39. Do you live in an area where there is heavy air pollution?
40. Are you bowlegged?
41. Do you have an excessively high or low serum calcium level?
42. Do you have a low serum phosphorus level?
43. Do you adhere to a low-fat low- cholesterol diet?
44. Do you have a history of duodenal ulcer, or has your duodenum been removed?
45. Do you take Tagamet, Zantac and/or antacids on a regular basis?
46. Do you have celiac disease or gluten intolerance?
47. Do you suffer from muscular weakness?
48. Do you have difficulty walking or climbing stairs?
49. Do you have congestive heart failure or enlarged heart?
50. Do you have gallstones, and/or have you had your gallbladder removed?
51. Do you have chronic kidney disease?
52. Do you have a cholesterol level below 155 mg/dl?
53. Have you been diagnosed with Osgood-Schlatter disease?
54. Do you have bone cancer?
55. Do you have a concave (pigeon) breast?

Your Score _____

Section 8

1. cold hands and/or feet
2. tendency to form blood clots
3. easy bruising
4. swollen legs and/or ankles
5. varicose veins
6. leg and/or foot cramps
7. infertility
8. impotence
9. liver spots (brown spots on the skin)
10. muscular wasting
11. intolerance to dietary oils
12. cataracts and/or macular degeneration
13. Do you have liver disease?
14. Do you consume alcohol on a daily basis?
15. Do you consume foods containing white flour on a daily or weekly basis?
16. Do you consume deep fried foods on a daily or weekly basis?
17. Do you use margarine as a spread, or do you use margarine/shortening in cooking?
18. Do you cook with refined vegetable oils such as Crisco oil, Canola oil, sunflower oil, peanut oil, or “light” olive oil?
19. Are you chronically exposed to radioactivity (nuclear plant workers, x-ray technicians, computer programmers, policemen, etc.)
20. Do you drink fluoridated and/or chlorinated water?
21. Are you taking cholesterol-lowering medications such as Mevacor, Pravachol, Lopid, Lipitor or Questran?
22. Are you taking iron supplements or multiple vitamin-mineral tablets containing iron?
23. Do you have a history of heart disease and/or angina?
24. Do you tear or injure your muscles or joints easily?
25. Do you consume snack foods, such as chips, pastries, candy bars, pretzels, popcorn, pop, cookies, etc., on a regular basis?
26. Do you have a history of chronic circulatory disease such as Raynaud’s syndrome, vasculitis, atherosclerosis, or coronary arterial occlusion?
27. Do you have a history of Peyronie’s disease (erection which fails to recede)?
28. Do you have hemolytic anemia and/or sickle cell anemia?
29. Have you had repeated miscarriages?
30. Do you have chronic obstructive lung disease, particularly emphysema?
31. Are you exposed to heavy air pollution?
32. Are you undergoing chemotherapy/radiation treatments?
33. Do you have fibrocystic breast disease?
34. Is your skin highly sensitive to sunlight?

Your Score _____

Section 9

1. joint pain
2. slow pulse rate

3. nervousness or irritability
4. tremors
5. twitching muscles and/or leg cramps
6. anxiety
7. chronic back and/or hip pain
8. vulnerability to fractures
9. loose teeth
10. tendency to form cavities
11. brittle nails
12. high blood pressure
13. numbness and/or tingling of the extremities
14. spastic stomach
15. muscular tension or tight , spastic muscles
16. chronic headaches
17. soft teeth
18. vertically ridged nails
19. Do you get little or no exposure to sunshine?
20. Do you have irritable bowel syndrome (colitis)?
21. Do you avoid eating fresh fish and/or milk products?
22. Do you drink three or more ups of coffee per day?
23. Are you a cigarette, pipe or cigar smoker?
24. Do you regularly take cortisone or use cortisone creams?
25. Do regularly consume antacids?
26. Do you regularly take tetracycline?
27. Are you on calcium channel blockers?
28. Have you undergone or are you currently undergoing chemotherapy?
29. Do you get little or no exercise?
30. Are you currently bedridden and/or wheelchair-bound?
31. Do you consume refined sugar on a daily basis?

Your Score _____

Section 10

1. heart rhythm disturbances (irregular heartbeat)
2. constipation and/or sluggish colon
3. chronic fatigue
4. muscles tear or injure easily
5. muscle cramps (or cramps in the bottom of the feet)
6. depression
7. muscular weakness
8. inability to control bladder
9. night sweats
10. excessive body odor
11. muscle twitching
12. lower or mid-back pain
13. muscular tension or tight muscles
14. dizziness
15. enlarged facial pores
16. uncontrollable sweating of the hands, feet, and/or armpits
17. painful menstrual cramps
18. PMS
19. restless leg syndrome
20. chronic knee and/or hip pain
21. cold hands and/or feet
22. lack of appetite
23. sudden episodes of loss of brain function (mesmerized)
24. nausea
25. rapid heartbeat (above 80 beats per minute)
26. carpal tunnel syndrome
27. nervous agitation (inability to relax)
28. repeated tapping of the hands and feet
29. Are you easily disoriented and/or confused?
30. Do you have high blood pressure?
31. Do you have chronic diarrhea or sloppy stools?
32. Are you easily weakened by stress, or are you physically intolerant of stress?
33. Do you have chronic arthritis?
34. Do you have heart disease and/or angina pectoris?
35. Do you suffer from headaches occurring prior to or during your menstrual cycle?
36. Do you have overactive or underactive thyroid function?
37. Do you have osteoporosis?
38. Do your bones fracture easily, or do they fail to heal after fracturing?
39. Do you suffer from epilepsy or convulsions?
40. Do you drink alcohol on a daily basis? **(add an additional 3 points)**
41. Do you have a history of kidney stones? (add an additional 2 points)
42. Do you suffer from chronic kidney disease?
43. Do you regularly take diuretic drugs? **(add 2 points)**
44. Are you a sugar addict? **(add an additional 3 points)**

Your Score _____

Section 11

1. cystic and/or sore ovaries
2. cystic breast disease
3. severe menstrual cramps
4. heavy menstrual bleeding
5. heightened susceptibility to infectious disease, especially bronchitis, pneumonia, ear infections, and/or strep throat
6. chronic fatigue or lethargy
7. morning fatigue improving as the day proceeds
8. chronic skin infections (boils, acne, fungal infections, etc.)
9. excess mucous and/or thick mucous in the throat
10. stuffy sinuses

11. cold extremities/highly sensitive to cold weather
12. muscular fatigue and/or cramps
13. stunted growth
14. coarse hair
15. reduced body temperature
16. mental sluggishness
17. Do you have an overactive or underactive thyroid?
18. Are you on a low sodium diet?
19. Do you avoid consuming fish or sea food?
20. Do you have a low libido (sluggish sex drive)
21. Do you have a history of goiter?
22. Are you 20 or more pounds overweight and/or do you have a difficult time losing weight?
23. Are you a night owl?
24. Are you a total vegetarian?
25. Do you have a history of infertility and/or low sperm count?
26. Do you have cellulite?
27. Do you have high cholesterol, above 220?

Your Score _____

Section 12

1. crow's feet (lines radiating from the eyes)
2. bags under the eyes
3. loss in the elasticity of the skin
4. noticeable thinning of the skin
5. cholesterol deposits on the face and/or eyelids
6. raised brown or flesh-colored spots on the face or hands
7. receding gums
8. age spots (liver spots) on the face, hands or arms
9. vitiligo (white spots due to loss of pigment on the skin)
10. wrinkle lines on the face radiating from the upper lip toward the nose
11. excessive wrinkling of the face, arms, chest and/or hands
12. moles that are increasing in number and/or changing in appearance
13. deepening wrinkle lines on the forehead
14. tiny red capillary spots on the face, arms, chest or legs
15. a noticeable tilting forward of the head and neck
16. nodular growths on the face, nose, hands or chest
17. loose skin or bags under chin and/or arms
18. stiffening of the spine
19. generalized decrease in joint mobility
20. pain and deformity of the joints
21. reduction of the size of the upper lip
22. tendency to shuffle instead of stride while Walking
23. ridges on the fingernails
24. increasing occurrence of varicose and/or spider Veins
25. gradual (or sudden) decline in visual capacity
26. constant coldness of the hands, feet, arms, legs, face and/or ears
27. skin that is easily damaged by sunlight
28. dryness of the mucous membranes (nose, vagina, sinuses, mouth, etc.)
29. generalized dryness of the skin
30. one bowel movement or less per day
31. circular lines around the skin of the neck
32. receding hairline or balding (or, in women, massive hair loss)
33. graying of the hair
34. skin tags
35. dryness of the eyes and/or nasal passages
36. persistent tremors
37. heart arrhythmia (irregular heartbeat)
38. rapid heartbeat (80 or more beats per minute)
39. floaters in the eyes
40. loss of muscle tissue in the arms, shoulders and/or legs
41. Have you noticed a reduction in the size of Fingers and/or wrists (reduced ring size)?
42. Are you becoming increasingly fatigued as the years go on?
43. Are you currently a heavy smoker (one half a pack or more per day)?
44. Have you previously smoked one half pack or more per day for a period longer than five years?
45. Do you or did you live in the same house as a heavy smoker (who smokes in the house)?
46. Are you currently a heavy drinker (six or more drinks per week)
47. Had you previously been a heavy drinker for more than five years (six or more drinks per week)?
48. Do you or did you consume large amounts of cane sugar or other refined sugars added to foods or as hidden food additives on a daily or weekly basis?
49. Do you or did you eat deep-fried foods, such as French fries, fried chicken, fried fish, etc. on a daily or weekly basis?
50. Do you or did you regularly consume nitrated and/or preserved meats (hot dogs, ham, bacon, pastrami, bologna, corned beef, salami, jerky, etc.)?
51. Do you currently work or have you in the past worked closely with volatile petrochemicals (gas station attendants, furniture refinishers, refinery workers, glue workers, road tarring crews, etc.)?
52. Are you exposed to excessive amounts of sunlight without protection (proper clothing)?
53. Are your teeth cracking or chipping?

54. Are you suffering from an increasing degree of muscular weakness?
55. Do you suffer from hearing loss?
56. Do you have a total or near total loss of taste or smell?
57. Do you suffer from macular degeneration, retinopathy or retinal detachment?
58. Do you suffer from loss of peripheral vision?
59. Are you becoming increasingly vulnerable to injuries (sprains, strains, bruises, cuts, etc.)?
60. Is your hair becoming fine or thin, or is it dull in appearance?
61. Is your recovery time becoming increasingly delayed after becoming ill with colds, flu or other infections?
62. Do you have a history of heart disease, stroke and/or hardening of the arteries?
63. Have you been diagnose with internal cancer?
64. Have you been diagnosed with skin cancer?
65. Have you been diagnosed with osteoporosis?
66. Do you have a history of cataracts?
67. Do you have high blood pressure?
68. Do you have psoriasis and/or eczema?
69. Do you use prescription drugs on a daily basis **(if you take 4 or more drugs, add an additional 5 points)**?

Your Score _____

Section 13

1. lethargy or weakness
2. tired in the morning and energetic at night
3. dry or coarse hair and/or skin
4. slow or slurred speech
5. swelling of the face and/or eyelids
6. cold hands and feet
7. bloating and indigestion after eating
8. hair loss from the outer third of the eyebrows
9. short-term memory loss
10. depression which is worse in the winter or on overcast days
11. white spots on the fingernails
12. chronic weight problems
13. easily constipated
14. PMS and/or other menstrual difficulties
15. infertility
16. swelling of hands and/or ankles
17. chronic headaches
18. emotionally unstable
19. brittle nails or nails which grow slowly
20. lack of sweating
21. poor appetite and/or lack of hunger
22. hair loss from the scalp, legs and/or arms
23. generally nervous
24. difficulty getting deep breaths
25. heart palpitations
26. severe muscle cramps, especially at night
27. tendency to bruise easily
28. joint stiffness
29. require prolonged periods to get “warmed up” after exposure to cold
30. excessive appetite (never get full)
31. slow growing hair and/or nails
32. light or heavy menstrual flow
33. brittle hair
34. cholesterol deposits on the face or eyelids
35. lack of sexual desire
36. enlarged facial pores
37. poor hand-to-eye coordination
38. hoarseness or coarse voice
39. inability to translate thoughts into action
40. Do you tend to become depressed in the winter or after exposure to the cold?
41. Do you have a history of ovarian cysts?
42. Do you have repeated breast inflammation and/or infections?
43. Have your periods stopped prematurely?
44. Have you been diagnosed with low stomach acid (hypochlorhydia)?
45. Do you fail to feel rested even after sleeping long hours?
46. Do you have heart disease or hardening of the arteries?
47. Do you have cystic breast disease (lumpy breasts)?
48. Have you noticed that your skin has developed a yellowish tint?
49. Do you have chronic migraine headaches manifested by pain over the bridge of the nose, along the temple or behind the ears?
50. Do you drink fluoridated water and/or use fluoridated toothpaste?
51. Do you receive regular fluoride treatments from your dentist or do you administer them at home?
52. Do you have high cholesterol or high triglyceride levels?
53. Do you suffer from cracks in the bottom of the heels?
54. Are you morbidly obese, and/or do you have a difficult time losing weight?
55. Do you have a history of repeated miscarriages?
56. Do you have a history of carpal tunnel syndrome?
57. Do you smoke a half of pack or more of cigarettes daily?
58. Are you constantly cold, even if you wear extra layers of warm clothing?
59. Do you have a low body temperature **(add 2 points for this)**?

Your Score _____

Section 14

1. constant fatigue
2. muscular weakness
3. sweating or wetness of hands and feet
4. nervousness
5. fainting spells
6. chronic heartburn
7. alternating constipation and diarrhea
8. insomnia
9. low blood pressure
10. blood sugar disturbances
11. mood swings
12. paranoia
13. lightheaded sensation
14. headaches, particularly migraines
15. heart palpitations
16. craving for salt
17. cravings for sweets
18. intolerance to alcohol
19. intolerance to cigarette smoke and/or exhaust fumes
20. hard pebble-like stools
21. vague indigestion
22. vague abdominal pain
23. vulnerability to food reactions/allergies
24. break out in hives or other rashes
25. clenching and/or grinding of teeth, especially at night
26. lack of appetite
27. infrequent urination and/or lack of thirst
28. premenstrual symptoms (PMS)
29. chronic pain in the lower neck and upper back
30. pain or tightness in the upper neck and/or lower scalp
31. inability to concentrate and/or confusion
32. panic attacks
33. phobias (agoraphobia, claustrophobia, etc.)
34. easily frustrated
35. compulsive behavior
36. intolerance to hot humid weather (heat exhaustion)
37. intolerance to cold and/or cold hands/feet
38. sense of well-being after eating, especially supper
39. depression often relieved by eating
40. difficulty relaxing (unless working)
41. easily distracted
42. tendency to have feelings of guilt
43. extreme sensitivity to odors and/or noises
44. inability to cope with stressful events
45. tendency to cry easily
46. clumsiness
47. hair loss on the outer parts of the lower legs
48. tightness of the armpits
49. Are you usually ticklish?
50. Do you have upper back pain/tightness, which worsens from stress or cold weather?
51. Do you have a lack of the sensation of fullness after eating?
52. Do you have fine thin hair?
53. Are your lower teeth (lower incisors) crowded, unequal in length, and/or misaligned? (if so, add an additional 2 points)
54. Is your index finger longer than your ring finger? (If so, add an additional 4 points)
55. Do you have a tendency to develop yeast or fungal infections?
56. Do you have a breathing disorder, particularly asthma?
57. Do you have an unusually small jaw bone or chin?
58. Have you taken cortisone pills (or prednisone) for prolonged periods (one month or longer)?
59. Do you drink caffeinated beverages on a daily basis?
60. Have you consumed large amounts of refined sugar throughout your life? (if so, add an additional 4 points)
61. Do you consume alcoholic beverages on a daily basis?
62. Do you smoke 1 or more packs of cigarettes daily? (if so, add an additional 3 points)
63. Do you have an excessively low cholesterol level (below 150 mg/dl)?
64. Do you regularly use cortisone creams or ointments?
65. Have you suffered or do you currently suffer from prolonged psychic/emotional stress?
66. Do you suffer from depression and/or weight gain during the winter months?
67. Were you regarded as a lazy child?
68. Are you or have you been frequently tormented or ridiculed by others?
69. Do you suffer from or have you suffered from severe infections such as TB, blood poisoning, sepsis or hepatitis?
70. Do you have the initiative and desire to perform tasks but physically incapable of doing so?
71. Have you undergone numerous prolonged surgeries?
72. Are you jumpy and/or easily startled?
73. Do you have brown pigment spots about your temples, upper back, or chest?
74. Do you wet the bed or did you previously wet the bed?
75. Do you prefer hot drinks rather than cold drinks, or are you intolerant to cold drinks?

Your Score _____

Section 15

1. craving for sweets

2. low body temperature
3. indigestion or abdominal discomfort after eating fruits or other sweet foods
4. itching of the vagina, penis, groin, and/or rectum
5. rectal or vaginal burning
6. burning during or after urination
7. vaginal discharge (white, off-white, or cottage-cheesy)
8. skin and/or scalp itches after eating sugar and/or fruit
9. bloating after meals
10. persistent indigestion and/or heartburn
11. itching of the ear canals or umbilicus
12. chronic sinus problems
13. intolerance to alcohol
14. sensitivity to chemicals, chemical odors, and/or cigarette smoke
15. seborrhea or heavy dandruff on the scalp, face or hands
16. ringworm
17. itchy skin and/or scalp
18. reduced white blood count
19. constipation
20. feeling of being in a mental fog
21. chronic diarrhea
22. attention deficit
23. chronic sore or scratchy throat
24. "ice cold" hands or feet
25. severe intolerance to cold weather
26. Do you feel worse on damp humid days?
27. Do you have athlete's foot, toenail, or fingernail fungus?
28. Do you have a history of fungal infection of the internal organs (lungs, brain, kidneys, bladder, etc.)?
29. Do you have a history of eczema and/or psoriasis?
30. Do you have an allergy or sensitivity to airborne molds?
31. Do you have a history of oral, rectal and/or vaginal thrush?
32. Do you have painful menstrual cramps?
33. Do you have an allergy or sensitivity to moldy and/or fermented foods (blue cheese, aged cheeses, vinegar, soy sauce, brewer's yeast, baker's yeast, etc.)?
34. Do you consume refined sugar on a daily basis?
35. Do you take antibiotics daily, weekly or monthly?
36. Have you taken ten or more courses (oral or IV) of antibiotics during your lifetime?
37. Do you consume large amounts of "natural sugars"
    on a daily basis, for instance, orange or apple juice,
    apples, bananas, raisins, pears, dates, prunes, prune juice, canned pineapple, pineapple juice, grape juice, etc.?
38. Do you eat commercially raised meats on a daily basis?
39. Do you have a history of ulcerative colitis or Crohn's disease?
40. Do you have a history of endometriosis?
41. Do you have recurrent urinary tract infections (bladder infections, urethritis, pyelonephritis)?
42. Do you use steroids (cortisone) on a regular basis (either orally, vaginally, on the skin, or as an inhalant)?
43. Do you use Tagament, Zantac, and/or antacids regularly?

Your Score _____

Section 16

1. rectal itching
2. rectal pressure
3. muscular wasting and/or weakness
4. chronic vague abdominal pain
5. ravenous appetite
6. bloating, especially after eating
7. weight loss or inability to gain weight
8. constant or frequent heartburn
9. diarrhea
10. mucous in stools
11. night sweats
12. insomnia
13. severe fatigue
14. nausea and/or vomiting
15. fever and/or chills
16. constant belching
17. stomach pain after eating
18. poorly formed stools
19. itchy skin, worse at night
20. dark circles under the eyes
21. colon pain
22. ulcerative colitis or Crohn's disease **(add an additional 2 points for each)**
23. Have you traveled frequently overseas and/or Mexico?
24. Have you ever developed diarrheal disease or severe fever while traveling abroad?
25. Do you frequently eat raw or smoked fish (sushi)?
26. Do you eat prosciutto and/or home-made sausages?
27. Do you own house dogs that you often handle, pet or kiss?
28. Did you live overseas before becoming a U.S. resident?
29. Have you ever lived in a tropical region?
30. Do you drink untreated and/or unfiltered water in the wilderness or when traveling overseas?
31. Do you fail to wash your hands carefully after

using the restroom?
32. Do you tend to experience digestive distress after eating fatty foods?
33. Do you have a long-term history of chronic anemia (low blood count)?
34. Do you suffer from persistent joint pain?
35. Are you a restless sleeper?

Your Score _____

Section 17

1. intestinal gas
2. bloating after meals
3. constipation
4. diarrhea
5. hard pebble-like stools
6. mucous in stool
7. foul-smelling stool
8. hemorrhoids
9. easy bruising
10. recurrent nosebleeds
11. psoriasis and/or eczema
12. seborrhea of the scalp
13. indigestion and/or heartburn
14. persistent stomach aches
15. excessive rectal pressure
16. rectal fissure
17. less than one bowel movement daily
18. Do you take antibiotics on a daily, weekly or monthly basis?
19. Do you often eat commercial meat, poultry and/or fish?
20. Do you rarely or never eat fermented milk products?
21. Were you, as a baby, bottle fed instead of breast fed?
22. Do you have a history of chronic candidiasis?
23. Are you unusually vulnerable to the development of
    intestinal flu and/or food poisoning?
24. Do you have ulcerative colitis, irritable bowel syndrome, leaky gut syndrome, or Crohn's disease?
25. Do you drink chlorinated water?
26. Do you have a history of diverticulitis or diverticulosis?

Your Score _____

Section 18

1. mood swings
2. fatigue after eating, worse if dessert is included
3. insomnia (especially waking up after falling asleep)
4. episodes of agitation or temper tantrums
5. dizziness and/or fainting spells
6. legs feel rubbery or weak
7. episodes of shakiness and/or tremors
8. clumsiness
9. headaches (worse after skipping a meal)
10. easily become upset and/or frustrated
11. episodes of cold sweats and/or nausea
12. disorientation
13. depression often relieved by eating
14. sleepiness after eating sugar, fruit or starch
15. bursts of violent behavior and/or fits of anger
16. attention deficit (or childhood behavior problems)
17. memory impairment or forgetfulness
18. paranoia and/or anxiety
19. crying spells
20. panic attacks
21. episodes of blurry vision
22. cantankerous behavior
23. sudden drop in energy level during mid-morning or mid-day **(if so, add an additional 2 points to your score)**
24. nightmares
25. constant worrying
26. indigestion
27. indecisiveness
28. sensations of impending doom
29. poor concentration
30. heart rhythm disturbances
31. uncontrolled negative or self-destructive thoughts
32. episodes of uncontrollable eating (binging)
33. episodes of sudden mental blackouts **(if so, add an additional 2 points to your score)**
34. Are you accident prone?
35. Do you constantly crave sweets and/or starches?
36. Do you drink alcohol heavily (2 or more drinks per day)
37. Do you consume sweets on a daily basis?
38. Do you have a history of liver and/or pancreatic disease?
39. Do you have a significant family history of diabetes?
40. Do you have chronic migraine headaches?
41. Do you eat fast food on a daily basis (pizza, hot dogs, hamburgers, subs, doughnuts, etc.)?
42. Do you have intense cravings for salty foods?
43. Do you take birth control pills on a regular basis, or have you done so in the past for two years or more?
44. Have you taken large doses of cortisone, orally or injectable, or do you take it currently on a regular basis?

Your Score _____

Section 19

1. constant fatigue unrelieved by sleeping
2. muscles are extremely weak
3. highly vulnerable to colds/flu
4. can't mount a strong defense against infection
5. break out in cold sores often
6. frequent sore throats
7. body temperature fluctuations
8. numbness and tingling in the legs, feet, arms or hands
9. muscular paralysis
10. canker sores
11. memory loss
12. dementia (senility)
13. work in a medical laboratory
14. work in a high rise building
15. work in a daycare center
16. persistent spasms or "locking" of back, neck and/or spinal muscles
17. muscles are spastic
18. persistent spinal pain
19. feel sleepy constantly
20. no desire for sexual activity
21. feel fatigued or sick from exercise
22. warts
23. poor wound healing
24. skin tags
25. consume refined sugar on a daily or weekly Basis
26. stress load is high
27. one or more blood transfusions
28. Do you allow the dog to lick your face, or do you kiss it?
29. Do you suffer from hepatitis?
30. Have you been diagnosed with Epstein-Barr syndrome or CMV?
31. Do you suffer from multiple sclerosis?
32. Do you suffer from AIDS or HIV **(add an additional 5 points)**?
33. Do you have a low white blood cell count? (below 5.0)
34. Are you a health care worker who works in a hospital?
35. Are you a health care worker who works in a clinic?
36. Do you work around or with radioactive chemicals?
37. Have you been diagnosed with a weak or enlarged heart muscle (cardiomyopathy)?
38. Are you a strict vegan?
39. Do you eat large amounts of commercial poultry?
40. Do you eat commercial eggs on a daily basis?
41. Do you suffer from shingles?
42. Is the protein level in your blood low (low albumin or globulin)?
43. Do you suffer from leukemia?
44. Do you feel flu-ish (even though you don't have the flu)?
45. Do you have night sweats?
46. Have you developed a chronic illness after a severe bout with the flu?
47. Do you suffer from Bell's palsy?
48. Do you suffer from chronic fatigue syndrome?
49. Are you taking immuno-suppresive drugs, like cortisone, prednisone, methotrexate, etc. on a daily or regular basis?
50. Are you currently undergoing chemotherapy?

Your Score _____

Section 20

1. intolerance to alcohol
2. intolerance to sugar
3. tendency to gain weight easily
4. blood sugar disturbances
5. pale, greasy stools that float
6. chronic indigestion unrelieved by antacids
7. intolerance to fatty foods and/or cooking oil
8. foul-smelling bowel gas
9. sensitivity to chemical fumes (exhaust fumes, diesel fumes, perfumes, etc.)
10. high cholesterol and/or triglycerides (or excessively low cholesterol – below 140 mg/dl
11. persistent sleepiness (narcolepsy) and/or fatigue
12. sudden hair loss
13. right sided upper abdominal pain
14. chronic itching (pruritus)
15. dark circles and/or bags under the eyes
16. Do you consume alcohol regularly (4 or more drinks per week)?
17. Are you 20 or more pounds overweight?
18. Do you have a history of hepatitis and/or cirrhosis?
19. Do you have a history of intestinal or hepatic parasites?
20. Do you consume Tylenol on a daily or weekly basis?
21. Has your gallbladder been removed, and/or do you have a history of gallstones?
22. Do you have chronic constipation (fewer than one bowel movement per day)?
23. Do you take two or more prescription medications on a daily basis?
24. Have you in the past or do you currently use recreational or hard drugs (marijuana, cocaine, heroine, etc.)?
25. Have you received or are you currently receiving chemotherapy treatments?
26. Are you taking cholesterol-lowering

medications?
27. Do you work with or near toxic chemicals, or have you worked with them in the past?
28. Do you have elevated bilirubin and/or liver enzymes?
29. Do you have a history of impaired immunity and/or immune deficiency?
30. Do you have thick ridges on the fingernails?
31. Do you take birth control pills, or have you taken them for one year or longer in the past?
32. Do you have a low blood globulin level?
33. Are you a diabetic, or do you have a significant family history of diabetes?
34. Do you have a tendency to bleed excessively (poor blood clotting)?
35. Do you have giardia infection, intestinal worms, or amoebic dysentery?

Your Score _____

Section 21 (women only)

1. night sweats
2. hot flashes
3. breast engorgement, worse during or before periods
4. insomnia
5. mood swings, worse during or before periods
6. heavy menstrual bleeding
7. excessive or painful menstrual cramps
8. dryness of the vaginal membranes
9. poor vaginal lubrication
10. PMS
11. loss of libido
12. Do you have a family history of breast cancer?
13. Do you currently have breast cancer, or did you have it in the past? **(add an additional 2 points)**
14. Do you have a history of endometriois?
15. Do you have a family history or current history of uterine fibroids?
16. Do you have a family history or current history of ovarian cysts?
17. Do you have a family history or current history of ovarian cancer?
18. Do you have a family history or current history of fibrocystic breast disease?
19. Do you take birth control pills?
20. Have you taken birth control pills for 5 or more years in the past?
21. Have you undergone a complete or partial hysterectomy?
22. Do you become weak or tired prior or during your menses?
23. Do you suffer from headaches occurring prior to or during menses?
24. Do you suffer from hirsutism (i.e. excessive hair growth), especially on your face?
25. Do you maintain excessive amounts of weight in your hips and/or breasts?
26. Do you suffer from chronic liver disease?
27. Do you consume refined sugar on a daily or weekly basis?
28. Do you consume margarine, refined vegetable oils, and/or deep fried foods on a daily basis?
29. Do you consume alcohol and/or caffeine on a daily basis?
30. Do you have a history of infertility and/or repeated miscarriages?
31. Do you adhere to a strict low-fat diet?
32. Have you had an abnormal pap smear, or do you suffer from cervical dysplasia?

Your Score _____

Section 22

1. dry, flaky skin
2. dryness or cracks behind the ears
3. brittle hair and/or fingernails
4. acne
5. enlarged facial pores
6. growth impairment
7. dry or oily hair
8. eczema/psoriasis/dermatitis
9. chronic diarrhea
10. alopecia (patchy hair loss)
11. nosebleeds
12. easy bruising
13. bleeding gums
14. dry patches of scaly skin on the face and/or nose
15. patches of hair which are unmanageable (stick up on end)
16. split ends
17. poor or delayed recovery from injuries
18. intolerance to or slow recovery from exercise
19. delayed wound healing
20. tingling in the arms and legs
21. lips which are constantly chapped
22. attention deficit disorder
23. asthma
24. loss of appetite
25. gritty feeling in or dryness of the eyes
26. irritability and/or nervousness
27. PMS (especially painful menstrual cramps, bloating, and/or sore breasts)
28. sensation of dryness of the mouth and throat, especially when speaking
29. lack of tearing
30. obesity
31. unexplained weight loss
32. Do you take aspirin, Motrin, Indocin, Feldene,

Naprosyn, or similar anti-inflammatory drugs on a daily or weekly basis?

33. Do you consume margarine on a daily or weekly basis?
34. Do you drink alcohol on a daily or weekly basis?
35. Do you consume refined sugars on a daily or weekly basis?
36. Do you have a history of repeated miscarriages?
37. Do you have Sjorgen's syndrome and/or lupus?
38. Do you have emphysema and/or other chronic lung diseases?
39. Do you have Crohn's disease and/or irritable bowel?
40. Do you suffer from chronic joint pain (arthritis)?
41. Do you have a history of sluggish kidneys, chronic kidney disease, and/or bladder infections?
42. Do you have dementia, senility, Alzheimer's disease, and/or Parkinson's disease?
43. Do you have a history of ovarian cysts and/or fibrocystic breast disease?
44. Are you a diabetic?
45. Are you a tobacco smoker?
46. Do you have a history of prostate problems?
47. Do you take cortisone or prednisone on a daily or weekly basis?
48. Do you regularly use cortisone creams?
49. Do you have a history of infertility or impotence?
50. Do you follow a very low-fat diet?
51. Do you take cholesterol lowering medicines?

Your Score _____