

GOALS

What are your primary goals for this program? Weight loss? More energy? Improved eating habits? Writing goals down is a great way for you to stay motivated during this program.

- 1) _____

- 2) _____

- 3) _____

WHOLE-BODY SYMPTOM ANALYSIS

Weight: _____

Waist Circumference: _____

BF%: _____

Overweight? _____

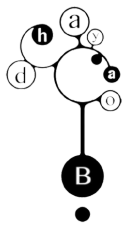
How far from goal weight? _____

How long at current weight? _____

Trying to lose or gain weight in the past 6 months? _____

Exercise program? _____

Other: _____



Answer the following questions as they apply to you in the last 90 days.

How often do you experience the following:

1=Never 2=Rarely 3=Often 4=Always

Weight Management

_____ Extreme or compulsive hunger

_____ Binge eating or drinking

Head, Eyes, Ears

_____ Headache

_____ Migraine

_____ Blurred Vision

_____ Dark circles, puffy bags under eyes

_____ Ear Infections

Upper Respiratory

_____ Nasal Congestion

_____ Chest pain

_____ Sore throat/Cough

_____ Sinus infection, congestion

_____ Upper Respiratory allergy symptoms

_____ Shortness of breath

_____ Asthma

Joint and Muscle

_____ Muscle pain

_____ Joint pain or stiffness

_____ Fracture, break, or strain

Gastrointestinal

_____ Nausea

_____ Loose stools/diarrhea

_____ Constipation

_____ Flatulence, gas, abdominal cramping

_____ Blood in stool

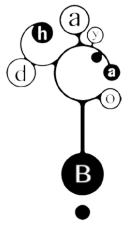
_____ Food sensitivity symptoms

Bladder/Kidneys

_____ Painful urination

_____ Frequent urination

_____ Blood in urine



Answer the following questions as they apply to you in the last 90 days.

How often do you experience the following:

1=Never 2=Rarely 3=Often 4=Always

Skin

- | | | | |
|-------|----------------------------------|-------|------------------------------|
| _____ | Dry or cracked skin | _____ | Rashes, hives, or itchy skin |
| _____ | Acne or break outs | | |
| _____ | Excessive sweating, night sweats | | |

Mental Well-Being

- | | | | |
|-------|----------------------------------|-------|--------------------|
| _____ | Depression or mood swings | _____ | Ongoing fatigue |
| _____ | Decreased memory, foggy thinking | _____ | Anxiety |
| | | _____ | Hyperactivity |
| | | _____ | Sleep Disturbances |

TOTAL SCORE: _____

Total scores higher than 70 or high scores in one particular area may be indicative of an underlying healthcare condition that requires more intense treatment.