



The **Love Yourself Club Nutritional and Wellness Testing Questionnaire**© is the most comprehensive computerized Holistic Symptomology Test for holistic living and nutritional assessment purposes, developed to date.

This test is not for everyone. It has been designed for health conscious, intelligent, motivated individuals seeking an alternative to orthodox drug medicine and who are also willing to become proactive and responsible for their personal life, wellness and future.

Degenerative disease takes many years to develop. Nutritional deficiencies manifest themselves by way of symptoms, body signs and signals, long before the disease process gets a foothold. When nutritional deficiencies remain unaddressed, they eventually develop into "full blown", named medical conditions. Because the human body was created from the dust of the ground, (it's minerals and nutrients), nutrition is essential to the preventative regeneration and treatment process. No medical treatment is complete, nor can it achieve its full therapeutic potential without the implementation of proper nutrition. Nutritional Therapy is both primary and foundational to every known medical and human condition.

At one time in our medical history, medical doctors asked symptomological questions for one to two hours as part of their initial evaluation. In recent times, this detailed form of examination has become a lost art. The good news is, as a result of today's modern computerized technology, we are once again able to deliver the full benefits of the comprehensive evaluation of old, eliminate the chances of human error and improve on the analytical skills of the best doctors in history.

Alone though, it would be impossible for any scientist, doctor or technological device to be able to discover the physiological and psychological symptoms that you already know subconsciously about yourself.

The **Love Yourself Club Nutritional and Wellness Testing Questionnaire**© is designed to analyze and sequence over 2,500 symptoms that correlate to over 100 possible deficiency patterns. This data is then interpreted and presented in a clear easy to understand report of findings.

Instructions

1. This test may take some people from 2 to 4 hours of "quiet time" to complete. It may require that you split the required time into 2 or more sessions.
2. Focus. Be sure to find a quiet place free of intrusion and interruptions, television, radio, talking, door bells or cell phones.
3. Each section addresses multiple symptoms. Underline the most serious condition in the group and score it from 1 to 10 based on the intensity of the condition. (See scoring cart below).
4. Total your scores in each section with a calculator for accuracy and convenience. Place each section score on the respective line and your grand total of all sections on the line at the end of the questionnaire.
5. There is a space allocated at the end of the questionnaire in the event that you feel you need to elaborate on any particular section or symptom. Also, feel free to use additional paper to address any health matter or personal concern that may not have been addressed by the questionnaire.
6. Some questions may appear repetitive. This is all calculated into the master equation. Score each question to the best of your knowledge. In the event no condition exists in a section or if you simply don't know if it does exist, give it a score of "0" (zero score).

Score Definitions:

(Remember to underscore the most serious condition, and then score it from 1 to 10 based on the level of intensity).

0=Does not Exist/Do not know
1=Rarely
2=Mild
3=Sometimes
4=Bothersome
5=Often

6=Very Often
7=Continuous
8=Intense
9=Very Intense
10=A Primary Complaint-Highest Intensity

Do you drink coffee?	Yes___ No___	___ cups per day
Do you smoke	Yes___No___	Smokes per day ___
Do you drink coke/diet coke or soda?	Yes___No___	# per day___
Do you consume wine, beer or alcohol?	Yes___No___	# per month___
Colds, Flues per year: #___		
Do you sleep soundly?	Yes___No___	Sleep ___hrs. per night
Have you done enemas?	Yes___No___	
Have you had colonics?	Yes___No___	
Have you had spinal adjustments?	Yes___No___	

Do you fast (no food)? Yes___No___ Days per year?___
 Do you have a vegetable juicer? Yes___No___
 Do you have a blender? Yes___No___
 Do you have a gym membership? Yes___No___
 Do you exercise? Yes___No___
 Types: _____

How often/hours per week?___ How long?___
 Desire to improve eyesight? Yes___No___
 Desire to strengthen spine? Yes___No___
 Desire to strengthen heart? Yes___No___
 Desire to strengthen muscles? Yes___No___
 Do you have a rebounder? Yes___No___
 Are you able to swallow pills? Yes___No___
 Satisfied with your current weight? Yes___No___
 Have you been on a supervised
 Nutritional program previously? Yes___No___ Dates: _____
 Have you been bed ridden for 1 wk
 or more in the past 2 yrs? Yes___No___
 Chemotherapy in the last 3 yrs? Yes___No___
 # of treatments: _____ Dates: _____
 Radiation in the last 3 yrs? Yes___No___
 # of treatments: _____ Dates: _____
 Major surgery in last 3 yrs? Yes___No___
 # of treatments: _____
 List Type: _____ Date: _____
 List Type: _____ Date: _____
 List Type: _____ Date: _____

Delivered a child in last 3 yrs? Yes___No___
 Are you pregnant? Yes___No___
 If so, how many months:_____
 Do you desire to become pregnant? Yes___No___
 Do you have children? Yes___No___
 If so, how many; what are their names and ages:_____

Have you been on calcium channel blockers
 in the last 2 years? Yes___No___
 Have you taken Tetracycline type drugs in
 the last 3 yrs? Yes___No___
 Have you taken anti-biotics? Yes___No___ When? _____
 For how long a period?_____

Have you taken Cortisone or used
Cortisone creams in last 2 yrs? Yes__No__
Are you a vegetarian? (no flesh products) Yes__No__
Do you avoid milk products? Yes__No__
Do you avoid sunshine? Yes__No__
Glasses/quarts of water drank per day? #_____

Do you consume "refined white sugar"
in any form, more than 1 time per wk? Yes__No__

Do you take aspirin or ibuprofen type
products? Yes__No__

Do you take antacids? Yes__No__

List specific pains, complaints, problems and areas that you would like to address;

What is the "main" complaint you would like us to help you with?

CLIENT'S INFORMATION

Today's Date: ___/___/___

NAME: _____ Date of Birth: ___/___/___

Please print clearly: First Name, Middle Initial, Last Name

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE:() _____ - _____ BUSINESS:() _____ - _____

CELL:() _____ - _____ FAX:() _____ - _____

E-MAIL: _____

OCCUPATION: _____

MEDICAL DOCTOR: _____ PHONE:() _____ - _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CHIROPRACTOR: _____

NUTRITONIST: _____

BLOOD TYPE: _____ HEIGHT: _____ WEIGHT: _____

WEIGHT AT AGE 20: _____ BODY FAT: _____ %

WAIST: _____ " HIPS: _____ " CHEST/BUST: _____ " ARM FLEXED: _____ "

LIST OPERATIONS AND DATES: _____

LIST DIAGNOSED ILLNESSES AND DATES: _____

LIST MEDICATIONS: _____

LIST VITAMINS AND SUPPLEMENTS: _____

SECTION 1

1. Muscle cramps, leg cramps, hip/back pain toes cramp? _____
 2. Nervous, high strung, irritable, nervous habits, hyperactive, listless? _____
 3. Complaining, difficult thinking, sighing? _____
 4. Aching joints, carpal tunnel syndrome? _____
 5. Brittle nails or kidney stones? _____
 6. Spastic colon/stomach, colitis? _____
 7. Cavities, tooth decay, loose teeth, dental fillings, crowded teeth, excessive saliva? _____
 8. PMS, osteoporosis, soft bones, menstrual pain/cramps excessive or engthy? _____
 9. Bell's Palsy, twitches, convulsions? _____
 10. Arthritis symptoms _____
 11. Chronic headache or afternoon headaches? _____
 12. Insomnia, sleeplessness? _____
 13. Acne, eczema or slow healing sores? _____
 14. Heart palpitations, enlarged heart, high blood pressure, heart cramps _____
 15. Chronic fatigue syndrome or fibromalgia? _____
 16. Panic attacks; discourage easily, anxiety, lack of courage, and lack of will power? _____
- Total** _____

SECTION 2

1. Diabetes? _____
2. Hypoglycemia, pre-diabetes? _____
3. Episodes of shakiness and/or tremors? _____
4. Sugar or sweet cravings? _____
5. High or low triglycerides? _____
6. Manic depression, bipolar mental instability? _____
7. Mood/personality change, hyperirritability? _____
8. Do you have blurry vision, nausea, history of cataracts or mucular degeneration? _____
9. Depression, mental instability, lack of ambition, loss of creativity? _____
10. Obesity, 20 pounds or overweight, difficulty loosing weight? _____
11. High LDL or VLDL cholesterol? _____
12. Pre-mature aging, looking and/or feeling older than you are? _____
13. Undue fatigue, tiredness? _____
14. Asthma, allergies? _____

- 15. Easily angered, moody? _____
 - 16. Craving for starches, tendency to gain weight after eating starch? _____
- Total** _____

SECTION 3

- 1. History of parasites, fungus infections, yeast overgrowth, eczema, discoloration around fingernails? _____
 - 2. History of low blood pressure? _____
 - 3. History of hypo/hyper thyroid? _____
 - 4. Mal-absorption problem, require extra vitamin C? _____
 - 5. Loss of skin pigmentation, muddy skin or wrinkled skin, loss of skin color, skin rashes? _____
 - 6. History of anemia or chronic fatigue? _____
 - 7. Mental instability or Jekyll and Hyde personality, forgetfulness? _____
 - 8. Dry hair, graying hair, hair loss, brittle hair, alopecia? _____
 - 9. Parkinson's disease, gulf war syndrome, osteoporosis, ruptured disc? _____
 - 10. Bitter mouth taste, infertile? _____
- Total** _____

Please check mark the Body, Mind and Spirit Services that you may be interested in or may like to receive more information on.

BODY SERVICES:

- 1. Male/Female Hormone Testing?
- 2. Natural Hormone Replacement therapy?
- 3. Anti-aging testing?
- 4. Anti-Aging/Optimal Aging Program?
- 5. Natural Growth Hormone (Anti-Aging Shots)?
- 6. Allergy/Food sensitivity Testing?
- 7. Indican testing (for malabsorption and bowel toxicity)?
- 8. Medical Doctor's appointment?
- 9. Non-Invasive Heart check-up?
- 10. I.V. Super Nutrition?
- 11. Spinal Adjustments?
- 12. Spine Strengthening?

- 13. Fitness Medicine and Personal Training?
- 14. Massage Therapy?
- 15. Hair/Mineral Analysis for heavy metal and/or toxicity?
- 16. Food Reflexology?
- 17. Five Day Boot Camp? (in-patient detoxification, body fat loss, fitness vacation)
- 18. Hyperbaric oxygen Therapy?
- 19. Ozone Therapy?
- 20. Thermogenic Fat Burning and Internal Purification Room?
- 21. Medical Hypnotherapy?
- 22. Colon Hydrotherapy (colonics)?
- 23. Urine Metabolic Testing?
- 24. Comprehensive blood diagnostics for Metabolic and Nutritional Assessment?
- 25. Comprehensive Gastro-intestinal/Stole analysis?

MIND SERVICES:

- 1. Stop Smoking Program?
- 2. Medical Hypnotherapy for
 - a. Stress
 - b. Learning
 - c. Weight/Eating Disorders
 - d. Focus
 - e. Motivation
 - f. Confidence
 - g. Emotional Trauma
 - h. Sexual Dysfunction
 - i. Personality Disorder
 - j. Immune Enhancement
 - k. Speeding the Healing Process
- 3. Psycho-Visual Therapy?
- 4. Career Skills and Aptitude Evaluation?
- 5. Personal Family and Professional Health, Nutrition and Naturopathic Educational Programs leading to certification?
- 6. Self-help Motivational Books?
- 7. Nutritional/Self-Help Books?
- 8. Motivational or Educational health cassette tapes and videos?
- 9. FREE online and e-mail subscriber Holistic Health newsletters and Self-help Videos?

Enter E-mail address: _____

10. Part-time income opportunities as a Prophetic Physician, Holistic Health Counselor or Wellness Coach product distributor for **Dr. Shammah Womack-El, head Naturopath and Prophetic Physician** at the Chapel of Miracles wellness center?

SPIRIT SERVICES:

1. Biblically based Spiritual Literature?
2. Biblically based CDs and videos?
3. Christian Books?
4. FREE membership via e-mail to spiritual literature and online sermon distribution?
- Enter E-mail address: _____
5. Free trial Bible Study/cassette tape membership?
6. Do you desire prayer?
7. Do you care to pray for others?

SECTION 4

1. Gain weight fast, lose weight slowly, puffy face, puffy body? _____
2. History of over or under active thyroid? _____
3. Sever PMS, cystic breast, cystic ovaries, heavy menstrual bleeding? _____
4. Cholesterol over 200, swelling of fingers and/or toes, dull headaches? _____
5. Cold hands or feet, feel cold, reduce body temperature, and can't stand cold? _____
6. Tired in morning, energy improves as the day proceeds, chronic fatigue, or lethargy, mental sluggishness? _____
7. Chronic skin conditions, boils, acne, fungal infections, dry, scaly skin, coarse hair? _____
8. Stuffy nose, sinuses, bronchitis, pneumonia, ear infections, strep throat, dislike for moisture or humidity? _____
9. High strung, frustration, depression, nervousness, inability to concentrate, mentally dull, loss of animation for life? _____
10. Inability to gain weight, constipation, sterility, miscarriages, infertility, appear dull and/or listless, slow moving? _____
- Total** _____

SECTION 5

1. Dizziness, light headedness, sensations of seeing spots before your eyes after sudden movement? _____
 2. Pale skin, palms or hands pale? _____
 3. Anemia, chronic headaches, easily fatigued? _____
 4. Confusion, depression, slow mental reactions, inability to concentrate, forgetfulness, irritability, crying spontaneously? _____
 5. Shortness of breath, difficulty swallowing, dull hearing? _____
 6. Pains in heel and/or soles of feet, soles of feet burn, ice eating, craving for cold drinks? _____
 7. Picky eater, lack of appetite, undue fatigue, mentally/emotionally hard to please? _____
 8. Inflamed and/or sore tongue, heavy menstruation? _____
 9. Sensitivity to cold, constipation, painful breathing, stinging pain in head, flattened fingernails? _____
 10. Tingling of fingers or toes, rapid heart beat with minimal exercise? _____
- Total** _____

SECTION 6

1. Insomnia, PMS, excessive body odor? _____
 2. Hypertension, rapid heart beat, heart disease, myocardial infraction, arrhythmia, irregular heart bear? _____
 3. Kidney stones, gall stones, sluggish colon, chronic arthritis, gas and/or wind in intestines, inflated or bloated intestine? _____
 4. Fibermyalgia, chronic pain, muscles tear or injure easily, aching neck and/or shoulder muscles? _____
 5. Irritable Bowel Syndrome, spastic colon, constipation, colitis, allergies to wool, chilly after retiring? _____
 6. Sensitive to noise, easily irritated, uncontrolled sweating, burning sensation in mouth, bedwetting? _____
 7. Unexplainable ear noises, difficulty hearing, sudden episodes of loss of brain function, confusion, disorientation? _____
 8. Jerky repeated tapping of hands and/or feet, movements lack muscular coordination, muscle twitching, back pain, restless leg syndrome, restless movement of eyes and/or fingers, tremors? _____
 9. Easily weakened by stress, depression, fears, grief, apprehension, grief suppression? _____
 10. Muscle cramps in bottom of feet, nervous heart palpitations, teeth sensitive to cold water, tooth ache when nothing is wrong, muscle spasms? _____
- Total** _____

SECTION 7

1. Brain dysfunction, confusion depression, irritability, nervousness, lack of concentration, crying spells, negative mental attitude, mental disagreement to most every statement, dislike of children, desire to be left alone? _____
 2. Hearing difficulties, tinnitus, deafness, eyes red and/or swollen? _____
 3. Stuttering, tooth grinding, convulsions, tremors? _____
 4. Stiff tendons, gout, carpal tunnel syndrome, glands swell easily? _____
 5. History of miscarriage, loss of libido, breast ailments, still birth, infertility, tenderness in nipples, enlargement of ovaries, womb falling and/or protruding? _____
 6. Creaking and/or clinking of joints, arthritis, join pain? _____
 7. Sprain or injure joints easily, gripping sensation in limbs and body? _____
 8. Bone loss, thinning of bones, brittle bones? _____
 9. Chronic knee, hip and/or ankle pain, gripping sensation in limbs and body? _____
 10. History of low levels of serum blood protein, globulin or albumin? _____
- Total** _____

SECTION 8

1. Loose teeth, teeth that crack or chip, chronic toothaches, cavities? _____
 2. Arthritis, chronic joint pain, bone pain, swollen joints, osteoporosis, paralysis, prone to bronchitis? _____
 3. Brain fog, slow thinking, sluggish mental function, can't get the words out in time? _____
 4. Tremors, nervousness, irritability, neuralgia, neuritis, general weakness, numbness in limbs, loss of muscle tone in arms and/or legs? _____
 5. Hardened wax in ear, afraid of tomorrow, fearful of the unknown? _____
 6. Muscular weakness, physically lazy, hard wax in ears? _____
 7. Sex indifference, infertility, low sperm count, enlarged prostate, sterility, dislike of the opposite sex? _____
 8. Asthma, sinus trouble, catarrh, bronchitis, frequent colds? _____
 9. Poor eyesight, prone to swollen glands, need for glasses (non-stigmatism)? _____
 10. Low red blood count, low hemoglobin? _____
- Total** _____

SECTION 9

1. Rapid heart beat, irregular heart beat, angina, heart disease, stroke, slow heart beat, poor circulation? _____

2. High blood pressure above 140/90 or low blood pressure under 100/70, or on blood pressure medication? _____
 3. Muscle cramps, muscle weakness, muscle softness, intolerance to exercise, lack of desire to exercise? _____
 4. Edema, fluid retention, swelling of ankles, salt retention, impaired kidney function? _____
 5. Muscle twitches, tremors, bitter taste in mouth, tendency to blisters? _____
 6. Acidosis, high acid urine, protein in urine, electrolyte imbalance, highly toxic liver sluggishness, repeat of low grade infection? _____
 7. Swollen glands, nausea, edema, thirst, chills, vomiting, constipation, earaches, swollen ovaries or testicles, swollen ankles? _____
 8. High cholesterol, headaches, dry throat, swollen ovaries or testicles, weakness in female system? _____
 9. Acne, dry skin, itchy skin, eczema, dropsy, inability to digest sugar, pyorrhea, weak ligaments? _____
 10. Inability to recover quickly, chronic fatigue, glucose intolerance, diabetes, distention of stomach? _____
- Total** _____

SECTION 10

1. Prematurely aging and/or looking older than your calendar years, nervous exhaustion, no ambition for brain work, lack of determination and/or mental strength? _____
 2. Hair thinning or falling out, brittle hair, premature graying? _____
 3. Acne, eczema, muddy skin, boils, psoriasis, dermatitis, itchy eyes? _____
 4. Highly toxic, autointoxication, biliousness, tendency to boils? _____
 5. Acid serum blood bio-chemistry, high or low serum calcium? _____
 6. Sinus trouble, bronchitis, frequent colds, catarrh, history of TB, smoking or lung trouble? _____
 7. Weak or swelling joints and/or ligaments, ear discharge, ulcerated gums and/or tongue, parched lips and/or fingernails? _____
 8. High blood pressure, osteoporosis, scleroderma, rheumatoid arthritis, lupus, fibromyositis? _____
 9. Brittle nails, slow healing, teeth sensitive to cold? _____
 10. Dry flaky skin, teeth sensitive to air, sties on eye lids, drug addiction? _____
- Total** _____

SECTION 11

1. Hypochlohydria, Stomach, Digestive, Intestinal and Colon Absorption problems? _____
2. Unable to stand the heat, nauseous if over heated, eyes sensitive to bright lights, constipation, indigestion? _____

3. Feel exhausted early in morning, general debility, decrease in strength or weight, mental depression, loss of temper over nothing, hysterical behavior? _____
 4. History of sun stroke, heat exhaustion, dehydration? _____
 5. Joint stiffness, dry tongue, craving for salt, excessive thirst? _____
 6. History of low serum platelets, cholesterol, or sodium, adrenal exhaustion, electrolyte imbalance, acid bio-chemistry, eyeglass prescription has to be changed often? _____
 7. Heart palpitations, arteriosclerosis, low blood pressure hay fever? _____
 8. Vomiting, nauseated, diarrhea, loss of appetite, sourness of digestive tract, fowl breath, protein foods cause gas? _____
 9. History of high serum platelets, gout, seizures? _____
 10. Excessive perspiration, acidosis, autointoxication, highly toxic condition, use diuretics, bloating? _____
 11. Memory loss, mental or physical apathy, loss of smell? _____
- Total** _____

SECTION 12

1. History of chronic and/or severe allergies? _____
 2. Respiratory congestion/inflammation, toxic condition? _____
 3. Migraine headaches, nerve disorders, moodiness, difficulty speaking and/or singing, voice gives out easily? _____
 4. Itching, skin disorders, acne, dry skin, desire to massage and knead the muscles of the arms and legs? _____
 5. Joint pain, connective tissue pain, arthritis, backache, bone disorders, inflammation, sports injury? _____
 6. Infection, allergies, joyless appearance and/or feelings, throat is whiter than rest of neck? _____
 7. Muscle cramping, wrinkles, burning feet, disc trouble, fingernails thin and/or split, delayed and/or irregular menstruation, repeated women's ailments? _____
 8. Stress, tension, tightness, worry anxiety, uptight, appearance is unhappy or joyless, moodiness? _____
 9. Urinary tract disorders, alkaline urine or saliva, alkalosis? _____
 10. Stomach, reflux, acid stomach, inability to recuperate after illness, exercise, or overwork? _____
- Total** _____

SECTION 13

1. Enlarged prostate, infertility, still births, impotency, low sperm count, loss of sex drive, lack of erection? _____

2. Slow wound healing, slow hair growth, dry/brittle hair, slow nail growth, hair loss? _____
 3. Acne, dermatitis, stretch marks, sunburn easily, sun-induced rashes, canker sores? _____
 4. Loss of smell, loss of taste, lack of appetite? _____
 5. Body odor, oral ulcerations? _____
 6. Weak immune system, recurring ear infections, susceptibility to colds or flu, recurring urinary tract infections, Candida? _____
 7. Experienced a prolonged period of mental/emotional stress in the last 2 years? _____
 8. White spots on fingernails? _____
 9. Slow growth, stunted growth, delayed sexual maturity? _____
 10. Diabetes, hypoglycemia, pancreatic disorders, thyroid disorders? _____
- Total** _____

SECTION 14

1. Excessive gas or indigestion, periods of constipation alternating with diarrhea? _____
 2. Constipation, poorly formed stools, greasy, pale or gray floating stool? _____
 3. Bloating, super bloating after meals, sour stomach, bad breath? _____
 4. Colitis, spastic colon, irritable bowel syndrome, chronic diarrhea, undigested food particles in stool? _____
 5. Stomach or bowel pain after eating, gastric distress while eating? _____
 6. History of diabetes, pancreatitis, hypochlorhydria, low stomach acid, history of stomach or intestinal cancer? _____
 7. History of overeating, been treated for anemia or other nutritional deficiencies? _____
 8. Fatigued or tired after eating? _____
 9. White coated tongue? _____
 10. History of slow or sluggish digestion, incomplete assimilation of nutrients, feeling that food is not digesting fast enough, pieces of undigested food and/or vitamin pills in stool? _____
- Total** _____

SECTION 15

1. Brittle hair, slow hair growth, hair loss, dry hair, split ends? _____
2. Brittle nails, slow growing nails, splitting or soft nails, cataracts, red lines in eyes? _____
3. Mood swings, nervousness, agitation, grouchy, diminished ability to handle stress, inability to recall dreams or insomnia? _____
4. Digestion disturbances, susceptibility to infection? _____
5. Anxiety, depression, panic attacks? _____

- 6. Dry skin, chronic pain, slow cut, burn or wound healing, sore muscles, slow recovery after exercise? _____
 - 7. History of hypoglycemia, diabetes, alcoholism, pancreatitis? _____
 - 8. Low serum protein, BUN, albumin, globulin or creatinine, low hormone levels? _____
 - 9. Chronic fatigue, muscular weakness, history of anemia, feeling of overall weakness? _____
 - 10. Difficulty losing fat weight, difficulty gaining muscle weight, difficulty digesting protein foods? _____
- Total** _____

SECTION 16

- 1. Anxiety, rapid personality changes, depression, mood swings? _____
 - 2. Cracks in corner of mouth, sore tongue or mouth? _____
 - 3. Sugar intolerance and/or sensitivity? _____
 - 4. Blurred vision, dry, burning and/or itching of eyes, feeling of sand in eyes? _____
 - 5. Chronic fatigue, dizziness, muscular weakness, weight loss? _____
 - 6. Eczema, dandruff, patches of dry scaly or rough skin? _____
 - 7. Sleep apnea, insomnia? _____
 - 8. Painful tongue, red or blue tongue, burning tongue, swollen tongue, tongue trenches? _____
 - 9. Agitation, irritability, anger, nervousness? _____
 - 10. Sugar and/or junk food craving and/or addiction? _____
 - 11. Mental dullness, poor concentration, attention deficit? _____
 - 12. Nausea, vomiting, loss of appetite, constipation, indigestion? _____
 - 13. Eye fatigue, eye twitches, macular degeneration, near sightedness, cataracts, constantly rubbing eyes? _____
 - 14. Confusion, fear of unknown origin, paranoia, phobias? _____
 - 15. MSG sensitive, dark circles under eyes? _____
 - 16. Vulnerability to insect bites? _____
 - 17. Compulsive behavior, emotional/mental instability, crying spells, jumpiness, shakiness? _____
 - 18. Hypochlorhydria, bloating, distension after eating? _____
 - 19. Dryness and/or scaling behind ears? _____
 - 20. Burning feet and/or heels, vague abdominal pains? _____
 - 21. Chapped lips, seborrhea dermatitis of face or nose? _____
 - 22. Inability to cope with stress, overwhelmed? _____
 - 23. Convulsions, epilepsy? _____
 - 24. Dry hair loss of texture or shine of hair, oily hair? _____
- Total** _____

SECTION 17

1. Attention deficit, mental dullness, inability to mentally focus, poor concentration, short attention span, alcoholism, listlessness? _____
 2. Anxiety, depression, nervousness, agitation, temper tantrums, quarrelsome, violent behavior or thoughts, argumentative, vague fears of unknown origin, emotionally unstable? _____
 3. Craving for sweets, headache, insomnia, constipation, excessive sweating, nightmares, sleep walking, lack of or excessive appetite, vulnerability to insect bites, nausea, and constipation? _____
 4. Apathy, feeling of impending doom, find yourself feeling you would to cry, noise sensitivity, heaviness, weakness, burning, or numbness of arms, feet, hands or toes, loss of muscle tone in arms and/or legs, slight paralysis? _____
 5. Undue fatigue, diastolic blood pressure over 90, irregular heartbeat, excessive heart beat after moderate exercise, rapid pulse above 80 beats per minute, loss of stomach and digestive acidity, loss of morale, loss of sense of humor, nerves on edge? _____
- Total** _____

SECTION 18

1. Feeling of sand in eyes, cataract, eyes tear spontaneously, blurred vision blood shot eyes, conjunctivitis, light sensitivity, eye fatigue, eye twitches or spasms, nearsightedness, burning and/or itching of eyes, cracks in corner of eyes? _____
 2. Red or blue tongue, inflamed or swollen tongue, painful tongue, tongue bald spots or atrophy? _____
 3. Dandruff, chronic acne, chronic sinus problems, facial white heads, greasy facial skin or nose, oily hair, genitals itch, eczema, chronic dermatitis? _____
 4. Corners of mouth and/or lips cracked, swollen, inflamed or chapped, loss in width fullness of upper lip, sore around or in mouth? _____
 5. Mood swings, nervousness, depression, low blood sugar type dizziness, anemia, vaginal itching? _____
- Total** _____

SECTION 19

1. Dull hair or dandruff, dry, dull, brittle or falling hair, scalp abscesses? _____
2. Susceptibility to infections, sore nose, lungs or throat ear aches, colds, flu, pus n urine, pneumonia, bronchitis? _____
3. Rough or dry skin, acne, warts, eczema, low serum platelets? _____

- 4. Deep trenches or ulcerations in the tongue, sensitive, inflamed or burning mouth or throat, red tongue? _____
 - 5. History of anxiety, irritability, manic depression, schizophrenia, recreational drug use or emotional instability, psychotic behavior, poor thinking, psychosis, nervous disorder? _____
- Total** _____

SECTION 20

- 1. Low libido, impotency, frigidity? _____
 - 2. History of liver sluggishness, hepatitis, cirrhosis, anemia? _____
 - 3. History of lime disease, Epstein bar virus? _____
 - 4. History of candidiasis, parasites, herpes, athletes foot, canker sores, ringworm? _____
 - 5. History of Bell’s palsy, MS? _____
 - 6. History of prostate infection, bladder infection? _____
 - 7. Had a long-term battle with obesity, difficulty-losing weight even when trying to? _____
 - 8. History of cancer? _____
 - 9. Acidosis, high toxicity, acid urine or saliva? _____
 - 10. History of eczema, acne, gout, asthma? _____
- Total** _____

SECTION 21

- 1. History of cancer? _____
 - 2. PMS, insomnia? _____
 - 3. History of brain injury, neuralgia, nerve damage? _____
 - 4. Poor concentration, poor memory, headaches? _____
 - 5. Weak immune system, frequent colds, viral conditions, fungus conditions? _____
- Total** _____

SECTION 22

- 1. Feel you look older for your age, prematurely aging, history of heart disease? _____
- 2. History of cancer? _____
- 3. Infertility or age/liver spots? _____
- 4. History of Parkinson’s disease, muscular dystrophy, multiple sclerosis, cystic fibrosis, Alzheimer’s? _____
- 5. History of liver problems? _____
- 6. Anemia, sickle cell, undue fatigue? _____
- 7. Pancreatitis, pancreatic atrophy? _____

- 8. Muscle weakness? _____
 - 9. Immune deficiencies, frequent colds? _____
- Total** _____

SECTION 23

- 1. History of Candida, Athlete’s foot, E. Coli, impetigo, ringworm, parasites, colds, flu, sore throat, influenza? _____
 - 2. History of infection, staph, tonsillitis, boils, meningitis, ear infections, impetigo? _____
 - 3. History of TB, whooping cough, pneumonia, shingles, impetigo, gonorrhea? _____
 - 4. Enlarged prostate, bladder irritation, cystitis, hemorrhoids? _____
 - 5. Colitis, dysentery, intestinal troubles? _____
- Total** _____

SECTION 24

- 1. Diabetic or insulin resistant, pancreatic dysfunction? _____
 - 2. Hypoglycemic? _____
 - 3. Chronic eight gain, excess body fat? _____
 - 4. High cholesterol or triglycerides, cardiovascular disease? _____
 - 5. Undue fatigue, excessive thirst, infertility, Jekyll/Hyde personality? _____
- Total** _____

SECTION 25

- 1. Presently diagnosed with cancer? _____
 - 2. History of cancer now in remission? _____
 - 3. Family history of cancer and/or exposed to carcinogens? _____
 - 4. High ECA or AMAF or cancer antibody score on blood test? _____
 - 5. Do you desire to go on a special cancer prevention protocol over and above personal nutritional program? _____
- Total** _____

SECTION 26

- 1. History of hemorrhages or inability for the blood to timely clot? _____
 - 2. Low serum platelets? _____
 - 3. Tendency to excessive bleeding from minor wounds? _____
 - 4. Malfunction of the intestinal tract, liver or bile duct causing mal-absorption? _____
 - 5. Use of sulfa drugs, x-rays, radiation, chemotherapy in the last two years? _____
- Total** _____

SECTION 27

1. Extreme exhaustion, hot weather fatigue? _____
 2. Obesity or recent sudden decrease in weight? _____
 3. Cramps, sinus infection, pyorrhea, stiff joint? _____
 4. Acne, pimples, eczema, boils, muddy skin? _____
 5. Constipation, digestive disorders? _____
 6. History of gallstones, gall bladder disorder? _____
 7. History of jaundice, biliousness or spleen problem? _____
 8. Weak voice or pyorrhea, bad body odor? _____
 9. Goiter or thyroid deficiency? _____
 10. History of electrolyte imbalance, high or low serum chlorine, high toxicity? _____
- Total** _____

SECTION 28

1. Tooth decay or spongy bleeding gums, weak tooth enamel, poor tooth structure? _____
 2. Brittle fingernails, skin disorders, brown spots on skin, chapped hands? _____
 3. Hard crusts form on nose, oily, yellowish skin pigmentation, varicose veins? _____
 4. History of osteoporosis, silicon deficiency, calcium deficiency, TB? _____
 5. History of cataracts, failing eyesight, murky color of eyes, backwardness in manners, great aversion to darkness, puffed, swollen lips, ankles, abdomen, and/or neck? _____
- Total** _____

SECTION 29

1. History of depressed mental state? _____
 2. Pituitary gland imbalance? _____
 3. Over age 50? _____
- Total** _____

SECTION 30

1. Vision failing, glaucoma? _____
2. History of stomach and/or duodenal ulcer, hemorrhages or excess bleeding? _____
3. Blood in stool or urine, hemorrhoids? _____
4. History of stroke, hardening of arteries, coronary artery disease, respiratory infections, poor circulation, weak heart? _____
5. Bleeding gums, nose bleeds, lose teeth? _____
6. Spider veins and/or varicose veins, tiny red spots on skin, weak capillaries? _____
7. History of fever blisters, shingles, genital herpes outbreaks, psoriasis? _____

- 8. History of miscarriage, heavy menstrual bleeding? _____
 - 9. Arthritis, swelling or inflammation of joints, swollen extremities? _____
 - 10. Bruise easily, fragile blood vessels, black and blue marks? _____
- Total** _____

SECTION 31

- 1. Blood serum electrolyte imbalance, liver or kidney disorder? _____
 - 2. Urine, saliva acid/alkaline imbalance, mal-absorption, acidosis/alkalosis, indigestion, gallstones? _____
 - 3. Bad breath, body odor? _____
 - 4. Twitches, nervousness, hyper motion, hyperactivity, anxiety, insomnia? _____
 - 5. Heart disease, high blood pressure, poor circulation, rapid heartbeat, arteriosclerosis? _____
 - 6. Gas, constipation, bloating, fluid retention, toxicity? _____
 - 7. PMS, cramps, weakness after sweating? _____
 - 8. Brain fog, depression, attention deficit? _____
 - 9. Sugar craving, hypoglycemia, diabetes? _____
 - 10. Overweight, fatigue? _____
- Total** _____

SECTION 32

- 1. History of heart disease, stroke, angina, coronary artery disease? _____
 - 2. History of cancer? _____
 - 3. Heart rhythm disturbances, high blood pressure, enlarged heart? _____
 - 4. Immune deficiency disorder, increased susceptibility to infections? _____
 - 5. Muscular weakness, chronic unrelenting fatigue? _____
 - 6. Chronic lung infection, shortness of breath, slow recovery after exercise, asthma? _____
 - 7. Severe muscle pain, feel ill after exercise, unable to tolerate exercise, or have an aversion to exercise? _____
 - 8. Obese or difficulty losing weight even when counting calories? _____
 - 9. Muscular atrophy, loss of muscle tone? _____
 - 10. Accelerated aging skin, prematurely aging, looking older than your years? _____
- Total** _____

SECTION 33

- 1. Inability to get or hold an erection? _____
- 2. Infertile or low sperm count? _____
- 3. Decreasing interest in sex or lack of sex drive? _____
- 4. Loss of muscle size, tone or strength? _____
- 5. Premature ejaculation or slow atrophy of the penis? _____
- 6. More difficult remembering things, memory weakening, less patients for _____

- problem solving and figuring things out, trouble focusing? _____
 - 7. Increase in fat weight, flab, hanging skin, stomach larger than hips? _____
 - 8. Increasing loss of physical and/or mental energy? _____
 - 9. Increasing loss of ambition, creativity, get up and go, animation of life,
motivation and manly drive? _____
 - 10. Loss of skin tone, wrinkles? _____
- Total** _____

SECTION 34

- 1. Difficulty urinating or increased straining with less flow? _____
 - 2. History of prostatic infections? _____
 - 3. Pain in rectum? _____
 - 4. Ejaculation causes pain? _____
 - 5. Discharge from penis? _____
 - 6. Lack of sex drive? _____
 - 7. Sense of bladder fullness? _____
 - 8. Blood in urine or rose-colored urine? _____
 - 9. Dripping after urination? _____
- Total** _____

SECTION 35

Optional Female Hormone Replacement / Anti-Aging Medicine Questionnaire (by special request)

SECTION 36

- 1. History of low blood pressure? _____
- 2. Cravings and/or intolerance for sweets? _____
- 3. Constant fatigue? _____
- 4. Mood swings? _____
- 5. Alcohol intolerance? _____
- 6. Muscular weakness? _____
- 7. Nervousness? _____
- 8. Fainting spells, lightheaded? _____
- 9. Insomnia? _____
- 10. Low serum sodium, glucose, insulin, triglycerides? _____
- 11. Paranoia? _____
- 12. Migraines? _____
- 13. Heart palpitations? _____
- 14. Craving for salt? _____
- 15. Break out in hives or rashes? _____
- 16. Clenching and/or grinding of teeth? _____
- 17. Confusion, easily frustrated? _____

- 18. Inability to concentrate, easily distracted? _____
 - 19. Compulsive behavior? _____
 - 20. Can't stand hot humid weather? _____
 - 21. Natural high after eating? _____
 - 22. Extreme sensitivity to odors? _____
 - 23. Difficulty relaxing? _____
 - 24. Tendency to suffer from guilt feelings? _____
 - 25. Can't stand noise? _____
 - 26. Tendency to cry easily? _____
 - 27. Can't stand the stress? _____
 - 28. Clumsiness? _____
 - 29. Fine thin hair? _____
 - 30. Index finger longer than the ring finger? _____
 - 31. Unusually small jawbone? _____
 - 32. Using cortisone cream in the last year? _____
 - 33. Jumpy and/or easily startled? _____
 - 34. Prefer hot drink to cold drinks and/or intolerance to cold drinks? _____
- Total** _____

SECTION 37

- 1. Rectal itching? _____
- 2. Intermittent fever and/or chills? _____
- 3. Constant belching? _____
- 4. Stomach pain after eating? _____
- 5. Rectal pressure? _____
- 6. Loss of muscular size and/or tone? _____
- 7. Uncontrollable appetite? _____
- 8. Bloating after eating? _____
- 9. Weight loss and/or inability to gain weight? _____
- 10. Frequent or constant heartburn? _____
- 11. Diarrhea? _____
- 12. Mucus in stools? _____
- 13. Insomnia? _____
- 14. Night sweats? _____
- 15. Severe fatigue? _____
- 16. Nausea and/or vomiting? _____
- 17. Poorly formed stools? _____
- 18. Itchy skin, worse at night? _____
- 19. Dark circles under eyes? _____
- 20. Digestive distress after eating fatty foods? _____
- 21. House dogs that you pet or kiss? _____
- 22. Eat sushi? _____
- 23. Eat pork, ham, sandwich meats, prosciutto, and sausages? _____

- 24. Are you from a foreign country? _____
 What Country? _____
 - 25. Low serum red blood count, iron or RBC? _____
- Total** _____

SECTION 38

- 1. High serum cholesterol triglycerides, bilirubin or liver enzymes? _____
 - 2. Persistent sleepiness? _____
 - 3. Upper abdominal pain on right side? _____
 - 4. Dark circles and/or bags under eyes? _____
 - 5. Consume alcohol weekly or more? _____
 - 6. History of hepatitis and/or cirrhosis? _____
 - 7. History of intestinal and/or hepatic parasites? _____
 - 8. Gall bladder removed and/or history of gallstones? _____
 - 9. Chronic constipation? _____
 - 10. Take one or more prescription medications? _____
 - 11. Recreational drugs in the past or present? _____
 - 12. History of chemotherapy? _____
 - 13. Taken cholesterol medications? _____
 - 14. Sugar intolerance? _____
 - 15. Gain weight easily? _____
 - 16. Alcohol intolerance? _____
 - 17. History of blood sugar disturbances? _____
 - 18. Pale, greasy stools that float? _____
 - 19. Chronic indigestion? _____
 - 20. Intolerance to fatty foods? _____
 - 21. Foul smelling bowel gas? _____
 - 22. Low serum globulin or platelets? _____
 - 23. History of diabetes? _____
 - 24. History of glardia infection? _____
 - 25. Intestinal worms or amoebic dysentery? _____
- Total** _____

SECTION 39

- 1. Undigested food in stool and/or vitamin pills in stool? _____
- 2. Excessive weight loss or gain? _____
- 3. Liver or pancreatic disease? _____
- 4. Greasy foul smelling stools? _____
- 5. Constipation? _____
- 6. Diarrhea? _____
- 7. Bloating and/or indigestion after meals? _____

- 8. Belching after meals? _____
 - 9. Chronic heartburn? _____
 - 10. Dry flaky and/or chapped skin? _____
 - 11. Chronic fatigue? _____
 - 12. Blood sugar disturbances? _____
 - 13. Use antacids, zantac or tagament on a weekly basis? _____
 - 14. Use alcohol on a weekly basis? _____
 - 15. History of diabetes or hypoglycemia? _____
 - 16. Lactose or milk intolerance? _____
 - 17. History of stomach or intestinal ulcer? _____
 - 18. Gluten intolerance or celiac disease? _____
 - 19. History of Crohn's disease, ulcerated colitis? _____
 - 20. Irritable Bowel Syndrome? _____
 - 21. Psoriasis, eczema or dermatitis? _____
 - 22. Antibiotics in the past year? _____
- Total** _____

SECTION 40

- 1. Itching vagina, penis, groin or rectum? _____
- 2. Abdominal comfort after eating sweet food? _____
- 3. Low body temperature? _____
- 4. Craving for sweets? _____
- 5. Burning urination? _____
- 6. Bloating after meals? _____
- 7. Rectal or vaginal burning? _____
- 8. Vaginal discharge, off white or cottage cheesy? _____
- 9. Skin and/or scalp itches after eating sweets? _____
- 10. Persistent indigestion and/or heartburn? _____
- 11. Itching ear canals and/or belly button? _____
- 12. Chronic sinus problems? _____
- 13. Intolerance to alcohol? _____
- 14. Sensitivity to chemicals, odors, cigarette smoke? _____
- 15. Heavy dandruff, seborrhea? _____
- 16. Itchy skin or scalp? _____
- 17. Ring worm? _____
- 18. Low serum white blood count? _____
- 19. Chronic constipation? _____
- 20. Feeling of being in a mental fog? _____
- 21. Chronic sore and/or scratchy throat? _____
- 22. Feel worse on damp, humid days? _____
- 23. Athlete's foot? _____
- 24. Toenail and/or fingernail fungus? _____
- 25. History of fungal infections? _____
- 26. History of eczema and/or psoriasis? _____

- 27. Allergy or sensitivity to air born molds? _____
 - 28. History of oral, rectal, vaginal thrush? _____
 - 29. Allergy or sensitivity to aged cheese, soy sauce, vinegar, yeast products? _____
 - 30. Taken antibiotics in the past two years? _____
 - 31. Recurrent urinary tract infections? _____
 - 32. Taken steroids, tetracycline, prednisone, cortisone in the past two years? _____
 - 33. Birth control pills? _____
 - 34. Crave bread? _____
 - 35. Crave alcoholic beverages? _____
 - 36. Less than one bowel movement per day? _____
 - 37. Belching? _____
 - 38. Intestinal gas? _____
 - 39. Dry mouth? _____
 - 40. Bad breathe? _____
 - 41. Nasal itching? _____
 - 42. Postnasal drip? _____
 - 43. Burning or tearing eyes, failing vision? _____
 - 44. Ear pain, loss of hearing, fluid in ears? _____
 - 45. Wheezing or shortness of breath? _____
- Total** _____

SECTION 41

- 1. Mood swings? _____
- 2. Fatigued after sugar or desserts? _____
- 3. Insomnia? _____
- 4. Dizziness and/or fainting spells? _____
- 5. Headaches after missing a meal or going too long without eating? _____
- 6. Episodes of shakiness and/or tremors? _____
- 7. Legs feel rubbery and/or weak? _____
- 8. Episodes of agitation or temper tantrums? _____
- 9. Clumsiness? _____
- 10. Easily upset and/or frustrated? _____
- 11. Feelings of disorientation? _____
- 12. Episodes of cold sweats? _____
- 13. Episodes of nausea and/or upset stomach? _____
- 14. Sleepiness after eating a carbohydrate meal? _____
- 15. Bursts of violent or irrational behavior, fits of anger? _____
- 16. Behavior problems in school? _____
- 17. Forgetfulness and/or memory impairment? _____
- 18. Crying spells? _____
- 19. Paranoia or panic attacks, anxiety? _____
- 20. Episodes of blurry vision? _____
- 21. Sudden drop in energy levels during mid-morning and/or mid-day? _____
- 22. Nightmares? _____

- 23. Constant worrying? _____
 - 24. Indecisiveness? _____
 - 25. Feeling of insecurity? _____
 - 26. Sensations of impending doom? _____
 - 27. Poor concentration? _____
 - 28. Heart rhythm disturbances? _____
 - 29. Uncontrollable negative and/or self-destructive thoughts? _____
 - 30. Episodes of uncontrollable eating binges? _____
 - 31. Accident prone? _____
 - 32. Episodes of mental shut down? _____
 - 33. Significant family history of diabetes? _____
 - 34. Craving for salty foods? _____
 - 35. Taken cortisone type drugs within past year? _____
- Total** _____

SECTION 42

- 1. Foul smelling stools? _____
 - 2. Foul smelling intestinal gas? _____
 - 3. Constipation, hard pebble like stools? _____
 - 4. History of colon cancer, lupus, Crohn's disease? _____
 - 5. History of diverticulitis, irritable bowel syndrome, ulcerated colitis, hepatitis? _____
 - 6. History of intestinal parasites, food poisoning, vulnerable to intestinal flu? _____
 - 7. Acne, psoriasis, eczema, seborrhea of the scalp? _____
 - 8. Chronic candidiasis? _____
 - 9. Acid reflux, bloating between meals, indigestion, mal-absorption syndrome, low gear, high gear, heart-burn, acid stomach? _____
 - 10. Taken antibiotics within the past two years? _____
- Total** _____

SECTION 43

- 1. Basil Body Temperature: place mercury thermometer under the arm first time in the morning upon awaking before your feet hit the ground. Record temperature to the tenth degree (example 96.2). My Basil Temperature? _____
- 2. Iodine Test: paint tincture of iodine on the inside of your arm the size of a penny. Record the time. How many hours does it take for the iodine to disappear? Record: hours? # _____ hrs.
- 3. History of hypo/hyper thyroidism or synthoroid or thyroid medication? _____
- 4. High serum cholesterol or triglycerides? _____
- 5. Obesity, excess body fat percentage above 35%, difficult losing weight even when counting calories, chronic weight problems? _____
- 6. Inability or lack of sweating? _____
- 7. Lethargy or weakness? _____

- | | |
|--|-------|
| 8. Slow or slurred speech? | _____ |
| 9. Tired in morning and energetic at night? | _____ |
| 10. Dry or coarse hair, brittle hair? | _____ |
| 11. Cold hands and/or feet? | _____ |
| 12. Bloating and/or indigestion after eating? | _____ |
| 13. Hair loss from outer third of eyebrow? | _____ |
| 14. Dry or coarse skin? | _____ |
| 15. Short-term memory loss? | _____ |
| 16. Swelling of hands and/or ankles? | _____ |
| 17. Chronic headaches? | _____ |
| 18. History of constipation and bowel problems? | _____ |
| 19. PMS and/or other menstrual difficulties? | _____ |
| 20. Infertility history? | _____ |
| 21. History of emotional instability? | _____ |
| 22. Hair loss, slow growing hair? | _____ |
| 23. Heart palpitation? | _____ |
| 24. Excess appetite? | _____ |
| 25. Decrease in sexual desire? | _____ |
| 26. Poor hand to eye coordination? | _____ |
| 27. Hoarseness or coarse voice? | _____ |
| 28. Inability to translate thoughts into action? | _____ |
| 29. Slow reaction time? | _____ |
| 30. Slow thinking? | _____ |
| 31. Difficulty translating words into speech? | _____ |
| 32. Depressed in cold weather? | _____ |
| 33. History of ovary cysts? | _____ |
| 34. Repeated breast inflammation and/or infection? | _____ |
| 35. Received fluoride treatments from dentists? | _____ |
| 36. Cracks on the bottom of your heels? | _____ |
| 37. History of miscarriages? | _____ |
| 38. History of carpal tunnel syndrome? | _____ |
| 39. Cystic breast or lumpy breast history? | _____ |
| 40. History of prematurely stopped periods? | _____ |
| 41. Tendency to feel cold? | _____ |
| Total | _____ |

SECTION 44

- | | |
|--|-------|
| 1. History of chronic, undue mental and/or physical fatigue, adrenal depletion, nervous exhaustion, stress overwhelm, burn out, Epstein Barr, convalescence from illness, inability to recover or recuperate? | _____ |
| 2. History of weak immune system, weak muscles, excess body fat, liver sluggishness, liver disease, male sterility, slow heart, delayed growth, diabetes, under active pituitary, low insulin, low T Cell count? | _____ |
| 3. History of hardening of the arteries, rheumatoid arthritis, cancer, heavy metal | _____ |

- toxicity, mucus, respiratory disorders, bronchitis, T.B., emphysema, chemotherapy, radiation, weak nails, aging skin, dull hair, smoking, autointoxication, high toxicity, sluggish liver, high blood iron, high or low white blood count? _____
4. History of poor fat metabolism, low energy, high triglycerides, weak muscles, neuromuscular disorders, confusion, heart pain, obesity, vegetarian, fatty and/or sluggish liver, excess body fat, heart surgery? _____
 5. History of anxiety, panic disorder, high strung, epilepsy, hypertension, enlarged prostate, attention deficit disorder, hyperactivity, tranquilizers, sleeping pills, inability to relax and let go, over firing nerve cells, nervous break down, frustration, burn out? _____
 6. History of personality disorders, behavioral disorders, epilepsy, slow thinking, ulcers, diabetes, insulin complications, coma, severe hypoglycemia, severe mood swings, sugar and/or alcohol cravings? _____
 7. History of mental lethargy, lack of ambition, inability to think clearly, feeling of "jet lag", inability to focus or mentally concentrate, lack of enthusiasm, exaggerated mood swings, lack of mental energy, recent surgeries (2 years), arthritis, autoimmune disease, fibrosis, intestinal disorders, peptic ulcers, connective tissue problems, epilepsy, undue fatigue, schizophrenia, senility, recovering alcoholic? _____
 8. History of lack of muscular coordination, tremors, difficulty maintaining balance, mental disorientation, confusion, pre-mature aging, liver sluggishness, poor fat metabolism, arteriosclerosis related conditions? _____
 9. History of rheumatoid arthritis, low sex drive, indigestion, weak immune system, heart burn, nerve deafness, radiation exposure, heavy metal toxicity, frigidity, high blood pressure, (women) inability to achieve orgasm, schizophrenia, poor appetite, nausea, lethargy, anger, allergies? _____
 10. History of bi-polar, prostate problems, epilepsy, seizures, manic depression, muscle degeneration, weak stomach, poor digestion, slow healing, gall bladder troubles, poor fat metabolism? _____
 11. High or low serum hemoglobin, blood sugar abnormalities, hypoglycemia symptoms, weak muscles, loss of strength? _____
 12. History of low energy, weak bones and/or muscles, slow healing, slow recovery after exercise, convalescing after an illness, slow healing skin, weak or thin skin, diabetes, high serum glucose, high blood sugar? _____
 13. History of weak immune system, recovering from surgery or illness (2 yrs), cold sores, herpes, anemia, bloodshot eyes, hair loss, poor appetite, weight loss, irritability, enzyme disorders, inability to concentrate? _____
 14. History of difficulty in the digestion of fats, heavy metal toxicity, brittle hair, radiation exposure, osteoporosis, chemical allergies, liver disease, liver sluggishness, auto intoxication, chronic constipation, kidney disorders, hardening of the arteries, muscle weakness, high triglycerides and/or cholesterol, brain fog? _____
 15. History of obesity, excess body fat, poor muscle tone, weak muscles, lack of muscle, weak immune response, sluggish liver, liver disease, slow healing, muscle, bone, joint or connective tissue injury convalescing from illness, low resistance, high toxic condition, chronic constipation? _____
 16. History of depression, brain fog, negative mental attitude, anxiety, stress _____

- overwhelm, obesity, emotionally drained, hypothyroidism, overeating, adrenal exhaustion, tightness of feelings, undue fatigue, uncontrolled eating, mental dullness, Parkinson's disease, schizophrenia, migraines, menstrual cramps? _____
17. Need of a drugless pain control remedy? _____
18. History of weak connective tissue soft bones, bruise easily, weak and/or inflamed joints, cartilage, tendons or connective tissue, bleeding gums? _____
19. History of weak immune system, unsaturated fatty acid deficiency, difficulty digesting fatty foods or dairy, dry skin? _____
20. History of high cholesterol and/or triglycerides, difficulty digesting fats, atherosclerosis, edema, heart disorders, clogged arteries, hypertension, hypoglycemia, electrolyte imbalances, cardiac arrhythmia, anxiety, epilepsy, seizures, dons syndrome, dystrophy, zinc deficiency, nervousness, breast cancer, high platelets, angina, Candida, diabetes, facial twitches? _____
21. History of depression, insomnia, mood swings, hyperactivity, attention deficit disorders, stress overwhelm, nervous break down, feeling of not being able to “take it anymore”, whipped out, migraine, coronary artery spasms? _____
22. History of stress overwhelm, mental and/or physical fatigue, narcolepsy, anxiety, depression, allergies, headaches, drug medication, tobacco, alcohol and/or withdrawal, Parkinson's disease, thyroid troubles, excess body fat, uncontrollable appetite, slow metabolism? _____
23. Desire to build stronger, firmer muscles, desire to improve athletic performance, desire to increase energy? _____
24. History of alcoholism, junk food habit, undue mental and/or physical fatigue, neurological and/or brain disorders, confusion, inability to “get the words out on time”, brain fog, low resistance, toxicity, liver disorders, liver sluggishness, autointoxication, lack of physical or mental energy, chronic constipation, (body builder, athlete) desire to increase energy, high serum bun, A/G ratio, high or low liver enzyme? _____
- Total** _____
- GRAND TOTAL** _____

***“I am come that you may have life, and have it more abundantly.”
(John 10:10)***

Typically, what do you eat and drink each day?			
Breakfast Time:	Lunch Time:	Dinner Time:	Snack Time:

Please use the space provided below to list any additional concerns or areas that you would care to elaborate on. Be sure to reference the section of the questionnaire and the number that you are addressing.

Section: _____

Section: _____

Section: _____

Section: _____

Section: _____

Section: _____

Section: _____

Section: _____

Section: _____

Section: _____

