Andelana

Comprehensive Integrative Health Assessment

Name: ________________________________Age: ____Sex: ___Date: ________

How did you hear about us?____

Please list the 3 major health concerns in your order of importance:

1. ____
2. ____
3. ____

1) **When did symptoms begin? ______Did they begin suddenly or ______ gradually?**
2) **What stresses were occurring in your life when the disease began?**
   ____
3) **Did the illness begin _____ soon after _____ childbirth? _____An injury? ____**
4) **Have you had an:**
   _____Autoimmune illness (e.g. - Lupus, Rheumatoid Arthritis. If yes, list
   ____
   ____

Please list any medications you currently take and for what conditions:
____
____

Please list any natural supplememnts you currently take and for what conditions:
____
____

Any testing done previously? ____
____

Results:____
____
____

How many alcohol beverages do you consume per week? _______How many caffeinated beverages do you consume per day? _______Do you eat organic food? ______How many times a week do you eat raw nuts or seeds? _______
How many times a week do you eat fish? _______How many times a week do you workout? _______
List the 3 healthiest foods you eat during the average week: ________________________, ________________________, ________________________. Do you smoke? ______If yes, how much? ___________Rate your stress levels on a scale of 1-10 during the average week: ____________

Adrenal

0= never/ least | 1= rarely | 2= sometimes | 3= always/ most

(Increased Adrenal)

- Cannot fall asleep 0 1 2 3
- Perspire easily 0 1 2 3
- Under high amounts of stress 0 1 2 3
- Wake up tired even after 6 hours of sleep 0 1 2 3
- Excessive perspiration or perspiration with little or no activity 0 1 2 3

(Decreased Adrenal)

- Cannot Stay Asleep 0 1 2 3
- Crave salt 0 1 2 3
- Slow starter in the morning 0 1 2 3
- Afternoon fatigue 0 1 2 3
- Afternoon headaches 0 1 2 3
- Headaches with excretion or stress 0 1 2 3
- Weak nails 0 1 2 3
- Joint pain 0 1 2 3
- Muscle pain 0 1 2 3
- Low libido 0 1 2 3
- Hair loss 0 1 2 3
- Fatigue 0 1 2 3
- Allergies 0 1 2 3
- Asthma 0 1 2 3
- Recurrent infections 0 1 2 3
- Severe emotional stress 0 1 2 3
- Do you suffer from chronic pain or physical stress? 0 1 2 3

(Hypoglycemia)

- Crave sweets during the day 0 1 2 3
- Irritable if meals are missed 0 1 2 3
- Depend on coffee to keep yourself going or started 0 1 2 3
- Get lightheaded if meals are missed 0 1 2 3
- Eating relieves fatigue 0 1 2 3
- Feel shaky, jittery, tremors 0 1 2 3
- Agitated, easily upset, nervous 0 1 2 3
- Poor memory, forgetful 0 1 2 3
- Blurred vision 0 1 2 3
- Shakiness or irritability relieved with eating 0 1 2 3

(Insulin Resistance)

- Fatigue after meals 0 1 2 3
- Crave sweets during the day 0 1 2 3
- Eating sweets does not relieve cravings for sugar 0 1 2 3
- Must have sweets after meals 0 1 2 3
- Waist girth is equal or larger than hip girth 0 1 2 3
- Frequent urination 0 1 2 3
- Increased thirst and appetite 0 1 2 3
- Difficulty loosing weight 0 1 2 3

(Orthostatic Intolerance/low blood pressure (NHM/POTS)

- **Do you have dizziness or low blood pressure?** **Yes No**
- **Did you ever have a positive Tilt Table Test?** **Yes No**
- **Do you have chronic fatigue without widespread pain?** **Yes No**
- **Do you have low blood pressure?** **Yes No**
- **Do you have a low pulse rate? (less than 70 beats per min. w/o exercise)** **Yes No**
- **When you rise quickly, do you feel as though you might pass out?** **Yes No**

(Anxiety/Hyperventilation)

- **Panic attacks** **Yes No**
- **Shortness of breath that comes and go suddenly (not with exercise) or sudden attacks of inability to take a deep enough breath?** **Yes No**
- **Numbness or tingling around lips, mouth, or fingertips** **Yes No**

(Depression)

- **Do you feel depressed (as opposed to frustration over not being able to function)?** **Yes No**
- **Do you have suicidal thoughts?** **Yes No**

(Disordered Sleep)

- **Trouble falling and/or staying asleep?** **Yes No**
- **Do your legs jump a lot at night?** **Yes No**
- **Do you snore? If yes:** **Yes No**

_____1) Do you fall asleep easily during the day (e.g.- driving or watching T.V)?
_____ 2) Do you have periods that you stop breathing during sleep?
_____ 3) Do you have high blood pressure?
_____ 4) Are you more than 20lbs overweight?
_____ 5) Shirt collar size of 17'' or larger?

(Other Infections)

- **Has any antibiotic improved your fatigue?** **Yes No**
- **Do you have chronic or intermittent low-grade fevers?** **Yes No**
- **Do you get scabbing scalp sores?** **Yes No**
- **Do you have chronic lung congestion?** **Yes No**
- **Are you allergic to 2 or more unrelated antibiotics?** **Yes No**
- **Do you have vertigo (feeling like you or the room is spinning in a circle)** **Yes No**
- **Chronic nasal congestion or post nasal drip** **Yes No**
- **Chronic yellow or green nasal discharge** **Yes No**

(Essential Fatty acid deficiency)

- **Dry eyes?** **Yes No**
- **Dry mouth?** **Yes No**

LOW THYROID FUNCTIUON

Question	Score
• Do you experience fatigue?	Yes-4 No-0
• Do you have elevated cholesterol?	Yes-4 No-0
• Do you have difficulty losing weight?	Yes-2 No-0
• Do you have cold hands and feet?	Yes-2 No-0
• Are you sensitive to cold?	Yes-2 No-0
• Do you have difficulty thinking?	Yes-2 No-0
• Do you find it hard to concentrate?	Yes-2 No-0
• Do you have poor short-term memory?	Yes-2 No-0
• Are your moods depressed?	Yes-2 No-0
• Are you experiencing hair loss?	Yes-2 No-0
• Do you have less than one bowel movement?	Yes-2 No-0
• Do you have dry itchy skin?	Yes-2 No-0
• Do you have dry itchy skin during the winter?	Yes-1 No-0
• Do you experience fluid retention?	Yes-2 No-0
• Do you have recurrent headaches?	Yes-1 No-0
• Do you sleep restlessly?	Yes-1 No-0
• Are you tired when you awaken?	Yes-2 No-0
• Do you have afternoon fatigue?	Yes-2 No-0
• Do you experience tingling or numbness in your hands or feet?	Yes-2 No-0
• Do you experience decreased sweating?	Yes-2 No-0
• Have you had problems with infertility or miscarriages?	Yes-2 No-0
• Do you have recurrent infections?	Yes-2 No-0
• Do your muscles ache?	Yes-2 No-0
• Do you have joint pain?	Yes-2 No-0
• Do you have thinning of your eyebrows or eyelashes?	Yes-2 No-0
• Is your tongue enlarged with teeth indentions?	Yes-2 No-0
• Is your skin pasty, puffy, or pale?	Yes-2 No-0
• Do you have decreased body hair?	Yes-2 No-0
• Is your voice hoarse?	Yes-1 No-0
• Do you have low blood pressure?	Yes-2 No-0
• Does your body temperature run below the normal 98.6?	Yes-4 No-0
• Do you have sleep apnea?	Yes-2 No-0
	Total Score

<11 Low Thyroid Function not likely
Between 11 and 30 suggests that Low Thyroid Function is a possibility
>30 Low Thyroid Function is likely

Thyroid

0= never/ least 1= rarely 2= sometimes 3= always/ most

Symptom	Score
(Decreased Pituitary)	
• Diminished sex drive	0 1 2 3
• Menstrual disorders of lack of menstruation	0 1 2 3
• Increased ability to eat sugars without symptoms	0 1 2 3
(Increased Pituitary)	
• Increased sex drive	0 1 2 3
• Tolerance to sugars reduced	0 1 2 3
• "Splitting" type headaches	0 1 2 3
(Increased Thyroid)	
• Heart palpations	0 1 2 3
• Inward trembling	0 1 2 3
• Increased pulse even at rest nervous and emotional	0 1 2 3
• Insomnia	0 1 2 3
• Night sweats	0 1 2 3
• Difficulty gaining weight	0 1 2 3

HGH Deficiency

1.	Increase in the visceral fat?	Yes No
2.	Decrease in muscle mass and strength?	Yes No
3.	Decrease in bone density?	Yes No
4.	Increase in fracture risk?	Yes No
5.	Increase LDL cholesterol and Apo-protein B?	Yes No
6.	Decreased in insulin sensitivity?	Yes No
7.	Increased fibrinogen levels with disturbed endothelial function?	Yes No
8.	Decrease sense of well being?	Yes No
9.	Decrease sex drive, depression, anxiety, including social anxiety?	Yes No

Male Hormone

0= never/ least 1= rarely 2= sometimes 3= always/ most

(Male Prostate)

- Urination difficulty or dribbling 0 1 2 3
- Urination frequent 0 1 2 3
- Pain inside of legs or heels 0 1 2 3
- Feeling of incomplete bowel evacuation 0 1 2 3
- Leg nervousness at night 0 1 2 3

(Male Andropause)

- Decrease in libido 0 1 2 3
- Decrease in spontaneous morning erections 0 1 2 3
- Difficulty in maintain morning erections 0 1 2 3
- Spells of mental fatigue 0 1 2 3
- Inability to concentrate 0 1 2 3
- Episodes of depression 0 1 2 3
- Muscle soreness 0 1 2 3
- Decrease in physical stamina 0 1 2 3
- Unexplained weight gain 0 1 2 3
- Increase in fat distribution around chest and hips 0 1 2 3
- Sweating attacks 0 1 2 3
- More emotional than in the past 0 1 2 3
- Are you frequently irritable 0 1 2 3
- High blood pressure of high cholesterol (or on medication for these) 0 1 2 3
- Do you have difficult time making decisions 0 1 2 3
- Have you had a decline in your mental sharpness 0 1 2 3
- Has your stamina and endurance lessened 0 1 2 3
- Have you lost muscle mass, strength, or tone 0 1 2 3
- Have you gained body fat around your waist 0 1 2 3
- Do you experience fatigue 0 1 2 3
- Do you lack initiative 0 1 2 3
- Are you less assertive 0 1 2 3
- Do you have decline in your sense of well being 0 1 2 3
- Do you have sleep apnea 0 1 2 3
- Has your self-confidence declined 0 1 2 3
- Do you find it difficult to set goals 0 1 2 3

Female Hormone

- Age First Menstrated? ________________
- Cycle: every______day for_________days
- Average flow? ___________
- Age at first child? ______last child? __________
- Number of pregnancies? _______number of children? ______number of miscarriages? _______
- Infertility? _______________
- Treatment method? ______________
- History of Endometriosis? _____________
- Painful periods? ______________
- Fibroid tumors? ______________
- Poly cystic ovarian disease? _____________
- Postpartum depression? ______________
- Fibrocystic Disease? ______________
- Method of Birth control? ____
- Menopause at age? ________
- Post Menopausal Hormonal replacement
- Therapy? ________________
- Benefits? ________________
- Drawbacks? ________________

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(Menstruating Females)

- Alternating menstrual cycle lengths — Yes No
- Extended menstrual cycle, greater than 32 days — Yes No
- Shortened menses, less than every 24 days — Yes No
- Pain and cramping during periods — 0 1 2 3
- Scanty blood flow — 0 1 2 3
- Heavy blood flow — 0 1 2 3
- Breast pain and swelling during menses — 0 1 2 3
- Pelvic pain during menses — 0 1 2 3
- Irritable and depressed during menses — 0 1 2 3
- Acne break outs — 0 1 2 3
- Facial hair growth — 0 1 2 3
- Hair loss/thinning — 0 1 2 3
- Do you have premenstrual mood swings — 0 1 2 3
- Do you experience premenstrual headaches? — 0 1 2 3
- Do you experience migraine headaches? — 0 1 2 3
- Do you have uterine fibroids? — 0 1 2 3
- Do you have fibrocystic breast disease? — 0 1 2 3
- Endometriosis or infertility — 0 1 2 3
- Have you had a hysterectomy, ovaries removed, or tubal ligation? ________ When? ______
- Are your symptoms worse the week before your period? — 0 1 2 3

(Menopausal Females)

- How many years have you been menopausal? _______
- Since menopause, do you ever have uterine bleeding? — Yes No
- Hot flashes — 0 1 2 3
- Do you have night flashes — 0 1 2 3
- Mental fogginess — 0 1 2 3
- Disinterest in sex — 0 1 2 3
- Mood swings — 0 1 2 3

- **Depression** **0 1 2 3**
- **Painful intercourse** **0 1 2 3**
- **Shrinking breasts** **0 1 2 3**
- **Facial hair growth** **0 1 2 3**
- **Acne** **0 1 2 3**
- **Increased vaginal pain, dryness of itching** **0 1 2 3**
- **Do you urinate frequently** **0 1 2 3**
- **Do you have difficulty sleeping** **0 1 2 3**

GI Health

0= never/ least 1= rarely 2= sometimes 3= always/ most

(Hypocholorhydria)

- **Excessive belching, burping, or bloating** **0 1 2 3**
- **Gas immediately following a meal** **0 1 2 3**
- **Offensive breath** **0 1 2 3**
- **Difficult digesting fruits and vegetables** **0 1 2 3**
- **Undigested foods found in stools** **0 1 2 3**

(Hyperacidity)

- **Stomach pain, burning, or aching 1-4 hours after eating** **0 1 2 3**
- **Do you frequently use antacids** **0 1 2 3**
- **Feeling hungry an hour or two after eating** **0 1 2 3**
- **Heartburn when lying down or bending forward** **0 1 2 3**
- **Temporary relief from antacids, foods, milk, or carbonated beverages** **0 1 2 3**
- **Digestive problems subside with rest and relaxation** **0 1 2 3**
- **Heartburn due to spicy foods, chocolate, citrus peppers, alcohol, and caffeine** **0 1 2 3**

(Small intest/ pancrease)

- **Roughage and fiber cause constipation** **0 1 2 3**
- **Indigestion and fullness last 2-4 hours after eating** **0 1 2 3**
- **Pain, tenderness, soreness on left side under rib cage)** **0 1 2 3**
- **Excessive passage of gas** **0 1 2 3**
- **Nausea and/ or vomiting** **0 1 2 3**
- **Stool undigestive, foul smelling, mucous-like, greasy, or poorly formed** **0 1 2 3**
- **Frequent urination** **0 1 2 3**
- **Increased thirst and appetite** **0 1 2 3**
- **Difficulty losing weight** **0 1 2 3**

(Biliary)

- **Greasy or high fat foods cause distress** **0 1 2 3**
- **Lower bowel gas and or bloating several hours after eating** **0 1 2 3**
- **Bitter metallic taste in mouth especially in the morning** **0 1 2 3**
- **Unexplained itchy skin** **0 1 2 3**
- **Yellowish cast to eyes** **0 1 2 3**
- **Stool color alternates from clay colored to normal brown** **0 1 2 3**
- **Reddened skin, especially palms** **0 1 2 3**
- **Dry of flaky skin and /or hair** **0 1 2 3**
- **History of gallbladder attacks or stones** **0 1 2 3**
- **Ave you had your gallbladder removed** **Yes No**

(Colon)

- **Feeling that bowels do not empty completely** **0 1 2 3**
- **Lower abdominal pain relief by passing stool or gas** **0 1 2 3**
- **Alternating constipation and diarrhea** **0 1 2 3**
- **Diarrhea** **0 1 2 3**

- Constipation 0 1 2 3
- Hard, dry or small stool 0 1 2 3
- Coated tongue of “fuzzy” debris on tongue 0 1 2 3
- Pass large amount of foul smelling gas 0 1 2 3
- More than 3 bowel movements daily 0 1 2 3
- Use laxatives frequently 0 1 2 3

Yeast

0= never/ least 1= rarely 2= sometimes 3= always/ most

- Have you taken a broad spectrum antibiotic drug:
  a) In the last 6 months 0 1 2 3
  b) If the response to A is no, have you ever taken antibiotics? 0 1 2 3
- Have you been treated for acne with tetracycline, erythromycin, or any other antibiotic for one month or longer? 0 1 2 3
- Have you taken antibiotics for any type of infection for more than two consecutive months or shorter courses over 3 times in a twelve-month period? 0 1 2 3
- Do you have spastic colon or Irritable Bowel Syndrome(gas, bloating, diarrhea and/ or constipation)? 0 1 2 3
- Do you have chronic sinusitis, nasal congestion, or post nasal drip? 0 1 2 3
- Do you have allergy symptoms? 0 1 2 3
- Have you ever had prostatitis or vaginitis? 0 1 2 3
- Have you taken birth control pills? 0 1 2 3
- Have you taken corticosteroids such as Prednisone, Cortef, or Medrol 0 1 2 3
- Have you ever had a fungal infection , such as jock itch, athlete’s foot, or a nail or skin infection, that was difficult to treat? 0 1 2 3
- Do you crave sugar? 0 1 2 3
- Do you crave breads? 0 1 2 3
- Do you crave alcoholic beverages? 0 1 2 3
- Have you ever had Candida/yeast? 0 1 2 3
- Symptoms worse on damp, muggy days or in moldy place 0 1 2 3
- Fatigue or lethargy 0 1 2 3
- Poor memory 0 1 2 3
- Depression 0 1 2 3
- Muscle and or joint aches or weakness 0 1 2 3
- Abdominal pain 0 1 2 3
- Constipation 0 1 2 3
- Diarrhea 0 1 2 3
- Bloating, belching, or intestinal gas 0 1 2 3
- Vaginal burning, itching, or discharge 0 1 2 3
- Premenstrual tension 0 1 2 3
- Irritability 0 1 2 3
- Inability to concentrate 0 1 2 3
- Frequent mood swings 0 1 2 3
- Recurrent rashes or itching 0 1 2 3
- Rectal itching 0 1 2 3
- Urgency of urinary frequency 0 1 2 3
- Burning while urinating 0 1 2 3
- Do you have indigestion or heartburn? 0 1 2 3
- Do you have abnormal bodily reactions to wine, beer, or liquor such as flushing, headache, sinus congestion, or itchy skin? 0 1 2 3

Parasites

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ONLY ANSWER FIRST 4 IF YOU HAVE DIARRHEA, GAS OR BLOATING

1. Did your problems begin with a diarrhea attack? Yes No
2. Did you sometimes have severe diarrhea? Yes No
3. Did loose stool symptoms begin in association with antibiotics? Yes No
4. Do you have well water? Yes No

- Have you traveled outside the USA? Yes No
  since traveling abroad, have you had an
  elevated white blood count, intestinal problems, night sweats, or unexplained fever?
- Do you drink untested or unfiltered water? Yes No
- Do you use a microwave oven for cooking Yes No
  (instead of reheating) beef, fish, or pork?
- Do you prefer fish or meat that is undercooked, Yes No
  i.e. rare or medium rare?
- At home, do you use the same cutting board for Yes No
  chicken, fish, or meats as you do for vegetables?
- Have you lied with, or do you currently live with or handle pets? Yes No
- Do you work of have children in a daycare center? Yes No
- Do you garden or work in a yard to which cat and dogs have access? Yes No
- Have you ever had parasites? Yes No
- Red blood in stool 0 1 2 3
- Abdominal pain and cramps 0 1 2 3
- Lower back pain 0 1 2 3
- Gas, bloating 0 1 2 3
- Fever 0 1 2 3
- Chronic fatigue 0 1 2 3
- Constipation 0 1 2 3
- Diarrhea 0 1 2 3
- Foul smelling stools 0 1 2 3
- Anal itching 0 1 2 3
- Bad breath 0 1 2 3
- Grind teeth 0 1 2 3
- Lethargic 0 1 2 3
- Mucus in stool 0 1 2 3
- Lack of stamina 0 1 2 3

ALLERGIES

Question	Yes	No
• Do you experience fatigue?	Yes-3	No-0
• Do you have frequent headaches?	Yes-2	No-0
• Do you experience sneezing, post nasal drip, or itching in nose?	Yes-4	No-0
• Do you have frequent colds?	Yes-2	No-0
• Do you experience dizziness?	Yes-4	No-0
• Do you get sinus infections every year?	Yes-3	No-0
• Do your eyes get itches, water, get red or swell?	Yes-4	No-0
• Do you have recurrent ear infections?	Yes-2	No-0
• Do you have asthma. wheezing, and tightness in the chest or chronic fatigue?	Yes-4	No-0
• Do you have skin problems such as eczema, skin rash, • itching or hives?	Yes-3	No-0
• Do you have indigestion, bloating, diarrhea, or constipation?	Yes-1	No-0
• Do your symptoms worsen during a particular season, such as spring or fall?	Yes-4	No-0
• Do your symptoms change when you go indoors or outdoors?	Yes-3	No-0
• Are your symptoms worse in the parks or grassy areas?	Yes-4	No-0
• Are your symptoms worse in the bedroom after going to bed, or in the morning upon rising?	Yes-2	No-0
• Do you awaken in the middle of the night with congestion?	Yes-2	No-0
• Are your symptoms worse around animals?	Yes-2	No-0
• Do you have any blood relatives with allergies?	Yes-2	No-0
• Do you have mood swings or have depression for no reason?	Yes-1	No-0
• Do you have recurrent yeast infections, jock itch, athletes foot, or fungus under your toenails?	Yes-2	No-0
• Do you develop symptoms after or drinking or eating certain foods?	Yes-2	No-0
• Do you sometimes feel stimulated,hyperactive,or fatigued after meals?	Yes-2	No-0
• Do you have dark circles under your eyes?	Yes-2	No-0
• Do you have a crease across the bridge of our nose?	Yes-2	No-0

If your score is less than 9, it is less likely that you have allergies.
A score between 9 and 12 suggests the possibility of allergies.
A score between 13 and 30 means that allergies are possible.
A score above 30 indicates that allergies are very likely.

Liver Detox

1. Are you presently using prescription drugs? Yes No
   If yes, how many are you currently taking? ___________
   List:
   ____
   ____
   ____
2. Are you currently taking one or more of the following over-the counter drugs?
   ____ Cimetidine
   ____ Acetaminophen
3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
   - Experience side effects, drug(s) is (are) efficacious at lowered dose(s)
   - Experience side effects, drug(s) is (are) efficacious at usual dose(s)
   - Experience no side effects, drug(s) is (are) usually not efficacious
   - Experience no side effects, drug(s) is (are) usually efficacious
4. Do you have drug allergies? If so to which drugs and what type of reaction have You experience?
   ____
   ____
   ____
5. Do you currently use or within last 6 months had you regularly used tobacco products? Yes / No
6. Do you have strong negative reactions to caffeine or caffeine containing products? Yes / No
7. Do you commonly experience "brain fog" , fatigue, or drowsiness? Yes / No
8. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors? Yes / No / don't know

10. Do you feel ill after you consume even small amounts of alcohol? Yes / No / don't know
11. Do you have a personal history of:
    ____Environmental and/or chemical sensitivities
    ____Chronic fatigue syndrome
    ____Multiple chemical sensitivity
    ____Fibromyalgia
    ____Parkinson's type symptoms
    ____Alcohol or chemical dependence
    ____Asthma

12. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents? Yes No

13. Do you have an adverse of allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, ect? Yes / No / don't know

Toxicity Exposure

- Do you drink from aluminum cans or cookware made of Teflon or aluminum? Yes No
- Do you eat organic/ no organic foods? Yes No
- Do you garden? If yes, do you use pesticides or fertilizer in you garden? Yes No
- Do you work in an environment with chemical/ metal exposure? Yes No
  (i.e. solderizing/ planting/ electronics/ glass manufacture/ pottery/ batteries)
- Do you grill with charcoal? Yes No
- Do you eat seafood? Yes No
- How often do you eat fish? _____________, what type of fish? ___________________
  ____
- Do you smoke_______, and are you exposed to second hand smoke? Yes No
- Do you refinish furniture? Yes No
- Do you live in a home built before the 1970's? Yes No
- Have you had a "nuclear" scan? Yes No
- Do you dye, perm, or bleach your hair? Yes No
- Have you been exposed to black mold? Yes No
- Do you wear clothes with natural/synthetic fibers? Yes No
- Do you have well water? Yes No
- Have you had surgery recently? Yes No

Toxicity Exposure Symptoms

Rate each of the following symptoms passed on your typical health profile for the specified duration

---Past Month ---Past week ---Past 48 hours

0= never/ least 1= rarely 2= sometimes 3= always/ most

Head
______Headaches
______Faintness
______Dizziness
______Insomnia

Eyes
______Watery or itchy eyes
______Swollen, reddened or sticky eyelids
______Bags or dark circles under eyes
______Blurred or tunnel vision

Ears
______Itchy ears
______Earaches, ear infections
______Drainage from ear
______Ringing in ears, hearing loss

Nose
______Stuffy nose
______Sinus problems
______Hay fever
______Sneezing attacks
______Excessive mucus formation
______Sensitive to smells & chemicals

Mouth/ Throat
______Chronic Fatigue
______Gagging, frequent need to clear throat
______Coated tongue
______Sore throat, hoarseness, loss of voice -
______Swollen or discolored tongue, gums, lips(black spot)
______Canker sores
______Sensitive teeth
______Metallic taste in mouth
______Gum disease

Skin
______Acne
______Hives, rashes, dry skin
______Hair loss
______Flushing, hot flashes
______Excessive sweating

Heart
______Chest Pain
______Irregular or skipped heartbeat
______Rapid or pounding heartbeat

Lungs
______Chest congestion
______Asthma, bronchitis
______Shortness of breath
______Difficulty breathing

Digestive Tract
_______Nausea, vomiting
_______Diarrhea
_______Constipation
_______Bloated feeling
_______Belching, passing gas
_______Heartburn
_______Intestinal/stomach pain

Joints/ Muscle
_______Pain or aches in joints
_______Arthritis
_______Stiffness or limitation of movement
_______Feeling of weakness or tiredness
_______Pain or aches in muscles
_______Muscle tremors
_______Tingling/ numbness of extremities
_______Unsteady gait

Weight
_______Binge eating/drinking
_______Craving certain foods
_______Excessive weight
_______Water retention
_______Underweight
_______Compulsive eating

Energy/ Activity
_______Fatigue, sluggishness
_______Apathy, lethargy
_______Hyperactivity
_______Restlessness
_______Insomnia

Mind
_______Poor memory
_______Confusion, poor compression
_______Difficulty in making decisions
_______Stuttering or stammering
_______Slurred speech
_______Learning disabilities
_______Poor concentration/ brain fog
_______Poor physical coordination

Emotions
_______Mood swings
_______Anxiety, fear, nervousness
_______Anger, irritability, aggressiveness
_______Depression

Other
_______Frequent illness
_______Frequent or urgent urination
_______Genital itch or discharge
_______Multiple allergies(food and environmental)
_______Intolerance to medications and vitamins

Score:________________> 15 likely < 14 less likely