



Category VII

Fatigue after meals	0	1	2	3
Heart palpitates if meals missed	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 losing weight	0	1	2	3
Afternoon headaches	0	1	2	3
Fatigue, eating relieves	0	1	2	3

Category VIII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slower start in the morning	0	1	2	3
Afternoon fatigue (chronic fatigue)	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3
Exhaustion (muscular/nervous)	0	1	2	3
Bowel disorders	0	1	2	3
Swollen ankles	0	1	2	3
Tendency to hives	0	1	2	3
Allergies (tendency to asthma)	0	1	2	3
Low blood pressure	0	1	2	3
Perspiration increase	0	1	2	3
Brown spots/bronzing skin	0	1	2	3
Arthritic tendencies	0	1	2	3
Poor circulation	0	1	2	3

Category IX

Hair growth on face/body (female)	0	1	2	3
Sugar in urine (not diabetes)	0	1	2	3
Cannot fall asleep	0	1	2	3
Hot flashes	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up feeling tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3
Masculine tendencies (female)	0	1	2	3
Increased blood pressure	0	1	2	3
Headaches	0	1	2	3
Dizziness	0	1	2	3

Category X

Tired, sluggish, fatigue easily	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Ringing in ears	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow things	0	1	2	3
Thinning of hair on scalp, face, or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3
Slow pulse below 65	0	1	2	3
Decrease in appetite	0	1	2	3
Frequency of urination	0	1	2	3
Impaired hearing	0	1	2	3

Category XI

Cannot work under pressure	0	1	2	3
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
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
Flush easily	0	1	2	3
Intolerance to heat	0	1	2	3
Irritable and restless	0	1	2	3
Eyelids and face twitch	0	1	2	3
Thin, moist skin	0	1	2	3

Category XII

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3
Bloating of abdomen	0	1	2	3
Weight gain (hips/waist)	0	1	2	3
Abnormal thirst	0	1	2	3
Tendency to ulcers (colitis)	0	1	2	3

Category XIII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3
Low blood pressure	0	1	2	3
Failing memory	0	1	2	3

Category XIV (Males only)

Urination difficulty or dribbling	0	1	2	3
Frequent urination and/or at night	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 as night	0	1	2	3
Prostate trouble	0	1	2	3

Category XV (Males only)

Decreased libido (sex drive)	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining 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/pain	0	1	2	3
Decrease in physical stamina (fatigue easily)	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
Avoid activity	0	1	2	3

Category XVI (Menstruating females only)

Organs removed	Yes	No		
Are you peri-menopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menstrual cycle, 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 breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3
Very easily fatigued	0	1	2	3
Vaginal discharge	0	1	2	3
Hot flashes	0	1	2	3

Category XVII (Menopausal Females Only)

How many years have you been menopausal?				
Organs removed	Yes	No		
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot Flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex (low libido)	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 or itching	0	1	2	3

Category XVIII

Hands and feet go to sleep easily (numbness)	0	1	2	3
Muscle cramps (charley horse)	0	1	2	3
Swollen ankles (worse at night)	0	1	2	3
Get "drowsy" often	0	1	2	3
Bruise easily (black and blue)	0	1	2	3
High altitude discomfort	0	1	2	3
Opens windows in closed room	0	1	2	3
Noises in head, or "ringing in ears"	0	1	2	3
Tendency to anemia	0	1	2	3
Shortness of breath on exertion	0	1	2	3
Tension under breastbone, or feeling of tightness, worse on exertion	0	1	2	3
Aware of breathing heavy	0	1	2	3
Sigh frequently, "air hunger"	0	1	2	3
Dull pain in chest or radiating into left arm, worse on exertion	0	1	2	3
Frequent nose bleeds	0	1	2	3
Susceptible to colds and/or fevers	0	1	2	3
Afternoon "yawner"	0	1	2	3

Category IXXa

Acid food upset	0	1	2	3
Get chilled often	0	1	2	3
"Lump" in throat	0	1	2	3
Dry mouth-eye-nose	0	1	2	3
Pulse speeds after meal	0	1	2	3
Keyed up-fail to calm	0	1	2	3
Gag easy	0	1	2	3
Unable to relax, startles easily	0	1	2	3
Extremities cold, clammy	0	1	2	3
Strong light irritates	0	1	2	3
Urine amount reduced	0	1	2	3
Heart pounds after retiring	0	1	2	3
Appetite reduced	0	1	2	3
Cold sweats often	0	1	2	3
Fever easily raised	0	1	2	3
Neuralgia-like pains (extremities)	0	1	2	3
Staring, blinks little	0	1	2	3
Sour stomach frequent	0	1	2	3
Cuts heal slowly	0	1	2	3
"Nervous stomach"	0	1	2	3

Category IXXb

Joint stiffness after arising	0	1	2	3
Muscle-leg-toe cramps at night	0	1	2	3
"Butterfly" stomach, cramps	0	1	2	3
Eyes blink often	0	1	2	3
Eyes or nose watery	0	1	2	3
Feels "lightheaded" often	0	1	2	3
Digestion rapid	0	1	2	3
Vomiting frequent	0	1	2	3
Hoarseness frequent	0	1	2	3
Pulse slow; feels "irregular"	0	1	2	3
Breathing irregular	0	1	2	3
Subject to colds	0	1	2	3
"Slow starter"	0	1	2	3
Get "chilled" infrequently	0	1	2	3

Category IXXb continued

Perspire easily	0	1	2	3
Eyelids swollen, puffy	0	1	2	3
Circulation poor, sensitive to cold	0	1	2	3
Subject to asthma or bronchitis	0	1	2	3
Difficulty swallowing	0	1	2	3
Constipation, diarrhea, alternating	0	1	2	3
Gagging reflex slow	0	1	2	3
Indigestion soon after meals	0	1	2	3
Always seems hungry	0	1	2	3

Category XXa

Is your memory noticeably declining?	0	1	2	3
Are you having a hard time remembering names and phone numbers?	0	1	2	3
Is your ability to focus noticeably declining?	0	1	2	3
Has it become harder for you to learn things?	0	1	2	3
How often do you have a hard time remembering your appointments?	0	1	2	3
Is your temperament getting worse in general?	0	1	2	3
Are you losing your attention span endurance?	0	1	2	3
How often do you find your self down or sad?	0	1	2	3
How often do you fatigue when driving compared to the past?	0	1	2	3
How often do you fatigue when reading compared to the past?	0	1	2	3
How often do you walk into rooms and forget why?	0	1	2	3
How often do you pick up your cell phone and forget why?	0	1	2	3
How high is your stress level?	0	1	2	3
How often do you feel that you have something that must be done?	0	1	2	3
Do you feel you never have time for yourself?	0	1	2	3
How often do you feel you are not getting enough sleep or rest?	0	1	2	3
Do you find it difficult to get regular exercise?	0	1	2	3
Do you feel uncared for by the people in your life?	0	1	2	3
Do you feel you are not accomplishing your life's purpose?	0	1	2	3
Is sharing your problems with someone difficult for you?	0	1	2	3

Category XXb

1 - S

How often do you feel overwhelmed with ideas to manage?	0	1	2	3
How often do you have feelings of inner rag (anger)?	0	1	2	3
How often do you have feelings of paranoia?	0	1	2	3
How often do you feel depressed in overcast weather?	0	1	2	3
How often do you have difficulty falling into deep restful sleep?	0	1	2	3
How often do you have feeling of unprovoked anger?	0	1	2	3
How much are you losing interest in life?	0	1	2	3

2 - D

How often do you have feelings of hopelessness?	0	1	2	3
How often do you have self-destructive thoughts?	0	1	2	3
How often do you have an inability to handle stress?	0	1	2	3
How often do you prefer to isolate yourself from others?	0	1	2	3
How easily are you distracted from your tasks?	0	1	2	3
How often do you feel the need to consume caffeine to stay alert?	0	1	2	3
How often do you feel your libido has been decreased?	0	1	2	3

3 - G

How often do you feel anxious or panic for no reason?	0	1	2	3
How often do you feel knots in your stomach?	0	1	2	3
How often do you have feelings of being overwhelmed for no reason?	0	1	2	3
How often does your mind feel restless?	0	1	2	3
How often do you have disorganized attention?	0	1	2	3
How often do you have feelings of inner tension and inner excitability?	0	1	2	3

4 - ACH

Do you feel your visual memory (shapes & images) is decreased?	0	1	2	3
Do you feel your verbal memory is decreased?	0	1	2	3
Has your comprehension been diminished?	0	1	2	3
Do you have difficulty calculating numbers?	0	1	2	3
Do you have difficulty recognizing objects and faces?	0	1	2	3
Are you experiencing excessive urination?	0	1	2	3
Are you experiencing slower mental response?	0	1	2	3

How many caffeinated beverages do you consume per day? _____ How many alcoholic beverages do you consume per week? _____

How many times a week do you eat fish? _____ How many times a week do you eat raw nuts or seeds? _____

How many times do you eat out per week? _____ How many times a week do you workout? _____

List the three worst foods you eat during the average week: _____

List the three healthiest foods you eat during the average week: _____

Do you smoke? _____ If so, how many times a day: _____

Rate your stress levels on a scale of 1-10 during the average week: 1 2 3 4 5 6 7 8 9 10