Flavorfulfit

Intake Questionnaire

Personal Information

First name

Last name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Date of birth

Gender

Relationship status

Occupation

Hours per week

Referred by

Height, Weight , Age

Family History

Paternal Family Illnesses

Paternal Family Member	Illness

Maternal Family Illnesses

Maternal Family Member	Illness

Personal Health History

Medical Diagnosis

Diagnosis	Current	Past	Date of Onset
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Past Hospitalizations/Surgeries

Hospitalization/Surgery	Date	Reason

Have you ever taken antibiotics? ○ Yes ○ No

Have you ever taken birth control? ○ Yes ○ No

Have you ever been on hormone replacement therapy? ○ Yes ○ No

Supplements

List all supplements you're currently taking including vitamins, herbs, minerals.

Supplement	Dose	Frequency	Start Date	Reason

Medications

List all medications you're currently taking.

Medication	Dose	Frequency	Start Date	Reason

List your current health concerns in order of importance

Health Concerns

Do you experience digestive difficulties?

(i.e. bloating constipation, gas, constipation)

How often do you have a bowel movement?

Do you strain to have a bowel movement? ◯ Yes ◯ No

Are your bowels loose? ◯ Yes ◯ No

Do you take laxatives? ◯ Yes ◯ No

List any food or environmental allergies you experience

Food/Environmental Allergies	Reaction

Do you avoid these foods? ◯ Yes ◯ No

Diet

How much water do you drink daily?

Do you consume coffee? ○ Yes ○ No

Do you consume tea? ○ Yes ○ No

Do you consume alcohol? ○ Yes ○ No

List any other drinks you consume

How many times a week do you eat meat?

How many vegetables do you eat per day?

How many fruits do you eat per day?

What are your favorite foods?

What foods do you avoid?

Do you experience any symptoms after meals?

Describe your relationship with food

Please be very specific

Are you working with a nutritonist or Dietitian , personal trainer etc in terms of nutrition? If yes whom?

Have you tried other diets? If so explain which and why they haven't worked for you.

Do you eat out often

◯ Yes ◯ No

Do you think you suffer with emotional eating, binging or any other eating disorder? If Yes please explain more in detail.

List any foods that you crave regardless of their nutritional value (includes chocolate, sweets, sour, salty, bread, rich/fatty food):

If you are breastfeeding leave information below. How many times ? Hows your sleep etc

Lifestyle

How many hours do you sleep a night?

Do you have trouble falling asleep? Staying asleep? You wake frequently during the night?

Do you wake feeling rested? ◯ Yes ◯ No

How often do you exercise?

What types of exercise do you do? and do you have any injuries..

What do you do to have fun?

How do you express your creativity?

Do you have any pets? ◯ Yes ◯ No

What level of stress are you currently experiencing?

List your main stressors

Please provide any other information that may be relevant but hasn't been covered in regard to emotions

How many hours per day do you use a computer?

How many hours per day do you use a cell phone?

How many hours per day do you use watch TV?

Chemicals

Where did you grow up?
City or country?

◯ City ◯ Country

What type of environment do you/ have you worked in?

How many cigarettes do you smoke per day?

For how many years? If you quit, how long ago?

Do you or have you used recreational drugs?

◯ Yes ◯ No

Have you had any dental work done?
Do you have fillings (metal), root canals, crowns, etc?

Have you ever had shots/vaccinations?
List all that apply (including flu shots)

Is there anything that will get in the way of following a treatment plan in order to achieve results?

What is your level of commitment to improving your health?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

1 = Lowest, 10 = Highest

Is your home well ventilated or were you ever exposed to mold?

Have you or you family recently experienced any major life changes or trauma?

Do you feel safe, respected, and valued in your current relationship?

Do odors or body products affect you? if so, which ones?

Have you ever had psychotherapy or counseling? ○ Yes ○ No

It is common practice for nutritionists and other non-licensed practitioners to collect your signature on a liability waiver form such as this. By doing so you acknowledge that it is your responsibility to deliver all laboratory results, now and in the future, to your own physician for any medical interpretation or opinion regarding any laboratory results provided by flavorfulfit. Check to agree to each of the following before submitting:

- ☐ I understand and acknowledge that FlavorFul FIT INC. Trademarked is an approach to health and weight loss-focused wellness and fitness for people in good health, and not a medical, nutrition, or diet program, and that its Accountability Coach are not licensed health professionals and have no healthcare training. I understand that Coaches focus only on proper nutrition and weight loss and maintenance goal, not other personal issues.
- ☐ I agree to seek the clearance of a physician or qualified medical professional to manage my health and determine if FLavorfulFIT™ and its components are appropriate for me. I understand that I should not apply for FlavorfulFIT™ if I have a medical condition that would limit my ability to restrict my eating or to exercise vigorously on a daily basis.
- ☐ I understand that Flavorfulfit does not diagnose, cure or treat any illness or disease. I release Flavorfulfit from any and all liability for any failure to identify any medical conditions or disease.
- ☐ I understand that my success participating FlavorfulFITi™ depends upon my commitment. I am ready, willing, and able to devote the time needed to complete and fulfill the Program. I agree to responsive and cooperate in meeting the ongoing requirements of participation in FlavorfulFIT™ in a timely manner.
- ☐ Upon paying and signing up to the program I cannot request a refund after documents are sent out to me.

Gut Health

(Not present=0 severe and or experience regularly =10)

Excess Gas	
Bloating	
Diarrhea	
Constipation	
Indigestion	
Acid Reflux/GERD	
Heartburn	
Abdominal Pain	
Brain Fog	
Skin Issues(Psoriasis, Acne, Rosacea)	
Below 20 mild, Moderate 40 above Severe 41	

Liver and Gallbladder

Alcohol Intolerance	
sensitive to fumes and fragrances	
caffeine sensitivity	
nausea from fatty meals	
floating stool	
pain between shoulder blades	
Motion Sickness	
Dry Skin	
Mild=15 Moderate=35 Severe=36 more TOTAL:	

Sex Hormone Balance

Low Libido	
Weight Gain	

Stubborn Lower Body fat	
Fluid Retention(puffy)	
Mood Swings	
Oily Skin / Acne	
Irritability	
Unwanted hair growth	
Decreased Muscle Strength or SIze	
Infertility	
Mild=20 Moderate=40 Severe=41 TOTAL:	

Hormone Balance

PMS	
Heavy or irregular period	
Breast Tenderness	
Vaginal Dryness	
Breast Cysts, Fibroids	
Endometriosis	
Hot Flashes	
Nigh Sweats	
Miscarriages	
Mild=20 Moderate=20 Severe=41 TOTAL:	

Thyroid Function

Weight Gain	
Weight Loss resistance	
Fatigue	
brain sluggishness	
Cold often	
Unwanted hair loss	
flush easily	

high cholesterol	
chronic constipation	
get hot or cold easily	
mild=20 Moderate=40 Severe=41 TOTAL:	

Adrenal Function

Feel wired but tired	
difficulty waking and getting out of bed	
tend to be a night person	
afternoon fatigue	
racing thoughts and trouble calming down	
insomnia poor sleep	
high blood pressure	
low blood pressure	
dizzy upon standing	
salt cravings	
sweet cravings	
Mild=20 Moderate=40 Severe=41 TOTAL:	

Blood Sugar Balance

Wake up in middle of night	
thirsty in the middle of the night	
binge eating	
sugar cravings	
get hangry between meals	
headache between meals	
frequent thirst or urination	
crave caffeine	
shaky between meals	

nausea and sweating if meals are delayed	
light headed if meals delayed	
fatigue relieved by meals	
mild=25 Moderate=45 Severe=46 TOTAL:	

Nutrient Deficiencies

Racing Heart	
Exercise Intolerance or Fatigue Easily	
Difficulty recovering from activity	
Cracked Brittle Nails	
Pale Skin	
Nose Bleeds	
Bruise Easily	
Restless Leg syndrome	
Numbness or tingling	
Ringing in Ears	
Cracks at corner of mouth	
Bleeding gums	
Shortness of Breath	
dizziness	
Mild=30 Moderate=55 Severe=56 TOTAL:	

Neurotransmitter Balance

Depression	
Seasonal affective disorder	
Anxiety	
OCD	
Brain Fog	
Poor memory	

Low self esteem	
Inability to focus or finish tasks	
Difficult Learning	
Lack of pleasure	
Carb sugar cravings	
binge eating	
feelings of apathy or indifference	
lack of joy	
irritability	
feelings of overwhelm	
dark thoughts	
Mild=30 Moderate=60 Severe=61	

Flavorfulfit

Assumption of Risk and Release of Liability

I hereby acknowledge and agree:

1. The purpose of nutritional counselling is to improve the overall health, vitality and well-being of the body through nutritional education and the use of natural foods and non-medicinal nutritional supplements. The **Health Practitioner**, **Eve scaba**, does not diagnose diseases, disorders or conditions.

2. The **Health Practitioner**, **Eve scaba**, is not a licensed Dietitian, Naturopathic Doctor or Medical Physician.

3. As part of the Nutritional Counselling Services, I may be asked to provide information concerning my physical habits, medical history, moods, energy levels, likes and dislikes, lifestyle and diet. This information is collected to enable the **Health Practitioner** to: (i) assess my knowledge of nutrition, (ii) education me about the benefits of sound nutritional practices and (iii) recommend dietary changes to improve my general health, vitality and overall

well-being. The **Health Practitioner**, **Eve scaba** will hold this information in confidence and will not release or disclose this information to any other person, without my prior consent, except as required by applicable law.

4. If the **Health Practitioner**, **Eve scaba,** suspects the existence of disease, disorder or condition, I will be informed of this suspicion. However, I acknowledge this is not a diagnosis or conclusion about the state of my health and that I am directed to promptly consult a licensed Physician or Naturopath about any suspected problems.

5. Should I request the **Health Practitioner**, **Eve scaba**, to recommend dietary changes and/or nutritional supplements to enhance my body's natural ability to resist and/or overcome a known disease, disorder or condition, it is my responsibility to disclose the nature of the disease, disorder or condition and all other relevant details to the **Health Practitioner**, **Eve scaba**. If I have not previously consulted a licensed Physician or Naturopath about this disease, disorder or condition, I acknowledge that I am directed to promptly do so. I am not to alter or discontinue treatments prescribed by a licensed Naturopath, Physician or other licensed health professional without consulting the individual who prescribed the treatment.

6. In providing Nutrition Counselling Services to me, the **Health Practitioner**, **Eve scaba**, is relying upon the truth, accuracy and completeness of all information I have provided to her. Any recommendations I follow for changes in diet, including the use of nutritional supplements, are entirely my responsibility.

7. **Eve scaba** is in no way liable for my health or safety.

8. In consideration of my participation in the **Nutritional Counselling Services**, I hereby accept all risk to my health, including injury or death that may result from such participation and I hereby release the **Health Practitioner**, **Eve scaba**, on my behalf and on behalf of my personal representatives, estate, heirs, next of kin, and assigns from any and all costs, claims, causes of action and damages arising from any and all illness or injury to my person, including my death, that may result from or occur as a result of my participation in the **Nutrition Counselling Services**, whether caused by negligence or otherwise.

9. **%NUMBER_OF_HOURS%** is required for cancelling appointments. Appointments cancelled within **%NUMBER_OF_HOURS%** of your appointment time, you will be billed at **%PERCENTAGE%**.

10. I understand that any therapies I undertake at **Flavorfulfit** are undertaken of my own free will. I accept that the ultimate responsibility for my health care is my own and that **Flavorfulfit** is here to support me in this. I understand that my practitioner reserves the right to determine which cases fall outside their scope of practice, in which event an appropriate referral will be recommended. I hereby agree to assume full responsibility for any manner of loss, injury, claim or damage whatsoever, known or unknown, incurred as a result of same and I, my heirs, executors, administrators or assigns for any loss, injury, claim or damage sustained as a result of my attendance and/or participation. I have read the above release and waiver of liability, and fully understand its contents and voluntarily agree to the terms and conditions stated.

Client Signature

I HAVE CAREFULLY READ THIS AGREEMENT AND AGREE TO THE TERMS OUTLINED ABOVE. I UNDERSTAND THIS AGREEMENT TO BE A FULL AND FINAL RELEASE OF ALL COSTS, CLAIMS, CAUSES OF ACTION AND DAMAGES OF ANY KIND ARISING FROM OR IN CONNECTION WITH THE **NUTRITION COUNSELLING** SERVICES.

X

Print name: **Date:**

ASSESSMENT FORMS

NAME .....

DATE .....

Mitochondrial Dysfunction

	Never	Occasionally	Often	Regularly
History of infections (EBV, Lyme, etc.)?	N	Y		
Dizziness upon standing up quickly	0	1	2	3
Unable to tolerate much exercise	0	1	2	3
Poor exercise or muscle stamina	0	1	2	3
Low muscle tone?	N	Y		
Brain fog	0	1	2	3
Difficulty focusing	0	1	2	3
Vision or hearing problems	0	1	2	3
General or chronic fatigue	0	1	2	3
Afternoon headaches	0	1	2	3
Migraines or seizures	0	1	2	3
Mood problems: anxiety, depression, or bipolar	0	1	2	3
Poor brain processing (cognition)	0	1	2	3
Blood sugar issues	0	1	2	3
Breathing problems	0	1	2	3
Overweight?	N	Y		
Low body temperature	N	Y		
Intolerant to heat	0	1	2	3
Low thyroid lab numbers?	N	Y		
Little or no skin sweating?	N	Y		
Suppressed immune system?	N	Y		
Catch colds or get sick easily?	N	Y		
Chronic inflammation	0	1	2	3
Cannot fall asleep	0	1	2	3
Cannot stay asleep	0	1	2	3
Slow mover in the morning (hard to get going)	0	1	2	4
Wake up tired, even after 6 or more hours of sleep	0	1	2	3
Eyes sensitive to bright or direct light	0	1	2	3
Weight gain when under stress	0	1	2	3
Loss of libido	N	Y		

Mitochondrial Dysfunction Total .....

GREEN	YELLOW	RED
0-16	17-45	46-107

Drainage Dysfunction Susceptibility

	Never	Occasionally	Often	Regularly
Constipation (pooping one or fewer times daily)	0	1	2	3
Feeling that bowels do not empty completely	0	1	2	3
General or chronic fatigue	0	1	2	3
Mood problems: anxiety, depression, or bipolar	0	1	2	3
Poor brain processing (cognition)	0	1	2	3
Chronic inflammation	0	1	2	3
Wake up between 1 a.m. to 4 a.m.	0	1	2	3
Edema, swelling or retain extra fluids	0	1	2	3
Skin problems, rashes, itches, hives, eczema, or acne	0	1	2	3
Yellowish skin, face	0	1	2	3
Suppressed immune system	0	1	2	3
Can't clear infections, despite following pathogen protocols	0	1	2	3
Sore or swollen breast tissue	0	1	2	3
Heart palpitations or irregular heartbeat	0	1	2	3
Light, sound, or EMF sensitivities	0	1	2	3
Morning stiffness	0	1	2	3
Brain fog	0	1	2	3
Swollen glands	0	1	2	3
Cellulite or flabby skin	0	1	2	3
Varicose or spider veins	0	1	2	3
Kidney problems	0	1	2	3
Breathing or lung issues	0	1	2	3
Skin doesn't sweat	0	1	2	3
Puffy Eyes	0	1	2	3

Drainage Dysfunction Total .....

GREEN	YELLOW	RED
0-14	15-35	36-72

ASSESSMENT FORMS

NAME .....

DATE .....

Minerals & Electrolytes

	Never	Occasionally	Often	Regularly
Edema (swelling) in ankles or wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Unable to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3
History of carpal tunnel syndrome	N	Y		
History of lower right abdominal pains or ileocecal valve problems	N	Y		
History of stress fracture	N	Y		
Bone loss (reduced density on bone scan)	0	1	2	3
Crave chocolate	0	1	2	3
Feet have a strong odor	0	1	2	3
History of anemia	0	1	2	3
Whites of eyes (sclera) are blue-tinted	0	1	2	3
Hoarse voice	0	1	2	3
White spots on fingernails	0	1	2	3

Minerals & Electrolyte Total .....

GREEN	YELLOW	RED
0-19	20-35	36-59

Blood Sugar

	Never	Occasionally	Often	Regularly
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Fatigue after meals	0	1	2	3
Must have sweets after meals	0	1	2	3
Forgetful; poor memory	0	1	2	3
Feel better or calmer after eating	0	1	2	3
Prone to infections and colds	0	1	2	3
History of diabetes in your family	N	Y		
Sugar (glucose) detected in urine test?	N	Y		
Hair loss at ankles/frictional alopecia?	N	Y		

Blood Sugar Total .....

GREEN	YELLOW	RED
0-10	11-24	25-45

Instructions

Rate each of the symptoms to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number next to your answer, if there is a number. Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

Organs

NAME .....

DATE .....

Stomach

	Never	Occasionally	Often	Regularly
Belching or burping	0	1	2	3
Gas quickly following a meal	0	1	2	3
Bad breath	0	1	2	3
Feel full while eating and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Stomach pain, burning, or aching 1 to 4 hours after eating	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, or caffeine	0	1	2	3
Indigestion	0	1	2	3
Abdominal bloating	0	1	2	3
Constipation	0	1	2	3
Diminished appetite	0	1	2	3

Stomach Total .....

GREEN	YELLOW	RED
0-11	12-26	27-36

Small Intestine

Increased gut motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Mucus in stool	0	1	2	3
Poorly formed or loose stools	0	1	2	3
Four or more large stools daily	0	1	2	3
Stools have foul odor	0	1	2	3
Suspect nutrient malabsorption	0	1	2	3
Diagnosed with celiac disease, irritable bowel syndrome (IBS), or diverticulosis/diverticulitis	0	1	2	3
Stomach cramps	0	1	2	3
Flatulence (gas)	0	1	2	3
Fiber-rich diet doesn't help constipation	0	1	2	3
History of pimples or skin eruptions?	N	Y		
Any known food allergies?	N	Y		

Small Intestine Total .....

GREEN	YELLOW	RED
0-10	11-24	25-45

Colon

	Never	Occasionally	Often	Regularly
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or buildup of debris on tongue	0	1	2	3
Use laxatives	0	1	2	3
History of bladder and/or kidney infection	0	1	2	3
Yeast infection (including vaginal)	0	1	2	3
Fingernail and/or toenail fungus	0	1	2	3
Use of antibiotics in past year?	N	Y		

Colon Total .....

GREEN	YELLOW	RED
0-9	10-24	25-36

Intestinal Permeability

Adverse reactions to foods	0	1	3	4
Unpredictable food reactions	0	2	4	6
Aches, pains, and swelling throughout your body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Food allergies	0	2	4	5
Frequent bloating and distention after eating	0	1	2	3

Leaky Gut Total .....

GREEN	YELLOW	RED
0-7	8-15	16-24

Organs

NAME .....

DATE .....

Hypothyroid

	Never	Occasionally	Often	Regularly
Tired or sluggish	0	1	2	3
Feel cold (hands, feet, or your whole body)	0	1	2	3
Require an excessive amount of sleep to function properly	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression or lack of motivation	0	1	2	3
Thinning of outer third of eyebrows	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dry skin and/or scalp	0	1	2	3
Slow brain processing	0	1	2	3
Lack of or diminished sex drive	0	1	2	3
Infertility or impotency	N	Y		
Heavy or profuse menstrual bleeding (women only)	0	1	2	3

Hypothyroid Total .....

GREEN	YELLOW	RED
0-11	12-22	23-40

Hyperthyroid

	Never	Occasionally	Often	Regularly
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse, even at rest	0	1	2	3
Nervous or emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Eyes appear bulging or swollen	0	1	2	3
Difficulty gaining weight	0	1	2	3

Hyperthyroid Total .....

GREEN	YELLOW	RED
0-5	6-10	11-24

Instructions

Rate each of the symptoms to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

Pathogens

NAME ..... DATE .....

Parasites

	Never	Occasionally	Often	Regularly
Restless sleep (toss, turn, or wake up often)	0	1	2	3
Skin issues, rashes, itches, hives, eczema, or acne	0	2	4	6
Frequent diarrhea or loose stools	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
SIBO (small intestinal bacterial overgrowth), feel bloated or gassy	0	1	2	3
Bowel urgency, occasional accidents	0	1	2	3
Abdominal pains, cramps, or burning	0	1	2	3
Rectal, anal itch	0	2	4	6
Anal fissures (small, painful tears or cracks)	0	2	4	6
Stomach or small intestinal ulcers or lesions	0	1	2	3
Grinding of teeth when asleep	0	2	4	6
Picking at nose, boring nose with finger	0	2	4	6
Excess boogers in nose and scab-like boogers	0	2	4	6
Fingernail biting	0	1	2	3
Headaches/Migraines	0	2	4	6
Irritable (no apparent reason)	0	1	2	3
Mood disorder, depression, anxiety, or suicidal thoughts	0	1	2	3
Hyperactive tendency (nervous)	0	1	2	3
Dark circles under eyes	0	2	4	6
Need for extra sleep, wake unrefreshed	0	1	2	3
Allergies and/or food sensitivities	0	2	3	4
Fevers of unknown origin	0	1	2	3
Night sweats (not menopausal)	0	1	2	3
Kiss pets, allow pets to lick your face	0	1	2	4
Increase of symptoms around a full moon	0	2	6	8
Anemia (low iron/hemoglobin on blood test)	0	1	2	4
Iron deficiency	0	2	4	6
Vitamin B6 deficiency	0	2	4	6
Zinc deficiency and/or white spots on nails	0	2	4	6
Frequent colds, flu, sore throats	0	1	2	3

	Never	Occasionally	Often	Regularly
Travel in developing nations	0	2	4	6
Eat pork products	0	1	2	3
Eat sushi, raw fish	0	2	4	6
Sleep with pets on bed	0	1	2	3
Bed-wetting	0	1	2	3
Frequent vomiting	0	1	2	3
Loss of appetite	0	1	2	6
Hungry all the time, bottomless pit, hungry after meals	0	2	4	6
Strong sugar and processed food cravings	0	1	2	3
Breathing problems, asthma	0	2	4	6
Pain in belly button area (umbilicus)	0	1	2	4
Blurry, unclear vision	0	1	2	3
Eye floaters	0	2	4	6
Lethargy, apathy (disinterest)	0	1	2	3
Menstrual problems	0	1	2	3
Dry lips	0	1	2	3
Drooling while asleep	0	1	2	3
Occult blood in stool (from lab test)	0	1	2	3
Swim in creeks, rivers, lakes	0	2	4	6
History of *Giardia*, pinworms, or other parasites?	N	Y		
Do you work in childcare?	N	Y		
History of or currently have cancer?	N	Y		

Parasite Infection Total .....

GREEN	YELLOW	RED
0-46	47-96	97-242

Pathogens

NAME .....

DATE .....

SIBO (Small Intestinal Bacterial Overgrowth)

	Never	Occasionally	Often	Regularly
Abdominal distention after consuming fiber, starches, or sugar	0	1	2	3
Abdominal distention after taking certain probiotics or other dietary supplements	0	1	2	3
Abdominal distention, bloating, or a noisy gut after eating healthy vegetables	0	1	2	3
Bloating or feeling full in upper abdominal area (just below rib cage)	0	1	2	3

SIBO Total .....

GREEN	YELLOW	RED
0-1	2-4	5-12

Lyme Disease Risks

	Never	Occasionally	Often	Regularly
Ever diagnosed with Lyme disease?	N	Y		
Dry sockets or infected tooth extractions	0	1	2	3
Ever bitten by a tick?	N	Y		
Ever had a bullseye rash on any part of your body?	N	Y		
Mother ever diagnosed with Lyme disease?	N	Y		
Spouse/partner/significant other diagnosed with Lyme disease?	N	Y		
Ever diagnosed with chronic fatigue syndrome, fibromyalgia, lupus, rheumatoid arthritis (RA), multiple sclerosis (MS), or an autoimmune condition?	N	Y		
Ever diagnosed with Parkinson's disease, Alzheimer's disease, or Tourette's syndrome?	N	Y		
Frequently go camping, hunting, or engage in outdoor activities?	N	Y		
History of a heart murmur or valve prolapse?	N	Y		

Lyme Disease Risks Total .....

GREEN	YELLOW	RED
0-9	10-18	19-59

Pathogens

NAME

DATE

Lyme

	Never	Occasionally	Often	Regularly
Arthritis-like joint pain or swelling	0	2	4	6
Pain migrates or moves around to different areas of your body	0	2	4	6
Forgetfulness or poor short-term memory	0	2	4	6
Confusion, difficulty thinking	0	1	2	3
Disorientation (getting lost; going to wrong places)	0	1	2	3
Difficulty with speech or writing	0	4	6	8
Tingling, numbness, burning, or stabbing sensations	0	4	6	8
Disturbed sleep: too much, too little, early awakening	0	2	4	6
Unexplained fevers, sweats, chills, or flushing	0	1	2	3
Unexplained weight change (loss or gain)	0	1	2	3
Difficulty swallowing	0	1	2	3
Fatigue, lack of energy	0	1	2	3
Sore throat or swollen glands	0	1	2	3
Pelvic or testicular pain	0	4	6	8
Crepitus (joint cracking)	0	4	6	8
Stiff neck	0	2	4	6
Twitching of facial or other muscles	0	1	2	3
Muscle pain or cramps	0	1	2	3
Costochondritis (sternum/breastbone and rib junction pain)	0	4	6	8
Right shoulder pain (AC joint)	0	1	2	3
Facial paralysis (Bell's palsy)	0	4	6	8
Unexplained menstrual irregularity	0	4	6	8
Unexplained breast milk production	0	4	6	8
Irritable bladder or bladder dysfunction	0	4	6	8
Sexual dysfunction or low libido	0	4	6	8
Blurry or double vision	0	1	2	3
Ear buzzing, ringing, or pain	0	1	2	3
Vertigo or increased motion sickness	0	4	6	8
Light-headedness, poor balance, difficulty walking	0	4	6	8

	Never	Occasionally	Often	Regularly
Woozy (mentally unclear or hazy)	0	2	4	6
Tremors	0	2	4	6
Headaches	0	1	2	3
Impulsivity, aggression, or bipolar	0	1	2	3
Depression	0	1	2	3
Hallucinations, paranoia, or schizophrenia	0	2	4	6
Panic attacks	0	1	2	3
Eating disorder	0	4	6	8
Pulse skips	0	4	6	8
Skin hypersensitivity	0	2	4	6
Gastrointestinal problems	0	4	6	8
Change in bowel function	0	4	6	8

Lyme Disease Current Symptoms Total

GREEN	YELLOW	RED
0-31	32-95	96-230

Pathogens

NAME .....

DATE .....

Babesia

	Never	Occasionally	Often	Regularly
Abdominal pain	0	2	4	6
Shortness of breath	0	1	2	3
Air hunger (episodes of breathlessness)	0	4	8	10
Anemia (low iron/hemoglobin on blood test)	0	1	2	3
Low back stiffness or pain	0	1	2	3
Low blood sugar	0	2	4	6
Cough	0	1	2	3
Disturbed sleep: frequent waking	0	4	6	8
Excessive sleepiness	0	1	2	3
Encephalopathy (brain malfunction, brain issues)	0	1	2	3
Fatigue, tiredness, poor stamina	0	1	2	3
Fevers	0	1	2	3
Headaches	0	4	6	8
Hemolysis (destruction of red blood cells)	0	2	4	6
Enlarged liver	0	2	4	6
Imbalance	0	2	4	6
Generalized ill feeling	0	1	2	3
Muscle pains or cramps	0	1	2	3
Nausea, vomiting	0	2	4	6
Neck stiffness, pain	0	1	2	3
Night sweats	0	1	2	3
Poor appetite	0	2	4	6
Shaking chills	0	4	6	8

	Never	Occasionally	Often	Regularly
Enlarged spleen	0	1	2	3
Heart palpitations, pulse skips, Tachycardia	0	4	6	8
Dark urine with or without blood	0	4	6	8
Weakness	0	1	2	3
Weight loss	0	1	2	3
Elevated sedimentation (sed) rate on lab test	0	1	2	3
Dizziness	0	1	2	3
Light headedness	0	1	2	3

Babesia Total .....

GREEN	YELLOW	RED
0-29	30-60	61-146

Pathogens

NAME ..... DATE .....

Bartonella

	Never	Occasionally	Often	Regularly
Abdominal pain	0	2	4	6
Anemia (low iron/hemoglobin on blood test)	0	1	2	3
Anxiety	0	2	4	6
Back stiffness	0	1	2	3
Chills	0	1	2	3
Disturbed sleep: too much, too little, fractionated, early awakening	0	1	2	3
Ear buzzing, ringing, pain, sound sensitivity	0	2	4	6
Brain dysfunction	0	1	2	3
Hemolysis (destruction of red blood cells)	0	2	4	6
Endocarditis	0	2	4	6
Myocarditis	0	2	4	6
Fatigue, tiredness, poor stamina	0	1	2	3
Low-grade fever	0	2	4	6
Headaches	0	1	2	3
Enlarged liver	0	2	4	6
Immune deficiency	0	2	4	6
Feeling of coming down with the flu	0	2	4	6
Insomnia	0	1	2	3
Jaundice (yellowing of skin)	0	4	6	8
Joint pain or swelling	0	1	2	3
Lymph nodes swollen	0	4	6	8
Generalized ill feeling	0	1	2	3
Muscle pains or cramps, especially in calves	0	4	6	8
Foot pain or plantar fasciitis-type pain (heels or soles of the feet)	0	4	6	8
Stretch mark-like rash (not from overweight)	0	6	8	12
Maculopapular rash (small red bumps)	0	4	6	8
Spider veins	0	2	4	6
Seizures	0	4	6	8
Sleepiness or drowsiness	0	2	4	6
Sore throat	0	2	4	6
Enlarged spleen	0	2	4	6
Shinbone pain	0	4	6	8
Tremors	0	2	4	6
Twitching of facial muscles	0	2	4	6
Weight loss	0	1	2	3
Eyes: blurred vision, red eyes, dry eyes, depth perception issue, light sensitivity	0	2	4	6
Anxiety, panic attacks, or excessive worry	0	2	4	6
Obsessive-compulsive disorder (OCD)	0	4	6	8

Bartonella Total .....

GREEN	YELLOW	RED
0-29	30-79	80-217

Instructions

Rate each of the symptoms to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number next to your answer, if there is a number. Total your score in the space provided for each section. Compare your results with the rating system for each section. A score in the yellow or red range suggests this area is more likely a problem for you.

General Toxicity

	Never	Occasionally	Often	Regularly
Live on or near a golf course?	N			Y
Live near a freeway or high-tension wires?	N			Y
Wear conventional sunscreen?	N			Y
Wear perfume or cologne?	N			Y
Use air fresheners in your house, car, or workplace?	N			Y
Were you the first-born child?	N			Y
Receive static shocks (doorknob, car, light switch, other people, etc.)	0	1	2	3
Headaches or migraines	0	1	2	3
Word reversal or trouble finding words	0	1	2	3
Sensitivity to skin or touch	0	1	2	3
Poor short-term memory	0	1	2	3
Chronic sinus issues or congestion	0	1	2	3
Difficulty losing weight regardless of diet or exercise	0	1	2	3
Excessive perspiring during day or night	0	1	2	3
Cold extremities (hands and feet)	0	1	2	3
Issues processing new information	0	1	2	3
Chronic fungal or viral infection, including *Candida*, foot fungus, warts, or jock itch	0	1	2	3
Get sick often	0	1	2	3
Weakness or numbness in extremities	0	1	2	3
Joint pain	0	1	2	3
Muscle cramps, aches, sharp pains	0	1	2	3
Muscle twitching	0	1	2	3
Stomach pain	0	1	2	3
Appetite swings	0	1	2	3
Rashes or rosacea	0	1	2	3

General Toxicity Total .....

GREEN	YELLOW	RED
0-19	20-50	51-81

Radioactive Elements

	Never	Occasionally	Often	Regularly
History of or currently have cancer?	N			Y
Suppressed immune system?	N			Y
Osteoporosis or osteopenia diagnosis?	N			Y
Can't clear infections, despite following pathogen protocols?	N			Y
Chronic *Candida* infection	0	2	4	6
Fatigue	0	2	4	6
Anemia	0	2	4	6
Skin (red, dry, itchy, color changes)	0	1	2	3
Hair loss	0	2	4	6
Loss of appetite	0	1	2	3
Nausea and vomiting	0	1	2	3
Low blood cell count	0	1	2	3
Seizures	0	1	2	3
Earaches or difficulty hearing	0	1	2	3
Hormone problems	0	1	2	3
Sore or dry mouth	0	1	2	3
Taste changes	0	1	2	3
Difficulty swallowing	0	2	4	6
Voice changes, hoarseness	0	1	2	3
Dry eyes	0	1	2	3
Stiff jaw	0	1	2	3
Tooth decay	0	1	2	3
Soreness or swelling of the breast	0	1	2	3
Heart palpitations	0	2	4	6
Irregular heartbeat	0	1	2	3
Stomach ulcers	0	2	4	6
Kidney problems	0	1	2	3
Bladder infection (cystitis)	0	2	4	6
Burning or pain during urination	0	1	2	3
Loss of bladder control	0	1	2	3
Fertility problems	0	1	2	3
Sexual problems (male & female)	0	1	2	3

Radioactive Elements Total .....

GREEN	YELLOW	RED
0-16	17-40	41-146

Toxicants & Toxins

NAME

DATE

Mercury Toxicity

	Never	Occasionally	Often	Regularly
Do you have amalgam (silver) fillings in your teeth?	N	Y		
Have you ever had an amalgam removed?	N	Y		
If you had amalgams removed, was it done by a biological dentist using a safe protocol?	N	Y		
Were there amalgam fillings in your mother's mouth while she was pregnant with you?	N	Y		
Worked in a dental office?	0	1	2	3
Wore contact lenses during the 1980s or early 1990s	0	1	2	3
Took oral contraceptives during the 1980s or early 1990s	0	1	2	3
Have had flu shots	0	1	2	3
Have had allergy shots	0	1	2	3
Eat tuna, shark, swordfish or Atlantic salmon more than twice per week	0	1	2	3
Urinate frequently (during the day, night, or both)	0	1	2	3
Sleep issues	0	1	2	3
Do you have compact fluorescent (CFL) bulbs in your home?	N	Y		
Have you broken any CFL bulbs? (reference) 	N	Y		
Anxiety	0	1	2	3
Mood swings	0	1	2	3
Anger for no apparent reason	0	1	2	3
Excessive shyness, timidity, social phobia (not typical to your personality)	0	1	2	3
Irritability (not typical to your personality)	0	1	2	3
Dizzy or balance issues	0	1	2	3
Insomnia (can't get to sleep or return to sleep)	0	1	2	3
Low body temperature (below 97.5 degrees Fahrenheit or 36.4 degrees Celsius)	0	1	2	3
Sound in ears (ringing or hearing your heart beat)	0	1	2	3
Psychological symptoms, even thoughts of suicide	0	1	2	3
Sound sensitivities	0	1	2	3

Mercury Toxicity Total .....

GREEN	YELLOW	RED
0-30	31-64	65-130

Lead Toxicity

	Never	Occasionally	Often	Regularly
Have lived in a home built before 1978 using lead-based paint	0	2	4	6
Do home renovation, including sandblasting or moving walls	0	2	4	6
Currently live or previously lived in a mining community or area	0	2	4	6
Involved in construction, soldering, metal salvage, or stained glass	0	2	4	6
Are an electrician, handle electrical devices, electrical wiring, ballasts, or TV glass	0	2	4	6
Paint or handle/make ceramics, brass, bronze, or crystal	0	2	4	6
Handle and/or reload ammunition	0	2	4	6
Read the newspaper regularly before 1985	0	2	4	6
Previously or currently consume a coral calcium supplement	0	2	4	6
Wear lipstick	0	2	4	6
Previously wore or currently wear eye cosmetics containing kohl (a dark pigment that's not FDA-approved for makeup)	0	2	4	6
Are around or have a lot of fake leather or vinyl	0	2	4	6
Get your hair colored	0	2	4	6
Get stomachaches in the morning	0	1	2	3
Eyelid swelling	0	1	2	3
Eyelid twitching	0	1	2	3
Chest or heart pain	0	1	2	3
Metallic taste in mouth	0	1	2	3
Teeth sensitivity	0	1	2	3
Bleeding gums	0	1	2	3
High blood pressure	0	1	2	3
Inability to decide/indecisiveness	0	1	2	3
Overwhelmed or fearful feeling	0	1	2	3
Anemia (low iron/hemoglobin on blood test)	0	1	2	3
Peeling of top layer of skin (hands, feet)	0	1	2	3
Dry skin	0	1	2	3
Depression	0	1	2	3
Dyslexia or loss of your place while reading, even as a child	0	1	2	3
Gout (arthritic pain, especially in big toes)	0	1	2	3

Lead Toxicity Total .....

GREEN	YELLOW	RED
0-37	38-65	66-126

Toxicants & Toxins

NAME

DATE

Mycotoxins

	Never	Occasionally	Often	Regularly
See mold growing at home, work, or school?	N	Y		
Ever experienced water damage at home, work, or school?	N	Y		
Home, workplace, or school has a damp or mildewy odor	0	1	2	3
Spending time in basement causes or worsens symptoms	0	4	6	8
Basement ever wet?	N	Y		
Symptoms decrease when spend time in a different location for at least a few days?	N	Y		
Plumbing in your kitchen or bathroom leaks or has leaked in the past?	N	Y		
Wet spots anywhere in your home (whether currently or past)?	N	Y		
Often see condensation (fog) on the inside of windows and/or cold surfaces in your home?	N	Y		
Car has a mildewy smell?	N	Y		
Brain fog	0	1	2	3
Reactions to supplements opposite of expected	0	1	2	3
Nosebleeds	0	1	2	3
Body rashes	0	1	2	3
Any skin conditions?	N	Y		
Anyone in your home have asthma-like symptoms?	N	Y		
Sinus infections	0	1	2	3
One or more family members have chronic sinus infections or irritations	0	1	2	3
Runny, blocked, or stuffy nose	0	1	2	3
Experience static shocks	0	1	2	3
Wheezing or whistling in your chest	0	1	2	3
Wake up in the morning with a feeling of tightness in your chest	0	1	2	3
Wake up during the night with shortness of breath	0	1	2	3
Shortness of breath when you're not doing anything strenuous	0	1	2	3

	Never	Occasionally	Often	Regularly
Wake up during the night with an attack of coughing	0	1	2	3
Chest tightness when around animals or a dusty part of the house	0	1	2	3
Achy all over	0	1	2	3
Headaches	0	1	2	3
Extreme or unusual fatigue	0	1	2	3
Hoarse voice	0	1	2	3
Memory loss	0	1	2	3
Difficulty recalling names of people you know	0	1	2	3
Sensitive to chemicals and smells	0	1	2	3
Sensitive to EMF's	0	1	2	3
Bloating or SIBO	0	1	2	3
Blurry vision	0	1	2	3
Difficulty sleeping or insomnia	0	1	2	3
Anxiety or depression	0	1	2	3
Frequent urination, unable to hold bladder	0	1	2	3

Mold Total .....

GREEN	YELLOW	RED
0-19	20-68	69-138

Instructions

Rate each of the symptoms to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number next to your answer, if there is a number. Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.