CORE HEALTH
CENTER OF RESTORING ESSENTIAL HEALTH

**Steps for your appointment:**

1) Please fill out all New Patient forms in their entirety.

2) If you have any recent labs (within 12 months), please bring them to your appointment.

3) Please arrive on time.

4) We require a 48-hour notice to change or cancel your appointment.

**Note:** *If these steps are not followed it may compromise the full value of your consultation and therefore we will kindly reschedule your appointment.*

**How did you hear about us?**

______ Friend or family member

______ Radio

______ Website (Google)

______ Facebook

______ Instagram

______ Youtube

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## Personal History:

Your Name: ______________________________________________
First Middle Last

Your Address:

______________________________________________
Street City/State Zip

Telephone: Home:_________________ cell: _________________

Email Address:

______________________________________________

Birth Date: Month: __________ Day: _________ Year: _____________

Marital Status: _____________________

Occupation: ______________________________________________

Employer: ______________________________________________

Primary Care Provider: ______________________________________

City: ____________________________

# HIPAA FORM

**Core Health**
**1034 S. Brentwood Blvd, Ste 1450**
**Richmond Heights, MO 63117**

**Notice of Privacy Practices**

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

**Treatment**: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with

another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

**Payment**: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

**Operations**: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

**Others Involved in Your Healthcare**: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

**Communication Barriers and Emergencies**: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication

barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or

disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

Patient signature: ________________________________________________________ Date: __________

Core Health staff signature: ________________________________________________ Date: __________

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On a scale of 1-10 (1 being poor, 10 being amazing), will you please rate your health and life in the following categories:

**Energy**

1 2 3 4 5 6 7 8 9 10

**Mental Capacity**

1 2 3 4 5 6 7 8 9 10

**Diet**

1 2 3 4 5 6 7 8 9 10

**Sleep**

1 2 3 4 5 6 7 8 9 10

**Fitness**

1 2 3 4 5 6 7 8 9 10

**Relationships**

1 2 3 4 5 6 7 8 9 10

**Peace (Opposite of stress)**

1 2 3 4 5 6 7 8 9 10

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## Initial Consultation

Name: ______________________________ Date: ____________________

Main Complaints:

1)___________________________ 2)___________________________

3)___________________________ 4)___________________________

How long have you suffered with this problem? ___________________________

Any other complaints: ___________________________________________

___________________________________________________________

What have you tried doing to resolve this problem that Did Not work?

______________________________________________________________________

____________________________________________

Have you become discouraged or stressed about handling this problem?

______________________________________________________________________

____________________________________________

When your problem is at its worst, how does it make you feel?

___________________________________________________________

How does this problem interfere with the following areas in your life?

Work: ________________________________________

Family: ________________________________________

Hobbies: _______________________________________

Life: __________________________________________

When it's at it's worst, how much older does this make you feel? _______________

Do you know how this problem may have started? _________________________

___________________________________________________________

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Are there any health conditions you are afraid this might turn into?

Diminished Future Abilities
Weight Gain
Cancer
Depression
Hormonal Imbalance
Stress
Heart Disease
Diabetes
Arthritis
Adrenal Fatigue

Where do you see yourself in 3-5 years if this problem is not taken care of? Please be specific.

What are your strengths that help you accomplish your goals?

Rate on a scale of 1-10:

_________ How important is it for you to resolve your health concerns?
_________ Do you feel that you are coachable and would enjoy a mentor in helping you?
_________ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

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**Current Medications:**

| Medication | Dose | Frequency | Start Date | Reason |
| --- | --- | --- | --- | --- |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Past Medications:**

| Medication | Dose | Frequency | Start Date | Reason |
| --- | --- | --- | --- | --- |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Supplements:**

| Supplement | Dose | Frequency | Start Date | Reason |
| --- | --- | --- | --- | --- |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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## Hospitalizations

| Date | Reason |
|---|---|
| | |
| | |
| | |
| | |
| | |

## Medication History

Have your medications or supplements ever cause you unusual side effects or problems? ☐ Yes ☐ No
Describe:
Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No
Have you had prolonged or regular use of Tylenol? ☐ Yes ☐ No
Frequent antibiotics >3 times/year? ☐ Yes ☐ No
Long term antibiotics? ☐ Yes ☐ No
Use of oral contraceptives? ☐ Yes ☐ No

## Dental

When was the last time you went to the dentist? ____________________________________
☐ Silver mercury fillings; How many? ______________________________
☐ Gold Fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain ☐ Bleeding Gums
☐ Gingivitis ☐ Problems with Chewing

## Social

Have you ever made any changes in your eating habits because of your health? ☐ Yes ☐ No
Describe: ___________________________________________________________________
Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

Check all that apply:
☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic
☐ No Dairy ☐ No Wheat ☐ Gluten Restricted ☐ Vegetarian ☐ Vegan
☐ Specific Program for Weight Loss/Maintenance Type:_______________________________
☐ Other _______________________________________________________________________

Do you cook? ☐ Yes ☐ No If no, who does the cooking?
How many meals do you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

Currently Smoking? ☐ Yes ☐ No How many years? ______ Packs Per Day________
Previous Smoking: How many years? __________ Packs per day ____________

How many drinks currently per week? 1 drink=5ounces wine, 12ounces beer, 1.5ounces spirits
☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10

Caffeine Intake: ☐ Yes ☐ No Coffee cups/day: ☐ 1 ☐ 2-4 ☐ >4 Tea cups/day: ☐ 1 ☐ 2-4 ☐ >4
Caffeinated Sodas or Diet Sodas Intake: ☐ Yes ☐ No
Are you currently using any recreational drugs? ☐ Yes ☐ No Type: _______________________

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# Family History

| Condition | Father | Mother | Grandmother(s) | Grandfather(s) | Spouse | Child | Child | Child |
|---|---|---|---|---|---|---|---|---|
| Allergy | | | | | | | | |
| ADHD | | | | | | | | |
| Anxiety | | | | | | | | |
| Asthma | | | | | | | | |
| Autism | | | | | | | | |
| Bed Wetting | | | | | | | | |
| Cancer | | | | | | | | |
| Colic | | | | | | | | |
| Celiac | | | | | | | | |
| Constipation | | | | | | | | |
| Depression | | | | | | | | |
| Diabetes | | | | | | | | |
| Dementia | | | | | | | | |
| Bipolar | | | | | | | | |
| Ear Infections | | | | | | | | |
| Epilepsy | | | | | | | | |
| Eczema | | | | | | | | |
| Headaches | | | | | | | | |
| Heartburn | | | | | | | | |
| High Blood Pressure | | | | | | | | |
| IBS | | | | | | | | |
| Environmental Sensitivities | | | | | | | | |
| Indigestion | | | | | | | | |
| Infertility | | | | | | | | |
| Insomnia | | | | | | | | |
| Heart Disease | | | | | | | | |
| Autoimmune Disease | | | | | | | | |
| Obesity | | | | | | | | |
| Food Allergies | | | | | | | | |
| Back Problems | | | | | | | | |
| Sinus Trouble | | | | | | | | |

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# Genetic Checklist

Please highlight or bold the statements that apply to you:

(1)
I have headaches
I have cold hands and feet
I take folic acid supplements
I sweat easily
My White Blood Cell Count has been on the low normal range for my whole life
I'm hypothyroid
I've had infertility issues
One or more of my children has Down's syndrome or is on the autism spectrum
I get string menstrual cramping
I don't tolerate alcohol very well
I don't eat green leafy veggies every day
I sometimes have trouble falling asleep
When I get irritated, it takes me awhile to calm down
I can be anxious or depressed at times

(2)
Im sensitive to red wine or alcohol
I felt better during pregnancy
Im sensitive to many foods
I've had: nosebleeds, irritability, headaches
I feel better hours after eating as compared to 20 minutes after eating
I cant tolerate citrus fruits, wine, or cheese
If my skin gets scratched, it will stay red for minutes
I can tolerate bone broth, yogurt, or kombucha
I cant tolerate red wine
I have sweaty feet
I get carsick easily
I have had asthma or wheezing
I have low blood pressure
I get itchy often
I have eczema, psoriasis, or other skin conditions
I've been diagnosed with SIBO
My nose runs or is stopped up quite often

(3a)
My pain tolerance is low
My PMS symptoms are bad
Its hard for me to fall asleep
I get headaches
I get anxious easily and irritable easily
I feel more irritable after eating high protein
I get irritable with too much caffeine
Im pretty cautious
I can focus for hours
Im not very patient
I have or have had PMS

(3b)
I lack motivation and drive
I'm prone to feeling depressed
I feel great initially after eating carbs, but feel worse quickly after
Im easily addicted to shopping, gaming, alcohol, social media
I have difficulty paying attention
I have a hard time getting going in the morning
I crave sugar
I fall asleep easily
Im pretty even-keeled
Im a risk taker/class clown type

(4a)
I have terrible migraines or headaches
I have trouble falling asleep
After I'm irritated or stressed, its hard to calm down
I get easily stressed , panicked, or made anxious
I feel irritable or 'off' after eating cheese, wine, or chocolate
Caffeine makes me irritable
SSRI's make me irritable
Melatonin doesn't work for me
I am aggressive
I don't crave carbs

(4b)
I smoke or drink alcohol
Im prone to depression  and anxiety
I fall asleep quickly but wake up throughout the night ir early in the morning
Chocolate picks my mood up
I feel better after eating carbohydrates
I have a hard time paying attention
I'm chronically inflamed
I get depressed in winter
Exercising helps my mood
SSRIs have helped m
Melatonin works well for me
I have fibromyalgia, constipation, or IBS
I have an autoimmune disease like Hashimotos, MS..etc

(5)
I developed gray hair early
I have neurological disorders like tics, seizures, tremors, problems with gait
I'm sensitive to chemicals
I have asthma, irritable bowel disease, diabetes, eczema, or psoriasis
I breathe air and drink water
I have high blood pressure
Its easy for me to gain weight
I am chronically stressed out
I have or have had asthma
Cancer runs in my family
I have early graying hair
I feel way better after sweating alot

(6)
Im postmenopausal
Im a type 2 diabetic
I have cold hands and feet
I tend to heal slowly after injury
I have high blood pressure
I have had a heart attacks
I don't exercise much
I have an autoimmune disease
My moods are all over the place
I had preeclampsia during pregnancy
My memory is getting worse

I snore or have sleep apnea

(7)
I have been diagnosed with fatty liver
I have muscle pain
I have gallstones or no gallbladder
I have SIBO (small intestinal bacterial overgrowth)
I'm postmenopausal
Breastfeeding wore me out
I don't tolerate fatty foods well
I don't eat green leafy vegetables daily
I have been diagnosed with a fatty liver
My estrogen levels are low
I'm a vegetarian or vegan
My symptoms have been worse since pregnancy

# **Support** Organs & Systems



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

## 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 | 4 |
| Sugar (glucose) detected in urine test? | | N | Y | 4 |
| Hair loss under your socks? | | N | Y | 10 |

Blood Sugar Total ..................

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

## Stomach

| | Never | Occasionally | Often | Regularly |
|---|---|---|---|---|
| Belching, bloating, 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 |

## SIBO (Small Intestinal Bacterial Overgrowth)

| | Never | Occasionally | Often | Regularly |
|---|---|---|---|---|
| Abdominal distention after consumption of 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 |

## Small Intestine

| | Never | Occasionally | Often | Regularly |
|---|---|---|---|---|
| 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), diverticulosis/diverticulitis | 0 | 1 | 2 | 3 |
| Stomach cramps | 0 | 1 | 2 | 3 |
| Flatulence (gas) | 0 | 1 | 2 | 3 |
| Fiber-rich diet doesn't stop constipation | 0 | 1 | 2 | 3 |
| History of pimples, skin eruptions? | | N | Y | 6 |
| Any known food allergies? | | N | Y | 6 |

Small Intestine Total ..................

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

### Instructions

Rate each of the following symptoms to the best of your ability based on the last **30 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.

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# **Support** Organs & Systems

## 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 | 6 |

Colon Total ..........

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

## Leaky Gut (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 |

## 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 | 4 |
| Heavy or profuse menstrual bleeding (women only) | 0 | 1 | 2 | 3 |

Hypothyroid Total ..........

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

## Hyperthyroid

| | | | | |
|---|---|---|---|---|
| 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 |


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# **Support** Organs & Systems



## Mitochondrial Dysfunction

| Symptom | Never | Occasionally | Often | Regularly |
|---|---|---|---|---|
| History of previous infections (EBV, Lyme, etc.) | | N | Y | 6 |
| Dizziness on 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 | 6 |
| 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 | 4 |
| Low body temperature | 0 | 1 | 2 | 3 |
| Intolerant to heat | 0 | 1 | 2 | 3 |
| Low thyroid lab numbers? | | N | Y | 4 |
| Little or no skin sweating? | | N | Y | 4 |
| Lack of digestive juices or undigested food | 0 | 1 | 2 | 3 |
| Leaky gut? | | N | Y | 4 |
| Suppressed immune system? | | N | Y | 4 |
| Catch colds or get sick easily? | | N | Y | 4 |
| SIBO or gut dysbiosis? | | N | Y | 4 |
| Reflux | 0 | 1 | 2 | 3 |
| Allergies | 0 | 1 | 2 | 3 |
| Food intolerances or sensitivities? | | N | Y | 4 |
| 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 day going) | 0 | 1 | 2 | 3 |
| Wake up tired, even after 6 or more hours of sleep | 0 | 1 | 2 | 3 |
| Weak nails | 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 | 4 |

Mitochondrial Dysfunction Total ..........

| GREEN | YELLOW | RED |
|---|---|---|
| 0-16 | 17-50 | 51-126 |

## Drainage Dysfunction Susceptibility

| Symptom | | | | |
|---|---|---|---|---|
| Constipation (pooping one or fewer times daily) | 0 | 1 | 2 | 3 |
| Feel full while eating and after meals | 0 | 1 | 2 | 3 |
| Diminished appetite | 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. - 4 a.m. | 0 | 1 | 2 | 3 |
| Edema or swelling | 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 pathogen protocols | 0 | 1 | 2 | 3 |
| Soreness 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 |
| Retain extra fluids | 0 | 1 | 2 | 3 |

Drainage Dysfunction Total ..........

| GREEN | YELLOW | RED |
|---|---|---|
| 0-14 | 15-35 | 36-78 |

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## Minerals & Electrolytes

| | Never | Occasionally | Often | Regularly |
|---|---|---|---|---|
| Edema (swelling) in ankles and 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 | 4 |
| History of lower right abdominal pains or ileocecal valve problems | | N | Y | 4 |
| History of stress fracture | | N | Y | 6 |
| 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 |

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# **Causes** Parasite Infection

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

## Parasite Infection

| Symptom | Never | Occasionally | Often | Regularly |
|---|---|---|---|---|
| Restless sleep (toss, turn, or wake often) | 0 | 1 | 2 | 3 |
| Skin issues, rashes, itches, hives, eczema, or acne | 0 | 1 | 2 | 3 |
| 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 |
| Gut ulcers, sores, 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 |
| Vertical wrinkles around mouth | 0 | 1 | 2 | 3 |
| Parallel lines (tracks) in soles of feet | 0 | 1 | 2 | 3 |
| 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 |

| Symptom | Never | Occasionally | Often | Regularly |
|---|---|---|---|---|
| Go barefoot in garden or parks | 0 | 1 | 2 | 4 |
| 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 |
| Sexual dysfunction | 0 | 1 | 2 | 3 |
| Forgetfulness | 0 | 1 | 2 | 3 |
| Slow reflexes | 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 |
| Yellowish skin, face | 0 | 1 | 2 | 3 |
| Rapid heartbeat | 0 | 1 | 2 | 3 |
| Heart, chest pain | 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 |
| Back, thigh, or shoulder pain | 0 | 1 | 2 | 3 |
| Lethargy, apathy (disinterest) | 0 | 1 | 2 | 3 |
| Numbness, tingling in hands, feet | 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 |

| Question | | | |
|---|---|---|---|
| History of *Giardia*, pin worms, worms, parasites? | N | Y | 6 |
| Do you work in childcare? | N | Y | 6 |
| History of or currently have cancer? | N | Y | 20 |

Parasite Infection Total ............

| GREEN | YELLOW | RED |
|---|---|---|
| 0-46 | 47-96 | 97-264 |

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# **Causes** Radioactive Elements

NAME ............................................................

DATE ..................................

## Radioactive Elements

| Radioactive Elements | Never | Occasionally | Often | Regularly |
|---|---|---|---|---|
| History of or currently have cancer? | | N | Y | 20 |
| Suppressed immune system? | | N | Y | 6 |
| Osteoporosis or osteopenia diganosis? | | N | Y | 6 |
| Can't clear infections, despite following pathogen protocols? | | N | Y | 6 |
| 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 |
| Headaches | 0 | 1 | 2 | 3 |
| Memory or speech problems | 0 | 1 | 2 | 3 |
| Cranial nerve dysfunction | 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 |
| Heartburn or indigestion | 0 | 1 | 2 | 3 |
| Chronic cough | 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 |
| Bloating or gas | 0 | 1 | 2 | 3 |
| Diarrhea | 0 | 1 | 2 | 3 |
| Stomach ulcers | 0 | 2 | 4 | 6 |
| Kidney problems | 0 | 1 | 2 | 3 |
| Pain with bowel movements | 0 | 1 | 2 | 3 |
| Loss of bowel control | 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 |
| Mental or emotional issues | 0 | 1 | 2 | 3 |

Radioactive Elements Total ..................

| GREEN | YELLOW | RED |
|---|---|---|
| 0-16 | 17-40 | 41-176 |

## Instructions

Rate each of the following symptoms to the best of your ability based upon the last **6 months**. 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.

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

## Mercury Toxicity

| | Never | Occasionally | Often | Regularly |
|---|---|---|---|---|
| Do you have amalgam (silver) fillings in your teeth? | | N | Y | 20 |
| Have you ever had an amalgam removed? | | N | Y | 12 |
| If you had amalgams removed, was it done by a biological dentist using a safe protocol? | 20 | N | Y | 4 |
| Were there amalgam fillings in your mother's mouth while she was pregnant with you? | 0 | N | Y | 3 |
| Worked in a dental office? | 0 | 1 | 2 | 3 |
| Did you wear contact lenses during the 1980s or early 1990s? | 0 | 1 | 2 | 3 |
| Did you take 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 | 6 |
| Have you broken any CFL bulbs? | | N | Y | 12 |
| 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 |

### Instructions

Rate each of the following symptoms to the best of your ability based on the last **6 months**. 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.

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## 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 or currently wear cosmetics containing kohl (a dark pigment that is 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 | 2 | 4 | 6 |
| 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 |
| Bad breath | 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 |
| Pain in shoulders or upper back | 0 | 1 | 2 | 3 |
| Wrist or ankle drop, weak extensor muscles | | N | Y | 6 |
| Hair falls out (not normal male pattern baldness) | | N | Y | 12 |

Lead Toxicity Total ..................

| GREEN | YELLOW | RED |
|---|---|---|
| 0-37 | 38-70 | 71-150 |


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# **Causes** Lyme Disease

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

## Biotoxin Illness

| Biotoxin Illness | Never | Occasionally | Often | Regularly |
|---|---|---|---|---|
| Shortness of breath with minimal activity | 0 | 1 | 2 | 3 |
| Excessive exhaustion after exercising | 0 | 1 | 2 | 3 |
| Excessive thirst | 0 | 1 | 2 | 3 |
| Morning stiffness | 0 | 1 | 2 | 3 |
| Irritated or red eyes | 0 | 1 | 2 | 3 |
| Non-restful sleep | 0 | 1 | 2 | 3 |
| Sensitive to light | 0 | 1 | 2 | 3 |
| Bad night vision or seeing halos around lights | 0 | 1 | 2 | 3 |
| Vision blurry | 0 | 1 | 2 | 3 |
| Sensitive to smells | 0 | 1 | 2 | 3 |
| Chronic fatigue or weakness | 0 | 1 | 2 | 3 |

Biotoxin Illness Total ............

| GREEN | YELLOW | RED |
|---|---|---|
| 0-9 | 10-20 | 21-33 |

## Lyme Disease Risks

| Lyme Disease Risks | Never | Occasionally | Often | Regularly |
|---|---|---|---|---|
| Ever diagnosed with Lyme Disease? | | N | Y | 10 |
| Dry sockets or infected tooth extractions | 0 | 1 | 2 | 3 |
| Ever bitten by a tick? | | N | Y | 6 |
| Ever had a bullseye rash on any part of your body? | | N | Y | 8 |
| Mother ever diagnosed with Lyme Disease? | | N | Y | 6 |
| Spouse/partner/significant other diagnosed with Lyme Disease? | 0 | 2 | 4 | 6 |
| Ever diagnosed with chronic fatigue syndrome, fibromyalgia, lupus, rheumatoid arthritis (RA), multiple sclerosis (MS), or an Autoimmune condition? | | N | Y | 6 |
| Ever diagnosed with Parkinson's disease, Alzheimer's disease, or Tourette's Syndrome? | | N | Y | 6 |
| Frequently go camping, hunting, or engage in outdoor activities? | | N | Y | 4 |
| History of a heart murmur or valve prolapse | | N | Y | 4 |

Lyme Disease Risks Total ............

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

## Instructions

Rate each of the following symptoms to the best of your ability based upon the last **6 months**. 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.

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## Lyme Disease Current Symptoms

| Symptom | Never | Occasionally | Often | Regularly |
|---|---|---|---|---|
| Arthritis-like joint pain or swelling | 0 | 2 | 4 | 6 |
| Pain migrates or moves around to different areas? | 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 (joing 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 |
| 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 |
| Exaggerated symptoms or worse hangover from alcohol | 0 | 4 | 6 | 8 |

Lyme Disease Current Symptoms Total ..........

| GREEN | YELLOW | RED |
|---|---|---|
| 0-31 | 32-95 | 96-238 |

### Instructions

Rate each of the following symptoms to the best of your ability based upon the last **6 months**. 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.

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# **Causes** Babesia

NAME ..................................................

DATE ..................................................

## Babesia

| Symptom | Never | Occasionally | Often | Regularly |
|---|---|---|---|---|
| Abdominal pain | 0 | 2 | 4 | 6 |
| Air hunger (episodes of breathlessness) | 0 | 4 | 8 | 10 |
| Anemia (low iron/hemoglobin on blood test) | 0 | 1 | 2 | 3 |
| Back stiffness | 0 | 1 | 2 | 3 |
| Chills | 0 | 1 | 2 | 3 |
| Cough | 0 | 1 | 2 | 3 |
| Depression | 0 | 1 | 2 | 3 |
| Diarrhea | 0 | 2 | 4 | 6 |
| Disturbed sleep: frequent waking | 0 | 4 | 6 | 8 |
| Excessive sleepiness | 0 | 1 | 2 | 3 |
| Exaggerated changes in mood | 0 | 1 | 2 | 3 |
| Encephalophathy *(brain malfunction, brain issues)* | 0 | 1 | 2 | 3 |
| Fatigue, tiredness, poor stamina | 0 | 1 | 2 | 3 |
| Fevers | 0 | 1 | 2 | 3 |
| Headaches | 0 | 1 | 2 | 3 |
| Hemolysis *(destruction of red blood cells)* | 0 | 2 | 4 | 6 |
| Enlarged liver | 0 | 2 | 4 | 6 |
| Imbalance | 0 | 2 | 4 | 6 |
| Joint stiffness | 0 | 1 | 2 | 3 |
| Joint pain or swelling | 0 | 1 | 2 | 3 |
| 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 |
| Shortness of breath | 0 | 1 | 2 | 3 |

| Symptom | Never | Occasionally | Often | Regularly |
|---|---|---|---|---|
| Enlarged spleen | 0 | 1 | 2 | 3 |
| Tachycardia | 0 | 1 | 2 | 3 |
| Heart palpitations, pulse skips | 0 | 4 | 6 | 8 |
| Unexplained fevers, sweats, chills, or flushing | 0 | 2 | 4 | 6 |
| Dark urine with or without blood | 0 | 4 | 6 | 8 |
| Weakness | 0 | 1 | 2 | 3 |
| Weight loss | 0 | 1 | 2 | 3 |
| Lymph gland swelling | 0 | 1 | 2 | 3 |
| Anxiety or panic attacks | 0 | 1 | 2 | 3 |
| Depression | 0 | 1 | 2 | 3 |
| Low white blood cell count on labs | 0 | 1 | 2 | 3 |
| Low platelet count on lab test | 0 | 1 | 2 | 3 |
| Elevated sedimentation (sed) rate on labs | 0 | 1 | 2 | 3 |
| Dizziness | 0 | 1 | 2 | 3 |
| Feeling spacey | 0 | 1 | 2 | 3 |

Babesia Total ..................

| GREEN | YELLOW | RED |
|---|---|---|
| 0-29 | 30-70 | 71-180 |

### Instructions

Rate each of the following symptoms to the best of your ability based upon the last **6 months**. 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.

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

## Bartonella

| 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 fascitis-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 |
| Upset stomach or abdominal pain | 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 | 80-223 |

### Instructions

Rate each of the following symptoms to the best of your ability based upon the last **6 months**. 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.

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# **Causes** Mold



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

## Mold

| Mold | Never | Occasionally | Often | Regularly |
|---|---|---|---|---|
| See mold growing at home, work, or school? | | N | Y | 10 |
| Ever experienced water damage at home, work or school? | | N | Y | 4 |
| Home, workplace or school has a damp or mildewy odor | 0 | 1 | 2 | 3 |
| Spending time in basement causes or worsens symptoms | 0 | 1 | 2 | 3 |
| Basement ever wet? | | N | Y | 4 |
| Symptoms decrease when spend time in a different location for at least a few days | | N | Y | 4 |
| Plumbing in your kitchen or bathroom leaks or has leaked in the past | | N | Y | 4 |
| Wet spots anywhere near your home (whether currently or past) | | N | Y | 4 |
| Often see condensation (fog) on the inside of windows and/or cold inside surfaces in your home | | N | Y | 4 |
| Car has a mildewy smell | | N | Y | 4 |
| 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 | 4 |
| Does anyone in your home have asthma-like symptoms? | | N | Y | 4 |
| 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 |
| 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<br>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 |
| Nausea | 0 | 1 | 2 | 3 |
| Vomiting | 0 | 1 | 2 | 3 |

Mold Total ..................

| GREEN | YELLOW | RED |
|---|---|---|
| 0-19 | 20-60 | 61-118 |

### Instructions

Rate each of the following symptoms to the best of your ability based upon the last **6 months**. 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.

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# **Causes** General Toxicity



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

## General Toxicity

| General Toxicity | Never | Occasionally | Often | Regularly |
|---|---|---|---|---|
| Live on or near a golf course? | | N | Y | 4 |
| Live near a freeway or high-tension wires? | | N | Y | 4 |
| Wear conventional sunscreen? | | N | Y | 4 |
| Wear perfume or cologne? | | N | Y | 4 |
| Use air fresheners in your house, car, or workplace? | | N | Y | 4 |
| Were you the first-born child? | | N | Y | 4 |
| 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 |

Gernal Toxicity Total ..........

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

## Are any of the following current or past occupations or hobbies?

- ☐ Agricultural product handler
- ☐ Asbestos abatement technician
- ☐ Auto mechanic
- ☐ Battery manufacturer
- ☐ Battery recycler
- ☐ Canning plant worker
- ☐ Carpenter
- ☐ Ceramic manufacturer
- ☐ Construction laborer or worker
- ☐ Cosmetic manufacturer
- ☐ Cosmetologist
- ☐ Dental assistant
- ☐ Dental lab worker
- ☐ Dentist
- ☐ Diesel equipment mechanic
- ☐ Dynamite manufacturer or Dynamiter
- ☐ Electronic assembly worker
- ☐ Electronic component manufacturer
- ☐ Electroplater
- ☐ Engraver
- ☐ Explosive expert
- ☐ Fertilizer manufacturer
- ☐ Fiberglass installer
- ☐ Fiberglass manufacturing worker
- ☐ Firefighter
- ☐ Firing range operator
- ☐ Fishermen
- ☐ Fluorescent tube manufacturer
- ☐ Foundry worker
- ☐ Glass manufacturing worker
- ☐ Glassblower
- ☐ Grinding operator
- ☐ Hairdresser
- ☐ Hazardous material worker
- ☐ Ink manufacturer
- ☐ Jeweler
- ☐ Laboratory worker
- ☐ Landfill worker
- ☐ Landscaper
- ☐ Lumber processor
- ☐ Lumber yard worker
- ☐ Metal recycler
- ☐ Metal sculptor
- ☐ Miner
- ☐ Nail technician
- ☐ Paint manufacturer
- ☐ Painter - Residential/ commercial
- ☐ Painter - Fine art
- ☐ Pharmaceutical worker
- ☐ Plastic product manufacturer
- ☐ Plumber
- ☐ Plumbing supply manufacturer
- ☐ Policeman
- ☐ Potter
- ☐ Preservative manufacturer
- ☐ Printer
- ☐ Search and rescue worker
- ☐ Ship repairer
- ☐ Shooting instructor
- ☐ Smelting plant worker
- ☐ Solderer
- ☐ Tanner
- ☐ Tattoo artist
- ☐ Truck mechanic
- ☐ Waste handler
- ☐ Welder
- ☐ Well digger

If you checked any of the above, you are at an increased risk of heavy metal toxicity.

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