Name: ________________ e-mail:____________________ Phone: ______________

Birth date: _____________ Address: ____

FEMALE EVALUATION SURVEY

Note: Some questions may repeat on each page, yet the questions are specific to that area we are testing.

0 = Never

1 = Seldom (Less than 30% of the time)

2 = Occasionally (Between 30% - 70% of the time)

3 = Frequent (More than 70% of the time)

General Health Assessment

1.	Do you feel tired most of the time?	0.	1.	2.	3.
2.	Does the fatigue alter your lifestyle?	0.	1.	2.	3.
3.	Intestinal gas	0.	1.	2.	3.
4.	Abdominal bloating	0.	1.	2.	3.
5.	Crave sugar	0.	1.	2.	3.
6.	Crave beer or bread	0.	1.	2.	3.
7.	Constipation or diarrhea	0.	1.	2.	3.
8.	Irritable or easily angered	0.	1.	2.	3.
9.	Trouble thinking clearly and/or short term memory loss	0.	1.	2.	3.
10.	Faint, dizzy, or lightheaded	0.	1.	2.	3.
11.	Muscle aches	0.	1.	2.	3.
12.	Weight gain	0.	1.	2.	3.
13.	Itching or burning of vagina, rectum, or prostate	0.	1.	2.	3.
14.	Loss of sexual desire	0.	1.	2.	3.
15.	White thrush or yellow fuzzy tongue	0.	1.	2.	3.
16.	Athlete's foot, ringworm, or jock itch	0.	1.	2.	3.
17.	Fungus of toenails or fingernails	0.	1.	2.	3.
18.	Bothered by exposure to perfumes, insecticides, or other chemical smells	0.	1.	2.	3.

19. Ever take antibiotics	0.	1.	2.	3.
20. Using birth control	0.	1.	2.	3.
21. On synthetic hormones	0.	1.	2.	3.
22. Ever taken steroid drugs for allergies, asthma, or injuries	0.	1.	2.	3.

Thyroid Function Assessment

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3 = Frequent (More than 70% of the time)

1. Do you have severe fatigue and find it hard to get up in the morning?	0.	1.	2.	3.
2. Do you have generalized low energy?	0.	1.	2.	3.
3. Do you need caffeine and/or other stimulants to get you going?	0.	1.	2.	3.
4. Do you have a family history of thyroid disease?	0.	1.	2.	3.
5. Do you to gain weight easily?	0.	1.	2.	3.
6. Have you had difficulty losing weight in the last 2 years?	0.	1.	2.	3.
7. Do you have dry skin?	0.	1.	2.	3.
8. Do you have constipation?	0.	1.	2.	3.
9. Are your menstrual cycles irregular?	0.	1.	2.	3.
10. Do you suffer from mood swings?	0.	1.	2.	3.
11. Is your hair thinning?	0.	1.	2.	3.
12. Are the outer third of your eyebrows missing or thinning?	0.	1.	2.	3.
13. Is your hair dry/brittle?	0.	1.	2.	3.
14. Do you have low sex drive?	0.	1.	2.	3.
15. Do you have any problems remembering things?	0.	1.	2.	3.
16. Do you have high cholesterol?	0.	1.	2.	3.

17. Do you have low blood pressure?	0.	1.	2.	3.
18. Do you suffer from depression?	0.	1.	2.	3.
19. Is your skin yellow?	0.	1.	2.	3.

Stress Assessment

Note: Some questions may repeat on each page, yet the questions are specific to that area we are testing.

0 = Never

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2 = Occasionally (Between 30% - 70% of the time)

3 = Frequent (More than 70% of the time)

1. Do you have a close support network of family and friends?	0.	1.	2.	3.
2. Are you happy with your current job/profession?	0.	1.	2.	3.
3. Do you exercise regularly (3 or more times per week)?	0.	1.	2.	3.
4. Do you eat 3 meals and 0-2 snacks per day?	0.	1.	2.	3.
5. Do you consume caffeine, sugar or refined carbohydrates?	0.	1.	2.	3.
6. Do you take downtime to recharge your batteries (trips and small daily amounts)?	0.	1.	2.	3.
7. Do you take a multivitamin/mineral complex daily?	0.	1.	2.	3.
8. Are you comfortable financially?	0.	1.	2.	3.
9. Are you satisfied with your life and its direction?	0.	1.	2.	3.
10. Do you keep your weight within normal range easily?	0.	1.	2.	3.
11. Do you get 8 hours of uninterrupted sleep per night?	0.	1.	2.	3.
12. Are you frequently anxious, depressed, or have panic attacks?	0.	1.	2.	3.
13. Would you rate yourself as stressed?	0.	1.	2.	3.
14. Do you suffer from allergies, arthritis, fibromyalgia, or asthma?	0.	1.	2.	3.
15. Do you have trouble falling asleep?	0.	1.	2.	3.
16. Are you sensitive to smells?	0.	1.	2.	3.

17. Are you more tired after exercise?	0.	1.	2.	3.
18. Are you frequently irritable, angry, or upset?	0.	1.	2.	3.
19. Have you experienced any major life stresses in the past year?	0.	1.	2.	3.
20. Do you have trouble getting up, or making it through the day without caffeine?	0.	1.	2.	3.
21. Do you catch colds or flu more than 3 times a year?	0.	1.	2.	3.
22. Do you crave carbohydrates and sugar?	0.	1.	2.	3.

Female Hormone Balance Assessment

1. Vaginal dryness	Yes	No
2. Anxiety, mood swings	Yes	No
3. Sagging skin	Yes	No
4. Poor sleep quality	Yes	No
5. Memory problems	Yes	No
6. Fatigue	Yes	No
7. Lethargic depression	Yes	No
8. Night sweats	Yes	No
9. Hot flashes	Yes	No
10. Painful intercourse	Yes	No
11. Bladder infections	Yes	No
12. Low blood sugar	Yes	No
13. Salt and fluid retention	Yes	No
14. Foggy thought process	Yes	No
15. Migraine/tension headaches	Yes	No
16. Heavy blood flow	Yes	No
17. Puffy/bloated	Yes	No
18. Depression/anxiety	Yes	No
19. Insomnia	Yes	No
20. Infertility	Yes	No
21. Sleep disorders	Yes	No
22. Weight gain	Yes	No

23. Miscarriages	Yes	No
24. PMS symptoms	Yes	No
25. Mood swings	Yes	No
26. Anxiety/depression	Yes	No
27. Painful or lumpy breasts	Yes	No
28. Endometriosis	Yes	No
29. Tumors	Yes	No
30. Osteoporosis	Yes	No
31. Depressed libido	Yes	No
32. Thinning hair	Yes	No
33. Unusual facial/arm/leg hair	Yes	No
34. Acne breakouts	Yes	No
35. Hypoglycemia	Yes	No
36. Blood sugar highs and lows	Yes	No
37. Painful ovaries	Yes	No
38. Fatigue	Yes	No
39. Blood sugar highs and lows	Yes	No
40. Thin dry skin	Yes	No
41. Brown age spots	Yes	No
42. Inability to exercise	Yes	No

Toxic Burden Assessment

1. How many fast food meals do you eat each week?

   None 1-2 meals 3 or more meals

2. Do you consume 'diet foods' sweetened with aspartame, Splenda, or saccharin?

   Yes No

3. Do you tend to overeat?

   Yes No

4. Do you consume damaged fats (hydrogenated oils or oxidized/rancid fats)?

   Yes No

5. Do you regularly consume foods preserved with MSG (monosodium glutamate)?

   Yes No

6. Do you eat foods that are artificially colored?

   Yes No

7. Do you chew your food completely?

Yes No

8. How many refined carbs or sugar servings do you eat per day?

None One 2-3 4 or more

9. Do you eat only organic produce? (Grown with no pesticides)

Always Sometimes Never

10. How many different colors of vegetables & fruits do you eat in a day?

0-1 different colors 2-4 different colors 5 different colors

11. Do you have an excessive consumption of sodas, coffee (more than two cups a day)?

Yes No

12. Is your coffee and/or tea certified organic?

Always Sometimes Never

13. Do you use freshly ground flaxseed meal?

Yes No

14. Is your oil organic and in a dark bottle?

Yes No

15. Do you drink alkaline-type green drinks or chlorella beverages?

Yes No

16. Do you drink 8-10 glasses of filtered, spring or mineral water every day?

Yes No

17. Do you use fresh dark green herbs like cilantro, in your cooking?

Yes No

18. About how many grams of fiber do you eat each day?

****Grams Guide:** 2 slices **Whole Wheat Bread**: 6 grams 3/4 cup **Broccoli:** 7 grams **6 Wheat Thins**: 2.2 grams **20 Grapes**: 1 gram **1 cup Cooked Beans**: 19 grams **1 tbsp Peanut Butter**: 1.1 gram **1 cup Bran Cereal**: 20 gram **Low Fiber Foods (1-2 grams) include:** Cereal, White bread, Meats, Pancake, Eggs, Dairy, Pasta, Cheese

0-10 grams 10-15 grams 15-20 grams 20-25 grams 25+grams

19. Do you cook or re-heat foods in plastic containers in the microwave?

Yes No

20. Do you consistently take high quality antioxidants?

Yes No

21. Do you use whey protein?

Yes No

22. Do you use probiotics or prebiotics?

Yes No

23. Do you exercise 2 or more times per week for 30 minutes or more to induce a hard sweat? Yes No

24. Do you experience GI distress?

Yes No

25. Do you consume alcohol?

    No Yes 1-4 drinks per week Yes 5 or more drinks per week

26. Do you regularly use prescription or over the counter (OTC) medication?

    Yes No

27. Do you use nicotine? Yes No
28. Do you use a sauna 1-2 times a week?

    Yes No

29. For women, is your body fat 30% or greater? Or for men, is your body fat 20% or greater? Yes No
30. Do you use a cell phone with a headset or hands free?

    Yes No

31. Do you live or work in an environment that recirculates the indoor air?

    Yes No

32. Do you use pesticides on your property?

    Yes No

33. How often do you travel by plane?

    Never 1-3 times per year 4-6 times per year 6 or more times per year

34. Do you use a computer? Yes No
35. How many hours a day do you spend in front of a computer?

    Less than a ½ hour 1-2 hours 3-6 hours 7 or more hours

36. Do you live with someone who uses nicotine?

    Yes No

37. Do you have green plants in your house?

    Yes No

38. Do you expose yourself to toxins like household cleaners?

    Yes No

39. Do you consistently use air purifiers?

    Yes No

40. Do you use water filters?

    Never Sometimes Always

Frequency of Purchase

Please select the average number of times Daily OR Weekly you purchase these items.

Circle Frequency based on per day <u>OR</u> per week:

1. Can of soda Daily: 1, 2, 3, 4, 5, 6 OR Weekly: 1, 2, 3,4 ,5, 6
2. Cup of Brewed Coffee Daily: 1, 2, 3, 4, 5, 6 OR Weekly: 1, 2, 3,4 ,5, 6
3. Cup of Specialty Coffee Daily: 1, 2, 3, 4, 5, 6 OR Weekly: 1, 2, 3,4 ,5, 6
4. Small Bag of Chips Daily: 1, 2, 3, 4, 5, 6 OR Weekly: 1, 2, 3,4 ,5, 6

5. Candy Bar Daily: 1, 2, 3, 4, 5, 6 OR Weekly: 1, 2, 3,4 ,5, 6
6. Pack of Gum Daily: 1, 2, 3, 4, 5, 6 OR Weekly: 1, 2, 3,4 ,5, 6
7. Alcoholic Beverage Daily: 1, 2, 3, 4, 5, 6 OR Weekly: 1, 2, 3,4 ,5, 6
8. Eating Lunch Out Daily: 1, 2, 3, 4, 5, 6 OR Weekly: 1, 2, 3,4 ,5, 6
9. Eating Dinner Out Daily: 1, 2, 3, 4, 5, 6 OR Weekly: 1, 2, 3,4 ,5, 6

The Top Three Reasons I am Here Today

1.

2.

3.