Name: _______________ e-mail:___________________ Phone: _____________

Birth date: _____________ Address: ____

MALE 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

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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.

Male Hormone Balance Assessment

1. Weight loss	Yes	No
2. Fatty breasts	Yes	No
3. Soft erections	Yes	No
4. Low libido	Yes	No
5. Loss of muscle	Yes	No
6. Loss of stamina	Yes	No
7. Hair loss	Yes	No
8. Water retention	Yes	No
9. Headaches	Yes	No
10. Weight gain	Yes	No
11. Enlarged prostate	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   <u>Daily:</u> 1, 2, 3, 4, 5, 6 OR <u>Weekly:</u> 1, 2, 3,4 ,5, 6
2. Cup of Brewed Coffee   <u>Daily:</u> 1, 2, 3, 4, 5, 6 OR <u>Weekly:</u> 1, 2, 3,4 ,5, 6
3. Cup of Specialty Coffee   <u>Daily:</u> 1, 2, 3, 4, 5, 6 OR <u>Weekly:</u> 1, 2, 3,4 ,5, 6
4. Small Bag of Chips   <u>Daily:</u> 1, 2, 3, 4, 5, 6 OR <u>Weekly:</u> 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.