

# YOUR NUTRI-BODY ANALYSIS™

## STEP 1

*READ THIS FIRST: This questionnaire is not intended to diagnose disease conditions. Its sole purpose is to educate and to inform, to assess bodily signs which may relate to nutritional imbalances. If you suspect that you may have a medical problem, please seek competent medical care.*

**TO COMPLETE THIS FORM: If any part of a statement is true for you, check the box “1”, “2” or “3”. Use “1” for “sometimes” or “mild”, “2” for “often” or “moderate”, and “3” for “very often” or “severe”. Skip over all statements which do not apply to you. At the end of each section total the numbers you have checked and multiply by the factor indicated. Do not “agonize” over any statement. If it is unclear or questionable, ignore it and go on to the next.**

### SECTION 1

**1** **2** **3**

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Indigestion or sourness 2 to 3 hours after meals |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal bloating, distension                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Full, loggy feeling after heavy meat meal        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of former taste or craving for meat         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive gas, belching or burping after meals   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heavy, tired feeling after eating                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Burning sensation in stomach                     |

[            ] TOTAL x 6 = Sec. 1 SCORE [            ]

### SECTION 2

**1** **2** **3**

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Consistent gas & bloating from most foods                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fats/greasy foods cause nausea, headaches                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Onions, cabbage, radishes, cucumbers cause bloating, gas, distress |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stool appears yellow, clay-colored, foul odored                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin oil on nose and forehead                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bad breath/bad taste in mouth, excess body odor                    |

[            ] TOTAL x 7 = Sec. 2 SCORE [            ]

SECTION 3

1	2	3
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- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea without apparent cause          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mucous shreds in stools                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have more than 3 bowel movements per day |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful, hard bowel movements            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thin, pencil-like bowel movements        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Alternating constipation and diarrhea    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids or rectal fissure            |

[       ] TOTAL x 7 = Sec. 3 SCORE [       ]

SECTION 4

1	2	3
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- |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excess fluid retention (edema) in hands or feet |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nausea or dizziness                             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor coordination                               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | General, overall weakness                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anemia  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cataracts                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Catch colds, flu, infections easily             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cuticles tear easily                            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle wasting                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Premature aging                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Low hormone levels                              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hair dull, dry, sparse, loose and falling out   |

[       ] TOTAL x 4 = Sec. 4 SCORE [       ]

SECTION 5

1	2	3
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- |                          |                          |                          |                                 |
|--------------------------|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rough, dry, flaky or scaly skin |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dry, brittle hair               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Wounds heal poorly              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Get infections easily           |

[       ] TOTAL x 12 = Sec. 5 SCORE [       ]

SECTION 6

1	2	3
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- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Brittle fingernails                            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain in forearm or biceps                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cramps in calf muscle during sleep or exercise |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful cramping of feet or toes               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Joint pains                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Teeth crowded, with poor placement in mouth    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Teeth prone to decay, frequent toothaches      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor quality of malformation of bones          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervous tics or twitches                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervousness or irritability                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Unusual sensitivity to noise                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insomnia                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart palpitations                             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | FEMALE: Excessive, lengthy, painful menses     |

[       ] TOTAL x 4 = Sec. 6 SCORE [       ]

SECTION 7

1	2	3
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- |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High cholesterol                            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Intolerance to alcohol                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Glucose intolerance, hypoglycemia, diabetes |

[       ] TOTAL x 16 = Sec. 7 SCORE [       ]

SECTION 8

1	2	3
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- |                          |                          |                          |                                      |
|--------------------------|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dry hair                             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Brittle nails                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Slow mental reactions                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High cholesterol in blood            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Enlargement of thyroid gland, goiter |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart palpitations                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritability                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Overweight, obesity                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sluggish metabolism                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation                         |

[       ] TOTAL x 5 = Sec. 8 SCORE [       ]

SECTION 9

1	2	3
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- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pale skin, palms of hands very pale        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fingernails very light in color            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fingernails flat or concave (spoon-shaped) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thin, fragile, brittle nails               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Inner side of lower eyelid is pale         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lack of endurance or stamina, anemia       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cravings for ice, ice eating               |

[       ] TOTAL x 7 = Sec. 9 SCORE [       ]

SECTION 10

1	2	3
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- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritable nerves or muscles, nervous tics/twitches |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle spasms, tremors, convulsions or seizures    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irregular heartbeat                                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful and cold hands or feet                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive body odor                                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loose or sensitive teeth                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety, confusion, disorientation, irritability   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nausea, dizziness or lightheadedness               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mental depression or apathy                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hypersensitivity to noise                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor coordination                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cravings for chocolate                             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insomnia, restlessness, hyperactivity              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bone spurs   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure                                |

[       ] TOTAL x 3 = Sec. 10 SCORE [       ]

SECTION 11

1	2	3
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- |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prone to athletic injuries, strained knees, elbow |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of ligament tone or strength                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscular weakness                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervous degeneration                              |

[       ] TOTAL x 12 = Sec. 11 SCORE [       ]

SECTION 12

**1** **2** **3**

- Swelling of ankles or hands
- Dry skin
- Slow, rapid or irregular heartbeat, palpitations
- Constipation
- Unusual thirst
- Unusually sore or stiff muscles after exercising
- High blood pressure

[       ] TOTAL x 7 = Sec. 12 SCORE [       ]

SECTION 13

**1** **2** **3**

- Muscular degeneration, muscular dystrophy
- Weakened heart tissue, cardiomyopathy
- Cancer
- Cataracts
- Cystic fibrosis

[       ] TOTAL x 10 = Sec. 13 SCORE [       ]

SECTION 14

**1** **2** **3**

- Cuts, wounds, sores heal slowly
- Hair or nails grow slowly
- Loss of sense of smell or taste
- Catch infections easily
- Brittle nails
- White spots on fingernails
- Acne
- Stretch marks
- Sterility or impotence
- White coating on tongue
- Loss of appetite, anorexia
- Sleep disturbances
- Diarrhea
- MALE: Prostate problems

[       ] TOTAL x 4 = Sec. 14 SCORE [       ]

SECTION 15

1	2	3
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- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor night vision, unable to see well in dim light                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eyes sensitive to glare, sunlight or bright lights                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Inability to adjust eyes when entering a dark room                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dry eyes   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eyelids red, scaly or dry  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye inflammation, discharge, mattering, eyelids swollen or pus laden     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Get colds or respiratory infections easily                               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinus problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abscesses in ears, mouth or salivary glands                              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Brittle hair   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dry, rough or scaly skin   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hard "goosebumps" on back of arms that won't go away                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acne, pimples or blackheads  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Warts  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney, urinary or bladder infections, burning or itching when urinating |

[       ] TOTAL x 3 = Sec. 15 SCORE [       ]

SECTION 16

1	2	3
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- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart palpitations or gallop rhythm              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Slow heart beat or rapid heart beat              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Enlarged heart                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diastolic blood pressure over 90                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Forgetfulness, poor memory, short attention span |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscular tenderness, weakness or wasting         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritability                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Feel depressed                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of appetite or loss of weight               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Numbness, pricking or tingling in hands or feet  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of ankle or knee jerk reflexes              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor coordination                                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stiffness or swelling in ankles, feet or legs    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cramping in pains in legs                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tenderness in calf muscle under pressure         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation                                     |

[       ] TOTAL x 3 = Sec. 16 SCORE [       ]

SECTION 17

1	2	3
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- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cracks or sores in corner of mouth           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Reddish-purple (magenta) colored tongue      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shiny, sore or swollen tongue                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lips red, white, scaly, swollen or chapped   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Conjunctivitis                               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cataracts                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sensation of sand on inside of eyelids       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eyes sensitive to light or dimming of vision |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eyes red, itchy, burning                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Red lines in whites of eyes                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | See spots before the eyes                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abnormally greasy or scaly skin around nose  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shrinking or “disappearing” upper lip        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Falling hair, abnormal hair loss             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Oily hair                                    |

[       ] TOTAL x 3 = Sec. 17 SCORE [       ]

SECTION 18

1	2	3
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- |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea                                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chapping of backs of hands              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Itchy, red or inflamed skin, dermatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritability, anxiety or depression     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mental aberrations or schizophrenia     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of sense of humor                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Indigestion                             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Small ulcers or canker sores in mouth   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Burning sensation in hands or feet      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insomnia                                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Whitish, coated tongue                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Brilliant red, painful tongue           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swollen tongue with red tips and sides  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Feel as if hands and feet go numb       |

[       ] TOTAL x 4 = Sec. 18 SCORE [       ]

SECTION 19

1	2	3
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- Irritability or nervousness
- Feel confused
- Can't remember dreams
- Dizziness
- Swelling of hands, feet or ankles (edema)
- Unable to close hands into tight, flat fists
- Soreness, tenderness, weakness of thumb muscles
- Greasy scaliness on skin near nose, mouth, eyes
- Greenish tint to urine
- Muscular twitching
- Hyperactivity
- Poor coordination in walking
- FEMALE: Nausea of pregnancy
- FEMALE: Acne worse during periods

[       ] TOTAL x 4 = Sec. 19 SCORE [       ]

SECTION 20

1	2	3
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- Sore, beefy red tongue
- Lemon-yellowish tint to skin, pale complexion
- Numbness, tingling, soreness or weakness in hands or feet
- Jerking of limbs
- Memory loss
- Stammer
- Apathy, feel as if have lost incentive in life
- Depression, irritability or moodiness
- Anemia
- Paranoia, delusions or hallucinations
- Loss of appetite
- Confusion, disorientation or agitation
- Back pains
- Dizziness
- Dimmed vision
- Poor stomach digestion, low stomach acid
- FEMALE: Menstrual disturbances

[       ] TOTAL x 3 = Sec.20 SCORE [       ]

SECTION 21

**1** **2** **3**

- Skin shiny, dry and scaly
- Tongue purplish-red (magenta) swollen & painful
- Nausea
- Muscular pains
- Mental depression
- Poor appetite
- Fingernails a pale color
- Sleeplessness
- Irregular heartbeat
- Hair loss
- Extreme weariness, exhaustion

[       ] TOTAL x 5 = Sec. 21 SCORE [       ]

SECTION 22

**1** **2** **3**

- Eczema
- High blood pressure
- High cholesterol levels
- Bleeding ulcer
- Have difficulty losing weight

[       ] TOTAL x 10 = Sec. 22 SCORE [       ]

SECTION 23

**1** **2** **3**

- Tongue red, shiny, smooth and painful
- Ulcers in mouth
- Red, swollen or bleeding gums
- Intestinal malabsorption, sprue
- Diarrhea
- Heart palpitations
- Swelling of ankles
- Lightheadedness, faintness
- Apathy or depression
- Forgetfulness
- Loss of appetite, weight loss
- Graying hair
- Excess pigmentation of skin
- Irritable, agitated, brooding or self-conscious
- Anemia

[       ] TOTAL x 3 = Sec. 23 SCORE [       ]

SECTION 24

1	2	3
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- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin sensitive to sun, photosensitivity          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | White patches on skin, loss of pigment, vitiligo |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritability                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Low sex drive                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lupus erythematosus                              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Scleroderma                                      |

[       ] TOTAL x 6 = Sec. 24 SCORE [       ]

SECTION 25

1	2	3
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- |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pupils in eyes are unusually large, dilated                             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Periods of deep depression  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Burning sensation of hands or feet                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor coordination   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lightheaded or dizzy when getting up out of a lying or sitting position |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea or constipation  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Numbness or tingling in hands or feet                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Joint pains   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle cramps   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rapid heartbeat on exertion   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritability  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headaches   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insomnia, sleeplessness   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fatigue, tiredness, lack of energy                                      |

[       ] TOTAL x 4 = Sec. 25 SCORE [       ]

SECTION 26

**1** **2** **3**

- Skin bruises easily, “black & blue” marks
- Hemorrhages or ruptured blood vessels in eye
- Gums bleed easily, especially when brushing teeth
- Bluish-red, swollen or inflamed gums
- Loose teeth, loss of dental fillings
- Cuts, sores or wounds heal slowly
- ”Fleeting” pains in joints or legs, joint tenderness
- Catch infections, colds, flu, or viruses easily
- Listlessness, lack of endurance, tire easily
- Cuticles tear easily
- Excessive hair loss
- Restlessness or irritability
- Nosebleeds
- Broken capillaries, hemorrhages or little pink spots on skin
- Bloating or puffiness in face
- Anemia
- Fragile bones

[       ] TOTAL x 3 = Sec. 26 SCORE [       ]

SECTION 27

**1** **2** **3**

- Burning in mouth and throat
- Poor bone development
- Abnormal number of dental cavities
- Osteoporosis (demineralized bone)
- Osteomalacia (softening of bone)
- Rickets (bowlegs, knock-knees)
- Joint pains
- Muscular cramps
- Nearsightedness, myopia
- Nervousness
- Insomnia
- Constipation

[       ] TOTAL x 5 = Sec. 27 SCORE [       ]

SECTION 28

**1** **2** **3**

- Muscular swelling or wasting, muscular dystrophy
- Brittle and falling hair
- Hemolytic anemia
- FEMALE: Menstrual discomfort
- MALE: Low sex drive

[       ] TOTAL x 12 = Sec. 28 SCORE [       ]

SECTION 29

**1** **2** **3**

- Rough skin
- Excessive perspiration
- Loss of former taste or craving for meat
- Nausea, inclination to vomit
- Potatoes disagree
- Belching accompanied by head colds
- Constipation accompanied by throbbing headaches
- Numbness, stiffness or loss of sensation in arms or legs
- Stitching or burning pain in head with dizziness, relieved by eating
- Poor or failing memory

[       ] TOTAL x 5 = Sec. 29 SCORE [       ]

SECTION 30

**1** **2** **3**

- High or low blood pressure
- Anemia
- Emphysema
- Kidney disease

[       ] TOTAL x 12 = Sec. 30 SCORE [       ]

SECTION 31

**1** **2** **3**

- Nausea or vomiting
- Abdominal pain
- Diarrhea
- Excessive hair loss
- Hyperactivity, irritability or nervousness
- Depression

[       ] TOTAL x 8 = Sec. 31 SCORE [       ]

SECTION 32

1	2	3
---	---	---

- |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cramps or vague abdominal aches or discomfort   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety or irritability                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervousness or restlessness                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lack of ambition, apathy or depression          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hand tremors                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor coordination                               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sallow complexion, grayish-greenish-yellow tint |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions, seizures                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Catch colds, infections easily                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | CHILDREN: Hyperactivity                         |

[       ] TOTAL x 4 = Sec. 32 SCORE [       ]

SECTION 33

1	2	3
---	---	---

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tremors or poor coordination               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Inflamed gums                              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of ability to speak                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tendency to diabetes                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mental disturbances or personality changes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor memory                                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression or uncontrollable crying        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Metallic taste in mouth                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergic tendencies                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of self-confidence                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Food cravings                              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Facial and back pain                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of appetite                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritability                               |

[       ] TOTAL x 3 = Sec. 33 SCORE [       ]

SECTION 34

1	2	3
---	---	---

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritability, restlessness, excitement |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nausea, vomiting                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions                            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tremors                                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irregular heartbeat                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ringling sound in ear, tinnitus        |

[       ] TOTAL x 6 = Sec. 34 SCORE [       ]

SECTION 35

**1** **2** **3**

- High blood pressure
- Shingles, hives
- Anemia

[       ] TOTAL x 16 = Sec. 35 SCORE [       ]

SECTION 36

**1** **2** **3**

- Whitish, yellowish, or brown mottling or discoloration of teeth
- Pitting of teeth
- Nausea or vomiting
- Pain and aching of bones and spine

[       ] TOTAL x 12 = Sec. 36 SCORE [       ]

SECTION 37

**1** **2** **3**

- Excitement
- Confusion
- Depression
- Muscular twitching
- Abdominal cramps
- Spasmodic muscular contractions
- Heart palpitations
- Rapid breathing

[       ] TOTAL x 6 = Sec. 37 SCORE [       ]

SECTION 38

**1** **2** **3**

- High blood pressure
- Stools dry, shrunken
- Excess fluid retention, edema
- Stomach ulcers
- Tremors, convulsions or seizures
- Irritability
- Excessive thirst or excessive urination

[       ] TOTAL x 7 = Sec. 38 SCORE [       ]

SECTION 39

**1** **2** **3**

- Eyes sensitive to bright lights, headlights, sunlight
- Tightness or “lump” in throat, hurts when emotionally disturbed
- Form gooseflesh easily or “cold sweats”
- Voice rises to high pitch or is “lost” during stress, arguments, public appearances, etc.
- Easily shaken up or startled, heart pounds hard from unexpected noise
- Prefer being alone, uneasy when center of attention
- Blood pressure fluctuates, sometimes too low
- Blood pressure decreases when going from a lying position to a standing position
- Known as a “perfectionist”, set high standards
- Avoid complaints, try to ignore discomforts or inconveniences
- Work off worries, things left undone cause unusual concern
- Allergies, such as skin rash, dermatitis, hay fever, severe sneezing attacks, asthma, etc.
- Emotional upsets cause complete exhaustion, must go and lie down when under heavy stress
- Inferiority complex
- Unusual craving for salt
- Perspire excessively
- Tend to be negative
- More than usual neck, head, shoulder tension

[       ] TOTAL x 3 = Sec. 39 SCORE [       ]

SECTION 40

**1** **2** **3**

- Persistent high blood pressure
- Rapid pulse
- Fluid retention of facial tissues, puffy face
- Stronger than average physically
- Strong feelings, tend to “blow up”, dislike being crossed
- FEMALE: Excess hair on face, arms, legs
- MALE: Baldness, excess hair on arms and back, muscular “square” build, aggressive in business or sports

[       ] TOTAL x 8 = Sec. 40 SCORE [       ]

SECTION 41

1	2	3
---	---	---

FEMALE:

- Irregular or discomforting menstrual periods
- Menopausal symptoms: hot flashes, nervousness, depression
- Have had uterus and/or ovaries removed
- Lost or diminished sex drive
- Feel nervous or depressed before periods
- Unable to have children because of sterility (not because of age or operation.)

[       ] TOTAL x 8 = Sec. 41 SCORE [       ]

MALE:

- Difficulty urinating – starting, burning
- Above associated with back or leg pains
- Have to urinate more than twice during night
- Prostate trouble or prostate surgery
- Lost or diminished sex drive

[       ] TOTAL x 10 = Sec. 41 SCORE [       ]

SECTION 42

1	2	3
---	---	---

- Burning sensation upon urination
- High diastolic blood pressure (above 90)
- Lower back pains
- Puffiness around eyes
- Have to urinate more than twice per night
- Legs often feel heavy
- Unable to control flow of urine, incontinence
- Joint pains
- Anemia

[       ] TOTAL x 6 = Sec. 42 SCORE [       ]

SECTION 43

**1** **2** **3**

- Pain on inside of left shoulder blade
- Pain on left side of abdomen
- Shingles on trunk of body
- Cold hands or feet
- Feel cold and sweaty
- Shakiness
- Slow healing of wounds, cuts, abrasions
- Constant, intense thirst
- Urinate more than 2 liters daily
- Breath smells sweet or of acetone
- Peculiar sensations in hands or feet – tingling, burning, sharp jabs, numbness, etc.
- Vision failing
- Urine contains sugar
- Moody with marked ups and downs, elations or depressions, hyperactivity or laziness
- Vague, unrelated complaints which can be relieved by eating, only to return with a vengeance
- Cold sweats of the hands even when warm
- Fainting, blacking out or convulsions

[       ] TOTAL x 3 = Sec. 43 SCORE [       ]

SECTION 44

**1** **2** **3**

- Cold hands or feet, cold all over
- Infertility or impotence
- Headaches affecting one side of head
- Excessive urination
- Left upper neck pain
- Left little finger pain
- Overweight from waste down
- Overweight from waist up
- Feelings of inadequacy
- Changeable temperament, moody
- Feelings dominate over logic
- Abdominal “apron” of fat
- Fluid swelling in ankles, fingers, feet or under eyes
- FEMALE: Loss of menstrual function

[       ] TOTAL x 4 = Sec. 44 SCORE [       ]

SECTION 45

**1** **2** **3**

- Stomach pain 5 or 6 hours after eating, usually at night, relieved by eating or by drinking milk
- Above complaints aggravated by worry/tension

[       ] TOTAL x 25 = Sec. 45 SCORE [       ]

SECTION 46

1	2	3
---	---	---

- Susceptible to flu, infections
- Swollen glands in armpit, groin, tonsils
- Feeling of puffiness in throat
- Soreness on both sides of neck at shoulder level
- Irregular heartbeat
- More than usual number of cavities
- Look older than chronological age

[            ] TOTAL x 7 = Sec. 46 SCORE [            ]

SECTION 47

1	2	3
---	---	---

- Muscles stiff in morning, feel need to limber up
- Feel “creaky” after sitting still for some time
- Heart seems to miss beats or turn “flip-flops”
- These symptoms worse at night: coughing, hoarseness, muscle cramps
- Nauseated in morning
- Start slow in morning, gain speed in afternoon
- Motion sickness when traveling
- Dizzy in morning or when moving up and down
- Cold hands or feet
- Sensitivity to cold, prefer warm climate
- Hair scanty, dry, brittle, dull, lusterless, lifeless
- Flaky, dry, rough skin
- Sleeplessness, restlessness
- Poor short term memory, forgetfulness
- Poor response to exercising
- Hypoglycemia (low blood sugar)
- High cholesterol
- Constipation, less than one bowel movement daily
- “Go to pieces” easily, cry easily
- Dislike working under pressure, being watched
- Diminished sex drive
- Gain weight easily, fail to lose on diets
- Difficulty concentrating, easily distracted
- Yellowish tint to skin on hands or feet
- Clogged sinuses
- Low pulse rate
- Low body temperature, especially at bed rest
- Recurrent infections
- Depression
- Headaches
- Puffiness of face or eyes
- Irritability, mood swings
- Multiple food allergies/sensitivities
- FEMALE: Menstrual irregularity, excess flow, premenstrual syndrome (PMS)

[            ] TOTAL x 2 = Sec. 47 SCORE [            ]

SECTION 48

1	2	3
---	---	---

- |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart beats above 90 beats per minute at rest     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart palpitations                                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Protruding tongue quivers, hands shake or tremble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strong drive followed by exhaustion               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Good appetite but fail to gain weight             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Erratic, "flighty" behavior, talk rapidly         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Protruding eyeballs                               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Warm, fine, moist skin                            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritability, nervousness, hyperactivity          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insomnia  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent bowel movements, diarrhea                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive sweating without exercise               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Feel warm & flushed at normal room temperature    |

[            ] TOTAL x 4 = Sec. 48 SCORE [            ]

SECTION 49

1	2	3
---	---	---

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Awake in morning not feeling rested            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | An almost "painful" fatigue not helped by rest |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dark or puffy circles under the eyes           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Spastic colon, colitis, irritable bowel        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Minor, chronic complaints that recur           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure                            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bed wetting, uncontrolled urination            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Enlargement of lymph glands in neck            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have been called a "hypochondriac"             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insomnia, sleep disturbances                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heavy sweating not related to exercise         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fluid retention                                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle spasms, aching muscles                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful, stiff or swollen joints               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression or crying spells                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinus attacks                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Catch colds easily                             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | History of bronchitis or pneumonia             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hyperactivity                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation or diarrhea                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Marked fluctuations in weight                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eczema, psoriasis, rashes, dermatitis          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritability                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bladder infections                             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hay fever, sneezing attacks                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dry stuffy nose, tendency to pick nose         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Runny nose                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bloating or puffiness in face                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bronchial asthma                               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Migraine headaches                             |

[            ] TOTAL x 2 = Sec. 49 SCORE [            ]

SECTION 50

1	2	3
---	---	---

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Repeated use of antibiotics or birth control pills       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cravings for sugars, bread or alcohol                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Severe reactions to perfume, tobacco or chemical odors   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hypersensitivity to certain foods                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea or constipation                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rectal itching   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bladder infections                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Coated or sore tongue                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Feel bad all over, without apparent cause                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hives psoriasis or skin rash                             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety or depression                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tiredness, feelings of being "drained"                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Feeling "spacey" or "unreal"                             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | FEMALE: Premenstrual tension, menstrual problems, cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | FEMALE: Vaginal discharge, burning, itching              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | FEMALE: Endometriosis, uterine fibroids                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | MALE: Prostate problems, impotence                       |

[            ] TOTAL x 3 = Sec. 50 SCORE [            ]

SECTION 51

1	2	3
---	---	---

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fingers and/or toes go cold                            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arms and/or legs "go to sleep"                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Numbness or heaviness in arms or legs                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cramps in hand when writing                            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sharp, diagonal crease in earlobe                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tingling sensation in lips or fingers                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Short walk causes cramping or pains in legs            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Memory not as good as it used to be                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ankles swell late in day                               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Persistent, nagging cough                              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Breathlessness on slight exertion or lying down        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Urinate more than twice during night                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Whitish ring under outer part of cornea in the eye     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Impotent or frigid                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain after physical exertion or emotional stress |

[            ] TOTAL x 3 = Sec. 51 SCORE [            ]

SECTION 52

**1** **2** **3**

- Nervousness, shaky feelings or headaches relieved by eating sweets
- Irritable if late for a meal or miss a meal
- Irritable before breakfast
- Sudden, strong cravings for sweets, coffee, or alcohol
- Asthmatic attacks
- Get hungry soon after eating
- Cold hands or feet
- Wake up at night feeling hungry
- Wake up in middle of night and can't go back to sleep

[       ] TOTAL x 6 = Sec. 52 SCORE [       ]

SECTION 53

**1** **2** **3**

- Tremors of hands or feet
- Double vision
- Slurred speech
- Irritability or impatience
- Loss of stamina while doing physical work
- Lose temper easily, emotionally unsettles

[       ] TOTAL x 8 = Sec. 53 SCORE [       ]

SECTION 54

**1** **2** **3**

- Muscles weak, weak grip, light objects feel heavy
- Muscles wasting in some particular part of body
- Numbness or loss of sensation
- Objects fall from hands, reach in wrong place for things

[       ] TOTAL x 12 = Sec. 54 SCORE [       ]

SECTION 55

1	2	3
---	---	---

FEMALE: Indicate which conditions apply **only if** they occur within 14 days prior to and two days after the menstrual period.

- |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety, nervous tension                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mood swings, emotional outbursts, crying spells |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness, fainting                             |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headache  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Backache, cramps                                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insomnia  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bloating, weight gain                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Forgetfulness, confusion                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Increased appetite                              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Craving for sweets                              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Breast tenderness                               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swelling of hands, feet, edema                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pounding heart                                  |

[       ] TOTAL x 3 = Sec. 55 SCORE [       ]

Congratulations --  
You have completed your questionnaire!

## STEP 2

If you have not already done so, please add up the total of all the checked boxes for each section. Multiply this total by the factor indicated to determine the score for each section.

Next, visit my website at [www.vegancoach.com](http://www.vegancoach.com) to discover what your results mean, and to discover which nutrients YOUR body needs.

Thank you. 😊

Sassy