INE INSTITUTE OF NUTRITIONAL ENDOCRINOLOGY

CHANGING LIVES WITH ROOT CAUSE HEALTH CARE

Body System and Organs Assessment Scorecard

Name	

Based upon your health profile for **the past 30 days**, please select the appropriate number, from '0 - 3' on all questions (0 as least/never/no and 3 as most/always/yes). Check the number you feel best applies, then add the number of checks in each column to create your score.

Point Scale:
0 = **Never, Rarely** or almost never have the experience/effect.
1 = **Mild/Sometimes** experiences/effects
2 = **Moderate/Frequent** experiences/effects
3 = **Severe/Daily** experiences/effects

For all **yes/no** questions, 0 = no and 3 = yes

Part A - Digestion

Section 1 (Upper Gastrointestinal - low stomach acid /digestive enzymes)	**0**	**1**	**2**	**3**
Do you experience belching or gas within one hour after eating?	0	1	2	3
Do you experience heartburn or acid reflux?	0	1	2	3
Do you experience bloating within one hour after eating?	0	1	2	3
Do you follow a vegan diet?	0	1	2	3
Do you have bad breath?	0	1	2	3
Have you experienced a loss of taste for meat?	0	1	2	3
Does your sweat have a strong odor?	0	1	2	3
Do you experience stomach upset by taking vitamins?	0	1	2	3
Do you feel a sense of excess fullness after meals?	0	1	2	3
Do you ever feel like skipping breakfast?	0	1	2	3
Do you feel better if you don't eat?	0	1	2	3
Do you feel sleepy after meals?	0	1	2	3

Do your fingernails chip, peel or break easily?	0	1	2	3
Do you have anemia (low red blood cells count) that is unresponsive to iron?	0	1	2	3
Do you experience stomach pains or cramps?	0	1	2	3
Do you have chronic diarrhea?	0	1	2	3
Do you experience diarrhea shortly after meals?	0	1	2	3
Is there ever undigested food in your stool?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Subtotal /54				
Section 2 (Upper Gastrointestinal - excess stomach acid)	**0**	**1**	**2**	**3**
Do you ever have black or tarry colored stools?	0	1	2	3
Do you experience stomach pain, burning or aching 1-4 hours after eating?	0	1	2	3
Do you use antacids?	0	1	2	3
Do you ever feel hungry an hour to two after eating?	0	1	2	3
Do you experience heartburn from spicy foods, chocolate, citrus, peppers, alcohol, and/or caffeine?	0	1	2	3
Do you receive temporary heartburn relief from antacids, food, milk or carbonated beverages?	0	1	2	3
Do your digestive problems subside with rest and relaxation?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Subtotal /21				
Section 3 (Liver and Gallbladder)	**0**	**1**	**2**	**3**
Do you experience pain between your shoulder blades?	0	1	2	3
Do you experience stomach upset by eating greasy foods?	0	1	2	3
Do you ever have greasy or shiny stools?	0	1	2	3
Do you experience nausea?	0	1	2	3
Do you ever experience sea, car, airplane or motion sickness?	0	1	2	3
Do you have a history of morning sickness? *0 = never* *1 = years ago* *2 = within last year* *3 = within past 3 months*	0	1	2	3
Do you ever have light or clay colored stools?	0	1	2	3
Do you have dry skin, itchy feet, or skin peels on your feet?	0	1	2	3
Do you ever feel headaches "over your eyes"?	0	1	2	3

Have you ever had a gallbladder attack(s)? *0 = never* *1 = years ago* *2 = within last year* *3 = within past 3 months*	0	1	2	3
Has your gallbladder been removed? *0 = no* *3 = yes*	0			3
Do you ever experience a bitter taste in your mouth, especially after meals?	0	1	2	3
Would you become sick if you were to drink wine?	0	1	2	3
Would you be easily intoxicated if you were to drink wine?	0	1	2	3
Would you be easily hung over if you were to drink wine?	0	1	2	3
How many alcoholic drinks do you consume per week? *0 = <3* *1 = <7* *2 = <14* *3 = >=14*	0	1	2	3
Are you a recovering alcoholic? *0 = no* *3 = yes*	0			3
Do you have a history of drug or alcohol abuse? *0 = never* *1 = years ago* *2 = within last year* *3 = within past 3 months*	0	1	2	3
Do you have a history of hepatitis? *0 = never* *1 = years ago* *2 = within last year* *3 = within past 3 months*	0	1	2	3
Do you have a history of long term use of prescription/recreational drugs? *0 = never* *1 = years ago* *2 = within last year* *3 = within past 3 months*	0	1	2	3
Are you sensitive to chemicals?	0	1	2	3
Are you sensitive to tobacco smoke?	0	1	2	3
Are you sensitive when exposed to diesel fumes?	0	1	2	3
Do you ever feel pain under the right side of your rib cage?	0	1	2	3
Do you have hemorrhoids or varicose veins?	0	1	2	3
Do you consume NutraSweet (aspartame)?	0	1	2	3
Are you sensitive to NutraSweet (aspartame)?	0	1	2	3
Do you have chronic fatigue or Fibromyalgia?	0	1	2	3

Do you experience lower bowel gas and/or bloating several hours after eating?	0	1	2	3
Is there a yellowish cast to your eyes?	0	1	2	3
Do you have reddened skin, especially your palms?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Subtotal /93				
Section 4 (Small Intestine and Pancreas)	**0**	**1**	**2**	**3**
Do you have any known food allergies?	0	1	2	3
Do you experience abdominal bloating 1 to 2 hours after eating?	0	1	2	3
Do specific foods make you tired or bloated?	0	1	2	3
Does your pulse speed after eating?	0	1	2	3
Do you have any airborne allergies?	0	1	2	3
Do you experience hives?	0	1	2	3
Do you experience sinus congestion or "stuffy head"?	0	1	2	3
Do you crave bread or noodles?	0	1	2	3
Do you alternate between constipation and diarrhea?	0	1	2	3
Do you have a history of Crohn's disease? *0 = never* *1 = years ago* *2 = within last year* *3 = within past 3 months*	0	1	2	3
Are you sensitive to wheat or grains?	0	1	2	3
Are you sensitive to dairy?	0	1	2	3
Are there foods you could not give up?	0	1	2	3
Do you have issues with asthma, sinus infections, and/or a stuffy nose?	0	1	2	3
Do you have bizarre, vivid dreams and/or nightmares?	0	1	2	3
Do you use over-the-counter pain medications?	0	1	2	3
Do you ever feel spacey or unreal?	0	1	2	3
Does eating roughage and fiber cause constipation?	0	1	2	3
Do you have indigestion and fullness that lasts 2-4 hours after eating?	0	1	2	3
Do you ever feel pain, tenderness, soreness on your left side under your rib cage?	0	1	2	3
Do you experience excessive passage of gas?	0	1	2	3
Do you experience nausea and/or vomiting?	0	1	2	3
Do you notice your stool is undigested, foul smelling, mucous-like, greasy, and/or poorly formed?	0	1	2	3
Do you frequently need to urinate?	0	1	2	3
Do you have intense thirst and appetite?	0	1	2	3

Do you have difficulty losing weight?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Subtotal /78				
Section 5 (Large Intestine)	**0**	**1**	**2**	**3**
Do you ever have issues with your anus being itchy?	0	1	2	3
Is your tongue coated?	0	1	2	3
Do you feel worse in moldy or musty places?	0	1	2	3
Have you taken antibiotics for a total accumulated time of: *0 = never* *1 = <1 month* *2 = <3 months* *3 = >3 months*	0	1	2	3
Do you ever have fungus or yeast infections?	0	1	2	3
Do you have ring worm, "jock itch", "athletes foot", and/or nail fungus?	0	1	2	3
Do any yeast related symptoms increase with sugar, starch or alcohol?	0	1	2	3
Are your stools hard or difficult to pass?	0	1	2	3
Do you have a history of parasites? *0 = never* *1 = <1 month* *2 = <3 months* *3 = >3 months*	0	1	2	3
Do you have less than one bowel movement per day?	0	1	2	3
Do your stools ever have: corners, edges, flat shapes, ribbon shapes	0	1	2	3
Are your stools not well formed (loose)?	0	1	2	3
Do you have irritable bowel or mucus colitis? *0 = no* *3 = yes*	0			3
Do you ever have blood in your stool?	0	1	2	3
Do you ever have mucus in your stool?	0	1	2	3
Do you ever have excessive foul smelling lower bowel gas?	0	1	2	3
Do you have bad breath or strong body odors?	0	1	2	3
Is it painful to press along the outer sides of your thighs (Iliotibial Band)?	0	1	2	3
Do you have cramping in your lower abdominal region?	0	1	2	3
Do you have dark circles under your eyes?	0	1	2	3
Do you ever have the feeling that your bowels do not empty completely?	0	1	2	3
Do you experience lower abdominal pain relief by passing stool or gas?	0	1	2	3
Do you have alternating constipation and diarrhea?	0	1	2	3
Do you ever experience diarrhea?	0	1	2	3

Do you ever experience constipation?	0	1	2	3
Do you have more than 3 bowel movements daily?	0	1	2	3
Do you ever have a need for laxatives?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Subtotal /81				
Part B Cardiovascular				
Section 6 - Cardiovascular	**0**	**1**	**2**	**3**
Are you aware of heavy and/or irregular breathing?	0	1	2	3
Do you feel discomfort at high altitudes?	0	1	2	3
Do you notice "air hunger" or do you sigh frequently?	0	1	2	3
Are you compelled to open windows in a closed room?	0	1	2	3
Do you experience shortness of breath with moderate exertion?	0	1	2	3
Do your ankles swell, especially at the end of the day?	0	1	2	3
Do you cough at night?	0	1	2	3
Do you blush or does your face turn red for no reason?	0	1	2	3
Do you feel dull pain or tightness in your chest and/or does it radiate into right arm; worsen with exertion?	0	1	2	3
Do you experience muscle cramps with exertion?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Subtotal /30				
Part C Kidney and Bladder				
Section 7 - Kidney and Bladder	**0**	**1**	**2**	**3**
Do you have pain in your mid-back region?	0	1	2	3
Are you puffy around the eyes and/or have dark circles under eyes?	0	1	2	3
Do you have a history of kidney stones? *0 = none* *1 = 1 year ago* *2 = within last year* *3 = within past 3 months*	0	1	2	3
Do you ever have cloudy, bloody or darkened urine?	0	1	2	3
Does your urine have a strong odor?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Subtotal /15				
Part D Immune System				
Section 8 - Immune System	**0**	**1**	**2**	**3**

Do you ever have a runny or drippy nose?	0	1	2	3
Do you catch colds at the beginning of winter?	0	1	2	3
Do you have a mucus producing cough?	0	1	2	3
Do you experience frequent colds or flu?	0	1	2	3
Are you prone to other infections (sinus, ear, lung, skin, bladder, kidney, etc.)?	0	1	2	3
Are you an "always sick" person?	0	1	2	3
Do you have acne (adult)?	0	1	2	3
Do you have itchy skin (Dermatitis)?	0	1	2	3
Do you have cysts, boils, rashes?	0	1	2	3
Do you have a history of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other? *0 = none* *1 = 1 year ago* *2 = within last year* *3 = within past 3 months*	0	1	2	3
Do you have a chronic viral condition?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Subtotal /33				
Grand Total /405				

Score Interpretation:

Convert each section's score to a percentage number to determine which body systems/organs need to be addressed more urgently than others.

0-10% - Overall good balance. Sound nutrition and healthy habits will maintain good balance.

11-20% - In need of a tune up to restore balance before serious illness sets in. Diet and lifestyle improvements should shift to normal.

21-35% - Things are out of balance and need attention.

36-50% - Very compromised and likely to significantly affect your state of health, well-being and energy level.

51-100% - Severely compromised and requires immediate attention.