Body System and Organ Assessment

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). Circle the number you feel best applies, then add the numbers to create your score.

POINT SCALE:

0 = NEVER (also: least, no, never tried/experienced)

1 = MILD (also: occasionally; symptom occurs rarely - i.e. a couple of times a month at most)

2 = MODERATE (also: some severity/intensity, and/or frequency, often; symptom occurs weekly)

3 = SEVERE/ABSOLUTE (also: frequent, intense, most, always, yes)

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

Part A - Digestion

Section 1 (Upper Gastrointestinal - low stomach acid /digestive enzymes)

1. **0 1 2 3** Do you experience belching or gas within one hour after eating?
2. **0 1 2 3** Do you experience heartburn or acid reflux?
3. **0 1 2 3** Do you experience bloating within one hour after eating?
4. **0 1 2 3** Do you follow a vegan diet?
5. **0 1 2 3** Do you have bad breath?
6. **0 1 2 3** Have you experienced a loss of taste for meat?
7. **0 1 2 3** Does your sweat have a strong odor?
8. **0 1 2 3** Do you experience stomach upset by taking vitamins?
9. **0 1 2 3** Do you feel a sense of excess fullness after meals?
10. **0 1 2 3** Do you ever feel like skipping breakfast?
11. **0 1 2 3** Do you feel better if you don't eat?
12. **0 1 2 3** Do you feel sleepy after meals?
13. **0 1 2 3** Do your fingernails chip, peel or break easily?
14. **0 1 2 3** Do you have anemia (low red blood cells count) that is unresponsive to iron?
15. **0 1 2 3** Do you experience stomach pains or cramps?
16. **0 1 2 3** Do you have chronic diarrhea?
17. **0 1 2 3** Do you experience diarrhea shortly after meals?
18. **0 1 2 3** Is there ever undigested food in your stool?

TOTAL: _____/54

Section 2 (Upper Gastrointestinal - excess stomach acid)

1. **0 1 2 3** Do you ever have black or tarry colored stools?
2. **0 1 2 3** Do you experience stomach pain, burning or aching 1-4 hours after eating?
3. **0 1 2 3** Do you use antacids?
4. **0 1 2 3** Do you ever feel hungry an hour to two after eating?
5. **0 1 2 3** Do you experience heartburn from spicy foods, chocolate, citrus, peppers, alcohol, and/or caffeine?
6. **0 1 2 3** Do you receive temporary heartburn relief from antacids, food, milk or carbonated beverages?
7. **0 1 2 3** Do your digestive problems subside with rest and relaxation?

TOTAL: _____/21

Section 3 (Liver and Gallbladder)

1. **0 1 2 3** Do you experience pain between your shoulder blades?
2. **0 1 2 3** Do you experience stomach upset by eating greasy foods?
3. **0 1 2 3** Do you ever have greasy or shiny stools?
4. **0 1 2 3** Do you experience nausea?
5. **0 1 2 3** Do you ever experience sea, car, airplane or motion sickness?
6. Do you have a history of morning sickness?
   0 = never
   1 = years ago
   2 = within last year
   3 = within past 3 months
7. **0 1 2 3** Do you ever have light or clay colored stools?
8. **0 1 2 3** Do you have dry skin, itchy feet, or skin peels on your feet?
9. **0 1 2 3** Do you ever feel headaches "over your eyes"?
10. Have you ever had a gallbladder attack(s)?
    0 = never
    1 = years ago
    2 = within last year
    3 = within past 3 months
11. **(0 = no; 3 = yes)** Has your gallbladder been removed?
12. **0 1 2 3** Do you ever experience a bitter taste in your mouth, especially after meals?
13. **0 1 2 3** Would you become sick if you were to drink wine?
14. **0 1 2 3** Would you be easily intoxicated if you were to drink wine?
15. **0 1 2 3** Would you be easily hung over if you were to drink wine?

16. How many alcoholic drinks do you consume per week?
    0 = <3
    1 = <7
    2 = <14
    3 = >=14
17. **(0 = no; 3 = yes)** Are you a recovering alcoholic?
18. Do you have a history of drug or alcohol abuse?
    0 = never
    1 = years ago
    2 = within last year
    3 = within past 3 months
19. Do you have a history of hepatitis?
    0 = never
    1 = years ago
    2 = within last year
    3 = within past 3 months
20. 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
21. **0 1 2 3** Are you sensitive to chemicals?
22. **0 1 2 3** Are you sensitive to tobacco smoke?
23. **0 1 2 3** Are you sensitive when exposed to diesel fumes?
24. **0 1 2 3** Do you ever feel pain under the right side of your rib cage?
25. **0 1 2 3** Do you have hemorrhoids or varicose veins?
26. **0 1 2 3** Do you consume NutraSweet (aspartame)?
27. **0 1 2 3** Are you sensitive to NutraSweet (aspartame)?
28. **0 1 2 3** Do you have chronic fatigue or Fibromyalgia?
29. **0 1 2 3** Do you experience lower bowel gas and/or bloating several hours after eating?
30. **0 1 2 3** Is there a yellowish cast to your eyes?
31. **0 1 2 3** Do you have reddened skin, especially your palms?

TOTAL: _____/93

Section 4 (Small Intestine and Pancreas)

1. **0 1 2 3** Do you have any known food allergies?
2. **0 1 2 3** Do you experience abdominal bloating 1 to 2 hours after eating?
3. **0 1 2 3** Do specific foods make you tired or bloated?
4. **0 1 2 3** Does your pulse speed after eating?
5. **0 1 2 3** Do you have any airborne allergies?
6. **0 1 2 3** Do you experience hives?
7. **0 1 2 3** Do you experience sinus congestion or "stuffy head"?
8. **0 1 2 3** Do you crave bread or noodles?
9. **0 1 2 3** Do you alternate between constipation and diarrhea?
10. Do you have a history of Crohn's disease?
    0 = never
    1 = years ago
    2 = within last year
    3 = within past 3 months
11. **0 1 2 3** Are you sensitive to wheat or grains?
12. **0 1 2 3** Are you sensitive to dairy?
13. **0 1 2 3** Are there foods you could not give up?
14. **0 1 2 3** Do you have issues with asthma, sinus infections, and/or a stuffy nose?
15. **0 1 2 3** Do you have bizarre, vivid dreams and/or nightmares?
16. **0 1 2 3** Do you use over-the-counter pain medications?
17. **0 1 2 3** Do you ever feel spacey or unreal?
18. **0 1 2 3** Does eating roughage and fiber cause constipation?
19. **0 1 2 3** Do you have indigestion and fullness that lasts 2-4 hours after eating?
20. **0 1 2 3** Do you ever feel pain, tenderness, soreness on your left side under your rib cage?
21. **0 1 2 3** Do you experience excessive passage of gas?
22. **0 1 2 3** Do you experience nausea and/or vomiting?
23. **0 1 2 3** Do you notice your stool is undigested, foul smelling, mucous-like, greasy, and/or poorly formed?
24. **0 1 2 3** Do you frequently need to urinate?
25. **0 1 2 3** Do you have intense thirst and appetite?
26. **0 1 2 3** Do you have difficulty losing weight?

TOTAL: _____/78

Section 5 (Large Intestine)

1. **0 1 2 3** Do you ever have issues with your anus being itchy?
2. **0 1 2 3** Is your tongue coated?
3. **0 1 2 3** Do you feel worse in moldy or musty places?
4. Have you taken antibiotics for a total accumulated time of:
   0 = never
   1 = <1 month
   2 = <3 months
   3 = >3 months
5. **0 1 2 3** Do you ever have fungus or yeast infections?
6. **0 1 2 3** Do you have ring worm, "jock itch", "athletes foot", and/or nail fungus?
7. **0 1 2 3** Do any yeast related symptoms increase with sugar, starch or alcohol?
8. **0 1 2 3** Are your stools hard or difficult to pass?
9. Do you have a history of parasites?
   0 = never
   1 = <1 month
   2 = <3 months
   3 = >3 months
10. **0 1 2 3** Do you have less than one bowel movement per day?
11. **0 1 2 3** Do your stools ever have: corners, edges, flat shapes, ribbon shapes
12. **0 1 2 3** Are your stools not well formed (loose)?
13. **(0 = no; 3 = yes)** Do you have irritable bowel or mucus colitis?
14. **0 1 2 3** Do you ever have blood in your stool?
15. **0 1 2 3** Do you ever have mucus in your stool?
16. **0 1 2 3** Do you ever have excessive foul smelling lower bowel gas?
17. **0 1 2 3** Do you have bad breath or strong body odors?
18. **0 1 2 3** Is it painful to press along the outer sides of your thighs (Iliotibial Band)?
19. **0 1 2 3** Do you have cramping in your lower abdominal region?
20. **0 1 2 3** Do you have dark circles under your eyes?
21. **0 1 2 3** Do you ever have the feeling that your bowels do not empty completely?
22. **0 1 2 3** Do you experience lower abdominal pain relief by passing stool or gas?
23. **0 1 2 3** Do you have alternating constipation and diarrhea?
24. **0 1 2 3** Do you ever experience diarrhea?
25. **0 1 2 3** Do you ever experience constipation?
26. **0 1 2 3** Do you have more than 3 bowel movements daily?
27. **0 1 2 3** Do you ever have a need for laxatives?

TOTAL: _____/81

Part B - Cardiovascular

1. **0 1 2 3** Are you aware of heavy and/or irregular breathing?
2. **0 1 2 3** Do you feel discomfort at high altitudes?
3. **0 1 2 3** Do you notice "air hunger" or do you sigh frequently?
4. **0 1 2 3** Are you compelled to open windows in a closed room?
5. **0 1 2 3** Do you experience shortness of breath with moderate exertion?
6. **0 1 2 3** Do your ankles swell, especially at the end of the day?
7. **0 1 2 3** Do you cough at night?
8. **0 1 2 3** Do you blush or does your face turn red for no reason?
9. **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?
10. **0 1 2 3** Do you experience muscle cramps with exertion?

TOTAL: _____/30

Part C - Kidney and Bladder

1. **0 1 2 3** Do you have pain in your mid-back region?
2. **0 1 2 3** Are you puffy around the eyes and/or have dark circles under eyes?
3. Do you have a history of kidney stones?
   0 = none
   1 = 1 year ago
   2 = within last year
   3 = within past 3 months
4. **0 1 2 3** Do you ever have cloudy, bloody or darkened urine?
5. **0 1 2 3** Does your urine have a strong odor?

TOTAL: _____/15

Part D Immune System

1. **0 1 2 3** Do you ever have a runny or drippy nose?
2. **0 1 2 3** Do you catch colds at the beginning of winter?
3. **0 1 2 3** Do you have a mucus producing cough?
4. **0 1 2 3** Do you experience frequent colds or flu?
5. **0 1 2 3** Are you prone to other infections (sinus, ear, lung, skin, bladder, kidney, etc.)?
6. **0 1 2 3** Are you an "always sick" person?
7. **0 1 2 3** Do you have acne (adult)?
8. **0 1 2 3** Do you have itchy skin (Dermatitis)?
9. **0 1 2 3** Do you have cysts, boils, rashes?
10. 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
11. **0 1 2 3** Do you have a chronic viral condition?

TOTAL: _____/33

GRAND TOTAL: _____/411 = _____ X100 = _____%

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% - Your body systems/organs are out of balance and need attention.

36-50% - Your body systems/organs are very compromised and likely to significantly affect your state of health, well-being and energy level.

51-100% - Your body systems/organs are severely compromised and require immediate attention.