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Self Evaluation Health Questionnaire

Rate Yourself: The Higher The Score In A Category, The More Likely You Have A Nutritional Deficiency In That Category.

0= Never 1= Rarely 2= Occasionally 3= Often 4=Almost Always 5= Always

Today's Date _____

Fill out the **"Today"** column only.

Category 1 - Hard Tissue Problems

Do you have...	Today	30 Days	90 Days	6 Months
High Blood Pressure				
Back Pain, Neck Pain, Arthritis				
Stiff Shoulders, Headaches				
Numbness, Foot/Arm Fall Asleep				
Trouble Falling Asleep				
Bleeding Gums, Cavities				
Kidney Stones, Bone Spurs				
Knee, Shoulder, Joint Pain				
Do You Take Pain Killer Medication				
Do You Take Blood Pressure Medication				
Total	0	0	0	0

Category 2 - Soft Tissue Problems

Do you have...	Today	30 Days	90 Days	6 Months
Cardiovascular Disease, Eczema, or PMS				
Are You Forgetful				
Trouble Breathing				
Eye or Eyesight Problems				
Age Spots, Blemishes				
Gray Hair, Wrinkles,, Hemorrhoids				
Do You Take Cholesterol Medication				
Do You Take Blood Thinners or Diuretics				
Do You Take Fibromyalgia or MS Medication				
Do You Take Alzheimer or Parkinson Meds				
Total	0	0	0	0

Category 3 - Blood Sugar Problems

Do you have...	Today	30 Days	90 Days	6 Months
ADD/ADHD, Depression, or Diabetes				
Get Sleepy After Meals				
Cravings For Sugar or Sweets				
Sweat Excessively or Have Excessive Thirst				
Wake Up During The Night				
Trouble Losing Weight				
Trouble Controlling Your Blood Sugar Levels				
Do You Take Blood Sugar Medication				
Do You Take Mood Swing Medication				
Do You Take ADD, ADHD, Autism Medication				
Total	0	0	0	0

Category 4 - Digestion Problems

Do you have...	Today	30 Days	90 Days	6 Months
Food Sensitivities, Heartburn, or indigestion				
Stomach or Intestinal Pain				
Bloating or Gas				
Any Type of Allergies				
Constipation or Diarrhea				
Immune System Problems/Get Sick				
Do You Take Anti-Acids or Stomach Meds				
Fiber or Medication For Constipation				
Medication For Chrohn's Disease				
Immune System Medication				
Total	0	0	0	0

Do you have any other health problems that were not covered in the above questionnaire? _____

Is There Anything Else You Would Like To Improve About Your Health?

☐More Energy ☐Lose Weight ☐Heart Disease Prevention ☐Cancer Prevention ☐Anti-Aging Prevention

If you could change anything about your health, what would you change?

_____

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