**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_**

**Today’s Date:\_\_\_\_\_\_ Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Instructions:**

1. Print a copy of this questionnaire.
2. Circle YES or NO to answer the questions.
3. Fill in Your Score where indicated.
4. Save this questionnaire to compare your results from before and after cleansing.

**Overall Well-Being**

**Consider Your Current Symptoms and Overall Sense of Well-Being and Answer:**

* Do You Feel Basically Healthy? Yes No
* Do You Consider Yourself Happy? Yes No

**List any negative health symptoms you're experiencing:**

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**Do You Have Chronic Inflammation in Your Body?**

**If You Answer 3 or More Questions "YES" You May Have Chronic Inflammation.**

* Do you have elevated cholesterol or triglycerides? Yes No
* Do you have numbness or tingling in your arms or legs? Yes No
* Do you eat meat, commercially baked sweets, fried foods, or use vegetable oil daily? Yes No
* Do you consume fish less than two times per week? Yes No
* Do you have high blood pressure, asthma, or colitis? Yes No
* Do you smoke? Yes No
* Do you have gingivitis, periodontal disease, or not have regular dental cleansings and check-ups at least once every six months? Yes No   
  **What is your score? Add up the number of "YES" and "NO" responses. \_\_\_\_\_\_\_\_\_\_\_**

**Poor Nutrition and Lifestyle**

**Do You Have Poor Nutrition and Digestion?**

**If You Answer 4 or More Questions "YES" You May Have Poor Nutrition and Digestion.**

* Do you regularly include fast food in your diet (three or more times per week)? Yes No
* Do you experience belching, bloating, or persistent fullness soon after eating, or do you experience excess gas often? Yes No
* Do you experience heartburn or acid reflux two or more times per week? Yes No
* Are you allergic to any specific foods? Yes No
* Do you feel fatigued or lethargic after eating? Yes No
* Do you commonly have bad breath or a bad taste in your mouth? Yes No
* Do you use digestive aids such as laxatives, antacids, or acid-blocking drugs? Yes No
* Do you often feel "older" than you should for your age? Yes No
* Does your skin look sallow, gray, puffy, wrinkled, or aged? Yes No

**What is your score? Add up the number of "YES" and "NO" responses.\_\_\_\_\_\_\_\_\_**

**Do You Have Abnormal Blood Sugar Levels? Are You Pre-Diabetic or At Risk?**

**If You Answer 3 or More Questions "YES" You Could Have Abnormal Blood Sugar Levels.**

* Does your waistline extend beyond your hips or are you overweight? Yes No
* Do you become tired or light-headed or do you feel the need to eat again just two or three hours after your last meal? Yes No
* Do you eat dried beans e.g. pinto, navy, black, etc. less than three times per week? Yes No
* Do you exercise less than three times each week? Yes No
* Do you eat two or more servings of bread, pasta, candy, colas, or fruit juice a day? Yes No
* Do you eat fewer than five servings of fresh, raw vegetables and fruits per day? Yes No
* Do you have high blood triglyceride levels or suffer from hypertension? Yes No

**What is your score? Add up the number of "YES" and "NO" responses. \_\_\_\_\_\_\_**

**Do You Have Impaired Cellular/Mitochondrial Function? Yes No**

**If You Answer 3 or More Questions "YES" You May Have Impaired Cellular Function.**

* Are you frequently tired for no reason (especially around 3 P.M.)? Yes No
* Do you have stiff and sore muscles (unrelated to recent exercise)? Yes No
* Do you have poor stamina, shortness of breath, or feel exhausted after exercising? Yes No
* Do you exercise less than two hours per week? Yes No
* Have you ever been diagnosed with iron deficiency or do you have heavy menses? Yes No
* Do you look older than your true age? Yes No
* Have you ever been exposed to toxic chemicals or heavy metals? Yes No

**What is your score? Add up the number of "YES" and "NO" responses. \_\_\_\_\_\_\_**

**Exposure to Toxins**

**Is Your Detoxification Capacity Impaired?**

**If You Answer 4 or More Questions "YES" Your Body Needs Help to Detoxify.**

* Do you become physically ill when exposed to strong smells (perfume, auto-exhaust, cigarette smoke, etc.)?Yes No
* Do you use chemical cleaners or solvents at home, at work, or in your hobbies? Yes No
* Do you live in a house/apartment or work in an office less than 5 years old? Yes No
* Do you have any amalgam (mercury) dental fillings? Yes No
* Are you prone to side effects from medications or supplements, or have you become more sensitive to the effects of alcohol or caffeine (reduced tolerance)? Yes No
* Do you have fewer than 2 bowel movements daily? Yes No
* Do you smoke? Yes No
* Do you have or have you ever had breast implants? Yes No
* Do you have any pets, especially dogs, cats, birds, or other furred or feathered animals? Yes No
* Do you wake up often during the night to urinate? Yes No

**What is your score? Add up the number of "YES" and "NO" responses. \_\_\_\_\_**

**Is Your Home and/or Work Environment Toxic? Yes No**

**If You Answer 4 or More Questions "YES" Your Home or Office Needs a "Health Makeover."**

* Do you have carpet in your home? Yes No
* Do you vacuum less than 3 times per week? Yes No
* Have you changed or cleaned your air filters in the last 30 days? Yes No
* Do you routinely drink tap water? Yes No
* Are your clothes and bedding washed in unfiltered city water? Yes No
* Have you recently repainted your home on the inside? Yes No
* Have you noticed any black spots or mold on your air vents or walls? Yes No
* Have you had your air vents cleaned in the past year? Yes No
* Do you use chemical based cleaners in your home? Yes No
* Do you use chemical fertilizers, insecticides, or pesticides? Yes No

**What is your score? Add up the number of "YES" and "NO" responses. \_\_\_\_\_\_\_\_\_**

**Impaired Immune System**

**What is the Quality of Your Immune System Function?**

**If You Answer 4 or More Questions "YES" Your Immune System May be Overworked.**

* Do you catch colds or the flu easily? Yes No
* Do colds, flu, or other infections tend to linger in your system more than 5 days? Yes No
* Do you have a chronic cough, scratchy throat, sinus congestion, or excess mucous production making it necessary to clear your throat often? Yes No
* Do you have seasonal allergies or known allergies to dust, animals, or mold? Yes No
* Have you ever been diagnosed with an autoimmune disease? Yes No
* Do you have dark circles under your eyes? Yes No
* Do you have difficulty seeing at night, or do you have white spots on your fingernails? Yes No
* Have you recently had any vaccinations? Yes No
* Have you or anyone in your family served in the military in the last 15 to 20 years? Yes No

**What is your score? Add up the number of "YES" and "NO" responses. \_\_\_\_\_\_\_\_\_**

**Is Your Liver Impaired by Your Emotions? Yes No**

**If You Answer 5 or More Questions "YES" Your Liver May Be Impaired.**

* Do you feel angry from time to time? Yes No
* Are you agitated easily? Yes No
* Do you have frequent mood swings? Yes No
* Is it hard to stay in a good mood? Yes No
* Do you run out of energy during the day? Yes No
* Do you have brown spots on your skin or age spots? Yes No
* Does your skin break out or is it blemished? Yes No
* Are your emotions often on a "roller coaster"? Yes No
* Do you later have to apologize for your bad moods to friends, family, co-workers, etc.? Yes No
* Is there always "something wrong" in your life? Yes No
* Have you ever been physically or sexually abused? Yes No
* If you are upset, is it best not to talk to you about what's going on? Yes No
* Do you get annoyed by the "fake" cheeriness of others? Yes No
* Do these questions irritate you? Yes No

**What is your score? Add up the number of "YES" and "NO" responses. \_\_\_\_\_\_\_\_\_**

**Are Your Kidney and Urinary Systems Functioning Properly?**

**If You Answer 5 or More Questions "YES" Your Kidneys May Be Overworked.**

* Do you have pain in your muscles and joints? Yes No
* Have you had kidney or bladder infections in the last year? Yes No
* Have you experienced ankle pain or swelling in the last year? Yes No
* Do you have left shoulder pain? Yes No
* Do your fingernails chip or break easily? Yes No
* Do you have puffiness, "bags", or dark circles under your eyes? Yes No
* Is your hair thinning? Yes No
* Do you have frequent scalp irritations? Yes No
* Do you have painful, harsh menstrual cycles? Yes No
* Do you wake up often during the night to urinate? Yes No
* Do you feel exhausted in the morning even after sleeping 8 or more hours? Yes No
* Have you ever been diagnosed with thyroid problems? Yes No   
  **What is your score? Add up the number of "YES" and "NO" responses.\_\_\_\_\_\_\_\_**

**Do You Have Parasites, Viruses, Fungi, or other Microbes Inside Your Body? Yes No**

**If You Answer 4 or More Questions "YES" You May Need a Thorough Parasite Cleanse.**

* Do you have any yellowish discoloration on your fingernails or toenails? Yes No
* Do you have athlete's foot or noticeable foot odor? Yes No
* Do you have a history of yeast infections? Yes No
* Have you been "mouthed", scratched, or licked by an animal in the last 6 months? Yes No
* Have you been bitten by mosquitoes or bugs? Yes No
* Do you feel bloated, grumpy, or gassy after meals? Yes No
* Have you eaten at a sushi bar, salad bar, or buffet recently? Yes No
* Have you ever picked food up off the floor and eaten it? Yes No
* Do you often crave sugar, sweets, or bread? Yes No
* Do you experience anal itching? Yes No
* Do you have dandruff? Yes No
* Do you have indoor pets? Yes No

**What is your score? Add up the number of "YES" and "NO" responses.**

**Hormonal Imbalance**

**Are Your Adrenal Glands Functioning Properly? Yes No**

**If You Answer 3 or More Questions "YES" Your Adrenal System May Be Suffering.**

* Do you frequently feel "stressed out"? Yes No
* Do you have difficulty falling asleep or maintaining sleep through the night? Yes No
* Do sudden noises make you jump? Yes No
* Do you become dizzy or light-headed when standing up too quickly? Yes No
* Do you crave salt or sugar? Yes No
* Do you drink coffee? Yes No
* Have you taken any diet pills in the last 3 years? Yes No
* Do you drink any highly caffeinated beverages such as soft drinks or energy drinks? Yes No
* Do you exercise less than 3 times per week? Yes No

**What is your score? Add up the number of "YES" and "NO" responses. Yes No \_\_\_\_\_\_\_**

**Is Your Thyroid Imbalanced?**

**If You Answer 4 or More Questions "YES" Your Thyroid May Be Imbalanced.**

* Are you frequently cold or do you have cold hands and feet? Yes No
* Do you have trouble "getting going" in the morning? Yes No
* Do you often feel sad or depressed, especially in the morning? Yes No
* Are you unable to lose weight despite improving your diet and exercising more? Yes No
* Do you have diffused or "patches" of hair loss from your head, arms, or legs? Yes No

**What is your score? Add up the number of "YES" and "NO" responses. \_\_\_\_\_\_\_\_**

**Are Your Sex Hormones Reduced in Production or Quality? Yes No**

**If You Answer 2 or More Questions "YES" Your Sex Hormones May Be Reduced.**

* Are you "flabby" or have you experienced a loss of muscle tone? Yes No
* Do you suffer from a low sex drive? Yes No
* Do you frequently experience headaches or migraines? Yes No
* Do you have Pre-Menstrual Syndrome (PMS)? Yes No

**What is your score? Add up the number of "YES" and "NO" responses. \_\_\_\_\_\_\_\_\_\_**

**FOR WOMEN - Is Your Body Out of Balance? Yes No**

**If You Answer 6 or More Questions "YES" Your Body is Out of Balance!**

* Are you very easily fatigued? Yes No
* Do you suffer from Pre-Menstrual Syndrome (PMS)? Yes No
* Do you have painful menses (periods)?Yes No
* Do you frequently experience depression before or during menstruation? Yes No
* Is your menstrual cycle prolonged in duration or excessive in terms of blood flow? Yes No
* Are your breasts overly sensitive or "painful" before, during, or after menses? Yes No
* Do you menstruate too frequently (more than once per month or sporadic flow)? Yes No
* Do you produce a vaginal discharge? Yes No
* Have you had a hysterectomy or had your ovaries removed? Yes No
* Do you have menopausal "hot flashes"? Yes No
* Is your menses irregular or absent altogether? Yes No
* Do you have acne or other skin blemishes that worsen during menses? Yes No
* Have you felt depressed for 3 months or longer? Yes No
* Do you have hair growth on your face or body? Yes No
* Do you have or desire sex less than 2 times each month? Yes No

**What is your score? Add up the number of "YES" and "NO" responses. \_\_\_\_\_\_\_**

**FOR MEN - Is Your Body Out of Balance? Yes No**

**If You Answered 6 or More Questions "YES" Your Body May Be Out of Balance!**

* Are you very easily fatigued? Yes No
* Do you have premature ejaculation? Yes No
* Is urination difficult or do you "dribble" i.e. can't stop completely? Yes No
* Have you experienced or are you experiencing prostate trouble? Yes No
* Do you often wake up during the night to urinate? Yes No
* Do you have pain on the inside of your legs or heels? Yes No
* Do you have feelings of incomplete bowel evacuation or "not emptying fully"? No Yes
* Do you have problems sleeping? Yes No
* Do you avoid even routine or mild physical activity? Yes No
* Do you run out of energy during the day? Yes No
* Do you experience leg nervousness or "twitching" at night? Yes No
* Do you have difficulty falling asleep or maintaining sleep through the night? Yes No
* Have you felt depressed for 3 months or longer? Yes No
* Do you have or desire sex less than 2 times each month? Yes No

**What is your score? Add up the number of "YES" and "NO" responses. \_\_\_\_\_\_\_\_\_**