Personal Health Assessment

Name: _____

Rate each of the following symptoms based upon your typical health profile over the last year.

Point Scale
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have it, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

	Energy/Activity
	Fatigue, sluggishness
	Apathy, lethargy
	Hyperactivity
	Restlessness
	Easy fatiguability or lack of endurance
	Headaches
	Faintness
	Dizziness
	Insomnia
	Subtotal

	Emotional/Mental
	Mood swings
	Anxiety, fear or nervousness
	Anger or irritability
	Depression
	Poor memory
	Confusion, poor comprehension
	Poor concentration
	Difficulty in making decisions
	Stuttering or stammering
	Slurred speech
	Learning disabilities
	Subtotal

	Joints/Muscles/Skin
	Pain or aches in joints
	Stiffness or limitation of movement
	Pain or aches in muscles
	Feeling of weakness or tiredness
	Cramps in legs
	Acne
	Hives, rashes, or dry skin
	Hair loss
	Flushing or hot flashes
	Fingernail abnormalities (spots, ridges)
	Decreased sweating
	Night sweats
	Subtotal

	Ears/Mouth/Throat/Nose/Eyes
	Itchy ears
	Earaches, ear infections
	Ringing in ears, hearing loss
	Drainage from ear
	Stuffy nose
	Sinus problems
	Hay fever
	Excessive mucus formation, post-nasal drip
	Sneezing attacks
	Poor night vision
	Watery or itchy eyes
	Swollen, tender or sticky eyelids
	Bags or dark circles under eyes
	Blurred or tunnel vision (Does not include near or far sightedness)
	Chronic coughing
	Sore throat, hoarseness, loss of voice
	Swollen or discolored tongue, gums, lips
	Canker sores
	Subtotal

	Digestive Tract
	Nausea or vomiting
	Diarrhea
	Constipation
	Bloating feeling
	Belching or passing gas
	Heartburn
	Subtotal

	Heart/Lungs
	Irregular or skipping heartbeat
	Rapid or pounding heartbeat
	Chest pain
	Chest congestion
	Asthma, bronchitis
	Shortness of breath
	Subtotal

	Weight/Other
	Binge eating/drinking
	Craving certain foods
	Excessive weight
	Compulsive eating
	Water retention
	Underweight
	Frequent illness
	Frequent or urgent urination
	Genital itch or discharge
	Injury
	Subtotal
	TOTAL POINTS

Behavioral Audit Questionnaire

The first step to changing your health starts with the behaviors that are contributing to it. This audit examines common, yet sometimes mindless habits that are working against your lifestyle goals. The purpose of this audit is not to get the “correct” response, but to identify areas that need to be challenged.

1. Do you eat large amounts of food very fast in a short amount of time?
    (+1) Rarely
    (-1) Sometimes
    (-2) Most of the time

2. Do you eat a second helping, desert or leftovers, even if you are full after a meal?
    (+1) Rarely
    (-1) Sometimes
    (-2) Most of the time

3. Do you add more “extras” (i.e. sauces, jam, dressing or gravies)?
    (+1) Rarely
    (-1) Sometimes
    (-2) Most of the time

4. Do you eat while involved in other activities (watching TV, reading, writing or working)?
    (+1) Rarely
    (-1) Sometimes
    (-2) Most of the time

5. Do you sneak food?
    (+1) Rarely
    (-1) Sometimes
    (-2) Most of the time

6. During a normal day, do you feel the urge to eat:
    (+1) Only when it’s mealtime
    (-1) Sometimes, especially when you’re stressed
    (-2) Most of the time

7. Usual duration of your meals is:
    (+1) 30-45 minutes
    (-1) 15-30 minutes
    (-2) 5-15 minutes

8. When a craving or urge to overeat a certain food comes over you, you usually:
    (+1) Dismiss the thought because it will pass
    (+1) Purposely engage in non-food activities
    (-1) Use a substitute food
    (-2) Give in to it

9. Do you leave food on your plate?
    (-2) Rarely
    (-1) Sometimes
    (+1) Most of the time
    (+2) Always

10. Do you typically eat large meals even if you are not hungry?
    (+1) Rarely
    (-1) Sometimes
    (-2) Most of the time

11. Do you eat more, even if you're not hungry because of the taste?
    (+1) Rarely
    (-1) Sometimes
    (-2) Most of the time

12. Do you head to the kitchen as soon as you get home?
    (+1) Rarely
    (-1) Sometimes
    (-2) Most of the time

13. How many rooms of your home do eat in?
    (+1) Only 1 room
    (-1) 1-2 rooms
    (-2) 3+ rooms

14. How many of your pleasurable activities center around food?
    (+1) 0-25%
    (-1) 25-50%
    (-2) 50-75%
    (-3) Greater than 75%

15. How often do you engage in behaviors such as binge eating or nighttime eating?
    (+1) Rarely
    (-1) Sometimes
    (-2) Most of the time

16. Are your portions usually:
    (+1) Small
    (-1) Medium
    (-2) Large, sometimes with extra helpings

17. When you feel tired, you:
    (-1) Have a snack
    (-2) Have a high sugar and/or caffeine snack

18. Do you eat at regular meal times?
    (-2) Rarely
    (-1) Sometimes
    (+1) Most of the time

19. Do you thoroughly chew your food and savor each bite?
    (-2) Rarely
    (-1) Sometimes
    (+1) Most of the time

20. Do you eat in your car?
    (+1) Rarely
    (-1) Sometimes
    (-2) Most of the time

21. Do you eat standing up or lying down?
    (+1) Rarely
    (-1) Sometimes
    (-2) Most of the time

22. Do you eat in front of the refrigerator?
    (+1) Rarely
    (-1) Sometimes
    (-2) Most of the time

23. Do you stop for a “pick-me-up” at the coffee shop?
    (+1) Rarely
    (-1) Sometimes
    (-2) Most of the time

24. Do you drink 6-8 glasses of filtered water a day?
    (-2) Rarely
    (-1) Sometimes
    (+1) Most of the time

Add up your responses, and refer to the scoring below: _____ Total Score

A score of 15 – 24
Good for you, you are making an effort to control your weight by practicing positive habits. Go back through the audit and re-address those areas that your response was (-); Look closely at the (-) you may have some behavioral habits that are in need of change.

A score of 0 – 15
This range suggests that there are many behavior habits identified that could be contributing to your weight problem. You need to begin to adjust your behaviors so they are in line with your health goals. Consulting with a professional nutritionist can help in designing an individual program to support your goals.

A score of less than 0
You have done a very difficult yet empowering task by naming your behavioral issues. You will need to make a commitment to yourself to challenge each one of these areas if you want to experience weight loss success. However, do not feel as though you have to go it alone. Discuss your results with your health care provider or professional nutritionist who can help you determine the best plan of action.

How Does Your Diet Rate

This quiz is not about what you know; it is about what you eat. These questions are designed to give you a rough sketch of your current eating habits. The (+) and (-) will instantly draw your attention to areas that you can pat yourself on the back or areas that could be hindering your health.

1. Do you eat 3 meals and 0-2 snacks per day 90% of the time?
❏ Yes (+1) ❏ No (0)

2. Do you crave carbohydrates/sugar?
❏ Yes (-1) ❏ No (0)

3. Do you take a high quality multivitamin/mineral complex daily?
❏ Yes (+1) ❏ No (0)

4. Do you eat breakfast every day?
❏ Yes (+1) ❏ No (0)

5. Do you always make sure you that you take your time to eat properly, even if you feel tired or busy?
❏ Yes (+1) ❏ No (0)

6. Do you eat standing up, in front of the TV or while driving?
❏ Yes (-1) ❏ No (+1)

7. Do you eat at least one piece of raw fruit each day?
❏ Yes (+1) ❏ No (0)

8. Do you avoid foods that contain sugar or added sugar?
❏ Yes (+1) ❏ No (0)

9. Do you eat fresh non-starchy vegetables each day?
❏ (-1) None
❏ (0) 1-3 servings
❏ (+1) 4-6 servings
❏ (+2) 6-9 servings

10. Do you eat organic produce?
❏ (-1) Never
❏ (0) Sometimes
❏ (+1) Always

11. How many different colors of vegetables & fruits do you eat in a day?
❏ (-1) 0-1 different colors
❏ (+1) 2-4 different colors
❏ (+2) 5-7 different colors

12. About how many grams of fiber do you eat each day?
❏ (-2) 0 – 10 grams
❏ (-1) 10 – 15 grams
❏ (0) 15 – 20 grams
❏ (+1) 20 – 25 grams
❏ (+2) 25+ grams

13. How many times do you stop for a beverage at the "coffee-shop" weekly?
❏ (+1) 0-1 times a week
❏ (0) 1-3 times a week
❏ (-1) 3-5 times a week
❏ (-2) 5-7 times a week

14. Do you eat certified organic dairy products?
❏ Yes (+1) ❏ No (0)

15. Do you have a protein at every meal? ❑ Yes (+1) ❑ No (-1)

16. Do you eat organic eggs enriched with omega-3 fatty acids? ❑ Yes (+1) ❑ No (0)

17. Do you eat whole grains like quinoa, bulgur, brown/wild rice or barley?
❑ (-1) Never
❑ (0) Sometimes
❑ (+1) Always

18. How many servings of pasta or white rice do you eat per week?
❑ (+1) 0 serving
❑ (0) 1-3 servings
❑ (-1) 4-6 servings
❑ (-2) 6-9 servings

19. Do you use fresh herbs in your cooking? ❑ Yes (+1) ❑ No (0)

20. Do you rotate your food choices daily to ensure that you get a variety of nutrients? ❑ Yes (+1) ❑ No (-1)

21. What type of fats do you use?
❑ (+1) Flaxseed oil, Extra Virgin Olive oil, Sesame oil, Macadamia Nut oil or Walnut oil
❑ (0) Olive oil, Almond oil, Hemp oil, Canola oil
❑ (-2) Margarine, shortening, Palm oil, or other chemically processed oils

22. Is your oil organic and in a dark bottle? ❑ Yes (+1) ❑ No (-1)

23. How many fast food meals do you eat each week?
❑ (+1) None
❑ (-1) 1-2 meals
❑ (-2) 3 or more meals

24. Do you consume damaged fats? (particularly hydrogenated oils or oxidized/rancid fats)
❑ Yes (-2) ❑ No (+1)

25. Do you order olive oil vinaigrette on the side for your salad dressing?
❑ (-1) Never
❑ (0) Sometimes
❑ (+1) Always

26. Do you eat raw nuts and seeds each week?
❑ (0) 1–2 servings
❑ (+1) 3–4 servings
❑ (+2) 5–6 servings

27. How many times do you eat beans or lentils per week?
❑ (-1) Never
❑ (0) 1–2 servings
❑ (+1) 3–4 servings

28. Do you take a high quality fish oil supplement daily? ❑ Yes (+1) ❑ No (-1)

29. Do you use freshly ground flaxseed meal? ❑ Yes (+1) ❑ No (-1)

30. Do you consume clean 2-3 servings of clean cold water wild fish in a week? ❑ Yes (+1) ❑ No (-1)

31. Do you consume pasture-fed beef and free-range poultry when ever possible? ❑ Yes (+1) ❑ No (0)

32. Do you consume more than 2 cups of coffee per day? ❑ Yes (0) ❑ No (+1)

33. Do you consume more than 4 oz of alcohol per day? ❑ Yes (0) ❑ No (+1)

34. Do you drink bottled water every day? ❑ Yes (+1) ❑ No (0)

35. Do you carry water with you throughout the day? ❑ Yes (+1) ❑ No (0)

36. Do you drink 8-10 glasses of filtered, spring or mineral water every day? ❑ Yes (+1) ❑ No (0)

37. Do you drink alkaline-type green drinks? ❑ Yes (+1) ❑ No (0)

38. Are you taking any medication on a daily basis? ❑ Yes (-1) ❑ No (+1)

39. Do you experience reflux, heartburn or take antacids? ❑ Yes (-1) ❑ No (0)

Add up your responses, and refer to the scoring below: _____ Total Score

The goal of the questionnaire is not to act as a substitute for a professionally conducted nutritional assessment, but rather identify areas in which you can take an aggressive action against to improve your health.

32 - 39 - Keep up the good habits
You strive to make the best choices whenever possible, Kudos to you. You understand that what and how you eat has a direct impact on how you feel and your health. Please review the quiz and address the areas that not have a (+) response.

24 – 31 - You're on your way
You are trying, which is good, however there are many areas of your diet that need to be worked on. You would certainly benefit from professional nutritional services which would help guide you towards a healthful nutritional lifestyle.

Less than 24 - Your diet needs cleaning up
You are aware that you could improve your health by making better food choices, but you just haven't made a commitment to make a change. The great news is that we have identified the areas that need your attention. I would suggest you begin by committing to yourself on paper. Write out your goals and resolve to keep a food journal. Then RUN, don't walk to your professional nutritionist for individual nutritional consulting.

ARE YOU GETTING ENOUGH SLEEP?

By JJ Virgin, CNS, CHFI

Answer the following questions <u>YES</u> if this applies to your more than one night a week:

1. Do you have trouble falling asleep at night?
2. Do you have difficulty waking up in the morning?
3. Do you sleep less than 8-9 hours a night?
4. Do you wake up once or more during the night?
5. Do you sleep in a room with any light or noise?
6. Do you wake up feeling tired?
7. Do you wake up only with an alarm?
8. Do you go to bed later than 11 pm?
9. Do you get up earlier than 6 am?
10. Do you use medications (OTC or RX) for sleep?

If you answered yes to 2 or more of these questions then you will need to address your sleep issues. We recommend the Sleep Support Protocol including sleep supplements along with nutrition and lifestyle tips.

Gut Dysbiosis Quiz

Do you experience:

Nausea or vomiting	❑ Yes	❑ No	How Often? _____
Constipation	❑ Yes	❑ No	How Often? _____
Diarrhea	❑ Yes	❑ No	How Often? _____
Bloating	❑ Yes	❑ No	How Often? _____
Cramping	❑ Yes	❑ No	How Often? _____
Gas	❑ Yes	❑ No	How Often? _____
Bad breath/halitosis	❑ Yes	❑ No	How Often? _____
Heartburn	❑ Yes	❑ No	How Often? _____
Belching/burping	❑ Yes	❑ No	How Often? _____
Rashes/skin eruptions	❑ Yes	❑ No	How Often? _____

History of:

Autoimmune Disease ❑ Yes ❑ No _____
i.e. Rheumatoid arthritis, Ankylosing Spondylitis, Grave's Disease or Hashimotos Thyroiditis, Lupus, etc.

Chronic use of aspirin and/or NSAIDS
Non steroidal anti-inflammatory drugs
❑ Yes ❑ No _____

Chronic stress ❑ Yes ❑ No _____

ARE YOU WEIGHT LOSS RESISTANT?

By JJ Virgin, CNS, CHFI

1. Are you insulin resistant: *(if you answer yes to 3 or more of these, you most likely have metabolic syndrome)*
   - Is your fasting blood sugar 100 or greater?
   - Is your fasting insulin great than 10?
   - Is your hemoglobin A1C greater than 5.5?
   - Are your triglycerides greater than 150?
   - Are your HDLs less than 50 (women) or 40 (man)?
   - Is your waist measurement greater than 35 (woman) or 40 (man)?
   - Is your waist:hip ratio greater than 0.08 (woman) or 1.0 (man)?
   - Is your body fat percentage greater than 37% (woman) or 29% (man)?

2. Are you "stressed out"? *This can be confirmed by taking our stress questionnaire, an adrenal salivary stress index test and/or looking at your DHEA-sulfate and testosterone levels.*

3. Do you have a depressed metabolic rate? *This is either tested via the Tanita Segmental BIA machine or the Healthy Tech or MedTech BMR analyzer. Confounding data includes chronic yo-yo dieting.*

4. Have you been diagnosed with hypothyroidism by a health care practitioner through lab testing?

5. Have you failed on 3 or more diets in the past?

6. Do you have cravings that are extremely difficult to control?

7. Do you have a familial problem with obesity?

8. Do you get 7 hours or less of sleep two or more nights a week?

9. Have you ever suspected or been diagnosed with food allergies?

10. Are you exercising ineffectively? *(Any yes answer below is a yes answer to this question)*
    - Are you exercising 2 times or less per week?
    - Are you only doing cardiovascular exercise?
    - Are you combining cardio with strength training in the same session?

11. Do you have trouble building muscle?

    Are your hormones imbalanced (PMS, peri-menopause, etc.)?

If you answered yes to even ONE of the above questions, you have identified factors that can contribute to difficulty losing weight and especially losing fate and maintaining/increasing active muscle tissue.

If you have answered yes to 3 or more then you are moderately weight loss resistant (WLR), and if you have answered yes to 4 or more, you are very weight loss resistant. This means that you must address your weight loss resistance and correct the problems to ensure that you will have a successful long-term weight management.

ANDROPAUSE QUIZ
Men Only

1) Do you lack energy/feel tired much of the time?
2) Do you have decreased strength/endurance ability?
3) Do you lack the enthusiasm/excitement that you used to have for life in general?
4) Have you lost height?
5) Are you more irritable than you used to be for little reasons?
6) Are your erections less strong?
7) Do you have a decreased sex drive/libido?
8) Do you fall asleep soon after dinner?
9) Do you have difficulty playing sports as well as you used to?
10) Do you have decreased ability to build and maintain muscle?
11) Is your ability to handle stress harder than it used to be?
12) Do you have increased symptoms of moodiness (sad/grumpy)?
13) Are you gaining more fat and less muscle than you used to?

If you have answered yes to even <u>one</u> of these questions, you may be experiencing symptoms of andropause.