ASSESSMENT FORMS

Dr. Barbara Jennings
Natural Health In Real Life

NAME .....

DATE .....

Mitochondrial Dysfunction

	Never	Occasionally	Often	Regularly
History of infections (EBV, Lyme, etc.)?	N	Y		
Dizziness upon standing up quickly	0	1	2	3
Unable to tolerate much exercise	0	1	2	3
Poor exercise or muscle stamina	0	1	2	3
Low muscle tone?	N	Y		
Brain fog	0	1	2	3
Difficulty focusing	0	1	2	3
Vision or hearing problems	0	1	2	3
General or chronic fatigue	0	1	2	3
Afternoon headaches	0	1	2	3
Migraines or seizures	0	1	2	3
Mood problems: anxiety, depression, or bipolar	0	1	2	3
Poor brain processing (cognition)	0	1	2	3
Blood sugar issues	0	1	2	3
Breathing problems	0	1	2	3
Overweight?	N	Y		
Low body temperature	N	Y		
Intolerant to heat	0	1	2	3
Low thyroid lab numbers?	N	Y		
Little or no skin sweating?	N	Y		
Suppressed immune system?	N	Y		
Catch colds or get sick easily?	N	Y		
Chronic inflammation	0	1	2	3
Cannot fall asleep	0	1	2	3
Cannot stay asleep	0	1	2	3
Slow mover in the morning (hard to get going)	0	1	2	4
Wake up tired, even after 6 or more hours of sleep	0	1	2	3
Eyes sensitive to bright or direct light	0	1	2	3
Weight gain when under stress	0	1	2	3
Loss of libido	N	Y		

Mitochondrial Dysfunction Total .....

GREEN	YELLOW	RED
0-16	17-45	46-107

Drainage Dysfunction Susceptibility

	Never	Occasionally	Often	Regularly
Constipation (pooping one or fewer times daily)	0	1	2	3
Feeling that bowels do not empty completely	0	1	2	3
General or chronic fatigue	0	1	2	3
Mood problems: anxiety, depression, or bipolar	0	1	2	3
Poor brain processing (cognition)	0	1	2	3
Chronic inflammation	0	1	2	3
Wake up between 1 a.m. to 4 a.m.	0	1	2	3
Edema, swelling or retain extra fluids	0	1	2	3
Skin problems, rashes, itches, hives, eczema, or acne	0	1	2	3
Yellowish skin, face	0	1	2	3
Suppressed immune system	0	1	2	3
Can't clear infections, despite following pathogen protocols	0	1	2	3
Sore or swollen breast tissue	0	1	2	3
Heart palpitations or irregular heartbeat	0	1	2	3
Light, sound, or EMF sensitivities	0	1	2	3
Morning stiffness	0	1	2	3
Brain fog	0	1	2	3
Swollen glands	0	1	2	3
Cellulite or flabby skin	0	1	2	3
Varicose or spider veins	0	1	2	3
Kidney problems	0	1	2	3
Breathing or lung issues	0	1	2	3
Skin doesn't sweat	0	1	2	3
Puffy Eyes	0	1	2	3

Drainage Dysfunction Total .....

GREEN	YELLOW	RED
0-14	15-35	36-72

NAME .....

DATE .....

Minerals & Electrolytes

	Never	Occasionally	Often	Regularly
Edema (swelling) in ankles or wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Unable to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3
History of carpal tunnel syndrome	N	Y		
History of lower right abdominal pains or ileocecal valve problems	N	Y		
History of stress fracture	N	Y		
Bone loss (reduced density on bone scan)	0	1	2	3
Crave chocolate	0	1	2	3
Feet have a strong odor	0	1	2	3
History of anemia	0	1	2	3
Whites of eyes (sclera) are blue-tinted	0	1	2	3
Hoarse voice	0	1	2	3
White spots on fingernails	0	1	2	3

Minerals & Electrolyte Total .....

GREEN	YELLOW	RED
0-19	20-35	36-59

Blood Sugar

	Never	Occasionally	Often	Regularly
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Fatigue after meals	0	1	2	3
Must have sweets after meals	0	1	2	3
Forgetful; poor memory	0	1	2	3
Feel better or calmer after eating	0	1	2	3
Prone to infections and colds	0	1	2	3
History of diabetes in your family	N	Y		
Sugar (glucose) detected in urine test?	N	Y		
Hair loss at ankles/frictional alopecia?	N	Y		

Blood Sugar Total .....

GREEN	YELLOW	RED
0-10	11-24	25-45

Instructions

Rate each of the symptoms to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number next to your answer, if there is a number. Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

NAME .....

DATE .....

Stomach

	Never	Occasionally	Often	Regularly
Belching or burping	0	1	2	3
Gas quickly following a meal	0	1	2	3
Bad breath	0	1	2	3
Feel full while eating and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Stomach pain, burning, or aching 1 to 4 hours after eating	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, or caffeine	0	1	2	3
Indigestion	0	1	2	3
Abdominal bloating	0	1	2	3
Constipation	0	1	2	3
Diminished appetite	0	1	2	3

Stomach Total .....

GREEN	YELLOW	RED
0-11	12-26	27-36

Small Intestine

	Never	Occasionally	Often	Regularly
Increased gut motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Mucus in stool	0	1	2	3
Poorly formed or loose stools	0	1	2	3
Four or more large stools daily	0	1	2	3
Stools have foul odor	0	1	2	3
Suspect nutrient malabsorption	0	1	2	3
Diagnosed with celiac disease, irritable bowel syndrome (IBS), or diverticulosis/diverticulitis	0	1	2	3
Stomach cramps	0	1	2	3
Flatulence (gas)	0	1	2	3
Fiber-rich diet doesn't help constipation	0	1	2	3
History of pimples or skin eruptions?	N	Y		
Any known food allergies?	N	Y		

Small Intestine Total .....

GREEN	YELLOW	RED
0-10	11-24	25-45

Colon

	Never	Occasionally	Often	Regularly
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or buildup of debris on tongue	0	1	2	3
Use laxatives	0	1	2	3
History of bladder and/or kidney infection	0	1	2	3
Yeast infection (including vaginal)	0	1	2	3
Fingernail and/or toenail fungus	0	1	2	3
Use of antibiotics in past year?	N	Y		

Colon Total .....

GREEN	YELLOW	RED
0-9	10-24	25-36

Intestinal Permeability

Adverse reactions to foods	0	1	3	4
Unpredictable food reactions	0	2	4	6
Aches, pains, and swelling throughout your body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Food allergies	0	2	4	5
Frequent bloating and distention after eating	0	1	2	3

Leaky Gut Total .....

GREEN	YELLOW	RED
0-7	8-15	16-24

NAME .....

DATE .....

Hypothyroid

	Never	Occasionally	Often	Regularly
Tired or sluggish	0	1	2	3
Feel cold (hands, feet, or your whole body)	0	1	2	3
Require an excessive amount of sleep to function properly	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression or lack of motivation	0	1	2	3
Thinning of outer third of eyebrows	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dry skin and/or scalp	0	1	2	3
Slow brain processing	0	1	2	3
Lack of or diminished sex drive	0	1	2	3
Infertility or impotency	N	Y		
Heavy or profuse menstrual bleeding (women only)	0	1	2	3

Hypothyroid Total .....

GREEN	YELLOW	RED
0-11	12-22	23-40

Hyperthyroid

	Never	Occasionally	Often	Regularly
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse, even at rest	0	1	2	3
Nervous or emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Eyes appear bulging or swollen	0	1	2	3
Difficulty gaining weight	0	1	2	3

Hyperthyroid Total .....

GREEN	YELLOW	RED
0-5	6-10	11-24

Instructions

Rate each of the symptoms to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

NAME ..... DATE .....

Parasites

	Never	Occasionally	Often	Regularly
Restless sleep (toss, turn, or wake up often)	0	1	2	3
Skin issues, rashes, itches, hives, eczema, or acne	0	2	4	6
Frequent diarrhea or loose stools	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
SIBO (small intestinal bacterial overgrowth), feel bloated or gassy	0	1	2	3
Bowel urgency, occasional accidents	0	1	2	3
Abdominal pains, cramps, or burning	0	1	2	3
Rectal, anal itch	0	2	4	6
Anal fissures (small, painful tears or cracks)	0	2	4	6
Stomach or small intestinal ulcers or lesions	0	1	2	3
Grinding of teeth when asleep	0	2	4	6
Picking at nose, boring nose with finger	0	2	4	6
Excess boogers in nose and scab-like boogers	0	2	4	6
Fingernail biting	0	1	2	3
Headaches/Migraines	0	2	4	6
Irritable (no apparent reason)	0	1	2	3
Mood disorder, depression, anxiety, or suicidal thoughts	0	1	2	3
Hyperactive tendency (nervous)	0	1	2	3
Dark circles under eyes	0	2	4	6
Need for extra sleep, wake unrefreshed	0	1	2	3
Allergies and/or food sensitivities	0	2	3	4
Fevers of unknown origin	0	1	2	3
Night sweats (not menopausal)	0	1	2	3
Kiss pets, allow pets to lick your face	0	1	2	4
Increase of symptoms around a full moon	0	2	6	8
Anemia (low iron/hemoglobin on blood test)	0	1	2	4
Iron deficiency	0	2	4	6
Vitamin B6 deficiency	0	2	4	6
Zinc deficiency and/or white spots on nails	0	2	4	6
Frequent colds, flu, sore throats	0	1	2	3

	Never	Occasionally	Often	Regularly
Travel in developing nations	0	2	4	6
Eat pork products	0	1	2	3
Eat sushi, raw fish	0	2	4	6
Sleep with pets on bed	0	1	2	3
Bed-wetting	0	1	2	3
Frequent vomiting	0	1	2	3
Loss of appetite	0	1	2	6
Hungry all the time, bottomless pit, hungry after meals	0	2	4	6
Strong sugar and processed food cravings	0	1	2	3
Breathing problems, asthma	0	2	4	6
Pain in belly button area (umbilicus)	0	1	2	4
Blurry, unclear vision	0	1	2	3
Eye floaters	0	2	4	6
Lethargy, apathy (disinterest)	0	1	2	3
Menstrual problems	0	1	2	3
Dry lips	0	1	2	3
Drooling while asleep	0	1	2	3
Occult blood in stool (from lab test)	0	1	2	3
Swim in creeks, rivers, lakes	0	2	4	6
History of *Giardia*, pinworms, or other parasites?	N	Y		
Do you work in childcare?	N	Y		
History of or currently have cancer?	N	Y		

Parasite Infection Total .....

GREEN	YELLOW	RED
0-46	47-96	97-242

NAME ..... DATE .....

SIBO (Small Intestinal Bacterial Overgrowth)

	Never	Occasionally	Often	Regularly
Abdominal distention after consuming fiber, starches, or sugar	0	1	2	3
Abdominal distention after taking certain probiotics or other dietary supplements	0	1	2	3
Abdominal distention, bloating, or a noisy gut after eating healthy vegetables	0	1	2	3
Bloating or feeling full in upper abdominal area (just below rib cage)	0	1	2	3

SIBO Total .....

GREEN	YELLOW	RED
0-1	2-4	5-12

Lyme Disease Risks

	Never	Occasionally	Often	Regularly
Ever diagnosed with Lyme disease?	N	Y		
Dry sockets or infected tooth extractions	0	1	2	3
Ever bitten by a tick?	N	Y		
Ever had a bullseye rash on any part of your body?	N	Y		
Mother ever diagnosed with Lyme disease?	N	Y		
Spouse/partner/significant other diagnosed with Lyme disease?	N	Y		
Ever diagnosed with chronic fatigue syndrome, fibromyalgia, lupus, rheumatoid arthritis (RA), multiple sclerosis (MS), or an autoimmune condition?	N	Y		
Ever diagnosed with Parkinson's disease, Alzheimer's disease, or Tourette's syndrome?	N	Y		
Frequently go camping, hunting, or engage in outdoor activities?	N	Y		
History of a heart murmur or valve prolapse?	N	Y		

Lyme Disease Risks Total .....

GREEN	YELLOW	RED
0-9	10-18	19-59

NAME

DATE

Lyme

	Never	Occasionally	Often	Regularly
Arthritis-like joint pain or swelling	0	2	4	6
Pain migrates or moves around to different areas of your body	0	2	4	6
Forgetfulness or poor short-term memory	0	2	4	6
Confusion, difficulty thinking	0	1	2	3
Disorientation (getting lost; going to wrong places)	0	1	2	3
Difficulty with speech or writing	0	4	6	8
Tingling, numbness, burning, or stabbing sensations	0	4	6	8
Disturbed sleep: too much, too little, early awakening	0	2	4	6
Unexplained fevers, sweats, chills, or flushing	0	1	2	3
Unexplained weight change (loss or gain)	0	1	2	3
Difficulty swallowing	0	1	2	3
Fatigue, lack of energy	0	1	2	3
Sore throat or swollen glands	0	1	2	3
Pelvic or testicular pain	0	4	6	8
Crepitus (joint cracking)	0	4	6	8
Stiff neck	0	2	4	6
Twitching of facial or other muscles	0	1	2	3
Muscle pain or cramps	0	1	2	3
Costochondritis (sternum/breastbone and rib junction pain)	0	4	6	8
Right shoulder pain (AC joint)	0	1	2	3
Facial paralysis (Bell's palsy)	0	4	6	8
Unexplained menstrual irregularity	0	4	6	8
Unexplained breast milk production	0	4	6	8
Irritable bladder or bladder dysfunction	0	4	6	8
Sexual dysfunction or low libido	0	4	6	8
Blurry or double vision	0	1	2	3
Ear buzzing, ringing, or pain	0	1	2	3
Vertigo or increased motion sickness	0	4	6	8
Light-headedness, poor balance, difficulty walking	0	4	6	8

	Never	Occasionally	Often	Regularly
Woozy (mentally unclear or hazy)	0	2	4	6
Tremors	0	2	4	6
Headaches	0	1	2	3
Impulsivity, aggression, or bipolar	0	1	2	3
Depression	0	1	2	3
Hallucinations, paranoia, or schizophrenia	0	2	4	6
Panic attacks	0	1	2	3
Eating disorder	0	4	6	8
Pulse skips	0	4	6	8
Skin hypersensitivity	0	2	4	6
Gastrointestinal problems	0	4	6	8
Change in bowel function	0	4	6	8

Lyme Disease Current Symptoms Total

GREEN	YELLOW	RED
0-31	32-95	96-230

NAME .....

DATE .....

Babesia

	Never	Occasionally	Often	Regularly
Abdominal pain	0	2	4	6
Shortness of breath	0	1	2	3
Air hunger (episodes of breathlessness)	0	4	8	10
Anemia (low iron/hemoglobin on blood test)	0	1	2	3
Low back stiffness or pain	0	1	2	3
Low blood sugar	0	2	4	6
Cough	0	1	2	3
Disturbed sleep: frequent waking	0	4	6	8
Excessive sleepiness	0	1	2	3
Encephalopathy (brain malfunction, brain issues)	0	1	2	3
Fatigue, tiredness, poor stamina	0	1	2	3
Fevers	0	1	2	3
Headaches	0	4	6	8
Hemolysis (destruction of red blood cells)	0	2	4	6
Enlarged liver	0	2	4	6
Imbalance	0	2	4	6
Generalized ill feeling	0	1	2	3
Muscle pains or cramps	0	1	2	3
Nausea, vomiting	0	2	4	6
Neck stiffness, pain	0	1	2	3
Night sweats	0	1	2	3
Poor appetite	0	2	4	6
Shaking chills	0	4	6	8

	Never	Occasionally	Often	Regularly
Enlarged spleen	0	1	2	3
Heart palpitations, pulse skips, Tachycardia	0	4	6	8
Dark urine with or without blood	0	4	6	8
Weakness	0	1	2	3
Weight loss	0	1	2	3
Elevated sedimentation (sed) rate on lab test	0	1	2	3
Dizziness	0	1	2	3
Light headedness	0	1	2	3

Babesia Total .....

GREEN	YELLOW	RED
0-29	30-60	61-146

NAME .....

DATE .....

Bartonella

	Never	Occasionally	Often	Regularly
Abdominal pain	0	2	4	6
Anemia (low iron/hemoglobin on blood test)	0	1	2	3
Anxiety	0	2	4	6
Back stiffness	0	1	2	3
Chills	0	1	2	3
Disturbed sleep: too much, too little, fractionated, early awakening	0	1	2	3
Ear buzzing, ringing, pain, sound sensitivity	0	2	4	6
Brain dysfunction	0	1	2	3
Hemolysis (destruction of red blood cells)	0	2	4	6
Endocarditis	0	2	4	6
Myocarditis	0	2	4	6
Fatigue, tiredness, poor stamina	0	1	2	3
Low-grade fever	0	2	4	6
Headaches	0	1	2	3
Enlarged liver	0	2	4	6
Immune deficiency	0	2	4	6
Feeling of coming down with the flu	0	2	4	6
Insomnia	0	1	2	3
Jaundice (yellowing of skin)	0	4	6	8
Joint pain or swelling	0	1	2	3
Lymph nodes swollen	0	4	6	8
Generalized ill feeling	0	1	2	3
Muscle pains or cramps, especially in calves	0	4	6	8
Foot pain or plantar fasciitis-type pain (heels or soles of the feet)	0	4	6	8
Stretch mark-like rash (not from overweight)	0	6	8	12
Maculopapular rash (small red bumps)	0	4	6	8
Spider veins	0	2	4	6
Seizures	0	4	6	8
Sleepiness or drowsiness	0	2	4	6
Sore throat	0	2	4	6
Enlarged spleen	0	2	4	6
Shinbone pain	0	4	6	8
Tremors	0	2	4	6
Twitching of facial muscles	0	2	4	6
Weight loss	0	1	2	3
Eyes: blurred vision, red eyes, dry eyes, depth perception issue, light sensitivity	0	2	4	6
Anxiety, panic attacks, or excessive worry	0	2	4	6
Obsessive-compulsive disorder (OCD)	0	4	6	8

Bartonella Total .....

GREEN	YELLOW	RED
0-29	30-79	80-217

Instructions

Rate each of the symptoms to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number next to your answer, if there is a number. Total your score in the space provided for each section. Compare your results with the rating system for each section. A score in the yellow or red range suggests this area is more likely a problem for you.

NAME

DATE

General Toxicity

	Never	Occasionally	Often	Regularly
Live on or near a golf course?	N			Y
Live near a freeway or high-tension wires?	N			Y
Wear conventional sunscreen?	N			Y
Wear perfume or cologne?	N			Y
Use air fresheners in your house, car, or workplace?	N			Y
Were you the first-born child?	N			Y
Receive static shocks (doorknob, car, light switch, other people, etc.)	0	1	2	3
Headaches or migraines	0	1	2	3
Word reversal or trouble finding words	0	1	2	3
Sensitivity to skin or touch	0	1	2	3
Poor short-term memory	0	1	2	3
Chronic sinus issues or congestion	0	1	2	3
Difficulty losing weight regardless of diet or exercise	0	1	2	3
Excessive perspiring during day or night	0	1	2	3
Cold extremities (hands and feet)	0	1	2	3
Issues processing new information	0	1	2	3
Chronic fungal or viral infection, including *Candida*, foot fungus, warts, or jock itch	0	1	2	3
Get sick often	0	1	2	3
Weakness or numbness in extremities	0	1	2	3
Joint pain	0	1	2	3
Muscle cramps, aches, sharp pains	0	1	2	3
Muscle twitching	0	1	2	3
Stomach pain	0	1	2	3
Appetite swings	0	1	2	3
Rashes or rosacea	0	1	2	3

General Toxicity Total .....

GREEN	YELLOW	RED
0-19	20-50	51-81

Radioactive Elements

	Never	Occasionally	Often	Regularly
History of or currently have cancer?	N			Y
Suppressed immune system?	N			Y
Osteoporosis or osteopenia diagnosis?	N			Y
Can't clear infections, despite following pathogen protocols?	N			Y
Chronic *Candida* infection	0	2	4	6
Fatigue	0	2	4	6
Anemia	0	2	4	6
Skin (red, dry, itchy, color changes)	0	1	2	3
Hair loss	0	2	4	6
Loss of appetite	0	1	2	3
Nausea and vomiting	0	1	2	3
Low blood cell count	0	1	2	3
Seizures	0	1	2	3
Earaches or difficulty hearing	0	1	2	3
Hormone problems	0	1	2	3
Sore or dry mouth	0	1	2	3
Taste changes	0	1	2	3
Difficulty swallowing	0	2	4	6
Voice changes, hoarseness	0	1	2	3
Dry eyes	0	1	2	3
Stiff jaw	0	1	2	3
Tooth decay	0	1	2	3
Soreness or swelling of the breast	0	1	2	3
Heart palpitations	0	2	4	6
Irregular heartbeat	0	1	2	3
Stomach ulcers	0	2	4	6
Kidney problems	0	1	2	3
Bladder infection (cystitis)	0	2	4	6
Burning or pain during urination	0	1	2	3
Loss of bladder control	0	1	2	3
Fertility problems	0	1	2	3
Sexual problems (male & female)	0	1	2	3

Radioactive Elements Total .....

GREEN	YELLOW	RED
0-16	17-40	41-146

NAME ..... DATE .....

Mercury Toxicity

	Never	Occasionally	Often	Regularly
Do you have amalgam (silver) fillings in your teeth?	N	Y		
Have you ever had an amalgam removed?	N	Y		
If you had amalgams removed, was it done by a biological dentist using a safe protocol?	N	Y		
Were there amalgam fillings in your mother's mouth while she was pregnant with you?	N	Y		
Worked in a dental office?	0	1	2	3
Wore contact lenses during the 1980s or early 1990s	0	1	2	3
Took oral contraceptives during the 1980s or early 1990s	0	1	2	3
Have had flu shots	0	1	2	3
Have had allergy shots	0	1	2	3
Eat tuna, shark, swordfish or Atlantic salmon more than twice per week	0	1	2	3
Urinate frequently (during the day, night, or both)	0	1	2	3
Sleep issues	0	1	2	3
Do you have compact fluorescent (CFL) bulbs in your home?	N	Y		
Have you broken any CFL bulbs? (reference) 	N	Y		
Anxiety	0	1	2	3
Mood swings	0	1	2	3
Anger for no apparent reason	0	1	2	3
Excessive shyness, timidity, social phobia (not typical to your personality)	0	1	2	3
Irritability (not typical to your personality)	0	1	2	3
Dizzy or balance issues	0	1	2	3
Insomnia (can't get to sleep or return to sleep)	0	1	2	3
Low body temperature (below 97.5 degrees Fahrenheit or 36.4 degrees Celsius)	0	1	2	3
Sound in ears (ringing or hearing your heart beat)	0	1	2	3
Psychological symptoms, even thoughts of suicide	0	1	2	3
Sound sensitivities	0	1	2	3

Mercury Toxicity Total .....

GREEN	YELLOW	RED
0-30	31-64	65-130

NAME DATE

Lead Toxicity

	Never	Occasionally	Often	Regularly
Have lived in a home built before 1978 using lead-based paint	0	2	4	6
Do home renovation, including sandblasting or moving walls	0	2	4	6
Currently live or previously lived in a mining community or area	0	2	4	6
Involved in construction, soldering, metal salvage, or stained glass	0	2	4	6
Are an electrician, handle electrical devices, electrical wiring, ballasts, or TV glass	0	2	4	6
Paint or handle/make ceramics, brass, bronze, or crystal	0	2	4	6
Handle and/or reload ammunition	0	2	4	6
Read the newspaper regularly before 1985	0	2	4	6
Previously or currently consume a coral calcium supplement	0	2	4	6
Wear lipstick	0	2	4	6
Previously wore or currently wear eye cosmetics containing kohl (a dark pigment that's not FDA-approved for makeup)	0	2	4	6
Are around or have a lot of fake leather or vinyl	0	2	4	6
Get your hair colored	0	2	4	6
Get stomachaches in the morning	0	1	2	3
Eyelid swelling	0	1	2	3
Eyelid twitching	0	1	2	3
Chest or heart pain	0	1	2	3
Metallic taste in mouth	0	1	2	3
Teeth sensitivity	0	1	2	3
Bleeding gums	0	1	2	3
High blood pressure	0	1	2	3
Inability to decide/indecisiveness	0	1	2	3
Overwhelmed or fearful feeling	0	1	2	3
Anemia (low iron/hemoglobin on blood test)	0	1	2	3
Peeling of top layer of skin (hands, feet)	0	1	2	3
Dry skin	0	1	2	3
Depression	0	1	2	3
Dyslexia or loss of your place while reading, even as a child	0	1	2	3
Gout (arthritic pain, especially in big toes)	0	1	2	3

Lead Toxicity Total .....

GREEN	YELLOW	RED
0-37	38-65	66-126

NAME

DATE

Mycotoxins

	Never	Occasionally	Often	Regularly
See mold growing at home, work, or school?	N	Y		
Ever experienced water damage at home, work, or school?	N	Y		
Home, workplace, or school has a damp or mildewy odor	0	1	2	3
Spending time in basement causes or worsens symptoms	0	4	6	8
Basement ever wet?	N	Y		
Symptoms decrease when spend time in a different location for at least a few days?	N	Y		
Plumbing in your kitchen or bathroom leaks or has leaked in the past?	N	Y		
Wet spots anywhere in your home (whether currently or past)?	N	Y		
Often see condensation (fog) on the inside of windows and/or cold surfaces in your home?	N	Y		
Car has a mildewy smell?	N	Y		
Brain fog	0	1	2	3
Reactions to supplements opposite of expected	0	1	2	3
Nosebleeds	0	1	2	3
Body rashes	0	1	2	3
Any skin conditions?	N	Y		
Anyone in your home have asthma-like symptoms?	N	Y		
Sinus infections	0	1	2	3
One or more family members have chronic sinus infections or irritations	0	1	2	3
Runny, blocked, or stuffy nose	0	1	2	3
Experience static shocks	0	1	2	3
Wheezing or whistling in your chest	0	1	2	3
Wake up in the morning with a feeling of tightness in your chest	0	1	2	3
Wake up during the night with shortness of breath	0	1	2	3
Shortness of breath when you're not doing anything strenuous	0	1	2	3
Wake up during the night with an attack of coughing	0	1	2	3
Chest tightness when around animals or a dusty part of the house	0	1	2	3
Achy all over	0	1	2	3
Headaches	0	1	2	3
Extreme or unusual fatigue	0	1	2	3
Hoarse voice	0	1	2	3
Memory loss	0	1	2	3
Difficulty recalling names of people you know	0	1	2	3
Sensitive to chemicals and smells	0	1	2	3
Sensitive to EMF's	0	1	2	3
Bloating or SIBO	0	1	2	3
Blurry vision	0	1	2	3
Difficulty sleeping or insomnia	0	1	2	3
Anxiety or depression	0	1	2	3
Frequent urination, unable to hold bladder	0	1	2	3

Mold Total .....

GREEN	YELLOW	RED
0-19	20-68	69-138

Instructions

Rate each of the symptoms to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number next to your answer, if there is a number. Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

