



**CIRCLE** the number which best describes the frequency of your symptoms. If you do not know the answer to the question, leave it blank. When you are finished, please add the number of points in each section and enter the number in the Total Point box. The score for YES is the number inside the parentheses ( ).

**Key**

- (0) never or rarely
- (1) twice a week or less
- (2) three to six times a week
- (3) daily or several times a day

**PART I**  
Section A

<b>1)</b> Have you taken a broad spectrum antibiotic drug:			
A) in the last 6 months	N	Y	(10)
B) If the response to A is no, have you ever taken antibiotics?	N	Y	(5)
<b>2)</b> Have you had recurrent infections requiring prolonged antibiotic use?	N	Y	(20)
<b>3)</b> Have you taken birth control pills?	N	Y	(5)
<b>4)</b> Have you taken prednisone?	N	Y	(5)
<b>5)</b> Have you had athlete's foot, ringworm, jock itch, or other chronic fungus infections of the skin or nails?	N	Y	(5)
<b>6)</b> Do you crave sugar?	N	Y	(5)
<b>7)</b> Do you crave breads?	N	Y	(5)
<b>8)</b> Do you crave alcoholic beverages?	N	Y	(5)
<b>9)</b> Have you ever had candida/yeast?	N	Y	(10)
<b>10)</b> Endometriosis or infertility	N	Y	(5)
<b>11)</b> Symptoms worse on damp, muggy days or in moldy places	0	1	2 3
<b>12)</b> Fatigue or lethargy	0	1	2 3
<b>13)</b> Poor memory	0	1	2 3
<b>14)</b> Depression	0	1	2 3
<b>15)</b> Muscle and or joint aches or weakness	0	1	2 3
<b>16)</b> Abdominal pain	0	1	2 3
<b>17)</b> Constipation	0	1	2 3
<b>18)</b> Diarrhea	0	1	2 3
<b>19)</b> Bloating, belching, or intestinal gas	0	1	2 3
<b>20)</b> Vaginal burning, itching, or discharge	0	1	2 3
<b>21)</b> Premenstrual tension	0	1	2 3
<b>22)</b> Irritability	0	1	2 3
<b>23)</b> Inability to concentrate	0	1	2 3
<b>24)</b> Frequent mood swings	0	1	2 3
<b>25)</b> Recurrent rashes or itching	0	1	2 3
<b>26)</b> Rectal itching	0	1	2 3
<b>27)</b> Urgency or urinary frequency	0	1	2 3
<b>28)</b> Burning while urinating	0	1	2 3

**Total Points**

Section B

<b>1)</b> Have you traveled outside the USA?	N	Y	(5)
<b>2)</b> Since traveling abroad, have you had an elevated white blood count, intestinal problems, night sweats, or unexplained fever?	N	Y	(5)
<b>3)</b> Do you drink untested or unfiltered water?	N	Y	(5)
<b>4)</b> Do you use a microwave oven for cooking (instead of reheating) beef, fish, or pork?	N	Y	(5)
<b>5)</b> Do you prefer fish or meat that is under cooked, i.e., rare or medium rare?	N	Y	(5)
<b>6)</b> At home, do you use the same cutting board for chicken, fish, and meat as you do for vegetables?	N	Y	(5)
<b>7)</b> Have you lived with, or do you currently live with or handle pets?	N	Y	(5)
<b>8)</b> Do you work or have children in a day care center?	N	Y	(5)
<b>9)</b> Do you garden or work in a yard to which cats and dogs have access?	N	Y	(5)
<b>10)</b> Have you ever had parasites?	N	Y	(10)
<b>11)</b> Red blood in stool	0	1	2 3
<b>12)</b> Abdominal pain and cramps	0	1	2 3
<b>13)</b> Lower back pain	0	1	2 3
<b>14)</b> Gas, bloating	0	1	2 3
<b>15)</b> Fever	0	1	2 3
<b>16)</b> Chronic fatigue	0	1	2 3
<b>17)</b> Constipation	0	1	2 3
<b>18)</b> Diarrhea	0	1	2 3
<b>19)</b> Foul smelling stools	0	1	2 3
<b>20)</b> Anal itching	0	1	2 3
<b>21)</b> Bad breath	0	1	2 3
<b>22)</b> Grind teeth	0	1	2 3
<b>23)</b> Lethargic	0	1	2 3
<b>24)</b> Mucus in stool	0	1	2 3
<b>25)</b> Lack of stamina	0	1	2 3

**Total Points**

**Part II**

## Section A

1)	Indigestion	0	1	2	3
2)	Belching, burping	0	1	2	3
3)	Gas immediately following a meal	0	1	2	3
4)	Sense of fullness during meals	0	1	2	3
5)	Poor appetite, picky eater	0	1	2	3
6)	Difficult bowel movements	0	1	2	3
7)	Difficulty swallowing	0	1	2	3
8)	History of anemia, unresponsive to iron	0	1	2	3
9)	Vegetarian (no eggs, dairy)	0	1	2	3
10)	Spoon-shaped nails	0	1	2	3
11)	Unintentional weight loss	0	1	2	3
12)	Partial loss of taste or smell	0	1	2	3

**Total Points**

## Section B

1)	Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
2)	Pain, tenderness, soreness on left side under rib cage	0	1	2	3
3)	Bloated	0	1	2	3
4)	Excessive passage of gas	0	1	2	3
5)	Abdominal cramps, aches	0	1	2	3
6)	Nausea and/or vomiting	0	1	2	3
7)	Specific foods/beverages aggravate indigestion	0	1	2	3
8)	Roughage and fiber causes constipation	0	1	2	3
9)	Three or more large bowel movements daily	0	1	2	3
10)	Alternating constipation and diarrhea	0	1	2	3
11)	Undigested food in stool	0	1	2	3
12)	Mucus in stool	0	1	2	3
13)	Dry, flaky skin; dry-brittle hair	0	1	2	3
14)	Difficulty gaining weight	0	1	2	3

**Total Points****PART III**

## Section A

1)	Moderate to severe pain under right side of rib cage	0	1	2	3
2)	Abdominal pain worsens with deep breathing	0	1	2	3
3)	Regurgitate bitter fluid	0	1	2	3
4)	Bloated, full feeling	0	1	2	3
5)	Belching, heartburn, gas	0	1	2	3
6)	Fatty foods cause indigestion	0	1	2	3
7)	Nausea or vomiting	0	1	2	3
8)	Feel restless, agitated	0	1	2	3
9)	Unexplained itchy skin worse at night	0	1	2	3
10)	Stool color alternates from clay colored to normal brown	0	1	2	3

## Section C

1)	Lower abdominal pain, cramping and/or spasms.	0	1	2	3
2)	Lower abdominal pain relief by passing stool or gas	0	1	2	3
3)	Raw fruits, vegetables, and stress aggravate bowel pain	0	1	2	3
4)	Diarrhea (loose watery stool)	0	1	2	3
5)	More than three bowel movements a day	0	1	2	3
6)	Excessive gas and bloating	0	1	2	3
7)	Painful, difficult, straining during bowel movements	0	1	2	3
8)	Hard, dry, or small stools	0	1	2	3
9)	Alternating diarrhea/constipation	0	1	2	3
10)	Mucus, pus in stool	0	1	2	3
11)	Feeling that bowels do not empty completely	0	1	2	3
12)	Bright red blood following bowel movement	0	1	2	3
13)	Anal itching	0	1	2	3

**Total Points**

## Section D

1)	Stomach pain, burning, aching 1-4 hours after eating	0	1	2	3
2)	Feeling hungry an hour or two after eating	0	1	2	3
3)	Stomach discomfort, pain in response to strong emotions, thoughts, smell of food	0	1	2	3
4)	Heartburn, especially when lying down, bending forward	0	1	2	3
5)	Heartburn due to spicy and fatty foods, chocolate, peppers, citrus, alcohol, caffeine	0	1	2	3
6)	Difficulty or pain when swallowing	0	1	2	3
7)	Chest pain or infections, difficulty breathing	0	1	2	3
8)	For relief from carbonated beverages, cream/milk/food	0	1	2	3
9)	Constipation	0	1	2	3
10)	Black, tarry stool	0	1	2	3

**Total Points****Total Points**

11)	Feeling of poor health	0	1	2	3
12)	Fatigue, weakness, exhaustion	0	1	2	3
13)	Unable to concentrate, irritable, confused	0	1	2	3
14)	Swollen feet and/or legs	0	1	2	3
15)	Easy bruising	0	1	2	3
16)	Feeling of extreme dryness	0	1	2	3
17)	Reddened skin, especially palms	0	1	2	3
18)	Dark urine, diminished flow	0	1	2	3
19)	Dry, flaky skin, hair	N		Y	(3)
20)	Yellowish cast to skin, eyes	N		Y	(3)



Rate each of the following symptoms based upon your typical health profile for the past 30 days.

**Point Scale:**

0 = Never or almost never have the symptom  
 1 = Occasionally have it, effect is not severe

2 = Frequently have it, effect is not severe  
 3 = Occasionally have it, effect is severe  
 4 = Frequently have it, effect is severe

<b>Digestive Tract</b>	<input type="checkbox"/> Nausea or vomiting	Total	<b>Lungs</b>	<input type="checkbox"/> Chest congestion	Total
	<input type="checkbox"/> Diarrhea			<input type="checkbox"/> Asthma, bronchitis	
	<input type="checkbox"/> Constipation			<input type="checkbox"/> Shortness of breath	
	<input type="checkbox"/> Bloating Feeling			<input type="checkbox"/> Difficulty breathing	
	<input type="checkbox"/> Belching or passing gas				
	<input type="checkbox"/> Heartburn				
<b>Ears</b>	<input type="checkbox"/> Itchy ears	Total	<b>Mind</b>	<input type="checkbox"/> Poor memory	Total
	<input type="checkbox"/> Ear aches, ear infections			<input type="checkbox"/> Confusion, poor comprehension	
	<input type="checkbox"/> Drainage from ears			<input type="checkbox"/> Difficulty in making decisions	
	<input type="checkbox"/> Ringing in ears, hearing loss			<input type="checkbox"/> Stuttering or stammering	
<b>Emotions</b>	<input type="checkbox"/> Mood swings	Total	<b>Mouth/Throat</b>	<input type="checkbox"/> Slurred speech	Total
	<input type="checkbox"/> Anxiety, fear, or nervousness			<input type="checkbox"/> Learning disabilities	
	<input type="checkbox"/> Anger, irritability, or aggressiveness			<input type="checkbox"/> Chronic coughing	
	<input type="checkbox"/> Depression			<input type="checkbox"/> Gagging frequently; need to clear throat	
<b>Energy &amp; Activity</b>	<input type="checkbox"/> Fatigue, sluggishness	Total	<b>Nose</b>	<input type="checkbox"/> Sore throat, hoarseness, loss of voice	Total
	<input type="checkbox"/> Apathy, lethargy			<input type="checkbox"/> Swollen/discolored tongue/gums/lips	
	<input type="checkbox"/> Hyperactivity			<input type="checkbox"/> Canker sores	
	<input type="checkbox"/> Restlessness			<input type="checkbox"/> Stuffy nose	
<b>Eyes</b>	<input type="checkbox"/> Watery or itchy eyes	Total	<b>Skin</b>	<input type="checkbox"/> Sinus problems	Total
	<input type="checkbox"/> Swollen, reddened or sticky eyelids			<input type="checkbox"/> Hay fever	
	<input type="checkbox"/> Bags or dark circles under eyes			<input type="checkbox"/> Sneezing attacks	
	<input type="checkbox"/> Blurred or tunnel vision			<input type="checkbox"/> Excessive mucus formation	
	(does not include near or far sightedness)			<input type="checkbox"/> Acne	
<b>Head</b>	<input type="checkbox"/> Headaches	Total	<b>Weight</b>	<input type="checkbox"/> Hives, rashes, or dry skin	Total
	<input type="checkbox"/> Faintness			<input type="checkbox"/> Hair loss	
	<input type="checkbox"/> Dizziness			<input type="checkbox"/> Flushing or hot flashes	
	<input type="checkbox"/> Insomnia			<input type="checkbox"/> Excessive sweating	
<b>Heart</b>	<input type="checkbox"/> Binge eating	Total	<b>Other</b>	<input type="checkbox"/> Frequent illness	Total
	<input type="checkbox"/> Irregular or skipped heartbeat			<input type="checkbox"/> Craving certain foods	
	<input type="checkbox"/> Rapid or pounding heartbeat			<input type="checkbox"/> Excessive weight	
<b>Joint &amp; Muscles</b>	<input type="checkbox"/> Chest pain	Total	Grand Total	<input type="checkbox"/> Compulsive eating	Total
	<input type="checkbox"/> Pain or aches in joints			<input type="checkbox"/> Water retention	
	<input type="checkbox"/> Arthritis			<input type="checkbox"/> Underweight	
	<input type="checkbox"/> Stiffness or limitation of movement			<input type="checkbox"/> Frequent or urgent urination	
	<input type="checkbox"/> Pain or aches in muscles			<input type="checkbox"/> Genital itch or discharge	
<input type="checkbox"/> Feeling of weakness or tiredness					

\*These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure, or prevent any disease.