Lifestyle Evaluation Questionnaire

1. How many organs removed? _____ (Please specify which ones below and age) – don't forget adenoids, tonsils, appendix, gall bladder, uterus or ovaries.

Organs Removed	What age and why?

2. How many synthetic drugs are you taking? _____ (Please list name, dosage and what they are for)

Prescription Medications & dosage	What they are for?

3. What over the counter vitamins are you currently taking?

Vitamins & dosage	What they are for?

4. Amount of times you smoke/day _____ (use daily average over last two months)

5. Number of steroid type drugs used in the last year e.g. Cortisone: _____ (Please specify below)

Steroids used in the last year	What for?

6. Number of metal amalgam fillings: _____ (any metal fillings in teeth)

7. Number of street drugs used in the last month (total number of different types used): _____ Specify: _____

8. Have you ever used street drugs: No / Yes

   If yes please specify:

   _____

9. Number of all known allergies confirmed by a doctor: _____ (Please specify below)

   _____

   _____

   _____

   _____

10. I am responsible for my body _____ (0 – 10) 0 = not at all responsible; 10 = completely responsible

11. Amount of fat in diet as a percentage out of 100% _____% (most diets are over 40% fat, 20% is ideal)

12. Number of unresolved mental factors ____ e.g. Anger/ greed/ desire/ sadness/ fear/ Childhood traumas/ Abandonment/ Abuse / Death of a loved one If you are comfortable to, please list briefly:

    _____

    _____

    _____

    _____

    _____

13. Number of sugar type products per day _____ (any use of white processed sugar or wheat on average per day, incl. sweets, biscuits, soft drinks, sugar in tea or coffee)

14. Number of exercise sessions per week 20 min or more not including work: _____ (count only official workouts that end in a sweat)

15. Number of alcoholic drinks per day / month _____

16. Number of cups of coffee, tea per day (caffeine) _____ (caffeine is in chocolate, cola and other foods too)

17. Number of extreme toxic exposures in the last year _____ (insecticides, radiation, chemicals, include each chemotherapy and radiation treatment as well as accidental exposures)

    Please specify:

    _____

18. Number of major injuries in past _____ (count all emotional, physical or other traumas) - Please specify below:

    _____

    _____

    _____

    _____

19. Number of major infections past and present: _____ (count all major health threatening infections) - Please specify below:

    _____

    _____

    _____

    _____

20. Number of glasses of water per day: _____

21. How many kilograms if you perceive yourself to be overweight: _____

Stress related Questions

Personal stress _____ (0 – 10) 0 = not at all stressed; 10 = completely stressed

Please circle what feels true for you at this point in your life

Interpersonal Stress	0 1 2 3 4 5 6 7 8 9 10
Work / School Stress	0 1 2 3 4 5 6 7 8 9 10
Struggle with Self	0 1 2 3 4 5 6 7 8 9 10
Struggle with Money	0 1 2 3 4 5 6 7 8 9 10
Stress from Sickness	0 1 2 3 4 5 6 7 8 9 10
Family Stress	0 1 2 3 4 5 6 7 8 9 10
Stress from desire for things to be different	0 1 2 3 4 5 6 7 8 9 10
Problem with bowels	0 1 2 3 4 5 6 7 8 9 10
Problem with sweat	0 1 2 3 4 5 6 7 8 9 10
Problem with urine	0 1 2 3 4 5 6 7 8 9 10
Problem with mucous	0 1 2 3 4 5 6 7 8 9 10
Problem with menses	0 1 2 3 4 5 6 7 8 9 10
Problem with breath	0 1 2 3 4 5 6 7 8 9 10
Problem with skin	0 1 2 3 4 5 6 7 8 9 10
Problem with sleep	0 1 2 3 4 5 6 7 8 9 10

How many times a day do you meditate or use stress reduction techniques _____?

Number of Root Canal Treatments _____?