

Body Stress Assessment Form

Name: _____ DOB: _____ Sex: _____ Date: _____

Total Cholesterol _____ LDL _____ HDL _____

Triglycerides _____

Ratios: TC/HDL _____ LDL/HDL _____

Other tests conducted: _____

(_____) (_____) (_____)

Please circle the appropriate number "0 - 3" on questions below. 0 disagree to 3 highly agree.

List your most important health concerns or current symptoms: _____

Oxidative Score: _____

Sugars Questionnaires

Glucogenic

(Hypoglycemic Tendencies)

- | | | | | |
|---|---|---|---|---|
| Crave sweets after meals | 0 | 1 | 2 | 3 |
| Irritable or moody if meals are skipped | 0 | 1 | 2 | 3 |
| Need Carbs or Sugar to get you started | 0 | 1 | 2 | 3 |
| Get lightheaded if meals are missed | 0 | 1 | 2 | 3 |
| Do you drink a lot of Juices or Sodas | 0 | 1 | 2 | 3 |
| Do starches dominate your meal | 0 | 1 | 2 | 3 |
| Agitated, easily upset, nervous | 0 | 1 | 2 | 3 |
| Poor concentration, forgetfulness | 0 | 1 | 2 | 3 |
| Night snack frequently | 0 | 1 | 2 | 3 |
| Cold intolerance | 0 | 1 | 2 | 3 |
| Feel depressed or just get the blues | 0 | 1 | 2 | 3 |
| Periodic Headaches | 0 | 1 | 2 | 3 |
| Eating relieves fatigue or headaches | 0 | 1 | 2 | 3 |
| Feel shaky, jittery, tremors and seizures | 0 | 1 | 2 | 3 |
| Do you skip breakfast | 0 | 1 | 2 | 3 |
| Higher Triglycerides | 0 | 1 | 2 | 3 |
| If female do you suffer from PMS? | 0 | 1 | 2 | 3 |

Glucogenic Score _____

Ketogenic (High Sugar Patterns)

- | | | | | |
|--|---|---|---|---|
| History of Diabetes in Family | 0 | 1 | 2 | 3 |
| Struggle with weight/obesity | 0 | 1 | 2 | 3 |
| Poor Circulation issues | 0 | 1 | 2 | 3 |
| Chronic high Triglycerides & Cholesterol | 0 | 1 | 2 | 3 |
| History of high urine ketones | 0 | 1 | 2 | 3 |
| Is your fasting blood glucose above 110 | 0 | 1 | 2 | 3 |
| Chronic infections or skin abscesses | 0 | 1 | 2 | 3 |
| If female do you suffer from hot flashes | 0 | 1 | 2 | 3 |

Ketogenic Score _____

Adrenal Questionnaire

- | | | | | |
|---|---|---|---|---|
| Cold hands and feet | 0 | 1 | 2 | 3 |
| Anxiety, Worry, fear, panic Attacks | 0 | 1 | 2 | 3 |
| Do not wake up refreshed | 0 | 1 | 2 | 3 |
| Fatigue or Exhaustion(Wired or tired) | 0 | 1 | 2 | 3 |
| light headed suddenly upon standing | 0 | 1 | 2 | 3 |
| Insomnia or a light sleeper | 0 | 1 | 2 | 3 |
| Get tired in between meals | 0 | 1 | 2 | 3 |
| Prone to colds, flu, infections allergies | 0 | 1 | 2 | 3 |
| Inability to lose weight or sudden gains | 0 | 1 | 2 | 3 |
| Intolerance to temperature shifts | 0 | 1 | 2 | 3 |
| Was your glucogenic score very high | 0 | 1 | 2 | 3 |
| Edema fluid retention | 0 | 1 | 2 | 3 |
| Exercise is a struggle | 0 | 1 | 2 | 3 |
| Feel like you crash at the end of the day | 0 | 1 | 2 | 3 |
| Are you up all night | 0 | 1 | 2 | 3 |
| Headaches more migrane type | 0 | 1 | 2 | 3 |
| Heart palpitations | 0 | 1 | 2 | 3 |
| Cant focus on things | 0 | 1 | 2 | 3 |

Adrenal Score _____

Stress Level Questionnaire

- | | | | | |
|---|---|---|---|---|
| Take few vacations | 0 | 1 | 2 | 3 |
| Do you work over 45 hours a week | 0 | 1 | 2 | 3 |
| Few rest breaks throughout the day | 0 | 1 | 2 | 3 |
| Work more than 5 days a week | 0 | 1 | 2 | 3 |
| Have you gone through a crisis recently | 0 | 1 | 2 | 3 |
| Do you get anxious or upset quickly | 0 | 1 | 2 | 3 |
| Quick to anger or rage | 0 | 1 | 2 | 3 |
| Brood over mistakes & shortcomings | 0 | 1 | 2 | 3 |
| Disturbed Sleep Patterns | 0 | 1 | 2 | 3 |

Stress Level Questionnaire

(Continued)

Nervous, jumpy	0	1	2	3
Do you huff and puff up the stairs	0	1	2	3
Slow to recover from Illness, injuries	0	1	2	3
Use coffee to keep you going	0	1	2	3
High score on Adrenal Questionnaire	0	1	2	3
Stressful periods bring illness	0	1	2	3
Is there tension at work	0	1	2	3
Do not enjoy working or your profession	0	1	2	3
Binge eating during stressful times	0	1	2	3
Fail to see the humor in things	0	1	2	3
Irritated at large gatherings	0	1	2	3

Stress Level Score _____

Digestive Stress Questionnaire

Gas and Bloating at or after meals	0	1	2	3
Bad breath	0	1	2	3
See foods undigested in stools	0	1	2	3
Heart burn, acid reflux	0	1	2	3
Lower bowel gas	0	1	2	3
Use laxatives	0	1	2	3
Eat very fast at meals	0	1	2	3
Eating too much at meals	0	1	2	3
Eating late at night	0	1	2	3
Never consciously take time to chew	0	1	2	3
Chronic Constipation or diarrhea	0	1	2	3
Stomach, pancreas pain after meal	0	1	2	3
Never take enzymes or HCL tablets	0	1	2	3
Have difficulty digesting certain foods	0	1	2	3

Lipid/Fat Digestion Issues

Difficulty digesting fatty foods	0	1	2	3
Biliary obstruction(Pain/stones)	0	1	2	3
Migraine Headaches	0	1	2	3
Hard dry or small stool	0	1	2	3
Dry cracked skin at elbows, hands, feet	0	1	2	3

Digestive Stress Score _____

Scoring Summary

Sugar Scores:

Gluco____ High if above 18

Keto____ High if above 9

Adrenal Score _____ High if above 18

Stress Levels Score_____ High if above 20

Digestive Stress Score_____ High if above 20

Increased Nitric Oxide Potential

Chronic High Oxidation	<input type="checkbox"/>
Allergies or Inflammatory conditions	<input type="checkbox"/>
High score on Sugars Questionnaires	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>
Recent Bone Loss	<input type="checkbox"/>
High scores on Digestive Questionnaires	<input type="checkbox"/>
Liver Conditions (Liver Enzyme issues)	<input type="checkbox"/>
Chronic Infections	<input type="checkbox"/>
Estrogen dominance patterns	<input type="checkbox"/>
Rheumatoid arthritis or Fibromyalgia	<input type="checkbox"/>
Chronic Alcohol use	<input type="checkbox"/>
Tap Water use	<input type="checkbox"/>
Low levels of Exercise	<input type="checkbox"/>
Emotional Anger	<input type="checkbox"/>

Increased Electrolytes Potential

High Cholesterol	<input type="checkbox"/>
Chronic High Oxidation	<input type="checkbox"/>
Tap water use	<input type="checkbox"/>
Nervous disorders	<input type="checkbox"/>
Many skin tags, warts or moles	<input type="checkbox"/>
Bladder disorders(Incontinence)	<input type="checkbox"/>
Cardio-vascular Stress	<input type="checkbox"/>
Anal Sphincter: fecal incontinence	<input type="checkbox"/>
Cardiac Sphincter: Gerd	<input type="checkbox"/>
High salt intake in diet	<input type="checkbox"/>
Bone Calcium spurs, kidney stones	<input type="checkbox"/>
Sweating cakey layers on clothing	<input type="checkbox"/>
Urine or Sweat has a salty taste	<input type="checkbox"/>
Have fillings or metals in mouth	<input type="checkbox"/>
Tinnitus	<input type="checkbox"/>
Osteo-arthritic deformities	<input type="checkbox"/>
Diverticulitis	<input type="checkbox"/>
Aneurisms	<input type="checkbox"/>
Prostate disorders	<input type="checkbox"/>
Uterine fibroids	<input type="checkbox"/>

Increased Ammonia Potential

High Cholesterol	<input type="checkbox"/>
High Scores on Stress Questionnaire	<input type="checkbox"/>
High Scores on Adrenal Questionnaire	<input type="checkbox"/>
High Scores on Digestive Questionnaires	<input type="checkbox"/>
Increases in Uric Acid leading to Gout	<input type="checkbox"/>
High Protein diet	<input type="checkbox"/>
Urine smells like Ammonia or offensive	<input type="checkbox"/>
Kidney issues	<input type="checkbox"/>
Heavy Metals or chemical exposure	<input type="checkbox"/>
Degenerative conditions	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>
Brain Fog	<input type="checkbox"/>