

Health Appraisal Questionnaire

(all patients age 13 and over)

Kelly Wallace, N.D.

474-2727

Name: _____

Date: _____

Mark in the box which of the following medications you are taking. Use P if you have used them in the past.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Aspirin?/tylenol | <input type="checkbox"/> Lithium | <input type="checkbox"/> Ulcer Medication |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Oral Contraceptives | <input type="checkbox"/> Recreational Drugs (please list) |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Heart Medications | <input type="checkbox"/> Radiation | <input type="checkbox"/> Other (please list) |
| <input type="checkbox"/> Antidiabetic/Insulin | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Relaxants | |
| <input type="checkbox"/> Antifungals | <input type="checkbox"/> Hormones | <input type="checkbox"/> Sleeping Pills | |
| <input type="checkbox"/> Anti-inflammatories | <input type="checkbox"/> Laxatives | <input type="checkbox"/> Thyroid | |

Mark in the box if you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Diet often | <input type="checkbox"/> Salt food without tasting | <input type="checkbox"/> Are exposed to chemicals at work |
| <input type="checkbox"/> Do not exercise regularly | <input type="checkbox"/> Are under excessive stress | <input type="checkbox"/> Are exposed to cigarette smoke |

Mark in the box if you often (more than 2 x / week) eat, drink or use:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Fried foods | <input type="checkbox"/> Other artificial sweeteners |
| <input type="checkbox"/> Candy | <input type="checkbox"/> Herbal teas | <input type="checkbox"/> Luncheon meats | <input type="checkbox"/> Oils (list kind) |
| <input type="checkbox"/> Butter | <input type="checkbox"/> Coffee/regular tea | <input type="checkbox"/> Margarine | |
| <input type="checkbox"/> Vitamins, minerals & other supplements (please list) | <input type="checkbox"/> Fast food restaurants | <input type="checkbox"/> Whole grain foods | |
| <input type="checkbox"/> Carbonated beverages | <input type="checkbox"/> Purified water | <input type="checkbox"/> Refined sugars | |
| | | <input type="checkbox"/> Aspartame | |

Instructions: Answer only if you have the symptom. Do not circle if you do not have the symptom. For each question, circle the number which best describes the intensity of your symptom.

1 = Mild (occasional/slight) 2 = Moderate (more often/obvious) 3 = Severe (frequent/disabling)

PART II: DIGESTION

Section A: Hypoacidity

- | | | | |
|---|---|---|---|
| 1. Burping | 1 | 2 | 3 |
| 2. Fullness for extended time after meals | 1 | 2 | 3 |
| 3. Bloating | 1 | 2 | 3 |
| 4. Poor appetite | 1 | 2 | 3 |
| 5. Stomach upsets easily | 1 | 2 | 3 |
| 6. History of constipation | 1 | 2 | 3 |
| 7. Known food allergies | 1 | 2 | 3 |
| 8. Lack of interest in eating | 1 | 2 | 3 |

Section B: Small Intestine

- | | | | |
|---|---|---|---|
| 1. Abdominal cramps | 1 | 2 | 3 |
| 2. Indigestion 1-3 hours after eating | 1 | 2 | 3 |
| 3. Fatigue after eating | 1 | 2 | 3 |
| 4. Lower bowel gas | 1 | 2 | 3 |
| 5. Alternating constipation/diarrhea | 1 | 2 | 3 |
| 6. Diarrhea | 1 | 2 | 3 |
| 7. Roughage and fiber causes constipation | 1 | 2 | 3 |
| 8. Mucous in stools | 1 | 2 | 3 |
| 9. Stool poorly formed | 1 | 2 | 3 |
| 10. Shiny stool | 1 | 2 | 3 |
| 11. Three or more large bowel movements daily | 1 | 2 | 3 |
| 12. Foul smelling stools | 1 | 2 | 3 |
| 13. Dry flaky skin and/or dry brittle hair | 1 | 2 | 3 |
| 14 Pain in the left side under rib cage | 1 | 2 | 3 |
| 15. Acne | 1 | 2 | 3 |
| 16. Food allergies | 1 | 2 | 3 |
| 17. Difficulty gaining weight | 1 | 2 | 3 |

Section C: Hyperacidity

- | | | | |
|---|----|---|-----|
| 1. Stomach pains | 1 | 2 | 3 |
| 2. Stomach pains just before/after meals | | 2 | 3 |
| 3. Dependency on antacids | 1 | 2 | 3 |
| 4. Chronic abdominal pain | 1 | 2 | 3 |
| 5. Butterfly sensations in stomach | 1 | 2 | 3 |
| 6. Difficulty belching | | 2 | 3 |
| 7. Stomach pain when emotionally upset | 1 | 2 | 3 |
| 8. Sudden acute indigestion | No | | Yes |
| 9. Relief of symptoms by carbonated beverages | No | | Yes |
| 10. Relief of stomach pain by drinking milk | No | | Yes |
| 11. History of ulcer or gastritis | No | | Yes |
| 12. Current ulcer | No | | Yes |
| 13 Black stool | No | | Yes |
| (taking iron supplements?) | No | | Yes |

Section D: Colon

- | | | | |
|--|----|---|-----|
| 1. Seasonal diarrhea | 1 | 2 | 3 |
| 2. Frequent/recurrent infections (colds) | 1 | 2 | 3 |
| 3. Bladder and kidney infections | 1 | 2 | 3 |
| 4. Vaginal cramps | 1 | 2 | 3 |
| 5. Abdominal cramps | 1 | 2 | 3 |
| 6. Toe and fingernail fungal infections | 1 | 2 | 3 |
| 7. Alternating constipation/diarrhea | 1 | 2 | 3 |
| 8. Constipation | No | | Yes |
| 9. History of antibiotic use | No | | Yes |
| 10. Meat Eater | No | | Yes |
| 11. Rapidly failing vision | No | | Yes |

PART III: FAT METABOLISM

Section A: Liver/Gallbladder

1. Intolerance to greasy foods	1	2	3
2. Headaches after eating	1	2	3
3. Light coloured stool	1	2	3
4. Foul smelling stool	1	2	3
5. Less than one bowel movement daily	1	2	3
6. Constipation	1	2	3
7. Hard stool	1	2	3
8. Sour taste in mouth	1	2	3
9. Grey coloured skin	1	2	3
10. Yellow in whites of eyes	1	2	3
11. Bad breath	1	2	3
12. Body odor	1	2	3
13. Fatigue and sleepiness after eating	1	2	3
14. Pain in the right side under rib cage	1	2	3
15. Painful to pass stool	1	2	3
16. Retain water	1	2	3
17. Big toe painful	1	2	3
18. Pain radiates along outside of leg	1	2	3
19. Dry skin and/or hair	1	2	3
20. Red blood in stool	No		Yes
21. Have had jaundice or hepatitis	No		Yes
22. High blood cholesterol	No		Yes
23. Is your cholesterol level elevated? (above 5) No			Yes
24. Is your triglyceride level elevated? (above 1.5) No			Yes

Section B: Thyroid

1. Sensitive to the cold	1	2	3
2. Cold hands and feet	1	2	3
3. Strong smelling urine	1	2	3
4. Constipation	1	2	3
5. Chronic fatigue	1	2	3
6. Trouble waking up in morning	1	2	3
7. Depressed, apathetic	1	2	3
8. Sugar causes irritability & mood swings	1	2	3
9. Low sex drive	1	2	3
10. Swollen eyes (bulging)	1	2	3
11. Racing heart/trembling fingers	1	2	3
12. Dry skin	1	2	3
13. Puffy, wrinkly skin	1	2	3
14. Muscle pain or stiffness	1	2	3
15. Premenstrual tension	1	2	3
16. Excessive menstrual bleeding	1	2	3
17. Infertility	No		Yes
18. Thinning/loss of outside portion of eyebrow	No		Yes
19. Anemia unaffected by taking iron	No		Yes
20. Armpit temperature below 97.6F / 37°C (or oral temperature below 98.6 F / 37°C)	No		Yes
21. Gain weight easily	No		Yes

PART IV: IMMUNE FUNCTION

Section A: Hypoadrenal

1. Feel tired in the afternoon	1	2	3
2. Dizziness on standing	1	2	3
3. Low blood pressure	1	2	3
4. Cannot tolerate much exercise	1	2	3
5. Frequently feel weak or shaky	1	2	3
6. Itchy, red or inflamed eyes	1	2	3
7. Dark circles under the eyes	1	2	3
8. Eyes sensitive to bright light	1	2	3
9. Sensitive to exhaust fumes, smoke, Smog and petrochemicals	1	2	3
10. Periodic constipation	1	2	3
11. Depression or rapid mood swings	1	2	3
12. Lack of mental alertness	1	2	3
13. Headaches	1	2	3
14. Catch colds easily when weather changes	1	2	3
15. Difficulty breathing	1	2	3
16. Water retention	1	2	3
17. Hemorrhoids	1	2	3
18. Ringing in the ears	1	2	3

Section B HypoImmune

1. Inflamed or bleeding gums	1	2	3
2. Running, dripping nose	1	2	3
3. Nose bleeds	1	2	3
4. Loss of smell	1	2	3
5. Get boils or styes	1	2	3
6. Throat infections	1	2	3
7. Cold sores, fever blisters, herpes	1	2	3
8. Catch colds or flus easily	1	2	3
9. Slow to recover from colds or flu	1	2	3
10. Poor wound healing	1	2	3
11. Swollen lymph glands	1	2	3
12. Ear infection	1	2	3
13. Hair falls out	1	2	3

14. Loss of taste	1	2	3
15. Bumpy skin on back of arms	1	2	3

Section C: HyperImmune / Allergy

1. Itching of nose or eyes	1	2	3
2. Watery eyes	1	2	3
3. Discharge from eyes	1	2	3
4. Puffiness or dark circles under eyes	1	2	3
5. Itching of roof of mouth or throat	1	2	3
6. Mucous in throat	1	2	3
7. Post nasal drip	1	2	3
8. Running nose	1	2	3
9. Nasal congestion	1	2	3
10. Sneezing	1	2	3
11. Breathe through mouth	1	2	3
12. Chronic lung congestion/ asthma/ bronchitis	1	2	3
13. Wheezing	1	2	3
14. Swollen tongue	1	2	3
15. Difficulty swallowing	1	2	3
16. Ear discharge or ears stuffed up	1	2	3
17. Entire body aches, painful to touch	1	2	3
18. Swollen joints	1	2	3
19. Chronic pain	1	2	3
20. Food sensitivity or allergy	1	2	3
21. Certain foods make you sick, depressed, jittery	1	2	3
22. Painful stomach and/or intestine	1	2	3
23. Alternating constipation and diarrhea	1	2	3
24. Skin rashes, eczema, psoriasis	1	2	3
25. Hyperactivity	1	2	3
26. Migraine headaches	No		Yes
27. Use Aspirin or Tylenol regularly	No		Yes
28. Bedwetting	No		Yes

PART IV: CARDIOVASCULAR

Section A: Heart

1. Chest pain while walking	1	2	3
2. Heaviness in legs	1	2	3
3. Calf muscles cramp when walking	1	2	3
4. Heart pounds easily	1	2	3
5. Heart misses beats or has extra beats	1	2	3
6. Rapid beating heart	1	2	3
7. Feel jittery	1	2	3
8. Swelling of feet and ankles	1	2	3
9. Heartburn after eating	1	2	3
10. Pain in left arm	1	2	3
11. Exhaust with minor exertion	1	2	3
12. Difficulty breathing at night in bed	1	2	3
13. Do you do aerobic exercise?	Yes	No	
14. Have you ever exercised regularly?	Yes	No	
15. Bright red nose?	No	Yes	
16. Drink 5 or more cups of coffee daily	No	Yes	
17. Severe cough	No	Yes	
18. Has a doctor ever told you that you have heart trouble?	No	Yes	

Section B: Circulation

1. Cold hands and feet	1	2	3
2. Slurred speech	1	2	3
3. Calf muscles cramp while walking	1	2	3
4. Headaches	1	2	3
5. Numbness in extremities	1	2	3
6. Poor concentration	1	2	3
7. Ringing in ears	1	2	3
8. Ear canal hair	No	Yes	
9. Tingling and / or burning hands or feet	No	Yes	
10. Spider veins on nose or face	No	Yes	
11. Heart attack	No	Yes	
12. Stroke	No	Yes	
13. Vertical wrinkle in lower ear lobe	No	Yes	

Section C: Hypertension

1. Pain when getting up in morning in back of Head and neck	1	2	3
2. Dizziness	1	2	3
3. Vertigo	1	2	3
4. Blushing with no apparent cause	1	2	3
5. Is your blood pressure high?	No	Yes	

PART IV: SUGAR TOLERANCE

Section A: Hypoglycemia

1. Dizziness/ loss of vision when standing Suddenly	1	2	3
2. Crave sweets	1	2	3
3. Headaches relieved by sweets or alcohol	1	2	3
4. Often feel shaky or jittery	1	2	3
5. Have times of feeling faint	1	2	3
6. Irritable if a meal is missed	1	2	3
7. Feel tired or weak if a meal is missed	1	2	3
8. Feel tired 1 to 3 hours after eating	1	2	3
9. Calmer after eating	1	2	3
10. Wake in middle of night craving sweets	1	2	3
11. Heart palpitations after eating sweets	1	2	3
12. Need to drink coffee to get started	1	2	3
13. Impatient, moody, nervous	1	2	3
14. Poor memory, forgetful	1	2	3
15. Poor concentration	1	2	3

Section B: Hyperglycemia / Diabetes

1. Night sweats	1	2	3
2. Increased thirst	1	2	3
3. Lowered resistance to infection	1	2	3
4. Fatigue	1	2	3
5. Boils and leg sores	1	2	3
6. Lesions, cuts take a long time to heal	1	2	3
7. Overweight	1	2	3
8. Feel energized from exercise	1	2	3
9. Failing eyesight	1	2	3
10. Sugar in urine	1	2	3
11. Family history of diabetes	1	2	3
12. Crave sweets, but eating sweets does Not relieve craving	1	2	3

PART VII: LUNGS

1. Chest pain	1	2	3
2. Chronic cough	1	2	3
3. Difficulty breathing	1	2	3
4. Coughing up blood	1	2	3
5. Coughing up phlegm	1	2	3
6. Pain around ribs	1	2	3
7. Shortness of breath	1	2	3
8. Wheezing / asthma	1	2	3

9. Rattling mucous when you breathe	1	2	3
10. Sensitive to smog	1	2	3
11. Infections settle in lungs	1	2	3
12. Live or work around people who smoke	1	2	3
13. Bronchitis (now / in past)	No	Yes	
14. Exposed to chemicals and radiation	No	Yes	
15. Current smoker	No	Yes	
16. Smoker in the past? Quit how long ago	? No	Yes	

PART VIII: UROLOGICAL

1. Rarely need to urinate	1	2	3
2. Difficulty passing urine	1	2	3
3. General water retention	1	2	3
4. Frequent urination	1	2	3
5. Pain / burning when you pass urine	1	2	3
6. Urination when you cough or sneeze	1	2	3
7. Dripping after urination	1	2	3
8. Can't hold urine	1	2	3
9. For women, frequent vaginal infections	1	2	3
10. History of kidney or bladder infections How frequently?	1	2	3

11. Rose coloured (bloody) urine	1	2	3
12. Cloudy urine	1	2	3
13. Strong smelling urine	1	2	3
14. Back or leg pain associated with Dripping after urination	1	2	3
15. Back pain in kidney area	1	2	3
16. Used antibiotics to control urinary Tract infections?	No	Yes	
17. If Yes when did you last use them? Treatment duration?			

PART IX: MALES ONLY

Section A: Prostate

1. A sense of bladder fullness	1	2	3
2. Increased straining with only small Amounts of urine passed	1	2	3
3. Wake up to urinate at night	1	2	3
4. Pain or fatigue in legs or back	1	2	3
5. Lack of sex drive	1	2	3
6. Ejaculation causes pain	1	2	3

Section B: Reproductive

1. Difficulty attaining / maintaining an Erection	1	2	3
2. Low sex drive	1	2	3
3. Premature ejaculation	1	2	3

4. Pain / coldness in genital area	1	2	3
5. Low sperm count	No		Yes
6. Infertile	No		Yes
Had vasectomy?	No		Yes
7. Varicose veins on scrotum	No		Yes

Section C: Genital Infection

1. Discharge from penis	1	2	3
2. Past or present rash on penis	1	2	3
3. Swollen genitals	1	2	3
4. Swelling in groin	1	2	3
5. Venereal disease (gonorrhea, syphilis, Herpes, or other)	No		Yes
Have V.D. now? Had in past?			

PART X: FEMALES ONLY

Section A: Premenstrual Symptoms – for section A please answer for the time prior to menstruation

In general, how many days prior to menses do you have these symptoms?

1. Monthly weight gain, water retention	1	2	3
2. Bloating and swelling	1	2	3
3. Tender breasts	1	2	3
4. Depression	1	2	3
5. Moodiness / irritability	1	2	3
6. Anxiety	1	2	3
7. Easily distracted	1	2	3
8. Anger	1	2	3
9. Suicidal feeling	No		Yes
10. Nausea and / or vomiting	1	2	3
11. Headaches	1	2	3
12. Leg cramps	1	2	3
13. Low backache	1	2	3
14. Asthma attacks	1	2	3

Section B: Amenorrhea

1. Vaginal itching	1	2	3
2. Vaginal discharge	1	2	3
3. Low or no desire for sex	1	2	3
4. Dislike of intercourse	1	2	3
5. Over 15 years of age and have not Begun menstruation	No		Yes
6. Missed periods	No		Yes
7. Unable to get pregnant	No		Yes
8. Miscarriages	No		Yes
At what month?			
9. Abortion	No		Yes

Section C: Menstruation – for section C only, answer only if you experience any of these symptoms during menstruation

1. Menstrual pain	1	2	3
2. Low abdominal pain	1	2	3
3. Pelvic soreness	1	2	3
4. Dull ache radiating to low back or legs	1	2	3
5. Have to lie down on 1 st or 2 nd day of period	1	2	3
6. Have to take medication on day 1 or 2	1	2	3
7. Pain during periods is progressively Getting worse	1	2	3
8. Pain and cramps without blood flow	1	2	3
9. Light, scanty blood flow	1	2	3
10. Heavy menstrual bleeding	1	2	3
11. Diarrhea / constipation (circle which)	1	2	3

12. Abdominal bloating	1	2	3
13. Nausea and / or vomiting	1	2	3
14. Headaches	1	2	3
15. Increased urinary frequency	1	2	3
16. Craving for sweets	1	2	3
17. Insomnia	1	2	3
18. Anxiety about menstrual cycle	1	2	3

Section D: Fibrocystic Problems

1. Pubic area sore	1	2	3
2. Pain in ovaries	1	2	3
3. Vaginal bumps and sores	1	2	3
4. Breasts sore to touch	1	2	3
5. Breasts painful	1	2	3
6. Premenstrual breast pain or discomfort	1	2	3
7. General water retention / swollen feeling	1	2	3
8. Recent PAP smear was abnormal	No		Yes
9. Ovarian cysts	No		Yes
10. Uterine cysts	No		Yes
11. Breast lumps	No		Yes
12. Family history of breast cancer	No		Yes
13. Birth control pills	No		Yes
How long? When?			
14. Mother used D.E.S while pregnant	No		Yes

Section E: Menopause

1. Hot flashes	1	2	3
2. Night sweats	1	2	3
3. Sweating throughout day	1	2	3
4. Depression / mood swings	1	2	3
5. Insomnia / can't get to sleep	1	2	3
6. Waking up in night (can't get back to sleep)	1	2	3
7. Heavy bleeding for longer than 10 days / mo.	1	2	3
8. Painful intercourse	1	2	3
9. Vaginal pain	1	2	3
10. Vaginal itching	1	2	3
11. Dryness of skin, hair, and vagina	1	2	3
12. Craving for sweets	1	2	3
13. Memory loss	1	2	3
14. Osteoporosis (bone loss)	No		Yes
15. Joint pain	1	2	3
16. Hysterectomy	No		Yes
17. Ovaries removed	No		Yes
18. Periods stopped	No		Yes
Last period was approx. when?			

PART XI: MUSCULOSKELETAL**Section A: Bone Integrity**

1. Eat meat	1	2	3
2. Drink carbonated beverages (# / week)	1-3	4-7	7+
3. Use antacids (# / week)	1-3	4-7	7+
4. Pain in fingers	1	2	3
5. Bones sore / painful	1	2	3
6. Arthritis	1	2	3
7. Joint or bone deformity	No		Yes
8. Calcium deposits	No		Yes
9. Cavities (many fillings)	No		Yes
10. Dentures	No		Yes
11. Gum disease	No		Yes
12. Bone loss (jaw, spine, hip)	No		Yes
13. Recent bone fracture	No		Yes
14. Told you have osteoporosis / osteomalacia	No		Yes
15. Hysterectomy	No		Yes
16. Ovaries removed	No		Yes
17. Post-menopausal. Last period	mos.	years	No Yes

Section B: Muscle

1. Muscle cramps	1	2	3
2. Muscle spasms	1	2	3

3. Tightness in neck & shoulders	1	2	3
4. Pain in neck and / or shoulders	1	2	3
5. Pain in arms, hands	1	2	3
6. Unable to sit straight	1	2	3
7. Back pain. Where?	1	2	3
8. Stiff all over	1	2	3
9. Stiff in morning	1	2	3
10. Leg cramps at night	1	2	3

Section C: Connective Tissue

1. Overflexible joints	1	2	3
2. Athletic injury	1	2	3
3. Injure easily	1	2	3
4. Swollen knees / elbows / other joints	1	2	3
5. Bursitis	1	2	3
6. Tendonitis	1	2	3
7. Joint pain. Where?	1	2	3
8. Back pain	1	2	3
9. Slipped disc	No		Yes
10. Herniated disc	No		Yes
11. Loss in height	No		Yes

PART XII: NEUROLOGICAL

1. Head feels heavy	1	2	3
2. Light headedness / fainting	1	2	3
3. Loss of balance	1	2	3
4. Dizziness	1	2	3
5. Ringing / buzzing in ears	1	2	3
6. Trembling hands	1	2	3
7. Loss of feeling in hands and / or feet	1	2	3
8. Exhaustion on slightest effort	1	2	3
9. Limbs feel too heavy to hold up	1	2	3

10. Loss of grip strength	1	2	3
11. Tingling pain sensation	1	2	3
12. Uncoordinated	1	2	3
13. Nervousness	1	2	3
14. Convulsions	No		Yes
15. Accident prone	No		Yes
16. Loss of muscle tone	No		Yes
17. Need for 10-12 hours of sleep	No		Yes
18. Have had shingles. When?		No	Yes

PART XIII: SLEEP PATTERNS

1. Can't fall asleep	1	2	3
2. Awake frequently throughout night	1	2	3
3. Wake in middle of night, can't fall Back to sleep	1	2	3
4. Restless, uneasy sleeper	1	2	3

5. Nightmares	1	2	3
6. Intense dreams	1	2	3
7. Sleep walk	No		Yes
8. Leg cramps / restless legs at night	1	2	3

FOR OFFICE USE ONLY

XIII	Sleep Patterns		9+	8	7	5	4	2	1																	
XII	Neurological		30+	29	28	27	26	25	24	23	22	21	20	19	18	17	16	14	12	10	8	6	4	3	2	1
XI	C. Connective Tissue		12+	11	10	9	8	6	5	4	2	1														
	B. Muscle		15+	14	13	12	11	10	9	7	6	5	4	2	1											
	A. Bone Integrity		15+	14	13	12	10	9	8	7	6	4	3	2	1											
X	E. Menopause		19+	18	17	16	15	14	13	12	11	9	8	7	6	5	4	3	2	1						
	D. Fibrocystic Problems		30+	29	28	27	26	25	24	23	22	21	20	19	18	17	16	14	13	12	10	8	6	4	2	
	C. Dysmenorrhea		30+	29	28	27	26	25	24	23	22	21	20	19	17	15	13	11	9	7	5	4	3	2	1	
	B. Amenorrhea		15+	14	13	12	11	10	8	7	6	4	3	2	1											
	A. PMS		25+	24	23	22	21	20	19	18	17	16	15	14	13	12	9	8	7	6	4	3	2	1		
IX	C. Genital Infection		9+	8	7	6	4	3	2	1																
	B. Reproduction		15+	14	13	12	11	10	9	7	6	5	4	2	1											
	A. Prostate		15+	14	13	12	11	10	9	7	6	5	4	2	1											
VIII	Urological		21+	22	21	20	19	18	17	16	15	14	13	12	11	10	8	7	6	5	4	2	1			
VII	Lungs		15+	14	13	12	11	10	8	7	6	5	4	2	1											
VI	B. Hyperglycemia		24+	23	22	21	20	19	18	17	16	15	14	13	11	10	9	8	7	5	4	3	2	1		
	A. Hypoglycemia		21+	20	19	18	17	16	15	14	13	11	10	9	8	7	5	4	3	2	1					
V	C. Hypertension		9+	8	7	5	4	2	1																	
	B. Circulation		15	14	13	12	10	9	8	6	5	4	3	2	1											
	A. Heart		15	14	13	12	10	9	8	6	5	4	3	2	1											
IV	C. Hyperimmune		45+	40	35	30	25	20	14	12	10	8	6	4	3	2	1									
	B. Hypoimmune		20+	19	18	17	16	15	14	13	11	10	9	8	7	5	4	3	2	1						
	A. Hypoadrenal		20+	19	18	17	16	15	14	13	11	10	9	8	7	5	4	3	2	1						
III	B. Thyroid		25+	24	23	22	21	20	19	18	17	16	15	14	13	12	11	10	8	7	6	4	3	2	1	
	A. Liver / gallbladder		18+	17	16	15	14	13	12	11	10	9	8	7	5	4	3	2	1							
II	D. Colon		15+	14	13	12	11	10	8	7	6	4	3	2	1											
	C. Hyperacidity		15+	14	13	12	11	10	8	7	6	4	3	2	1											
	B. Small Intestine		15+	14	13	12	11	10	8	7	6	4	3	2	1											
	A. Hypoacidity		15+	14	13	12	11	10	8	7	6	4	3	2	1											
		Score	High Priority										Moderate Priority					Low Priority								