

Functional Medicine Health Survey

Full Name _____ Date of Birth _____ Today's Date: _____

What symptom or condition concerns you the most? _____

Please write a diagnosis of the conditions you received (or major symptoms you experience)	When diagnosed (or started)

	None	Once or Twice a Week	Everyday		None	Once or Twice a Week	Everyday
Alcohol or wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fast food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fried food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Candy, desserts, refined sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Margarine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soda drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Milk products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Refined flour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chewing tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tap water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electronic cigarette/pipes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distilled water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you currently follow any of the following special diets or nutritional programs? (Check all that apply or skip if not)

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Low Fat |
| <input type="checkbox"/> Vegan | <input type="checkbox"/> Low Sodium |
| <input type="checkbox"/> Paleo | <input type="checkbox"/> No dairy |
| <input type="checkbox"/> Gluten-free or no-wheat | <input type="checkbox"/> Other: _____ |

Do you have sensitivities, allergies, or reactions to certain foods? ☐ No ☐ Yes
If yes, please explain which foods: _____

Genetic predisposition: Please list medical conditions within your family's health history

Father	Mother	Siblings

Current Medication/Supplements

Medication/Supplement	Dosage	Start Date (Month/Year)	Reason for Use

How often do you experience the following:

Possible Low Stomach HCL	None	Daily	Weekly	Monthly	Possible High Stomach HCL	None	Daily	Weekly	Monthly
Bloating , burping, or discomfort after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burning sensation immediately after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling particularly full after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GERD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn is worse when lying down at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to have vitamin B12 deficiency	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning sensation 30-40 mins after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting or nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Undigested food in your stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consume more than one caffeinated or alcoholic drink	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food allergies or intolerances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you smoking?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Experience chronic stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Possible Small Intestine Bacterial Overgrowth	None	Daily	Weekly	Monthly	Possible Candida	None	Daily	Weekly	Monthly
Abdominal pain/ discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brain fog	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal dissension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Digestion problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Craving sweets or carbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flatulence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal itching, dis charge, or soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain during intercourse (Females)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin disorders, such as psoriasis or skin patches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamin B12 deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching of the skin in the lower abdominal or bra line	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iron deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to old carpet (older than 3 years) or moist environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess folate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Possible Heavy Metals Exposure & Environmental Chemicals	None	Daily	Weekly	Monthly	Possible Heavy Metals Exposure & Environmental Chemicals	None	Daily	Weekly	Monthly
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability or anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic joint or muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression or mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic inflammation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
An autoimmune condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty to concentrate or "brain fog"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have old dental fillings or had them removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drink tap water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Live or work in an industrial environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work in construction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Eat fish or seafood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you live in a house that was built before 1978?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Use deodorants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	None	Daily	Weekly	Monthly
Use pesticides or herbicides (bug or weed killers; flea and tick sprays, collars, powders, or shampoos) in your home or garden, or on pets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use household air fresheners, laundry detergents, or other cleaning products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you smoking or have you smoked before for longer than a few months?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		

	None	Daily	Weekly	Monthly
Cook with aluminum baking plates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often are you near any high-powered electrical wires or transformers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often are you in a place that does not have proper ventilation or does not have an air filter?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often were you exposed to chemicals in the past (occupational, at home, or at work)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Possible Mold Exposure	None	Daily	Weekly	Monthly
Dark spots on surfaces	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
A musty, damp, or earthy smell	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Dark tile grout	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Living with current or previous water damage	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Warping, bubbling, cracking wall surface	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Sneezing or Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Postnasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory impairments or brain fog	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Possible Mold Exposure	None	Daily	Weekly	Monthly
Weak voice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red or watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing or Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood disorders (depression, anger)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lightheadedness or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coordination problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergic reaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atopic dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Possible Deficiency of Nutrients	None	Daily	Weekly	Monthly
Irritability or depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite and weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cracked or sore lips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impaired immune function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A decline in your mental abilities, such as memory or concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Possible Deficiency of Nutrients	None	Daily	Weekly	Monthly
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impotence or loss of sexual function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle spasms or cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to feel depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower calcium levels in the blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type 2 Diabetes or pre-diabetic	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Loss of bone mass: Osteopenia or osteoporosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
A sensation of numbness, tingling, or pins and needles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Possible Secondary Mitochondrial Dysfunction	None	Daily	Weekly	Monthly
Fatigue during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic joint pain and inflammation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological conditions, such as Alzheimer's, dementia, Huntington's, or Parkinson's	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Neurobehavioral and psychiatric diseases such as autism, schizophrenia, or bipolar	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Depression and mood disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Type 2 Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Nerve pain (also called neuropathy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Takes time to recover from physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
An autoimmune condition such as Lupus, Rheumatoid Arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Multiple sclerosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Memory problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer diagnosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Heart or kidney disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes		

Possible Low Testosterone	None	Daily	Weekly	Monthly
Reduced libido (sex drive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of body hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity or significant weight gain	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Loss of muscle mass	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Men: Erectile dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decrease in bone mass	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Mood changes or depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory decline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Possible High Estrogen	None	Daily	Weekly	Monthly
Swelling and tenderness in your breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased or loss sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased symptoms of premenstrual syndrome (PMS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain (especially in the hips area)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal menstrual periods, bleeding too light or too heavy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular menstrual periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings, often presenting as depression or anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine fibroids or Fibrocystic breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Men: Enlarged breasts, sexual dysfunction, or infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Possible Adrenal Hypocortisolemia	None	Daily	Weekly	Monthly
Feel tired in the mornings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower back soreness or pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back pain increases if you are tired or standing for a long period of time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tend to be a night person	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Feel tired or tend to yawn in the afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Possible Low Thyroid or Thyroid Hormone Imbalance	None	Daily	Weekly	Monthly
Feeling cold when other people do not, or cold fingers and toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation or less than one bowel movement per day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain, even though you are not eating more food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Possible Adrenal Hypocortisolism	None	Daily	Weekly	Monthly	Possible Low Thyroid or Thyroid Hormone Imbalance	None	Daily	Weekly	Monthly
Feel dizziness when standing up quickly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty to lose weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath or asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint or muscle soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crave salty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling sad or depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain or arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grind or clench your teeth at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Morning headaches that reduce during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had or have allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Pale, dry skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel anxious or stressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry or loss of hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had or have a stressful/abusive relationship	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Less sweating than others or usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dark circles under your eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low motivation or "brain fog"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Puffiness under your eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Puffy face or excess fluids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep in and have difficulty getting out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A hoarse voice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired all the time	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Brittle nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work or used to work night shifts	<input type="checkbox"/> No	<input type="checkbox"/> Yes			More than usual menstrual bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consumed steroids (e.g. prednisone) for over a month	<input type="checkbox"/> No	<input type="checkbox"/> Yes			A decline in memory or "slower thinking"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms reduced with prescription of steroids	<input type="checkbox"/> No	<input type="checkbox"/> Yes							
Pain reduced with cortisol injection	<input type="checkbox"/> No	<input type="checkbox"/> Yes							
Possible High Thyroid or Thyroid Hormone Imbalance	None	Daily	Weekly	Monthly	Possible Pituitary Dysfunction	None	Daily	Weekly	Monthly
Difficulty in gaining weight, even with a large consumption of food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increased libido				
Feeling nervous, emotional, or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decreased libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Faster pulse at rest or heart palpitation (feeling your heartbeat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intolerance to high temperatures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory decline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Needs to eat sugar, sweets, or carbs to feel good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbance or insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes in vision, sensitivity to light, eye irritation, or dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive sweating and oily skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue, muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor growth or delayed sexual development (short height)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin thinning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inability to produce breast milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to sweat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Severe headache or stiff neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Possible (Low) Serotonin Imbalance	None	Daily	Weekly	Monthly
Do you have a tendency to be negative?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Are you often worried and anxious?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Are you a perfectionist or behave in an obsessive-compulsive way?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you have winter or seasonal depression?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you tend to be shy or have social phobias?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you have eating disorders?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you feel overwhelmed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you crave carbs or chocolate often?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Are you using artificial sweeteners often?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you have difficulty sleeping that is relieved by melatonin supplements?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		

Possible Low Endorphin	None	Daily	Weekly	Monthly
Do you tend towards addicting behaviors (such as alcohol, video games, pornography, or gambling)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you experience anxiety or depression?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you have low self-esteem?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you tend to avoid painful or stressful conversations?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Have you been suffering from chronic pain (over 3 months)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you crave chocolate, bread or sweets, wine, or marijuana?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble sleeping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Fibromyalgia?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Chronic Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Possible (Low) Norepinephrine	None	Daily	Weekly	Monthly
Feel depressed, "flat," or bored	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low motivation or enthusiasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low ability or difficulty to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attracted to take adventures or dangerous activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Possible Low GABA	None	Daily	Weekly	Monthly
Feel overworked or stressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Find it hard to relax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Find it hard to let go of thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get easily upset or frustrated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel overwhelmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Need alcohol or drugs to relax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Possible (Low) Dopamine Imbalance	None	Daily	Weekly	Monthly
Experience lethargy and lack of enjoyment of life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendency of addicting behavior, such as drugs, alcohol, pornography, video games, binge eating, or gambling	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Attention disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes		

Possible (Low) Dopamine Imbalance	None	Daily	Weekly	Monthly
Do you eat small amounts of protein?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Are you taking supplements of 5-HTP or L-Tyrosine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Are you taking supplement of magnolia bark (Magnolia officinalis) or licorice root (Glycyrrhiza glabra)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		

Possible (Low) Dopamine Imbalance

None	Daily	Weekly	Monthly
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Lack of motivation, apathetic, hopeless, or joyless

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Is it hard to start things and even harder to finish them?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Tendency to be deficient in vitamin D

<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Consume sugar, sweets, or soda drinks

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Possible (Low) Dopamine Imbalance

None	Daily	Weekly	Monthly
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Do you experience tremors of the arm or have Parkinson's disease?

<input type="checkbox"/> No	<input type="checkbox"/> Yes		
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Are you under stress?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Are you talking on your mobile phone frequently or for long hours?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Do you have fibromyalgia and chronic fatigue syndrome?

<input type="checkbox"/> No	<input type="checkbox"/> Yes
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