Lifestyle Analysis—What Is Your Health Profile?

Name: Date:

Step 1: List your most pressing health concerns.

1. 3.
2. 4.

Step 2: Take the Lifestyle Analysis.

Check all the boxes across a row at right if a statement applies to you. For example, if you lack energy, you would check boxes 1, 3, 4, 5 and 8 across the first row.

Step 3: Tally the analysis results.

After you've completed the analysis, add up the total number of checks in vertical columns 1–9. Enter the column totals in the empty boxes at the bottom of the page. To determine your system profile, refer to the chart following the analysis.

Lifestyle Analysis

	1	2	3	4	5	6	7	8	9
Lack of energy	☐		☐	☐	☐			☐	
Illness more than twice a year					☐				
Body odor and/or bad breath	☐	☐				☐	☐		
Difficulty digesting certain foods	☐				☐				
Eat meat more than 3 times a week		☐	☐			☐			
Monthly female concerns		☐					☐	☐	
Recent or frequent use of antibiotics		☐			☐				
Regular consumption of alcohol				☐				☐	
Frequent mood swings				☐				☐	
Food allergies	☐				☐	☐			
Bags under eyes			☐	☐			☐		
Smoking			☐	☐		☐			
Poor concentration or memory			☐	☐				☐	
Poor resistance to disease	☐				☐				
Belching or gas after meals	☐				☐				
Stressful lifestyle			☐	☐	☐			☐	
Skin/complexion problems	☐	☐					☐	☐	☐
Cravings for sweets, salt or junk foods				☐				☐	
Regular consumption of dairy products		☐				☐			
Feeling low, uninterested or depressed		☐		☐					
Too little sleep or restless sleep				☐				☐	
Menopausal concerns				☐				☐	☐
Frequent urination or urinary concerns							☐		
Hair loss			☐	☐				☐	☐
Sore or painful joints			☐		☐				☐
Difficulty in maintaining ideal weight				☐	☐			☐	☐
Low endurance/stamina			☐			☐			☐
Lack of a balanced diet	☐	☐						☐	
Slow recovery from illness		☐	☐		☐			☐	
Less than 2 bowel movements per day	☐	☐		☐					
Lack of appetite	☐			☐				☐	
Low sex drive								☐	
Brittle or easily broken fingernails	☐								☐
Dry, damaged or dull hair	☐						☐		
High-fat diet	☐	☐	☐						
Unsettled, apprehensive, pressured				☐				☐	
Low-fiber diet		☐	☐						
Muscle cramps or spasms				☐					☐
Exposure to air pollution daily					☐	☐			
Caffeinated beverage (16 oz.) daily				☐				☐	☐
Feeling out of control				☐	☐				☐
Food/chemical sensitivities	☐	☐			☐				
Recurrent yeast/fungal infections	☐	☐			☐				
Weak bones, teeth or cartilage	☐						☐		☐
Suffer from anxiety or worry	☐			☐					
Easily irritated or angered		☐		☐				☐	
Don't exercise regularly		☐		☐				☐	☐
Respiratory, sinus or allergy problems		☐				☐			
TOTALS									