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Reflect on your goals and observe where your body is now. I recommend to revisit this once a quarter.
Please email the results.
We will review during our course.

GOALS	
Describe your feelings around your Health Goals:	
Describe your feelings around your Fat Loss Goals:	
Describe your feelings around your Exercise Goals:	
What is your biggest struggle with your relationship with food and your body? Is it from your past or more current?	

GETTING TO KNOW YOU

What do you desire & value? Describe your perfect day and how you feel during this day(Place, people, food, activity, creativity, work, etc.); Response:
What motivates you to become the healthiest version of you? Response:
What is the biggest stress in your life? Response:
Do you stress eat? If so, what do you choose and crave when you are emotionally eating? Response:
What is your current relationship with food? (Example: Do food and diets consume your day, or do you never plan out what you eat?) Response:
What is your past relationship with food? (Example: Fad diets, emotional eating, etc.) Response:
Are you an “all or nothing” personality type, or do you adapt to change slowly? Response:
How easy is it for you to make lifestyle changes? Response:
What is your highest energy time of day? Response:
What is your lowest energy time of day? What has worked for you in the past to uplift your energy? Response:
What Vitamins & Supplements are you currently taking? How do you feel from your current supplement protocol? Response:
What Medications are you currently taking? Are you willing and able to reduce these in your future? Response:

HEALTH PROFILE

- **Check all that apply and rate on a scale of 0-5 (0 is least applicable, 5 is most applicable)**
- **Please also note if onset of symptom is recent (6 months to one year) or past (rest of your life)**

Track this prior to your 6-week process. We will revisit at the end of the process and we recommend to check back in with your body every 3 months (quarter).

Nervous System/Brain Chemistry/Fatty Acid Deficiency			
Symptoms	X	Scale Rating (0-5)	Recent or Past?
Poor memory			
Difficulty with attention/focus			
Difficulty getting to sleep			
Headaches			
Migraines			
Difficult staying asleep			
Depression			
Mood swings			
Dry, flaky skin			
Crave sugar			
Crave caffeine			
Crave salt			
Crave coffee			
Crave chocolate			
Total:			

Sensory System/Inflammation/Dairy or Gluten Allergy			
Symptoms	X	Scale Rating (0-5)	Recent or Past?

Chest Congestion			
Asthma, Bronchitis			
Allergies			
Sinus Problems			
Excessive mucus in the morning			
Swollen, reddened or sticky eye-lids			
Bags or dark circles under eyes			
Total:			

Skin/Liver/Congestion			
Symptoms	X	Scale Rating (0-5)	Recent or Past?
Acne			
Hives or rashes			
Flushing, hot flashes, excessive sweating			
Hair loss			
Yellow in whites of eyes			
Cellulite			
Dry skin on back of upper arms (malabsorption of nutrients)			
Total:			

Cardiovascular System/Blood/Triglyceride: HDL ratio			
Symptoms	X	Scale Rating (0-5)	Recent or Past?
Irregular or skipped heartbeat			
Rapid or pounding heartbeat			

High blood pressure			
Anemia			
Metabolic Syndrome (weight around abdomen)			
Diabetes			
Total:			

Digestive Tract/Bowel Cleansing			
Symptoms	X	Scale Rating (0-5)	Recent or Past?
Nausea			
Vomiting			
Diarrhea			
Constipation			
Bloated feeling			
Heartburn			
Belching			
Passing gas			
Gall Bladder Surgery/attacks			
Irritable Bowel Syndrome			
Celiac Disease			
Gluten Allergy			
Total:			
Please list any other food allergies:			
Bowel Movements Description – Color/Form: Times per day:			

Locomotor/Inflammation/Wheat allergy			
Symptoms	X	Scale Rating (0-5)	Recent or Past?
Pain or aches in joints			
Arthritis			
Fatigue & sluggishness			
Hyperactivity			
Restlessness			
Stiffness or limitation of move-ment			
Total:			
If yes to stiffness or limitation of movement, please describe where and how much:			

Immune System			
Symptoms	X	Scale Rating (0-5)	Recent or Past?
High Stress career and life			
Frequent illness			
Low energy			
Frequent infections (bacteria, yeast viruses)			
Dehydration			
Lack of exercise			
Swollen lymph nodes			
Unusually cold			
Unusually hot			
Thyroid Health			
Cancer			

Reproductive System			
Symptoms	X	Scale Rating (0-5)	Recent or Past?
Urinary Tract Infections			
Bladder infections			
Kidney Stones			
Incontinence			
Libido problems			
Emotional Stress			
MEN			
Prostate health (PSA Level)			
WOMEN			
PMS			
Ovarian cysts			
Heavy Periods			
Menopause			
	Total:		

Which category was the highest?

Here are some general suggestions from each category. Remember this isn't about "fixing" yourself. It is about increasing awareness of how your emotional and physical body respond to each other. We will review this during our course!

Nervous System: Try adding in Magnesium especially at night before bed. Try Omega 3-fish oil/algae before bed.

Inflammation: Try adding in water with lemon throughout the day.

Liver: Try adding in fermented veggies as a snack in the mid-day

Cardiovascular: Try adding in more fresh herbs and spices.

Digestion: Try adding in Digestive enzymes during the day.

Locomotor: Try adding in Wobenzyme supplement for aches and pains.

Immune System: Try extra vitamin C in the mid day

Reproductive System: Try Tulsi tea throughout the day.