HealthWatcher Analysis®

Date: ____________

First: ____________ Last: ____________ Age: ______ Birthdate: ____________ Ht: ______ Wt: ______

E-mail: ____________________ Desired Weight: ______ Marital: (M) (W) (D) (S)

Address: ____________________ Hm Phn: ____________ Cell Phn: ____________

Occupation: ____________ Print your regularly used signature: ____________ Surgeries (what/when) ____________

Main distressing symptom: ____________________ Worst Time Of Day: ____________

Group One:

Check ALL medications you use *regularly:*

- ( ) Antacids
- ( ) Antibiotics
- ( ) Antifungals
- ( ) Antidepressants
- ( ) Anti-diabetic/Insulin
- ( ) Aspirin/Tylenol
- ( ) Chemotherapy
- ( ) Cortisone/Anti-inflammatory
- ( ) Heart medications
- ( ) High blood pressure
- ( ) Hormones
- ( ) Laxatives
- ( ) Lithium
- ( ) Oral contraceptives
- ( ) Radiation
- ( ) Recreational drugs
- ( ) Relaxants/Sleeping pills
- ( ) Thyroid
- ( ) Ulcer medications
- ( ) Other: ____________________

Check if you consume:

- ( ) Alcohol
- ( ) Candy
- ( ) Carbonated beverages
- ( ) Cigarettes
- ( ) Coffee
- ( ) Distilled water
- ( ) Fast foods often
- ( ) Fried foods
- ( ) Luncheon meats
- ( ) Margarine
- ( ) Artificial Sweetener
- ( ) Refined sugars
- ( ) Quit Smoking? When? ____________
- ( ) Vitamins and/or minerals (list: ____________________

Check if you:

- ( ) Diet often
- ( ) Do not exercise regularly
- ( ) Regularly eat salted food
- ( ) Experience excessive stress
- ( ) Regularly exposed to chemicals
- ( ) Often exposed to cigarette smoke

Circle the number (0-1-2-3) which best describes the intensity of your symptoms. Leave all unknowns blank.

0 = No symptoms 1 = Mild 2 = Moderate 3 = Severe

"Yes" answers = 1-2-3 depending on column it's in (unless value otherwise indicated); "No" answers always = 0.

Place totals for each section on the *Section Total row on bottom of graph on page 6.

Group 2:

Section 2-A:

1.	Bloating	0	1	2	3
2.	Burping	0	1	2	3
3.	Constipation	0	1	2	3
4.	Extended fullness after meals	0	1	2	3
5.	Food allergies	0	1	2	3
6.	Poor appetite	0	1	2	3
7.	Stomach upsets	0	1	2	3

TOTAL Section 2-A: ________

Section 2-B:

1.	Abdominal cramps	0	1	2	3
2.	Acne	0	1	2	3
3.	Alternating constipation/diarrhea	0	1	2	3
4.	Diarrhea	0	1	2	3
5.	Difficulty gaining weight	0	1	2	3
6.	Dry, flaky skin and/or dry brittle hair	0	1	2	3
7.	Fatigue after eating	0	1	2	3
8.	Fiber causes constipation	0	1	2	3
9.	Food allergies	0	1	2	3
10.	Foul smelling stool	0	1	2	3
11.	Indigestion 1-3 hours after eating	0	1	2	3
12.	Lower bowel gas	0	1	2	3
13.	Mucous in stools	0	1	2	3
14.	Pain in left side under rib cage	0	1	2	3
15.	Poorly formed stools	0	1	2	3
16.	Shiny stool	0	1	2	3
17.	Three+ large bowel movements daily	0	1	2	3

TOTAL Section 2-B: ________

Do it yourself! Pages 6-10 contain a simple, fast Self-Evaluation form!

Biological Immunity Research Institute
POB 31322
Scottsdale, AZ 85046
888-221-4116 • 530-463-8744 (fax)
DrMartin@biri.org

If you prefer to have us calculate the results, email or fax this to us.

Section 2-C:

1.	Antacids dependency	0 1 2 3
2.	Black stool when not taking iron supplements	No Yes (10)
3.	Butterfly stomach sensations	0 1 2 3
4.	Chronic abdominal pain	0 1 2 3
5.	Cream/milk relieves stomach pain	No Yes (10)
6.	Current ulcer	No Yes (10)
7.	Difficulty belching	0 1 2 3
8.	Carbonated beverages cause relief of symptoms	No Yes
9.	Stomach pains when emotionally upset	0 1 2 3
10.	Stomach pains	0 1 2 3
11.	Stomach pains just before and/or after meals	0 1 2 3
12.	Sudden, acute indigestion	0 1 2 3
13.	Ulcers or gastritis history	No Yes

TOTAL Section 2-C: ________

Section 2-D:

1.	Abdominal cramps	0 1 2 3
2.	Alternating diarrhea/constipation	0 1 2 3
3.	Antibiotic use	No Yes
4.	Bladder or kidney infections	0 1 2 3
5.	Constipation	0 1 2 3
6.	Frequent infections (colds)	0 1 2 3
7.	Meat-eater	No Yes
8.	Rapidly failing vision	No Yes
9.	Seasonal diarrhea	0 1 2 3
10.	Toe or fingernail fungus	0 1 2 3
11.	Vaginal yeast infection	0 1 2 3

TOTAL Section 2-D ________

Group 3:

Section 3-E

1.	Bad breath	0 1 2 3
2.	Big toe painful	0 1 2 3
3.	Body odor	0 1 2 3
4.	Cholesterol level above 200	No Unk Yes
5.	Constipation	0 1 2 3
6.	Dry skin/hair	0 1 2 3
7.	Fatigue after eating	0 1 2 3
8.	Foul-smelling stool	0 1 2 3
9.	Gray-colored stools	0 1 2 3
10.	Greasy foods intolerance	0 1 2 3
11.	Hard stool	0 1 2 3
12.	Headaches after eating	0 1 2 3
13.	High blood cholesterol and low HDL cholesterol	No Unk Y (10)
14.	Jaundice or hepatitis	No Yes
15.	Less than one bowel movement daily	0 1 2 3
16.	Light-colored stool	0 1 2 3
17.	Pain in right side under rib cage	0 1 2 3
18.	Pain radiates along outside of leg	0 1 2 3
19.	Painful to pass stool	0 1 2 3
20.	Red blood in stool	No Yes (6)
21.	Retain water	0 1 2 3
22.	Sour taste in mouth	0 1 2 3
23.	Triglyceride level above 115	No Unk Yes
24.	Yellow in whites of eyes	0 1 2 3

TOTAL Section 3-E ________

Section 3-F

1.	Anemia unaffected by iron	No Yes
2.	Axillary (armpit) temperature below 97.6° F	No Unk Yes
3.	Chronic fatigue	0 1 2 3
4.	Cold hands and feet	0 1 2 3
5.	Constipation	0 1 2 3
6.	Depressed, apathetic	0 1 2 3
7.	Dry skin	0 1 2 3
8.	Excessive menstrual bleeding	0 1 2 3
9.	Gain weight easily	No Yes
10.	Infertility	No Yes
11.	Low sex drive	0 1 2 3
12.	Premenstrual tension (PMS)	0 1 2 3
13.	Puffy, wrinkled skin	0 1 2 3
14.	Sensitive to the cold	0 1 2 3
15.	Slow reflexes	No Yes
16.	Strong smelling urine	0 1 2 3
17.	Sugar causes irritability/mood swings	0 1 2 3
18.	Swollen eyes (bulging)	0 1 2 3
19.	Thick skin and fingernails	0 1 2 3
20.	Thinning or loss of outside portion of eyebrow	No Yes
21.	Trouble waking up	0 1 2 3

TOTAL Section 3-F ________

Group 4:

Section 4-G

1.	Cannot tolerate much exercise	0 1 2 3
2.	Catch colds easily when weather changes	0 1 2 3
3.	Dark circles under the eyes	0 1 2 3
4.	Depression or rapid mood swings	0 1 2 3
5.	Difficulty breathing	0 1 2 3
6.	Dizziness upon standing	0 1 2 3
7.	Eyes sensitive to bright light	0 1 2 3
8.	Feel weak and shaky	0 1 2 3
9.	Headaches	0 1 2 3
10.	Lack of mental alertness	0 1 2 3
11.	Periodic constipation	0 1 2 3
12.	Sensitive to exhaust fumes, smoke, smog	0 1 2 3
13.	Water retention	0 1 2 3

TOTAL Section 4-G ________

Section 4-H

1.	Bumpy skin on back of arms	0 1 2 3
2.	Catch colds or flu easily	0 1 2 3
3.	Cold sores/fever blisters	0 1 2 3
4.	Ear infection	0 1 2 3
5.	Get boils or sties	0 1 2 3
6.	Hair falls out	0 1 2 3
7.	Hair grows slowly	0 1 2 3
8.	Inflamed or bleeding gums	0 1 2 3
9.	Loss of smell	0 1 2 3
10.	Loss of taste	0 1 2 3
11.	Nose bleeds	0 1 2 3
12.	Poor wound healing	0 1 2 3

No.	Symptom				
13.	Running nose	0	1	2	3
14.	Slow to recover from cold or flu	0	1	2	3
15.	Swollen lymph glands	0	1	2	3
16.	Throat infections	0	1	2	3

TOTAL 4-H ________

Section 4-I

No.	Symptom				
1.	Alternating constipation /diarrhea	0	1	2	3
2.	Bedwetting	No	Yes (5)		
3.	Breathe through mouth	0	1	2	3
4.	Certain foods make you sick, depressed, jittery	0	1	2	3
5.	Chronic lung congestion	0	1	2	3
6.	Chronic pain	0	1	2	3
7.	Difficulty swallowing	0	1	2	3
8.	Discharge from eyes	0	1	2	3
9.	Ear discharge or ears stuffed up	0	1	2	3
10.	Entire body aches, painful to touch	0	1	2	3
11.	Food sensitivity or allergy	0	1	2	3
12.	Hyperactivity	0	1	2	3
13.	Itching of nose or eyes	0	1	2	3(5)
14.	Itching of roof of mouth or throat	0	1	2	3(5)
15.	Migraine headaches	No	Yes (10)		
16.	Mucous in throat	0	1	2	3
17.	Nasal congestion	0	1	2	3
18.	Painful stomach and/or intestine	0	1	2	3
19.	Post-nasal drip	0	1	2	3
20.	Puffiness or dark circles under eyes	0	1	2	3
21.	Running nose	0	1	2	3
22.	Skin rashes	0	1	2	3
23.	Sneezing	0	1	2	3
24.	Swollen joints	0	1	2	3
25.	Swollen tongue	0	1	2	3
26.	Use aspirin, Tylenol regularly	No	Yes		
27.	Watery eyes	0	1	2	3
28.	Wheezing	0	1	2	3

TOTAL 4-I ________

Group 5:

Section 5-J

No.	Symptom				
1.	Calf muscles cramp while walking	0	1	2	3
2.	Chest pain while walking	0	1	2	3
3.	Difficulty breathing at night	0	1	2	3
4.	Do you do aerobic exercise?	Yes	No		
5.	Drink 5 or more cups of coffee daily	No	Yes		
6.	Exhaust with minor exertion	0	1	2	3
7.	Feel jittery	0	1	2	3
8.	Has a doctor ever told you that you have heart trouble?	No	Yes		
9.	Have you ever exercised regularly?	Yes	No		
10.	Heart misses or has extra beats	0	1	2	3
11.	Heart pounds easily	0	1	2	3
12.	Heartburn after eating	0	1	2	3
13.	Heaviness in legs	0	1	2	3
14.	Pain in left arm	0	1	2	3
15.	Rapid beating heart	0	1	2	3
16.	Severe cough	No	Yes		
17.	Swelling of feet and ankles	0	1	2	3

TOTAL Section 5-J ________

Section 5-K

No.	Symptom				
1.	Calf muscles cramp while walking	0	1	2	3
2.	Cold hands and feet	0	1	2	3
3.	Ear canal hair	No	Yes		
4.	Headaches	0	1	2	3
5.	Numbness in extremities	0	1	2	3
6.	Poor concentration	0	1	2	3
7.	Ringing in ears	0	1	2	3
8.	Slurred speech	0	1	2	3
9.	Tingling /burning in hands or feet	No	Yes		
10.	Spider veins on nose and/or face	No	Yes		

TOTAL Section 5-K ________

Section 5-L

No.	Symptom				
1.	Calf muscles cramp while walking	0	1	2	3
2.	Dizziness	0	1	2	3
3.	High blood pressure	No	Yes (10)		
4.	Pain in back of head and neck when getting up	0	1	2	3
5.	Vertigo	0	1	2	3

TOTAL Section 5-L ________

Group 6:

Section 6-M

No.	Symptom				
1.	Calmer after eating	No	Yes		
2.	Crave sweets	0	1	2	3
3.	Feel faint	0	1	2	3
4.	Feel shaky or jittery	0	1	2	3
5.	Feel tired 1-3 hours after eating	0	1	2	3
6.	Feel tired or weak if a meal is missed	0	1	2	3
7.	Forgetful	0	1	2	3
8.	Headaches relieved by eating sweets or alcohol	0	1	2	3
9.	Heart palpitations after eating sweets	0	1	2	3
10.	Impatient, moody, nervous	0	1	2	3
11.	Irritable if a meal is missed	0	1	2	3
12.	Need to drink coffee to get started	0	1	2	3
13.	Poor concentration	0	1	2	3
14.	Poor memory	0	1	2	3
15.	Sudden dizziness when standing	0	1	2	3
16.	Sudden loss of vision when standing	0	1	2	3
17.	Wake up in middle of night craving sweets	0	1	2	3

TOTAL Section 6-M ________

Section 6-N

No.	Symptom				
1.	Boils and leg sores	0	1	2	3
2.	Crave sweets, but eating sweets does not relieve symptoms	0	1	2	3
3.	Failing eyesight	0	1	2	3
4.	Family history of diabetes	0	1	2	3
5.	Fatigue	0	1	2	3
6.	Feel pick up from exercise	0	1	2	3
7.	Increased thirst	0	1	2	3
8.	Lesions, cuts takes a long time to heal	0	1	2	3
9.	Lowered resistance to infection	0	1	2	3
10.	Night sweats	0	1	2	3
11.	Overweight	0	1	2	3
12.	Sugar in urine	No	Yes		

TOTAL Section 6-N ________

Group 7:

	Symptom	Rating
1.	Bronchitis	No Yes (10)
2.	Chest pain	0 1 2 3
3.	Chronic cough	0 1 2 3
4.	Coughing up blood	0 1 2 3
5.	Coughing up phlegm	0 1 2 3
6.	Difficulty breathing	0 1 2 3
7.	Exposed to chemicals and radiation	No Yes (6)
8.	Infections settle in lungs	0 1 2 3
9.	Live or work around people who smoke	0 1 2 3
10.	Pain around ribs	0 1 2 3
11.	Rattling mucous when you breathe	0 1 2 3
12.	Sensitive to smog	0 1 2 3
13.	Shortness of breath	0 1 2 3
14.	Smoker	No Yes (6)

TOTAL Section 7 ________

Group 8:

	Symptom	Rating
1.	Back or leg pains associated with dripping after urination	0 1 2 3
2.	Back pain in the kidney area	0 1 2 3
3.	Can't hold urine	0 1 2 3
4.	Cloudy urine	0 1 2 3
5.	Difficulty passing urine	0 1 2 3
6.	Dripping after urination	0 1 2 3
7.	Frequent bladder infections	0 1 2 3
8.	Frequent urination	0 1 2 3
9.	General water retention	0 1 2 3
10.	Have used antibiotics to control urinary tract infections	No Yes
11.	History of kidney/bladder infections	No Yes
12.	Painful/burning when passing urine	0 1 2 3
13.	Rarely need to urinate	0 1 2 3
14.	Rose-colored (bloody) urine	0 1 2 3
15.	Strong-smelling urine	0 1 2 3
16.	Urination when you cough or sneeze	0 1 2 3

TOTAL Section 8 ________

Group 9 (Males Only):

Section 9-O

	Symptom	Rating
1.	A sense of bladder fullness	0 1 2 3
2.	Difficulty urinating	0 1 2 3
3.	Dripping after urination	0 1 2 3
4.	Ejaculation causes pain	0 1 2 3
5.	Increased straining with smaller and smaller amounts of urine passed	0 1 2 3
6.	Lack of sex drive	0 1 2 3
7.	Pain or burning while urinating	0 1 2 3
8.	Pain or fatigue in the legs or back	0 1 2 3
9.	Rose-colored (bloody) urine	0 1 2 3
10.	Wake up to urinate at night	0 1 2 3

TOTAL Section 9-O ________

Section 9-P

	Symptom	Rating
1.	Difficulty attaining and/or maintaining an erection	0 1 2 3
2.	Infertile	No Unk Y (5)
3.	Low sexual drive	0 1 2 3
4.	Low sperm count	No Unk Y (5)
5.	Pain/coldness in genital area	0 1 2 3
6.	Premature ejaculation	0 1 2 3
7.	Varicose veins on scrotum	No Unk Yes

TOTAL Section 9-P ________

Section 9-Q

	Symptom	Rating
1.	Discharge from penis	0 1 2 3
2.	Past or present rash on penis	0 1 2 3
3.	Swelling in groin	0 1 2 3
4.	Swollen genitals	0 1 2 3
5.	Venereal disease (gonorrhea, syphilis, herpes or other)	No Yes (9)
	Have VD now?	No Yes
	Had in past?	No Yes

TOTAL Section 9-Q ________

Group 10 (Females Only):

Section 10-R (Circle if you experience any symptoms in this section around ovulation (2 weeks+– before period).

	Symptom	Rating
1.	Anger	0 1 2 3
2.	Anxiety	0 1 2 3
3.	Asthma attacks	No Yes (10)
4.	Bloating and swelling	0 1 2 3
5.	Depression	0 1 2 3
6.	Easily distracted	0 1 2 3
7.	Headaches	0 1 2 3
8.	Leg cramps and tenderness	0 1 2 3
9.	Low backache	0 1 2 3
10.	Monthly weight gain	0 1 2 3
11.	Moodiness/irritability	0 1 2 3
12.	Nausea and/or vomiting	0 1 2 3
13.	Suicidal feeling	No Yes (10)
14.	Tender breasts	0 1 2 3
15.	Other: ________	

TOTAL Section 10-R ________

Section 10-S

	Symptom	Rating
1.	Abortion(s) (How many?________)	No Yes
2.	Dislike for intercourse	0 1 2 3
3.	Low or no desire for sex	0 1 2 3
4.	Miscarriage(s) (How many?________)	No Yes
5.	Missed periods	No Yes
6.	Over 15 years of age and have not begun menstruation	No Yes
7.	Unable to get pregnant	No Unk Yes
8.	Vaginal discharge	0 1 2 3
9.	Vaginal itching	0 1 2 3

TOTAL 10-S ________

Section 10-T

	Symptom	Rating
1.	Abdominal bloating	0 1 2 3
2.	Anxiety about menstrual cycle	0 1 2 3
3.	Craving for sweets	0 1 2 3
4.	Diarrhea	0 1 2 3
5.	Dull ache radiating to low back or legs	0 1 2 3
6.	Have to lie down 1st 1-2 days of period	0 1 2 3
7.	Headaches	0 1 2 3
8.	Abnormal vaginal discharge	0 1 2 3
9.	Increased urinary frequency	0 1 2 3
10.	Insomnia	0 1 2 3
11.	Light scanty blood flow	0 1 2 3
12.	Low abdominal pain	0 1 2 3
13.	Menstrual pain	0 1 2 3
14.	Nausea and/or vomiting	0 1 2 3

15. Pain and cramps without blood flow — 0 1 2 3
16. Pain during period is progressively getting worse with time — 0 1 2 3
17. Pelvic soreness — 0 1 2 3

TOTAL Section 10-T ________

Section 10-U

1. Breast lumps — 0 1 2 3
2. Breasts painful — 0 1 2 3
3. Breasts sore to touch — No Yes (10)
4. Family history of breast cancer — No Yes
5. Form of birth control: ( ) None ( ) Pill ( ) IUD ( ) Sponge ( ) Diaphragm ( ) Foam Other:
6. Mother used DES while pregnant — No Yes
7. Ovarian cysts — No Yes (10)
8. Pain in ovaries — 0 1 2 3
9. Premenstrual breast pain/discomfort — 0 1 2 3
10. Pubic area sore — 0 1 2 3
11. Recent pap smear positive — No Yes (15)
12. Swollen feeling — 0 1 2 3
13. Uterine cysts — No Yes (10)
14. Vaginal bumps and sores — 0 1 2 3
15. Water retention — 0 1 2 3

TOTAL Section 10-U ________

Section 10-V

1. Craving for sweets — 0 1 2 3
2. Depression/mood swings — 0 1 2 3
3. Dryness of skin, hair, and vagina — 0 1 2 3
4. Heavy bleeding two weeks/month — 0 1 2 3
5. Hot flashes — 0 1 2 3
6. Hysterectomy — No Yes
7. Insomnia — 0 1 2 3
8. Night sweats — 0 1 2 3
9. Osteoporosis (bone loss) — No Unk Yes
10. Painful intercourse — 0 1 2 3
11. Sweating throughout day — 0 1 2 3
12. Vaginal itching — 0 1 2 3
13. Vaginal pain — 0 1 2 3

TOTAL Section 10-V ________

Group 11:

Section 11-W

1. Are you post-menopausal? — No Yes
2. Arthritis — 0 1 2 3
3. Bone deformity — No Yes
4. Bone loss — No Yes
5. Bones sore/painful — 0 1 2 3
6. Calcium deposits — No Yes
7. Cavities — 0 1 2 3
8. Dentures — No Yes
9. Drink carbonated beverages/soda — No Yes
   Ozs. consumed per week ________
10. Eat meat — 0 1 2 3
11. Gum disease — No Yes
12. Osteoporosis/Osteomalacia — No Yes (5)
13. Pain in fingers — 0 1 2 3
14. Recent bone fracture — No Yes
15. Use antacids # per week ______ — No Yes

TOTAL Section 11-W ________

Section 11-X

1. Back pain — 0 1 2 3
2. Leg cramps at night — 0 1 2 3
3. Muscle cramps — 0 1 2 3
4. Muscle spasms — 0 1 2 3
5. Pain in arms, hands — 0 1 2 3
6. Pain in neck and/or shoulders — 0 1 2 3
7. Stiff all over — 0 1 2 3
8. Stiff in morning — 0 1 2 3
9. Tightness in shoulder muscles — 0 1 2 3
10. Unable to sit straight — 0 1 2 3

TOTAL Section 11-X ________

Section 11-Y

1. Athletic injury — 0 1 2 3
2. Back pain — 0 1 2 3
3. Bursitis — 0 1 2 3
4. Herniated disc — No Yes (10)
5. Injure easily — No Yes
6. Joint pain — 0 1 2 3
7. Loss in height — No Yes
8. Over-flexible joints (double-jointed) — 0 1 2 3
9. Slipped disc — No Yes (5)
10. Swollen knees/elbows — 0 1 2 3
11. Tendonitis — 0 1 2 3

TOTAL Section 11-Y ________

Group 12:

1. Accident prone — No Yes
2. Convulsions — No Yes (10)
3. Dizziness — 0 1 2 3
4. Exhaustion on slightest effort — 0 1 2 3
5. Have had shingles — No Yes
6. Head feels heavy — 0 1 2 3
7. Lack of coordination — 0 1 2 3
8. Light-headedness/fainting — 0 1 2 3
9. Limbs feel too heavy — 0 1 2 3
10. Loss of balance — 0 1 2 3
11. Loss of feeling in hands and/or feet — 0 1 2 3
12. Loss of grip strength — 0 1 2 3
13. Loss of muscle tone — No Yes
14. Need for 10-12 hours sleep — No Yes
15. Nervousness — 0 1 2 3
16. Ringing/buzzing in ears — 0 1 2 3
17. Tingling pain sensation — 0 1 2 3
18. Trembling hands — 0 1 2 3

TOTAL Section 12 ________

Group 13:

1. Awake frequently through night — No Yes
2. Can't fall asleep — 0 1 2 3
3. Intense dreams — 0 1 2 3
4. Leg cramps/restless leg at night — 0 1 2 3
5. Nightmares — 0 1 2 3
6. Restless, uneasy sleeper — 0 1 2 3
7. Sleep walk — No Yes
8. Wake up in middle of night, can't fall back to sleep — No Yes

TOTAL Section 13 ________

Any other symptoms not covered? No Yes

____
____
____
____
____
____

Name: ______________________ Date: ____________

Group	Section	Range 3	Range 2	Range 1	Below Range 1	*Section Totals
Group 2 Digestion	A. Hypoacidity	15+, 13, 11	9	7, 5	3, 1	2-A
	B. Small Intestine	15+, 13, 11	9	7, 5	3, 1	2-B
	C. Hyperacidity	15+, 13, 11	9	7, 5	3, 1	2-C
	D. Colon	15+, 13, 11	9	7, 5	3, 1	2-D
Group 3 - Fat Metabolism	E. Liver/ Gallbladder	15+, 15, 12	9, 6, 5	4, 3	2, 1	3-E
	F. Thyroid	25+, 20, 18	12, 9	7, 5	3, 1	3-F
Group 4 Immune Function	G. Hypoadrenal	20+, 18, 15	12	9, 6	3, 1	4-G
	H. Hypoimmune	30+, 25, 20	15, 12	9, 6	3, 1	4-H
	I. Hyperimmune	45+, 35, 25	15	10, 5	3, 1	4-I
Group 5 Cardiovascular	J. Heart	15+, 13	11	9, 7	4, 1	5-J
	K. Circulation	15+, 13	11	9, 7	4, 1	5-K
	L. Hypertension	9+, 8, 7	6, 5	4, 3	2, 1	5-L
Group 6 Sugar Tolerance	M. Hypoglycemia	21+, 18, 15	12	9, 6	3, 1	6-M
	N. Hyperglycemia	24+, 21, 18	15, 12	9, 6	3, 1	6-N
Group 7 Lungs	Lungs	15+, 13, 11	9	6, 4	2, 1	7
8 - Urological	Urological	21+, 18, 15	12, 9	6, 3	2, 1	8
Group 9 Male	O. Prostate	15+, 12	9, 7	5, 3	2, 1	9-O
	P. Reproduction	15+, 12	9, 7	5, 3	2, 1	9-P
	Q. Genital Infection	9+, 7	5	4, 3	2, 1	9-Q
Group 10 Female	R. PMS	25+, 20, 15	11	8, 5	3, 1	10-R
	S. Amenorrhea	15+, 12	9	6, 3	2, 1	10-S
	T. Dysmenorrhea	30+, 27, 24, 21	18, 15, 12	9, 6	3, 1	10-T
	U. Fibrocystic Problems	30+, 25, 20	15	12, 9	6, 1	10-U
	V. Menopause	19+, 17, 15, 13	11, 9, 7	5	3, 1	10-V
Group 11 Musculoskeletal	W. Bone Integrity	15+, 13	11, 9	7, 5	3, 1	11-W
	X. Muscle	15+, 12	9, 7	5, 4	3, 1	11-X
	Y. Connective Tissue	12+, 9	7	5, 3	2, 1	11-Y
12	Neurological	30+, 25, 20	15	10, 5	3, 1	12
13	Sleep Patterns	9+, 8, 7	6, 5	4, 3	2	13

INSTRUCTIONS:

1. Transfer the total you got for each section (2-A, 2-B, 2-C, 2-D, etc. from pages 1-5) to ***Section Totals** bottom row of graph above.
2. Add the *Section Totals row to get your **Grand Total Score**: ________
3. Chart the number you wrote in each ***Section Total** in the appropriate place on the graph. For instance, if your result for Section 2-A is 10, put a dot between the "9" and "11" which appear in the 2-A column of the graph.
4. Connect with a dark line the dots you just charted from one section to the next.
5. Write down the Range (1, 2 or 3) for each Section Total on the **Product Consideration** pages following.