



Delgado Protocol Intake Form

with Nick Delgado, PhD, CHT Please fill out the following information. If you don't have data for certain questions, just skip it and move on, filling the form out as quickly and thoughtfully as possible. Completing or updating this questionnaire is important to *helping you achieve your health-related goals* and it will give you insight to your current health status. With this basic information we can continue to fine-tune your progress and adjust to your needs to give you the best possible care.

Please return this form by Fax (949) 666-5134; or Mail to Delgado Protocol 711 W 17th St , suite H-6, Costa Mesa, CA 92660. This questionnaire is reviewed before the in-person appointment, if you have any questions please call us at (866) 319-0566.

CLIENT INFORMATION

Name: _____ Male Female

Date _____ Age _____ Occupation _____

Address: _____

Phone Number: _____ Fax Number: _____

E-mail address: _____

Is your occupation stressful? Yes No Enjoyable? Yes No

Height _____ ft _____ in Weight (lbs) _____ Body Fat Percentage _____

Measurements (In Inches) Wrist _____ Upper Arm _____ Neck _____

Chest at nipple _____ Hips _____ Waist _____ Mid -Thigh _____ Calf _____

How did you learn of The Delgado Protocol?

Internet site _____ Friend/relative(name): _____ Radio _____

Magazine/paper _____ TV _____ Seminar _____

List your health goals (check all that apply):

- Increased energy ____
- Reduce body fat ____
- Improve sex ____
- Eliminate symptoms of specific health problems ____
- Weight & Fat reduction ____ Reduce how many pounds? ____
- Lean weight gain ____ How much gain? ____
- Tone, firm, tighten ____
- Longevity ____
- Sexual function ____
- Mobility, recover injury ____
- Mental function ____
- Increase energy, reduce fatigue ____
- Increase physical endurance ____
- Get in shape to prevent or reduce illness ____
- Improve Circulation ____
- Heart health ____
- Reduce cholesterol ____
- Blood Pressure ____
- Reduce diabetes ____
- Reduce arthritis ____
- Reduce risk cancer ____
- Improve immune system ____
- Stress reduction ____
- Alcohol / drug dependence ____
- Improve appearance ____
- Improve self ____ image/confidence ____
- Other _____

SUBSTANCES:

- Do you smoke? Yes ____ No ____
- Consume Alcohol? Yes ____ Occasional ____ Never ____
- Do you drink Coffee? Yes ____ No ____

- Add sugar/artificial Yes ____ No ____
- Add cream Yes ____ No ____

Please list all prescription medications (synthetic or over the counter) you use:

HORMONES, HERBS

List all supplements, vitamins, herbs and hormones that you are currently taking (you may copy labels and fax in with questionnaire):

Have you ever taken any supplements, vitamins, hormones, thermogenics or medication that has caused you discomfort or did not work? If so, please list:

WATER

What is the amount of water you drink each day in cups or liters? (Do not include coffee, soda, etc.) ___ cups or ___ liters

NUTRITION

What percentage of your diet is in pure, unheated, raw foods?

- ___ 0%
- ___ 10-25%(salad once day)
- ___ 50-90%
- ___ 25-50%(big salads, soup)

What is the percent or grams of fat that you consume each day?

- ___ 2 –20 grams/day(veggies, fruit, rice)
- ___ 20-80 g/day
- ___ 80+ (meat,cheese)

What is the percent or grams of simple(sugar, soda) and complex carbohydrates (veggies, fruit, brown rice) that you consume each day?

- ___ 0-20 g limited simple sugar
- ___ 20-100 excess sugar
- ___ 100-300 complex carb

Circle or check after if any of these foods are used 1 time a week, if more than two times a week, indicate the number of times consumed after the food:

Milk, whole___ non-fat milk___ cheese___ yogurt___ sour cream___ ice cream___ soy ice cream___ whole eggs___ egg whites___

Meats: beef___ pork___ chicken___ turkey___ fish___ liver___ hamburger___ pizza___ tacos___ bacon___ sausage___ hotdogs___ luncheon meats___

Oils___ olive oil___ vegetable oil___ Lard___ butter___ margarine___ mayo___ dressings___ peanut butter___ French fries___

- Sugar**__ sugar substitute__ cake__ pies__ cookies__ donuts__ pastries__
- Coffee**__ decaf__ tea__ herb tea__ fruit juice__
- Soda pops**__ diet soda__ protein whey drinks__ soy protein drink__ water__
- Alcohol**__ beer__ wine__ hard liqueur__
- Pasta**__ white bread__ processed cereal__
- Fruit, fresh**__ canned fruit__ dried fruit__ nuts__ seeds__ vegetable juice__
- Vegetables, fresh**__ canned veggies__ frozen veggies__ salads__ soups__ potatoes__ sweet potatoes__ beans__ burritos__
- Whole grain** cereal: cooked__ or cold__ puffed__ bran__
- Salt, sea**__ table salt__ salt substitute__

Which cuisine do you prefer, and how many times per week do you eat the following:

- American__
- Mexican__
- Italian__
- German__
- English__
- Chinese__
- Japanese__
- Thai__
- Other:__

Do you eat at restaurants? Yes No Frequency: 1 2 3 4 5 6 7 + per week.

DIET: *Please indicate diet programs that you have tried in the past:*

- ___ Atkins high fat, protein
- ___ Carb busters
- ___ Suzanne Sommers high fat, medium carb
- ___ Weight Watchers
- ___ Richard Simons
- ___ Ornish, Pritikin, McDougall
- ___ Barry Sears Zone diet
- ___ South Beach Diet
- ___ Vegetarian
- ___ Raw food Vegan
- ___ Macrobotic
- ___ Fit for Life Diamond
- ___ Ultimate Medical Research
- Other: _____

What did you like and dislike about them, and why did they fail to become a regular part of your lifestyle?

Are there situations, moods, or occasions that cause you to eat problem (unhealthy) foods or to eat or drink more than you should?

- ___ Stress
- ___ Past due bills, financial pressure
- ___ Relationship
- ___ Fear
- ___ Happy
- ___ Other

Please indicate any diet and foods your allergic to or “dislike” restrictions: (use a 1-5 scale)

- Vegetables, fruit (be specific) _____
- Dairy (list) _____
- Meat _____
- Carbs _____

DIETARY

Please list a **typical day's menu:**

Typical Breakfast

o Time:

Snack morning

o Time:

Typical Lunch

o Time:

Snack midday

o Time:

Typical Dinner

o Time:

Snack PM

o Time

Please list The “**Healthiest**” Meal Day menu:

Healthy Breakfast

o Time:

Snack morning

o Time:

Healthy Lunch

o Time:

Snack midday

o Time:

Healthy Dinner

o Time:

Snack PM

o Time

Please List the **Most Unhealthiest Day menu:**

Unhealthy Breakfast

- Time:
- Morning **snack**
- Time:

Unhealthy Lunch

- Time:
- Midday **snack**
- Time:

Unhealthy Dinner

- Time:
- PM **snack**
- Time

Exercise Training

If exercise is not part of your weekly routine, Please explain why and list or check any training restriction due to school ____, work ____, family ____, lack of motivation ____, lack of time ____, Don't enjoy it ____, Unsure of what to do ____, other _____

List any other sports or physical handicaps or pain restricted movements: _____

Do you use Weights? _____

- If so, how many body parts (chest, back, biceps, triceps, legs, shoulders, and abdominals) do you train each session?
- How many sets _____ per exercise? *i.e. number of times you perform a specific exercise*
- How many repetitions _____ per exercise? *i.e. The number of times you press the weight up.*
- How many times per week _____ or month _____ do you train?
- Do you intensify training with forced reps, pyramiding or negative reps? _____
- Do you use a training partner? _____

Do you do any kind of aerobic exercise, (please circle) walking, jogging, Stair stepping, bicycling, dance, other _____?

- How many times per Week _____ or month _____ do you do aerobic exercise?

How much time is each weight training gym session? 15 min 30 min 1 hr+

How much time is each aerobic exercise session? 15 min 30 min 1 hr + - 7 -

How long have you adhered to an exercise routine?

- __ 1-12 weeks
- __ 3 mos-6mos
- __ 6 mos- 1 year
- __ 1- 5 years
- __ over 5 years

Which type of equipment is available at your gym that you use?

- Free weights__
- Cables__
- Machines__
- Treadmill__
- Stair stepper__
- Other:_____

SLEEP

What time do you generally go to bed? _____

- Difficulty falling asleep? Yes__ No__
- What time do you generally wake up in the morning? _____
- Average number hours sleep?__
- Do you use an alarm clock? Yes__ No__
- Do you wake up during the night? Yes__ No__ if so how many times? _____
- Do you feel rested upon waking in the morning? No__ Yes__

Do you set aside time during the day for a nap, meditation, self hypnosis, quiet time or prayer? If so, what time of day _____ and how long? _____

DIGESTION AND ELIMINATION

What is the frequency of your bowel movements?

- Times per day_____
- Times per week_____
- Are the stools soft and naturally bulky? Yes No
- Are the stools hard, bullet shaped, straining to expel the stools Yes No
- Are you constipated? Yes No

What color is your urine? Mostly Clear Mostly Yellow (Please circle)

- Frequent nighttime urination Yes__ No__
- How many times per night? _____

SEXUAL FUNCTION

The following questions are personal and confidential related to sexual function. The purpose is to ascertain early signs of premature aging which is often associated with a decline in sexual interest and function in men and women.

- How often do you have sex? Times per week? _____ per day?__ per month__
- Do you achieve orgasm each time? Yes__ No__ Sometimes__
- Is your libido the same As__ less than__ greater than__ when you were in your 20'?
- Would you like to improve your libido or interest to pursue: Yes__ No__
- Do you usually wake up with a morning erection? __seldom __sometimes ____ most of time.
- Would you like to improve the firmness and frequency of erection? __Yes __not need improve.
- Prostate enlargement Yes_ No_

FEMALE:

- Describe your menstrual cycle: light heavy
- Date of last period:
- Do you experience cramps, night sweats, hot flashes (Please circle)
- Would you like to improve the intensity of your orgasm? ___yes ___ No

SYMPTOMS PROBLEMS

Check any of the following you have a problem with on a regular basis:

- Water retention__
- Bleeding gums__
- Toe, fingernail fungus_
- Acne or boils__
- Vaginal yeast infection (women)__
- Breast tenderness__
- PMS__
- Jock itch (men)__
- Bad breath__
- Memory problems__
- Poor concentration__
- Decrease self image__
- Depression__
- Sleep problems__
- Fatigue
- Anxiety attacks__
- Dry flaky hair, skin__
- Ulcers discolor skin__
- Stroke__
- Heart attack__
- Diabetes__
- High blood pressure__
- Sun damage__
- Premature wrinkling__
- Impatient, moody_
- Arthritis__
- Loss of drive to succeed__
- Rapid mood swings__
- Joint stiffness__
- Back spine problems__
- Joint problem__
- Headaches__
- Hearing loss, ringing ears__
- Chest pain__
- Shortness of breath__
- Swelling hands feet__
- Cold hands feet__
- Diarrhea__

- Constipation___
- Blood stool___
- Difficulty or slow urinating___
- Indigestion, bloating or gas after eating___
- Allergic reactions, sneezing, runny nose, sore throat___
- Chronic colds, flu___
- Infection___

LAB TESTS

Check which of the following tests you have undergone with us or others?

- Urine test for good and bad estrogen___
- Blood test for hormones, PSA, chemistries, lipids___
- 24 hour urine comprehensive hormone panel___
- Saliva hormone test___
- ALCAT or Prime delayed allergy test___

Are any of your hormone levels (blood, urine, saliva) deficient Yes_____ No_____

Are any of your hormone levels (blood, urine, saliva) elevated Yes_____ No_____

List: _____

It is critical to have your hormones retested after 30 days and not more than 90 days after starting on the plan, circle which of these tests that you have repeated to monitor your progress on the plan?

- Saliva hormone
- Urine estrogens
- 24-hour urine hormone panel with Growth hormone, thyroid, cortisol, electrolytes
- Blood test for hormones, binding proteins, PSA
- Blood lipids and chemistry

RESULTS:

If you have already started the Delgado Protocol, which health goals have you achieved? _____

Please respond to the following questions using this scale:

0 = Never/None 1 = Seldom/Slight 2 = Often/Moderate 3 = Always/Severe 4=Constant/Serious
Circle the Result Chart that corresponds to your score after you total each of your answers from 1 to 4

Section 1: Thyroid Deficiency of T1, T2, T3

1. Slow heart palpitations?	1	2	3	4
2. Poor appetite?	1	2	3	4
3. Nose bleeds?	1	2	3	4
4. Bedwetting as a child?	1	2	3	4
5. Intolerance to fatty foods?	1	2	3	4
6. Constipation (slow,difficult digestion)?	1	2	3	4
7. Always hungry?	1	2	3	4
8. Tendency to gain weight?	1	2	3	4
9. Swollen hands or feet?	1	2	3	4
10. Swollen eyelids or puffy face?	1	2	3	4
11. Irritable?	1	2	3	4
12. Nervous?	1	2	3	4
13. Headaches?	1	2	3	4
14. Depressed?	1	2	3	4
15. Distracted?	1	2	3	4
16. Slow movements, reaction time?	1	2	3	4
17. Sleepy during the day?	1	2	3	4
18. Lack of energy?	1	2	3	4
19. Reduced vitality?	1	2	3	4
20. Tired at rest when not moving?	1	2	3	4
21. Tired when waking in the morning?	1	2	3	4
22. Tired?	1	2	3	4
23. Poor circulation?	1	2	3	4
24. Cold hands or feet?	1	2	3	4
25. Sensitive to cold, need extra blankets during winter?	1	2	3	4
26. Muscle cramps at night (feet, calves, hands)?	1	2	3	4
27. Aching wrists or carpel tunnel syndrome?	1	2	3	4
28. Stiff joints in the morning?	1	2	3	4
29. Joint pain worse during cold/wet weather?	1	2	3	4
30. Hoarse voice in the morning?	1	2	3	4
31. Ear tingling and/or deafness?	1	2	3	4
32. Sore throat?	1	2	3	4
33. Bronchitis?	1	2	3	4
34. Dry skin (face, elbows, legs)?	1	2	3	4
35. Lack of perspiration during physical activity?	1	2	3	4
36. Finger nails (brittle/slow growing)?	1	2	3	4
37. Slow hair growth?	1	2	3	4
38. Rarely thirsty?	1	2	3	4

Total _____

Normal (verify with test) 0 - 2

Mild hormone deficiency 3 - 6

Moderate hormone deficiency 7 - 21

Excessive hormone deficiency 22 - 36

Severe hormone deficiency 37 or higher

Section 2:Growth Hormone Deficiency

1. Thinning hair?	1	2	3	4
2. Thin skin?	1	2	3	4
3. Deep wrinkled face?	1	2	3	4
4. Thin lips?	1	2	3	4
5. Sagging cheeks?	1	2	3	4
6. Loose skin under chin (double chin)?	1	2	3	4
7. Bags under eyes?	1	2	3	4
8. Ridges in your nails?	1	2	3	4
9. Receding gums?	1	2	3	4
10. Sagging skin under arm?	1	2	3	4
11. Flabby drooping belly?	1	2	3	4
12. Sagging body?	1	2	3	4
13. Increased body fat?	1	2	3	4
14. Wrinkled hands?	1	2	3	4
15. Sagging buttocks?	1	2	3	4
16. Cellulite?	1	2	3	4
17. Flabby inside thighs?	1	2	3	4
18. Fat cushions above the knees?	1	2	3	4
19. Frequent infections?	1	2	3	4
20. Frequent colds or flu?	1	2	3	4
21. Decreased muscle strength?	1	2	3	4
22. Decreased muscle mass?	1	2	3	4
23. Tire easily?	1	2	3	4
24. Constantly tired?	1	2	3	4
25. Difficulty recovering after staying up late?	1	2	3	4
26. Difficulty staying up past midnight?	1	2	3	4
27. Need for abundance of sleep?	1	2	3	4
28. Low resistance to stress?	1	2	3	4
29. Feel unable to cope with stress?	1	2	3	4
30. Meek or unassertive?	1	2	3	4
31. Too emotional?	1	2	3	4
32. Loss of self control?	1	2	3	4
33. Mood swings?	1	2	3	4
34. Low self esteem?	1	2	3	4
35. Anxious?	1	2	3	4
36. Depression?	1	2	3	4
37. Intolerance to cold?	1	2	3	4
38. Feel isolated, prefer to stay home?	1	2	3	4
39. Sharp voice?	1	2	3	4
40. Losing temper, screaming easily?	1	2	3	4
41. Decrease in sex drive and/or libido?	1	2	3	4
42. Weaker erections in men or decrease in vaginal lubrication for women?	1	2	3	4

Total _____

Normal (verify with test) 0 - 2

Mild hormone deficiency 3 - 6

Moderate hormone deficiency 7 - 21

Excessive hormone deficiency 22 - 36

Severe hormone deficiency 37 or higher

Section 3: DHEA Deficiency

1. Stress tires me out and interferes with my ability to sleep.	1	2	3	4
2. Thin and sparse pubic hair or under arm hair?	1	2	3	4
3. Fatty lower abdomen?	1	2	3	4
4. Ill-Being (non well-being)?	1	2	3	4
5. Lack of sexual attraction/interest?	1	2	3	4
6. Frequent Illness/Depressed Immune system?	1	2	3	4

Total _____

Normal (verify with test) = 0 - 2__

Mild hormone deficiency 3 - 6

Moderate hormone deficiency 7 -17

Excessive hormone deficiency 18 - 20

Severe hormone deficiency 21 or higher

Section 4: Cortisol Deficiency

1. Shortness of breath?	1	2	3	4
2. Allergic reactions, sneezing, runny nose, sore throat?	1	2	3	4
3. Need 20 minutes to one hour daily for nap or quiet time to get through the day?	1	2	3	4
4. Low resistance to stress?	1	2	3	4
5. Dizzy when standing up?	1	2	3	4
6. Low blood pressure?	1	2	3	4
7. Fast beating heart in stressful situations?	1	2	3	4
8. Feel better after eating something sweet?	1	2	3	4
9. Crave sugary, salty or spicy foods?	1	2	3	4
10. Digestive problems?	1	2	3	4
11. Nausea?	1	2	3	4
12. Underweight?	1	2	3	4
13. Inflammatory arthritis?	1	2	3	4
14. Intolerance to medications?	1	2	3	4
15. Food allergies?	1	2	3	4
16. Allergic symptoms present in nose, throat, ears and/or skin?	1	2	3	4
17. Brown age spots or large white spots of depigmentation?	1	2	3	4
18. Eczema?	1	2	3	4

Total _____

Normal (verify with test) 0 - 2

Mild hormone deficiency 3 - 6

Moderate hormone deficiency 7 - 21

Excessive hormone deficiency 22 - 36

Severe hormone deficiency 37 or higher

Section 5: Melatonin Deficiency

Section 5: Melatonin Deficiency

1. Consistently go to bed later than 10pm?	1	2	3	4
2. Feel tired and unrested after going to bed late the night before?	1	2	3	4
3. Awaken at night and have difficulty returning to sleep?	1	2	3	4
4. Need to darken room, remove noise, turn off TV or radio in order to sleep?	1	2	3	4
5. Mull over / worry over problems at night?	1	2	3	4
6. Suffer from jet lag when traveling?	1	2	3	4
7. Feel unrested upon waking in the morning?	1	2	3	4
8. Tendency to sleep late and use alarm clock to awaken?	1	2	3	4

Total _____

Normal (verify with test) 0 - 2

Mild hormone deficiency 3 - 6

Moderate hormone deficiency 7 - 21

Excessive hormone deficiency 22 - 24

Severe hormone deficiency 32 or higher

Section 6: Pregnenolone Deficiency

1. Poor memory (short/long term)?	1	2	3	4
2. Back pain?	1	2	3	4
3. Joint problems?	1	2	3	4
4. Headaches?	1	2	3	4
5. Hearing loss, ringing in ears?	1	2	3	4
6. Poor concentration?	1	2	3	4

Total _____

Normal (verify with test) 0 - 2

Mild hormone deficiency 3 - 6

Moderate hormone deficiency 7 - 15

Excessive hormone deficiency 16 - 20

Severe hormone deficiency 21 or higher

Section 7: Aldostrone Deficiency

1. Tired when standing, feel better laying down?	1	2	3	4
2. Urinate often, drinking water almost immediately passes as urine?	1	2	3	4
3. Absent minded?	1	2	3	4
4. Distracted with difficulty focusing?	1	2	3	4
5. Swollen feet/hands?	1	2	3	4
6. High blood pressure?	1	2	3	4
7. Crave salty or spicy foods?	1	2	3	4

Total _____

Normal (verify with test) 0 - 2

Mild hormone deficiency 3 - 6

Moderate hormone deficiency 7 - 11

Excessive hormone deficiency 12 - 16

Severe hormone deficiency 17 or higher

Section 8: Serotonin, Dopamine, Epi Ratio

1. I have an addictive nature to food, alcohol, tobacco, substances etc	1	2	3	4
2. I tend to be depressed	1	2	3	4
3. I feel panic or anxiety	1	2	3	4
4. I am uninspired, unmotivated, and rarely pursue pleasure	1	2	3	4
5. I have fears or phobias	1	2	3	4
6. Obsessions and compulsions are my nature	1	2	3	4
7. I rarely feel contentment, satisfied, or experience pleasure	1	2	3	4
8. I feel dull, lack mental alertness and feel fatigued	1	2	3	4
9. Flirting or overtures rarely interest or arouse me	1	2	3	4
10. I have trouble losing weight and tend to overeat	1	2	3	4

Total _____

Normal (verify with test) 0 - 2

Mild hormone deficiency 3 - 6

Moderate hormone deficiency 7 - 21

Excessive hormone deficiency 22 - 26

Severe hormone deficiency 27 or higher

Section 9: Vasopressin

1. I'm thirsty at night	1	2	3	4
2. I get up at night to urinate	1	2	3	4
3. I bleed a lot when injured	1	2	3	4
4. I'm losing my memory	1	2	3	4
5. I have a hard time thinking straight	1	2	3	4

Total _____

Result Chart

Normal (Verify with test) 0 - 2

Mild hormone deficiency 3 - 6

Moderate hormone deficiency 7 - 10

Excessive hormone deficiency 11 - 17

Severe hormone deficiency 18 or higher

Section 10: Insulin Deficiency or Inability to Utilize

1. I crave sugar and sweets and tend to eat a lot of them	1	2	3	4
2. I'm always thirsty	1	2	3	4
3. I urinate a lot during the day as well as night	1	2	3	4
4. I have difficulty healin	1	2	3	4
5. My stomach and buttocks are skinny	1	2	3	4
6. I eat fatty cheese, meat, oils	1	2	3	4

Total _____

Normal (Verify with test) 0 - 2

Mild hormone deficiency 3 -6

Moderate hormone deficiency 7 - 10

Excessive hormone deficiency 11 - 17

Severe hormone deficiency 18 or higher

Section 11: ACTH

1. I have patches of hair loss	1	2	3	4
2. I have a very pale complexion	1	2	3	4
3. I sunburn easily	1	2	3	4
4. I often have memory loss	1	2	3	4
5. I'm stressed out, I'm facing many difficulties	1	2	3	4
6. My blood pressure has dropped	1	2	3	4
7. My friends tell me I look thinner	1	2	3	4

Total _____

Normal (Verify with test)= 0-2

Mild hormone deficiency 3-6

Moderate hormone deficiency 7-10

Excessive hormone deficiency 11-17

Severe hormone deficiency 18-28

Section 12: Cortisol Excess

1. Balloon like swollen face?	1	2	3	4
2. Excitable?	1	2	3	4
3. Excessive Energy?	1	2	3	4

Total _____

Normal (verify with test) 0 - 2

Mild hormone deficiency 3 - 6

Moderate hormone deficiency 7 - 8

Excessive hormone deficiency 9 - 10

Severe hormone deficiency 11 or higher

Section 13: Calcitonin

1. I have vertebral fractures, crushes, compression, etc.	1	2	3	4
2. I've lost height	1	2	3	4
3. My back hurts	1	2	3	4
4. I'm very sensitive to pain	1	2	3	4
5. I have thyroid problems (goiter, thyroid insufficiency, radiation applied neck area)	1	2	3	4

Total _____

Normal (Verify with test) 0-2

Mild hormone deficiency 3-6

Moderate hormone deficiency 7-10

Excessive hormone deficiency 11-15

Severe hormone deficiency 16-20

Section 14: Vitamin & Mineral Deficiency

1. Anemia and related fatigue ?	1	2	3	4
2. Attention Deficit Disorder, difficulty concentrating or staying focused ?	1	2	3	4
3. Leg cramps ?	1	2	3	4
4. Skin lesions around lip or base of nose ?	1	2	3	4
5. blotchy patches of brown, suntan appearance around the neck, arms or hands ?	1	2	3	4

Total _____

Normal (verify with test) 0 - 2

Mild hormone deficiency 3 - 6

Moderate hormone deficiency 7 - 14

Excessive hormone deficiency 15 - 18

Severe hormone deficiency 19 or higher

Section 15: Water, Vegetable, Fiber Deficiency

1. Often constipated with infrequent bowel movements?	1	2	3	4
2. Stools are hard and compact?	1	2	3	4
3. Strain during bowel movement?	1	2	3	4
4. Diarrhea?	1	2	3	4
5. Bad breath	1	2	3	4
6. Indigestion, bloating or gas after eating?	1	2	3	4
7. Obesity?	1	2	3	4
8. Yellow color to urine without the influence of B vitamins?	1	2	3	4
9. Urine is cloudy and unclear?	1	2	3	4
10. Dandruff?	1	2	3	4

Total _____

Normal (verify with test) = 0 - 2

Mild hormone deficiency 3 - 6

Moderate hormone deficiency 7 - 21

Excessive hormone deficiency 22 - 36

Severe hormone deficiency 37 - or higher

Section 16: Do you have a history of...?

(1 = No 2= Yes)

1. Arthritis, Diabetes or Heart Disease?	1	2
2. Ulcerative colitis, Crohn's Disease (abdominal pain, bloody mucus stool)	1	2
3. Colon cancer ?	1	2
4. Ulcers ?	1	2
5. Varicose veins ?	1	2
6. Gallstones ?	1	2
7. Hemorrhoids/Piles or Hiatal Hernia?	1	2
8. Diverticulitis or colon inflammation ?	1	2
9. Appendix (problems) or Appendix removed?	1	2

Total _____

Normal (verify with test) 0 - 2

Mild hormone deficiency 3 - 6

Moderate hormone deficiency 7 - 14

Excessive hormone deficiency 15-17

Severe Hormone deficiency 18

0 = Never/None 1 = Seldom/Slight

2 = Often/Moderate 3 = Always/Severe

4=Constant/Serious

Section 17: Obesity, Difficulty reducing fat

1. Weight problem during most of my life	1	2
2. Over eat when under stress	1	2
3. Gained body fat after childbirth, or after age 35	1	2
4. 30 pounds over weight compared to best weight in Teen years/peak health?	1	2
5. Fat accumulates in the lower body, buttocks, hips and thighs	1	2
6. Fat accumulates in my upper body, arms, chest, face and stomach	1	2
7. Chicken, steak, cheese, butter, oil or sugar over raw vegetables, fruit	1	2

Total _____

Normal (verify with test) 0 - 2

Mild hormone deficiency 3 - 6

Moderate hormone deficiency 7 - 16

Excessive hormone deficiency 17 - 23

Severe hormone deficiency 24 or higher

Section 18: Nitrogen

1. Exhausted during Exercise?	1	2
2. Difficulty recovering after Exercise?	1	2
3. Not mentally alert or sharp, require coffee or stimulant to get going	1	2
4. Depression often, feel alone unable to cope?	1	2
5. Sex is a low priority in my life	1	2
6. The intensity or enjoyment from sex or life in general is not what it used to be	1	2
7. I still feel hungry even after eating	1	2

Total _____

Normal 0-3

Mild nitrogen deficiency 4-8

Moderate elemental nitrogen / protein deficiency 9-12

Excessive nitrogen deficiency 13-15

Severe Deficiency 16-25

Section 19: Testosterone and Exercise

1. Difficulty in going to the gym, make excuses of lack of time or energy?	1	2
2. Unsatisfactory outcome of workouts, no gains or progress in shape?	1	2
3. Difficulty in completing a workout to the point of perspiration?	1	2
4. Lack clarity- of exercise techniques:pyramiding, forced, negative reps, etc ?	1	2
5. Lack clarity of dietary and supplemental needs to achieve fitness goals?	1	2
6. Long periods of non exercise or inactivity; insufficient to stimulate the muscles/heart?	1	2
7. You feel that if current fitness/diet plan continues, you will be in worse shape as you age?	1	2

Total _____

Normal (verify with test) 0 - 2

Mild hormone deficiency 3 - 6

Moderate hormone deficiency 7 - 14

Excessive hormone deficiency 15 - 18

Severe hormone deficiency 19 or higher

Section 20: Testosterone to Estrogen Ratio

1. Poor flexibility?	1	2
2. Low tolerance to exercise/sports?	1	2
3. Poor muscle tone in arms?	1	2
4. Poor muscle tone in legs?	1	2
5. Loss of muscle strength?	1	2
6. Excess fat on breasts?	1	2
7. Fat on belly?	1	2
8. Fat on hips and buttocks?	1	2
9. Cellulite (thighs/buttocks)?	1	2
10. Sunburn easily?	1	2
11. Varicose veins?	1	2
12. Bruise easily?	1	2
13. Slow wound healing response?	1	2
14. Difficulty urinating?	1	2
15. Dry eyes?	1	2
16. Dry mouth?	1	2
17. Pale appearance to skin?	1	2
18. Skin acne and/or boils?	1	2
19. Wrinkles on forehead?	1	2
20. Gums bleed easily?	1	2
21. Loss of drive to succeed?	1	2
22. Poor self image?	1	2
23. Depression?	1	2
24. Overly emotional?	1	2
25. Poor memory?	1	2
26. Poor concentration?	1	2

Total _____

Result Chart

Normal (verify with test) = 0 - 2

Mild hormone deficiency 3 - 6

Moderate hormone deficiency 7 - 21

Excessive hormone deficiency 22 - 36

Severe hormone deficiency 37 - or higher

Section 21: Testosterone (Male) Deficiency

1. Lowered frequency of erections, especially early morning erections?	1	2
2. Greying hair?	1	2
3. Hair loss on upper scalp?	1	2
4. Irritable?	1	2
5. Poor beard growth?	1	2
6. Hearing loss?	1	2
7. Sparse hair on chest?	1	2
8. Sparse hair on abdomen?	1	2
9. Sparse hair on legs?	1	2
10. Shortness of breath?	1	2

Total _____

Normal (verify with test) 0 - 2

Mild hormone deficiency 3 - 6

Moderate hormone deficiency 7 - 21

Excessive hormone deficiency 22 - 36

Severe hormone deficiency 37 or higher

Section 22: Male Sexual Performance

1. Unable to get an erection as often as desired during sexual activity?	1	2
2. Unable to achieve erections hard enough to penetrate(enter) your partner?	1	2
3. Unable to penetrate (enter) your partner as often as desired?	1	2
4. Unable to maintain erection after penetrating your partner?	1	2
5. Difficulty maintaining erection to completion or orgasm?	1	2
6. Lack confidence in ability to obtain / maintain an erection when needed?	1	2

Total _____

Normal (verify with test) 0 - 2

Mild hormone deficiency 3 - 6

moderate hormone deficiency 7 - 16

Excessive hormone deficiency 17 - 20

Severe hormone deficiency 21 or higher

0 = Never/None 1 = Seldom/Slight

2 = Often/Moderate

3 = Always/Severe 4=Constant/Serious

Section 23: Female Sexual Response

1. Difficulty in achieving clitoral orgasm by oral sex, vibrator or masturbation?	1	2
2. Unsatisfactory orgasmic intensity?	1	2
3. Difficulty becoming sexual aroused?	1	2
4. Lack of interest (libido) in sex?	1	2
5. Inability to achieve sufficient vaginal lubrication?	1	2
6. Long periods of abstinence?	1	2
7. Poor ability to achieve satisfying orgasm?	1	2
8. Sex drive or enjoyment of sexual experience less than your peak?	1	2
9. Difficulty in achieving G-Spot orgasm by partners finger rubbing upper vaginal wall penetration?	1	2

Total _____

*Normal (verify with test) 0-2 Mild hormone deficiency 3-6 Moderate hormone deficiency 7 -21
Excessive hormone deficiency 22 - 23 Severe hormone deficiency 34 or higher*

0 = Never/None 1 = Seldom/Slight 2 = Often/Moderate 3 = Always/Severe 4=Constant/Serious

Section 24: Estrogen (Female) Deficiency

1. Periods are irregular and painful?	1	2	3	4
2. Periods have stopped (menopausal)?	1	2	3	4
3. Lethargy, fatigue, memory loss?	1	2	3	4
4. Vaginal dryness?	1	2	3	4
5. Pain during intercourse due to insufficient lubrication?	1	2	3	4
6. Excess body hair?	1	2	3	4
7. Small breasts?	1	2	3	4
8. Drooping, limp breasts?	1	2	3	4
9. Bladder infections?	1	2	3	4
10. Urinary incontinence?	1	2	3	4
11. Hot flashes?	1	2	3	4
12. Night sweats?	1	2	3	4
13. Loss of libido?	1	2	3	4
14. Tension, irritability, anxiety?	1	2	3	4
15. Headaches?	1	2	3	4
16. Joint pain and stiffness?	1	2	3	4
17. Weight gain?	1	2	3	4
18. Thinning hair?	1	2	3	4
19. Aging wrinkled skin?	1	2	3	4
20. Wrinkles above the lip?	1	2	3	4

Total _____

*Normal (verify with test) 0 - 2 Mild hormone deficiency 3 - 6 moderate hormone deficiency 7 - 21
Excessive hormone deficiency 22 - 36 Severe hormone deficiency 37 or higher*

Section 25: Progesterone (Female) Deficiency

1. Abdominal Cramping?	1	2	3	4
2. Night sweats?	1	2	3	4
3. Hot flashes?	1	2	3	4
4. PMS ?	1	2	3	4
5. Impatient?	1	2	3	4
6. Moody?	1	2	3	4
7. Anxiety attacks?	1	2	3	4
8. Vaginal yeast infections?	1	2	3	4
9. Water retention?	1	2	3	4
10. Rapid mood swings?	1	2	3	4
11. Depression prior to menstruation?	1	2	3	4
12. Ovulation pain prior to menstruation?	1	2	3	4
13. Painful swollen breasts?	1	2	3	4
14. Painful swollen belly?	1	2	3	4
15. Emotionally irritable and excitable?	1	2	3	4
16. Gums bleed easily?	1	2	3	4
17. Dry flaky hair/skin?	1	2	3	4
18. High blood pressure?	1	2	3	4

Total _____

Normal (verify with test) 0 - 2 Mild hormone deficiency 3 - 6

Moderate hormone deficiency 7 - 21 Excessive hormone deficiency 22 - 36

Severe hormone deficiency 37 or higher

Use the space below to further explain any health goals /concerns you'd like to address
