

DIRECTIONS: This questionnaire asks you to assess how you have been feeling and problems you have had during the last four months. This information will help know which systems you should focus on first. Repeat this every 30 days to track your progress. Take all the time you need to complete this questionnaire. For each question, circle the number that best describes your symptoms:

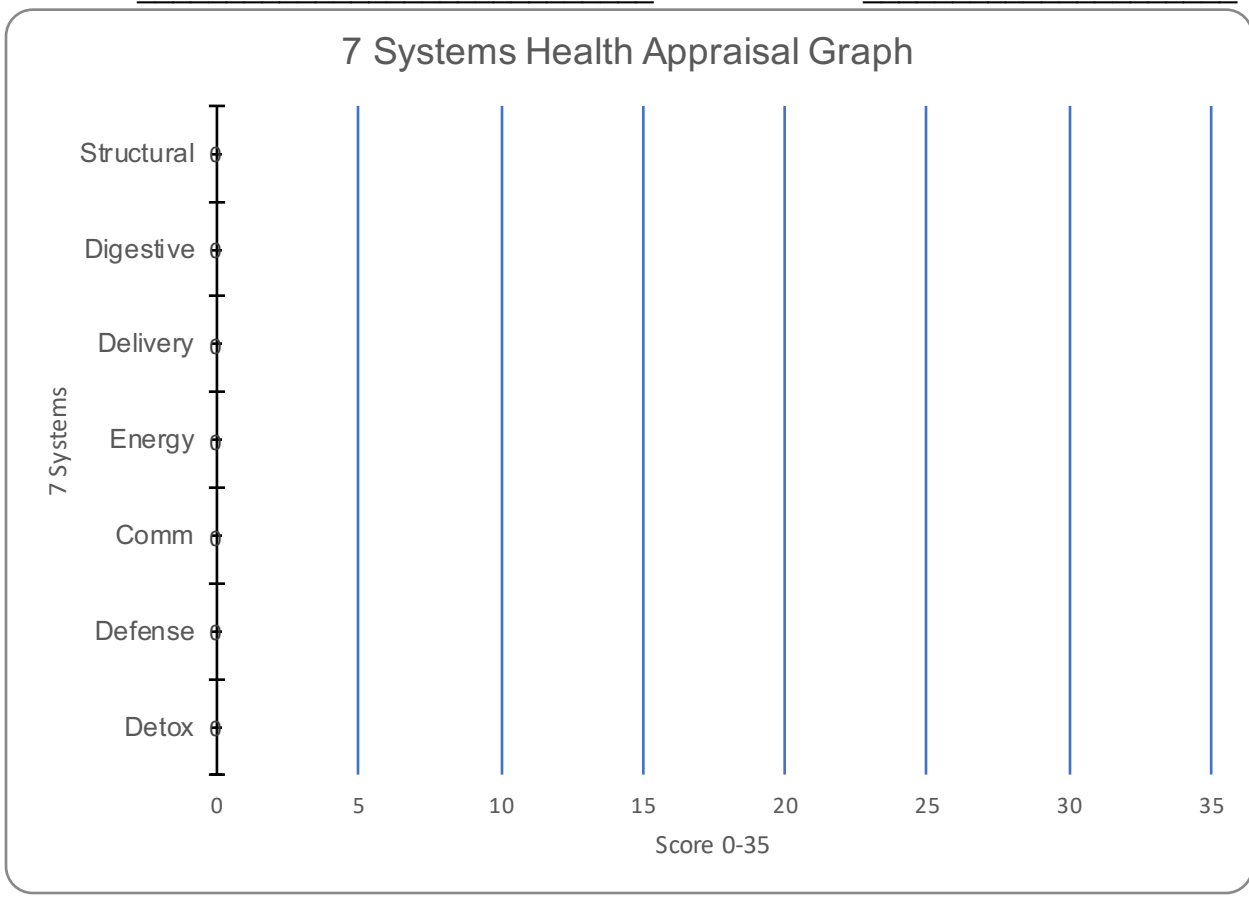
- 5 = Daily have or almost every day
- 4 = Frequently have
- 3 = Sometimes have
- 2 = Occasionally have, severe effect
- 1 = Occasionally have, mild effect
- 0 = Never have or almost never

7 Systems Plan Survey

Structural System		Digestive System		Delivery System	
	Food cravings or binge		Feeling bloated or gas		Low blood sugar, high
	Joint pain or aches,		Constipation, loose stools,		Brain fog or feeling sleepy
	Back, neck pain or		Use of antacids or		Frequent eating out
	Osteopenia or		Stomach or intestinal pain		High blood pressure, LDL
	Loss of strength,		Heartburn or bad breath		Heart, blood vessel
	Overweight or can't lose		Food allergies or		Frequent use of junk food,
	Weak memory or mental		Depression or mood		Resting pulse >70
0	Total	0	Total	0	Total
Energy System		Communication System		Defense System	
	Frequent eating or		Food craving or hunger		Headaches
	Getting winded easily		Anger, irritability, or		Chronic pain, joint pain with
	Brain fog or forgetful		Low morning energy		Autoimmune disease
	Low energy, fatigue or not		Night sweats, hot flashes		Frequent colds, flu or
	Loss of muscle or strength		Sleep problems or less		Skin problems
	Loss of smell or taste		Loss of sex drive		Frequent anti-inflammatory
	Just plain feeling old		More stress than you can		Periodontal disease
0	Total	0	Total	0	Total
Detox System					
	Tingling or sensitive skin	5	= Daily have or almost every day		
	Brain fog or ringing in ears	4	= Frequently have		
	Muscle pain or headaches	3	= Sometimes have		
	Decreased kidney function	2	= Occasionally have, severe effect		
	Skin problems	1	= Occasionally have, mild effect		
	Decreased energy	0	= Never have or almost never		
	medications, fragrances,				
0	Total				

Name: _____

Date: _____



Structur	Digestive	Delivery	Energy	Comm	Defense	Detox	Total
0	0	0	0	0	0	0	0