

Tulsa Natural Health



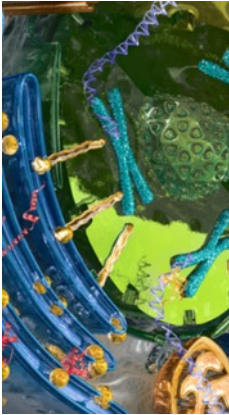
Clinic



*Health Appraisal
Questionnaire*

YOUR DOCTOR SAYS YOU'RE OK... but you just don't feel well; you don't know why. You have been tested, medicated, and even provided a diagnosis or two, but you still don't feel well, have no energy and possibly can't lose those unwanted pounds no matter what you try. Sound familiar? Reading this article right now may offer you the cause and the solution your body has been looking for.

If you want to feel better, ask yourself two questions:



1. **Are you addressing the true cause?**
2. **Are your current programs/methods working?**

Most who answer, "No," have missed the most common, but overlooked cause. Conventional methods are not prepared to identify or correct the equivalent of the latest plague: toxicity. The crazy part? Toxic people don't usually know they're toxic and/or have not been properly tested.

Now, the good news: there's a way to support the body to remove toxins safely and effectively...TCD! Dr Harris and the TNHC team are excited to introduce the world's first "**True Cellular Detox**" program. This program has been 12 years in the making and is now available to the public.

The True Cellular Detox (TCD) system is the first and only cellular detox program proven to enter brain cells, draw out health eroding poisons, and safely & firmly bind them for complete elimination from your body. **NO OTHER DETOXIFICATION SYSTEM** has been objectively and scientifically documented to cross the blood-brain barrier, as the TCD system does. This is a significant distinction, and one that can make all the difference in regaining and maintaining optimal health.

Let's face it...there are lots of beneficial "detox" systems out there, including colon cleanses, liver detoxes, kidney flushes, etc., however there are very few systems which can claim to actually remove toxins deep down at the **CELLULAR** level.

Most detox systems are designed help to enhance the function of your organs of waste elimination (which is important!), but **DO NOTHING** to truly capture and fully remove the most dangerous and damaging toxins of all...the ones which have already crossed your cell membranes and have become deeply embedded within those cells.

These embedded toxins are proven to cause inflammation of your external cell membranes, internal nuclear membranes, and mitochondrial membranes, and significantly erode your health by causing hormone resistance, epigenetic dysfunction, and loss of cellular energy leading to fatigue and chronic poor health. In other words, nutrients and hormones can't get in, and waste and toxins can't get out...a true recipe for disaster and disease formation!

Toxins stored in your cells can lead to inflammation, brain fog, inability to lose weight, low energy, hormone problems, and even long-term problems like autoimmune disease and fibromyalgia. True cellular detox is a program consisting of specialized supplements and resources designed to not only detoxify your brain and body, but get your cells functioning properly so you can get your life back.

If possible, In your own words and in chronological order describe your health history from childhood to where you are today. Example, when I was a child I had a lot of ear infections, or asthma etc.

Or what happened that you feel caused your health to decline. For example, I had the flu 5 years ago and after that I have never felt the same, or after my 3rd child my health began to deteriorate, etc.

Health Appraisal Questionnaire

Date: _____ Age _____ DOB _____

Name: _____ Weight _____ Height _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Business _____ Cell _____

What is the purpose of your visit and what are your health goals?

Circle and list any of the following medications (and doses) you are taking:



• Antacids

• Diabetic medication/Insulin, Metformin

• Anti-inflammatory medication

• High blood pressure medication

• Laxatives

• Tranquilizers/Sleep medication

• Chemotherapy

• Antibiotic/Antifungal

• Aspirin/Tylenol/other

• Lithium

• Recreational drugs

• Stomach medication/Ulcer

• Oral Contraceptive/Patch

• Thyroid

• Hormone replacement

• What is your blood pressure

• Who referred you to our clinic

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Circle if you eat, drink or use the following. If yes, please give details

Alcohol

• Cigarettes/Cigars/Other forms of tobacco

• Coffee/Tea, if yes how many cups or glasses daily

• Cola Drinks/Energy drinks/How many

• Luncheon meats

• Refined sugar/Candy

• Drink tap water

• Margarine or trans fats

• Artificial sweeteners

• Eat at fast food restaurants

• Eat fried foods

Do you diet often / list diets you have been on or are on now

LIST ANY HOBBIES YOU HAVE:

• Circle if these apply to you. Salt food without tasting • Are under excessive stress • Do not exercise • Exercise (describe)

• Are you now or have you been exposed to chemicals at home or work • Are you now, or have you been exposed to second hand smoke

List all dental procedures and/or surgeries: indicate year. Have you been diagnosed with a medical condition, e.g. diabetes, high BP ect.?

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INSTRUCTIONS: Circle the number which best describes the intensity of your symptoms for the past 3 months. If you don't know the answer to a question, leave it blank.

0 for symptom not present 1 for Mild 2 for Moderate 3 for Severe

Part 2		Section C _____	
Section A: _____			
1. Burping	0 1 2 3	1. Stomach pains	0 1 2 3
2. Stomach upsets easily	0 1 2 3	2. Stomach pains right after and/or before meals	0 1 2 3
3. Feel full for extended time after a meal	0 1 2 3	3. Dependency on antacids	0 1 2 3
4. Bloating	0 1 2 3	4. Chronic abdominal pain	0 1 2 3
5. History of constipation	0 1 2 3	5. Butterfly sensations in stomach	0 1 2 3
6. Poor appetite	0 1 2 3	6. Difficulty Belching	0 1 2 3
7. Known food allergies	0 1 2 3	7. Stomach pain when emotionally upset or stressed	0 1 2 3
Part 2 Section B: _____			
1. Abdominal cramps	0 1 2 3	8. Sudden, acute indigestion	0 1 2 3
2. Indigestion occurring 1-3 hours after eating	0 1 2 3	9. Relief of stomach pain by drinking cream or milk	0 1 2 3
3. Fatigue after eating	0 1 2 3	10. History of ulcers or gastritis	0 1 2 3
4. Lower bowel gas	0 1 2 3	11. Currently have an ulcer	0 1 2 3
5. Alternating constipation and diarrhea	0 1 2 3	12. Black stool when not taking iron supplements	0 1 2 3
6. Diarrhea	0 1 2 3	Part 2 Section D: _____	
7. Mucous in stools	0 1 2 3	1. Seasonal diarrhea	0 1 2 3
8. Roughage & fiber causes constipation	0 1 2 3	2. Frequent & recurrent infections (cold, flue, etc.)	0 1 2 3
9. Stool poorly formed	0 1 2 3	3. Vaginal yeast infection	0 1 2 3
10. Three or more large bowel movements daily	0 1 2 3	4. Bladder and kidney infections	0 1 2 3
11. Shiny stool	0 1 2 3	5. Abdominal cramps	0 1 2 3
12. Foul smelling stool	0 1 2 3	6. Toe and fingernail fungus	0 1 2 3
13. Dry flaky skin and /or dry brittle hair	0 1 2 3	7. Alternating diarrhea/constipation	0 1 2 3
14. Left sided pain under rib cage	0 1 2 3	8. Constipation	0 1 2 3
15. Acne	0 1 2 3	9. History of antibiotic or steroid use	0 1 2 3
16. Food allergies	0 1 2 3	10. Eat red meat	0 1 2 3
17. Difficulty gaining weight	0 1 2 3	11. Rapidly failing vision	0 1 2 3

Part 3**SECTION A:** _____

1. Cannot tolerate greasy food	0 1 2 3	5. Sensitive to the cold	0 1 2 3
2. Get headaches after eating	0 1 2 3	6. Cold hands or feet	0 1 2 3
3. Light colored stool	0 1 2 3	7. Excessive menstrual bleeding	0 1 2 3
4. Have less than one bowel movement daily	0 1 2 3	8. Chronic fatigue	0 1 2 3
5. Constipation	0 1 2 3	9. Difficulty waking in the mornings	0 1 2 3
6. Have hard stool	0 1 2 3	10. Fell depressed or apathetic	0 1 2 3
7. Foul smelling stool	0 1 2 3	11. Low or decreased sex drive	0 1 2 3
8. Sour taste in mouth	0 1 2 3	12. Puffy, wrinkly skin	0 1 2 3
9. Gray colored skin	0 1 2 3	13. Eating sugar causes irritability or mood swings	0 1 2 3
10. Yellow in whites of eyes	0 1 2 3	14. PMS	0 1 2 3
11. Bad breath	0 1 2 3	15. Constipation	0 1 2 3
12. Body odor	0 1 2 3	16. Thinning or loss of outside portion of eyebrow	0 1 2 3
13. Get tired or sleepy after meals	0 1 2 3	17. Gain weight easily	0 1 2 3
14. Pain in right side under rib cage	0 1 2 3	18. Anemia unaffected by taking iron	0 1 2 3
15. Difficulty or experience pain when passing stool	0 1 2 3	19. Axillary (underarm temp below 97.6 for 7-10 days)	0 1 2 3
16. Retain water (fluid)	0 1 2 3	20. Slow reflexes	0 1 2 3
17. Big toe is painful	0 1 2 3	21. Infertility	0 1 2 3
18. Have pain that radiates along outside of leg (s)	0 1 2 3	Part 4 SECTION A: _____	
19. Dry skin/hair	0 1 2 3	1. Sensitive to exhaust fumes, smoke, smog, petrochemicals	0 1 2 3
20. Bright red or dark blood in stool	No Yes (10)	2. Periodic constipation	0 1 2 3
21. Have had jaundice or hepatitis (A-B-C)	No Yes	3. Cannot tolerate much exercise	0 1 2 3
22. High cholesterol-Elevated LDL	No Unknown Yes (10)	4. Depression or rapid mood swings	0 1 2 3
23. Elevated triglycerides	No Unknown Yes (10)	5. Dark circles under the eyes	0 1 2 3

Part 3 SECTION B: _____

1. Swollen bulging eyes	0 1 2 3	6. Experience dizziness when standing or standing quickly	0 1 2 3
2. Strong smelling urine	0 1 2 3	7. Get colds easily with weather changes	0 1 2 3
3. Thick skin and or finger nails	0 1 2 3	8. Headaches	0 1 2 3
4. Dry skin	0 1 2 3	9. Exercise makes you feel worse	0 1 2 3

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Part 4 SECTION A continued

9. Difficulty breathing	0 1 2 3	8. Chronic pain	0 1 2 3
10. Water (fluid) retention	0 1 2 3	9. Painful stomach or intestines	0 1 2 3
11. Eyes are sensitive to the sun or bright lights	0 1 2 3	10. Alternating constipation and diarrhea	0 1 2 3
12. Occasionally feel weak or shaky	0 1 2 3	11. Mucous in throat	0 1 2 3

SECTION B: _____

1. Inflamed or bleeding gums	0 1 2 3	12. Post nasal drip	0 1 2 3
2. Running nose	0 1 2 3	13. Discharge from eyes	0 1 2 3
3. Get boils or styes	0 1 2 3	14. Watery eyes	0 1 2 3
4. Nose bleeds	0 1 2 3	15. Puffiness or dark circles under the eyes	0 1 2 3
5. Throat infections	0 1 2 3	16. Ears discharge or ears stuffed up	0 1 2 3
6. Cold sores, fever blisters	0 1 2 3	17. Nasal congestion	0 1 2 3
7. Loss of smell	0 1 2 3	18. Runny nose	0 1 2 3
8. Loss of taste	0 1 2 3	19. Breathe through mouth	0 1 2 3
9. Wounds, cuts heal slowly	0 1 2 3	20. Wheezing	0 1 2 3
10. Hair falls out	0 1 2 3	21. Difficulty swallowing	0 1 2 3
11. Swollen lymph glands	0 1 2 3	22. Sneezing	0 1 2 3
12. Ear infections	0 1 2 3	23. Hyperactivity	0 1 2 3
13. Hair grows slowly	0 1 2 3	24. Chronic lung congestion	0 1 2 3
14. Slow to recover from colds or flu	0 1 2 3	25. Use aspirin, Tylenol, ibuprofen regularly	0 1 2 3
15. Catch colds or flu easily	0 1 2 3	26. Skin rashes	0 1 2 3

SECTION C: _____

1. Itching of nose or eyes	0 1 2 3
2. Itching of roof of mouth or throat	0 1 2 3
3. Migraine headaches	0 1 2 3
4. Entire body aches, painful to touch	0 1 2 3
5. Swollen joints	0 1 2 3
6. Food sensitivity or allergies	0 1 2 3
7. Certain foods make you feel sick, depressed or jittery	0 1 2 3

Part 5 SECTION A: _____

1. Difficulty breathing	0 1 2 3
2. Chest pain while walking	0 1 2 3
3. Heaviness in legs	0 1 2 3
4. Calf muscles cramp while walking	0 1 2 3
5. Heart pounds easily	0 1 2 3
6. Feel jittery	0 1 2 3
7. Heart misses beats or has extra beats	0 1 2 3

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Part 5 SECTION A continued

8. Swelling of feet and ankles	0 1 2 3	6. Irritable if a meal is missed	0 1 2 3
9. Rapid beating heart	0 1 2 3	7. Wake up in middle of night craving sweets	0 1 2 3
10. Heartburn after eating	0 1 2 3	8. Feel tired or weak if a meal is missed	0 1 2 3
11. Pain in left arm	0 1 2 3	9. Heart palpitations after eating sweets	0 1 2 3
12. Exhausted with minor exertion	0 1 2 3	10. Need to drink coffee or tea to get started	0 1 2 3
13. Do you drink more than 5 cups of coffee daily	Yes No	11. Impatient, moody or nervous	0 1 2 3
14. Have you ever been diagnosed with heart trouble	Yes No	12. Feel tired 1 to 3 hours after eating	0 1 2 3

Part 5 SECTION B _____

1. Cold hands and feet	0 1 2 3	13. Poor memory	0 1 2 3
2. Slurred speech	0 1 2 3	14. Feel faint	0 1 2 3
3. Calf muscles cramp while walking	0 1 2 3	15. Poor concentration	0 1 2 3
4. Headaches	0 1 2 3	16. Forgetful	0 1 2 3
5. Numbness in extremities	0 1 2 3	17. Feel calmer after eating a meal	0 1 2 3

Part 6 SECTION B: _____

6. Poor concentration	0 1 2 3	1. Night sweats	0 1 2 3
7. Ringing in ears	0 1 2 3	2. Lowered resistance to infection	0 1 2 3
8. Hair in ear canal	0 1 2 3	3. Increased thirst	0 1 2 3
9. Tingling or burning in hands or feet	0 1 2 3	4. Fatigue	0 1 2 3
10. Spider vein on nose and or face	0 1 2 3		

Part 5 SECTION C: _____

1. Pain when getting up in morning in back of head and neck	0 1 2 3	5. Boils and leg sores	0 1 2 3
2. Dizziness	0 1 2 3	6. Lesions, cuts take a long time to heal	0 1 2 3
3. Blushing with no apparent cause	0 1 2 3	7. Overweight	0 1 2 3
4. High blood pressure	0 1 2 3	8. Feel better after exercise	0 1 2 3

Part 6 SECTION A: _____

1. Experience dizziness when standing quickly	0 1 2 3	9. Failing eyesight	0 1 2 3
2. Loss of vision when standing quickly	0 1 2 3	10. Crave sweets, but eating sweets does not relieve symptoms	0 1 2 3
3. Crave sweets	0 1 2 3	11. Family history of diabetes	0 1 2 3
4. Headaches relieved by eating sweets or consuming alcohol	0 1 2 3	12. Sugar in urine	0 1 2 3
5. Feel shaky or jittery	0 1 2 3	13. Skin tags	0 1 2 3

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Part 7 _____

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

Part 8 _____

1. Frequent urination 0 1 2 3
2. Frequent bladder infections 0 1 2 3
3. Rarely need to urinate 0 1 2 3
4. Urination when you cough or sneeze 0 1 2 3
5. Painful/burning when passing urine 0 1 2 3
6. Difficulty passing urine 0 1 2 3
7. Dripping after urination 0 1 2 3
8. Can't hold urine 0 1 2 3
9. Rose colored urine (bloody urine) 0 1 2 3
10. Cloudy urine 0 1 2 3
11. Strong smelling urine 0 1 2 3
12. Back or leg pains associated with dripping after urination 0 1 2 3
13. History of kidney or bladder infection 0 1 2 3

14. Have you used antibiotics for urinary tract infections? 0 1 2 3
15. Back pain in the kidney region? 0 1 2 3
16. General water retention 0 1 2 3

Part 9 (MALES ONLY) SECTION A: _____

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

SECTION B: _____

1. Difficulty attaining and/or maintaining an erection 0 1 2 3
2. Low sex drive 0 1 2 3
3. Premature ejaculation 0 1 2 3
4. Pain/coldness in genital areas 0 1 2 3
5. Infertile No Yes (6)
6. Varicose vein on scrotum 0 1 2 3
7. Low sperm count No Yes (6)

SECTION C: _____

1. Discharge from penis 0 1 2 3
2. Past or present rash on penis 0 1 2 3
3. Swollen genitals 0 1 2 3
4. Swelling in groin 0 1 2 3
5. Venereal disease No Yes (9)

Part 10 (Females - only if menstruating) SECTION A

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

SECTION B: _____

- 1. Vaginal itching 0 1 2 3
- 2. Vaginal discharge 0 1 2 3
- 3. Low or no desire for sex 0 1 2 3
- 4. Dislike for intercourse 0 1 2 3
- 5. Missed periods 0 1 2 3
- 6. Over 15 years of age and have not begun menstruation 0 1 2 3

Part 10 SECTION B Cont. (FEMALES ONLY)

- 7. Unable to get pregnant No Yes
- 8. Miscarriages No Yes
How many _____
- 9. Abortion No Yes
How many _____

Part 10 SECTION C: _____

Check if you experience any of these symptoms DURING MENSTRUATION.

- 1. Low abdominal pain 0 1 2 3
- 2. Dull ache radiating to low back or leg 0 1 2 3
- 3. Increased urinary frequency 0 1 2 3
- 4. Pelvic soreness 0 1 2 3
- 5. Diarrhea 0 1 2 3
- 6. Headaches 0 1 2 3
- 7. Abdominal bloating 0 1 2 3
- 8. Menstrual pain 0 1 2 3
- 9. Nausea and/or vomiting 0 1 2 3
- 10. Have to lie down on first or 2 day of period 0 1 2 3
- 11. Craving for sweets 0 1 2 3
- 12. Insomnia 0 1 2 3
- 13. Light scanty blood flow 0 1 2 3
- 14. Pain and cramps without blood flow 0 1 2 3
- 15. Heavy menstrual bleeding 0 1 2 3
- 16. Anxiety about menstrual cycle 0 1 2 3
- 17. Pain during period is progressively getting worse with time 0 1 2 3

Part 10 SECTION D: _____

- 1. Vaginal bumps and sores 0 1 2 3
- 2. Pubic area sore 0 1 2 3
- 3. Ovarian cysts 0 1 2 3
- 4. Uterine cysts 0 1 2 3
- 5. Pain in ovaries 0 1 2 3
- 6. Breast lumps 0 1 2 3
- 7. Breast sore to touch 0 1 2 3

Part 10 SECTION D: continued

- 8. Breast painful 0 1 2 3
- 9. Water retention 0 1 2 3
- 10. Swollen feeling 0 1 2 3
- 11. Premenstrual breast pain or discomfort 0 1 2 3
- 12. Mother used D.E.S. (hormones) while pregnant No Yes
- 13. Abnormal PAP smear No Yes (15)
- 14. Family history of breast cancer No Yes (10)
- 15. Form of birth control _____

Part 10 SECTION E: _____

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

Part 10 SECTION F: HORMONE BALANCE TEST



SYMPTOM GROUP 1

- PMS
- Early miscarriage
- Unexplained weight gain
- Anxiety
- Insomnia
- Painful and or lumpy breasts
- Cyclical headaches
- Infertility

Total boxes checked

If you have checked 2 or more boxes in this group, turn to answers to find out what type of hormonal imbalance you may have

SYMPTOM GROUP 2

- Vaginal dryness
- Painful intercourse
- Bladder infections
- Hot flashes
- Night sweats
- Memory problems
- Lethargic depression

Total boxes checked

If you have checked two or more boxes in this group, turn to answers to find out what type of hormonal imbalance you may have.

SYMPTOM GROUP 3

- Rapid weight gain
- Mood swings
- Anxious, depression
- Red flush on face
- Weepiness (crying)
- Cervical dysplasia (abnormal pap smear)
- Breast tenderness
- Heavy bleeding
- Migraine headaches
- Foggy thinking
- Gallbladder problems

Total boxes checked

If you have checked two or more boxes in this group, turn to answers to find out what type of hormonal imbalance you may have.

SYMPTOM GROUP 4

A combination of the symptoms in #1 and #3

Total boxes checked

SYMPTOM GROUP 5

- Acne
- Excessive facial and arm hair
- Thinning hair on head
- Ovarian cysts
- Polycystic ovary syndrome (PCOS)
- Hypoglycemia and/or unstable blood sugar
- Infertility problems
- Mid-cycle pain

Total boxes checked

If you have checked two or more boxes in this group, turn to answers to find out what type of hormonal imbalance you may have.

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SYMPTOM GROUP 6

- Debilitating fatigue
- Foggy thinking
- Thin and/or dry skin
- Brown spots on face
- Unstable blood sugar
- Low blood pressure
- Intolerance to exercise

Total boxes checked

If you have checked two or more boxes in this group, turn to answers to find out what type of hormonal imbalance you may have.

ANSWERS TO HORMONE TEST

1. SYMPTOM GROUP 1

Progesterone deficiency: This is the most common hormone imbalance among women of all ages. You may need to change your diet, ask your doctor about getting off of synthetic hormones and you may need to use some progesterone cream.

2. SYMPTOM GROUP 2

Estrogen deficiency: This hormone imbalance is most common in menopausal women; especially if you are petite and/or slim. You may need to make some special changes to your diet; take some women's herbs; and some women may even need natural estrogen.

3. SYMPTOM GROUP 3

Excess estrogen: In women, this is most often solved by getting off of the conventional hormones (with your primary care physician's approval) most often prescribed by doctors for menopausal women.

4. SYMPTOM GROUP 4

Estrogen dominance: This is caused when you don't have enough progesterone to balance the effects of estrogen. Thus, you can have low estrogen, but if you have even lower progesterone you may experience symptoms of estrogen dominance. Many women between the ages of 40 and 50 suffer from estrogen dominance.

5. SYMPTOM GROUP 5

Excess androgens (male hormones): This is most often caused by too much sugar and simple carbohydrates in the diet and is often found in women who have polycystic ovary syndrome (PCOS)

6. SYMPTOM GROUP 6

Cortisol deficiency: this is caused by tired adrenals, which is usually caused by chronic stress or chronic inflammation.



Our Recommended Adrenal-Hormone Function Test: DUTCH COMPLETE

Combining advanced hormone testing and nutritional support, Dried Urine Testing for Comprehensive Hormones (DUTCH)

The most advanced test for sex and adrenal hormones.

- More comprehensive than serum, saliva or 24-hour urine testing
- Easy patient collection (4 dried urine samples collected simply on filter paper)
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- Accurate and comprehensive testing of sex hormones and metabolites (including 2,4,16-OH estrogens)
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- 8 separate lab methods (GC-MS/MS, LC-MS/MS) to ensure the most accurate methods for each test
- One simple test to bring you unrivaled clinical information and confident clinical conclusions

DUTCH testing allows providers to make the most informed clinical decisions about treatment options. Precision Analytical has raised the bar on lab testing with **DUTCH**.

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Dried Urine Test for Comprehensive Hormones

Now A Single Test Gives You the Full Picture!
Simply. Better. Testing.

Part 11 SECTION A: _____

- 1. Painful fingers _____ 0 1 2 3
- 2. Bones sore/painful 0 1 2 3
- 3. Eat red meat 0 1 2 3
- 4. Cavities 0 1 2 3
- 5. Arthritis 0 1 2 3
- 6. Drink carbonated beverages/soda _____ cans per week Yes
- 7. Gum disease 0 1 2 3
- 8. Bone loss 0 1 2 3
- 9. Calcium deposits 0 1 2 3
- 10. Use antacids 0 1 2 3
- 11. Dentures 0 1 2 3
- 12. Bone deformity 0 1 2 3
- 13. Have you been diagnosed with osteoporosis or other bone Diseases. 0 1 2 3
- 14. Recent bone fracture or break 0 1 2 3
- 15. Postmenopausal 0 1 2 3

Part 11 SECTION B: _____

- 1. Muscle spasms 0 1 2 3
- 2. Tightness in shoulder muscles 0 1 2 3
- 3. Muscle cramps 0 1 2 3
- 4. Pain in arms, hands 0 1 2 3

- 5. Leg cramps at night 0 1 2 3
- 6. Stiff all over 0 1 2 3
- 7. Stiff in the morning 0 1 2 3
- 8. Unable to sit up straight 0 1 2 3
- 9. Pain in neck and or shoulders 0 1 2 3
- 10. Back pain 0 1 2 3

Part 11 SECTION C _____

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

Part 12

- 1. Head feels heavy _____ 0 1 2 3
- 2. Light headedness/fainting 0 1 2 3
- 3. Loss of balance 0 1 2 3
- 4. Dizziness 0 1 2 3
- 5. Ringing/buzzing in ears 0 1 2 3
- 6. Trembling hands 0 1 2 3
- 7. Loss of feeling in hands and/or feet (toes) 0 1 2 3
- 8. Exhaustion on slightest effort 0 1 2 3
- 9. Limbs feel too heavy to hold up 0 1 2 3
- 10. Loss of grip strength 0 1 2 3
- 11. Tingling pain sensation 0 1 2 3
- 12. Convulsions 0 1 2 3
- 13. Incoordination 0 1 2 3
- 14. Nervousness 0 1 2 3
- 15. Accident prone 0 1 2 3
- 16. Loss of muscle tone 0 1 2 3
- 17. Need for 10-12 hours of sleep 0 1 2 3
- 18. Have had shingles 0 1 2 3

Part 13 _____

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

Part 13B (Sleep Apnea)

Sleep apnea is a common disorder. Experts say it affects about eighteen million Americans. People with sleep apnea stop breathing for brief periods while they sleep. They may awaken for a few seconds as they struggle to breathe. The next day, the sleeper may not remember what happened. Signs of the disorder include *sleepiness* during the day and *restless sleep*. Some people make rough sounds while they sleep. More men have sleep apnea than women do. It is also common in older adults and in persons who are heavy.

Circle the numbers of the comments that apply to you.

- 1. I have been told that I snore.
- 2. I sometimes suffer from daytime sleepiness.
- 3. I have dozed off in church on occasion.
- 4. If I doze off, I sometimes wake up with a "snort."
- 5. I have been told that I hold my breath or stop breathing in my sleep.
- 6. I have high blood pressure.
- 7. I toss and turn a lot in my sleep.
- 8. I get up to visit the bathroom more than once a night.
- 9. I often feel sleepy and struggle to stay alert, especially during the afternoon
- 10. I sometimes fall asleep while watching TV.
- 11. I have fallen asleep at a stop light or stop sign.
- 12. I have actually fallen asleep while driving.
- 13. I wish I had more energy and less fatigue.
- 14. My neck measures over 17 inches (males) or over 16 inches (females)
- 15. I am more than 15 pounds overweight.
- 16. I seem to be losing my sex drive, or my ability to perform in bed.
- 17. I sometimes get heartburn in the middle of the night.
- 18. I frequently wake with a bad taste in my mouth, or a dry mouth and throat.
- 19. I often get morning headaches.
- 20. When I cannot wake up from a nightmare, I feel paralyzed and I panic.

- 21. I suddenly wake up gasping for breath.
- 22. I sometimes wake up with a pounding or irregular heartbeat.
- 23. I frequently feel depressed.
- 24. I feel as if I'm getting old too fast.
- 25. My friends and family say I'm sometimes grumpy and irritable.
- 26. I have short term memory problems.
- 27. I don't feel rested or refreshed, even after 8 or 10 hours of sleep.
- 28. I sometimes perspire a lot, especially at night.
- 29. I'm tired all the time.
- 30. I have great difficulty concentrating.

If you circled 5 or more symptoms, you could have OSA (obstructive sleep apnea). The risks of OSA include heart attacks, strokes, impotence, irregular heartbeat, high blood pressure and heart disease.

Take this form to your doctor. Treatments are available to eliminate sleep apnea and snoring without surgery or drugs, but you must visit a sleep center or clinic to be tested.

Part 14 (Acid/base imbalance)

- 1. Fatigue 0 1 2 3
- 2. Cold hands and feet 0 1 2 3
- 3. Headaches 0 1 2 3
- 4. Allergies 0 1 2 3
- 5. Acne 0 1 2 3
- 6. Bloating 0 1 2 3
- 7. Rapid breathing 0 1 2 3
- 8. Irritability 0 1 2 3
- 9. Candida or fungal infections 0 1 2 3
- 10. Depression and anxiety 0 1 2 3
- 11. Cold sores 0 1 2 3
- 12. Urinary tract infections 0 1 2 3

- 13. Arthritis 0 1 2 3
 - 14. Excess stress 0 1 2 3
 - 15. Difficult weight loss 0 1 2 3
 - 16. Constipation 0 1 2 3
 - 17. Rheumatic conditions 0 1 2 3
 - 18. Insomnia 0 1 2 3
 - 19. Gastric and stomach problems 0 1 2 3
 - 20. Water retention 0 1 2 3
- 1-5 low 6-9 moderate 10-15 high

Part 15 DENTAL RECORD & METAL ALLERGIES

This extensive Q&A gives us a preliminary indication of whether you may suffer with a metal allergy.

1. YOUR DENTAL RECORD

Dental restorations are the most common cause of metal allergy; the more intimate exposure to metals such as mercury and gold, the greater the chance of becoming sensitized. **NOTE: If you don't know the answer to a specific question, place a question mark.**

1.1 CURRENT DENTAL FILLINGS (if you're not sure, please ignore)

Dental Material	Year of placement:	Number of fillings:
Amalgam	_____	_____
Gold	_____	_____
Titanium	_____	_____
Composites	_____	_____
Metal-bound ceramic	_____	_____
Cobalt-crown	_____	_____
Non-metallic ceramic	_____	_____

1.2 ROOT CANAL FILLINGS

Amalgam	_____
Gutta Percha	_____
Calcium hydroxide	_____
Other	_____

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