

How often do you experience the following:

Possible Low Stomach HCL	None	Daily	Weekly	Monthly	Possible High Stomach HCL	None	Daily	Weekly	Monthly
Bloating , burping, or discomfort after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burning sensation immediately after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling particularly full after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GERD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn is worse when lying down at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to have vitamin B12 deficiency	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning sensation 30-40 mins after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting or nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Undigested food in your stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consume more than one caffeinated or alcoholic drink	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food allergies or intolerances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you smoking?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Experience chronic stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Possible Small Intestine Bacterial Overgrowth	None	Daily	Weekly	Monthly	Possible Candida	None	Daily	Weekly	Monthly
Abdominal pain/ discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brain fog	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal distension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Digestion problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Craving sweets or carbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flatulence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal itching, dis charge, or soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain during intercourse (Females)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin disorders, such as psoriasis or skin patches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamin B12 deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching of the skin in the lower abdominal or bra line	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iron deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to old carpet (older than 3 years) or moist environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess folate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Possible Heavy Metals Exposure & Environmental Chemicals	None	Daily	Weekly	Monthly	Possible Heavy Metals Exposure & Environmental Chemicals	None	Daily	Weekly	Monthly
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability or anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic joint or muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression or mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic inflammation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
An autoimmune condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty to concentrate or "brain fog"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have old dental fillings or had them removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drink tap water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Live or work in an industrial environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work in construction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you live in a house that was built before 1978?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Eat fish or seafood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Use deodorants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Use pesticides or herbicides (bug or weed killers; flea and tick sprays, collars, powders, or shampoos) in your home or garden, or on pets

None Daily Weekly Monthly

Use household air fresheners, laundry detergents, or other cleaning products

None Daily Weekly Monthly

Are you smoking or have you smoked before for longer than a few months?

No Yes

Cook with aluminum baking plates

None Daily Weekly Monthly

How often are you near any high-powered electrical wires or transformers?

None Daily Weekly Monthly

How often are you in a place that does not have proper ventilation or does not have an air filter?

None Daily Weekly Monthly

How often were you exposed to chemicals in the past (occupational, at home, or at work)?

None Daily Weekly Monthly

Possible Mold Exposure

None Daily Weekly Monthly

Dark spots on surfaces

No Yes

A musty, damp, or earthy smell

No Yes

Dark tile grout

No Yes

Living with current or previous water damage

No Yes

Warping, bubbling, cracking wall surface

No Yes

Sneezing or Coughing

Nasal congestion

Postnasal drip

Memory impairments or brain fog

Possible Mold Exposure

None Daily Weekly Monthly

Weak voice

Red or watery eyes

Wheezing or Shortness of breath

Mood disorders (depression, anger)

Lightheadedness or dizziness

Coordination problems

Allergic reaction

Atopic dermatitis

Mood disorders

Chronic fatigue

Possible Deficiency of Nutrients

None Daily Weekly Monthly

Irritability or depression

Headaches

Fatigue

Loss of appetite and weight loss

Muscle weakness

Cracked or sore lips

Difficulty to sleep

Loss of appetite

Impaired immune function

A decline in your mental abilities, such as memory or concentration

Possible Deficiency of Nutrients

None Daily Weekly Monthly

Hair loss

High blood pressure

Irregular heartbeat

Impotence or loss of sexual function

Muscle spasms or cramps

Tendency to feel depressed

Lower calcium levels in the blood

Type 2 Diabetes or pre-diabetic

No Yes

Loss of bone mass: Osteopenia or osteoporosis

No Yes

A sensation of numbness, tingling, or pins and needles

Possible Secondary Mitochondrial Dysfunction	None	Daily	Weekly	Monthly	Possible Low Testosterone	None	Daily	Weekly	Monthly
Fatigue during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reduced libido (sex drive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic joint pain and inflammation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of body hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological conditions, such as Alzheimer's, dementia, Huntington's, or Parkinson's	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Obesity or significant weight gain	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Neurobehavioral and psychiatric diseases, such as autism, schizophrenia, or bipolar	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Loss of muscle mass	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Depression and mood disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Men: Erectile dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type 2 Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Decrease in bone mass	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Nerve pain (also called neuropathy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mood changes or depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory decline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Takes time to recover from physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Possible High Estrogen	None	Daily	Weekly	Monthly
An autoimmune condition, such as Lupus, Rheumatoid Arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Swelling and tenderness in your breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple sclerosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Decreased or loss sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increased symptoms of premenstrual syndrome (PMS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight gain (especially in the hips area)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer diagnosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Abnormal menstrual periods, bleeding too light or too heavy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart or kidney disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Irregular menstrual periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Mood swings, often presenting as depression or anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Possible Adrenal Hypocortisolemia	None	Daily	Weekly	Monthly	Possible Low Thyroid or Thyroid Hormone Imbalance	None	Daily	Weekly	Monthly
Feel tired in the mornings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling cold when other people do not, or cold fingers and toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower back soreness or pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation or less than one bowel movement per day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back pain increases if you are tired or standing for a long period of time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tend to be a night person	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Weight gain, even though you are not eating more food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel tired or tend to yawn in the afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Possible Adrenal Hypocortisolemia	None	Daily	Weekly	Monthly	Possible Low Thyroid or Thyroid Hormone Imbalance	None	Daily	Weekly	Monthly
Feel dizzy when standing up quickly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty to lose weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath or asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint or muscle soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crave salty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling sad or depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain or arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grind or clench your teeth at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Morning headaches that reduce during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had or have allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Pale, dry skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel anxious or stressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry or loss of hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had or have a stressful/abusive relationship	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Less sweating than others or usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dark circles under your eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low motivation or "brain fog"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Puffiness under your eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Puffy face or excess fluids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep in and have difficulty getting out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A hoarse voice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired all the time	<input type="checkbox"/> No	<input type="checkbox"/> Yes			Brittle nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work or used to work night shifts	<input type="checkbox"/> No	<input type="checkbox"/> Yes			More than usual menstrual bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consumed steroids (e.g. prednisone) for over a month	<input type="checkbox"/> No	<input type="checkbox"/> Yes			A decline in memory or "slower thinking"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms reduced with prescription of steroids	<input type="checkbox"/> No	<input type="checkbox"/> Yes							
Pain reduced with cortisol injection	<input type="checkbox"/> No	<input type="checkbox"/> Yes							
Possible High Thyroid or Thyroid Hormone Imbalance	None	Daily	Weekly	Monthly	Possible Pituitary Dysfunction	None	Daily	Weekly	Monthly
Difficulty in gaining weight, even with a large consumption of food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increased libido				
Feeling nervous, emotional, or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decreased libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Faster pulse at rest or heart palpitation (feeling your heartbeat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intolerance to high temperatures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory decline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Needs to eat sugar, sweets, or carbs to feel good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbance or insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes in vision, sensitivity to light, eye irritation, or dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive sweating and oily skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue, muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor growth or delayed sexual development (short height)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin thinning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inability to produce breast milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to sweat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Severe headache or stiff neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Possible (Low) Serotonin Imbalance	None	Daily	Weekly	Monthly
Do you have a tendency to be negative?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Are you often worried and anxious?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Are you a perfectionist or behave in an obsessive-compulsive way?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you have winter or seasonal depression?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you tend to be shy or have social phobias?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you have eating disorders?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you feel overwhelmed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you crave carbs or chocolate often?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Are you using artificial sweeteners often?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you have difficulty sleeping that is relieved by melatonin supplements?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		

Possible Low Endorphin	None	Daily	Weekly	Monthly
Do you tend towards addicting behaviors (such as alcohol, video games, pornography, or gambling)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you experience anxiety or depression?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you have low self-esteem?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you tend to avoid painful or stressful conversations?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Have you been suffering from chronic pain (over 3 months)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Do you crave chocolate, bread or sweets, wine, or marijuana?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble sleeping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Fibromyalgia?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Chronic Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Possible Low Norepinephrine	None	Daily	Weekly	Monthly
Feel depressed, "flat," or bored	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low motivation or enthusiasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low ability or difficulty to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attracted to take adventures or dangerous activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Possible Low GABA	None	Daily	Weekly	Monthly
Feel overworked or stressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Find it hard to relax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Find it hard to let go of thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get easily upset or frustrated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel overwhelmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Need alcohol or drugs to relax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Possible (Low) Dopamine Imbalance	None	Daily	Weekly	Monthly
Experience lethargy and lack of enjoyment of life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendency of addicting behavior, such as drugs, alcohol, pornography, video games, binge eating, or gambling	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Attention disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes		

Possible (Low) Dopamine Imbalance	None	Daily	Weekly	Monthly
Do you eat small amounts of protein?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Are you taking supplements of 5-HTP or L-Tyrosine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Are you taking supplement of magnolia bark (Magnolia officinalis) or licorice root (Glycyrrhiza glabra)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		

Possible (Low) Dopamine Imbalance None Daily Weekly Monthly

Lack of motivation, apathetic, hopeless, or joyless

Is it hard to start things and even harder to finish them?

Tendency to be deficient in vitamin D No Yes

Consume sugar, sweets, or soda drinks

Possible (Low) Dopamine Imbalance None Daily Weekly Monthly

Do you experience tremors of the arm or have Parkinson's disease? No Yes

Are you under stress?

Are you talking on your mobile phone frequently or for long hours?

Do you have fibromyalgia and chronic fatigue syndrome? No Yes

Any other concerns? Please list here