**Nutrition & Lifestyle Questionnaires**

Directions

1. Answer each question with the response that best fits you. It is recommended that you either photocopy the questionnaires or record your answers on a separate piece of paper. You will hopefully be using them again to test your progress, and it will be easier if you do not have your previous answers in front of you at that point. It is extremely important to answer the questions as accurately and honestly as possible. There are no right or wrong answers. Supply the response that most accurately describes you, not what you think the answer should be.

When answering these questions, forget everything you've been told about nutrition. Answer the questions based on your gut instinct to how you would prefer to eat if you could eat what you innately desire.

2. Total your scores for each questionnaire. There are numbers in parentheses after each answer. Add up the numbers corresponding to each of your responses to get your total score for the section.

3. Graph your scores.

4. Calculate your total score by adding up the scores for each section.

**You Are What You Eat**

1. Do you shop for food less frequently than every four days?

\_\_\_\_\_ Yes (1)

\_\_\_\_\_ No (0)

1. Do you eat more packaged (frozen or canned) fruits and vegetables than fresh?

\_\_\_\_\_ Yes (3)

\_\_\_\_\_ No (0)

1. Do you eat more cooked vegetables than raw?

\_\_\_\_\_ Yes (3)

\_\_\_\_\_ No (0)

1. Do you eat vegetables with fewer than two meals daily?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. Do you buy more non-organic vegetables than organic vegetables?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. How often do you use a microwave oven?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ 1-2 times per week (2)

­\_\_\_\_\_ 3-4 times per week (5)

\_\_\_\_\_ 4+ times per week (10)

1. Do you eat white bread more often than whole grain breads?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. Do you eat quick cook grains such as Quaker Oats or Minute rice more often than slow cooked organic whole grains?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. How often do you consume pasteurized, homogenized milk or cheeses?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ 1-2 times per week (1)

­\_\_\_\_\_ 3 times per week (3)

\_\_\_\_\_ 3+ times per week (5)

1. How often do you eat non-organic yogurts?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ 1-2 times per week (1)

­\_\_\_\_\_ 3 times per week (3)

\_\_\_\_\_ 3+ times per week (5)

1. Do you eat typical store-bought eggs from cage-raised chickens (as opposed to eggs from free-range or pasture-raised chickens)?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. Do you eat non-organic red meat more than once every four days?

\_\_\_\_\_ Yes (3)

\_\_\_\_\_ No (0)

1. Do you commonly eat meats (beef, chicken, turkey) from sources other than a free-range and hormone-free source?

\_\_\_\_\_ Yes (3)

\_\_\_\_\_ No (0)

1. Do you eat canned fish more frequently than fresh fish?

\_\_\_\_\_ Yes (3)

\_\_\_\_\_ No (0)

1. How often do you use commercial salad dressings?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ Once a week (1)

­\_\_\_\_\_ Twice per week (2)

\_\_\_\_\_ 2+ times per week (3)

1. How often do you use products containing hydrogenated oils?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ Once a week (1)

­\_\_\_\_\_ Twice per week (2)

\_\_\_\_\_ 2+ times per week (5)

1. Do you eat nuts or seeds that are roasted or salted?

\_\_\_\_\_ Yes (1)

\_\_\_\_\_ No (0)

1. How often do you use white table sugar as a sweetener?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ Once per week (1)

­\_\_\_\_\_ 2-3 times per week (3)

\_\_\_\_\_ 3+ times per week (5)

1. How often do you use artificial sweeteners such as Sweet-n-Low, Equal or NutraSweet?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ Once a week (1)

­\_\_\_\_\_ 2-3 times per week (5)

\_\_\_\_\_ 3+ times per week (10)

1. Do you use standard white table salt?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. Do you eat TV dinners or highly-processed foods more than three times a week?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. How often do you eat from fast food restaurants like McDonalds, TacoBell, Starbucks, etc...?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ 1-2 times per week (2)

­\_\_\_\_\_ 3 times per week (5)

\_\_\_\_\_ 3+ times per week (10)

1. How often do you eat snacks from vending machines?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ 1-2 times per week (2)

­\_\_\_\_\_ 3 times per week (5)

\_\_\_\_\_ 3+ times per week (10)

1. Do you drink tap water?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. How often do you eat some form of store-bought dessert such as ice cream, cookies, donuts, cakes or pies?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ Once per week (1)

­\_\_\_\_\_ 2-3 times per week (3)

\_\_\_\_\_ 3+ times per week (5)

Total Score: \_\_\_\_\_

**Stress**

1. Do you eat more or less when stressed than when not stressed?

\_\_\_\_\_ More (10)

\_\_\_\_\_ Same or less (0)

1. Do you worry over job, income or money problems?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. Are any of your relationships causing you stress?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. Do you often feel anxious?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. Do you often get upset when things go wrong?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. Do you lash out at others?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. Do you feel your sex drive is lower than normal for you?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. Do you feel isolated or lonely?

\_\_\_\_\_ Yes (3)

\_\_\_\_\_ No (0)

1. Do you feel stressed due to lack of intimacy in one or more relationships?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. Have you had reduced contact with friends (feeling antisocial) or an increase in contact because you feel you need to vent your frustrations or stressed to others?

\_\_\_\_\_ Yes (3)

\_\_\_\_\_ No (0)

1. Do you take any form of medication prescribed by a physician directly or indirectly related to stress in your life or for a psychological disorder?

\_\_\_\_\_ Yes (15)

\_\_\_\_\_ No (0)

1. Do you commonly lose more than two fays or work a year due to illness?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

Total Score: \_\_\_\_\_

**Sleep Wake Cycles**

1. Do you live in the same time zone you were born in?

\_\_\_\_\_ Yes (0)

\_\_\_\_\_ No (5)

1. Do you travel across time zones more than once a month?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. How often do you wake up feeling un-rested and in need of more sleep?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ Once a week (1)

\_\_\_\_\_ 3 times per week (5)

\_\_\_\_\_ 3+ times per week (10)

1. Do you commonly go to bed after 10:30 p.m.?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. Are the times you have bowel movements consistent and predictable on a daily basis?

\_\_\_\_\_ Yes (0)

\_\_\_\_\_ No (5)

1. Do you suffer from reduced memory since moving to a new time zone or since traveling across time zones?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. Has your sense of hunger changed from being hungry at breakfast (upon rising), lunch (midday) and dinner times (sunset) since moving to a new time zone or traveling across time zones frequently (more than once a month)?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. How often do you wake up at night between 1:00 a.m. and 4:00 a.m. and have a hard time falling back to sleep?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ Once a week (1)

\_\_\_\_\_ 3 times per week (5)

\_\_\_\_\_ 3+ times per week (10)

1. How often do you tend to have a hard time staying awake in the afternoon after eating lunch?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ Once a week (1)

\_\_\_\_\_ 3 times per week (5)

\_\_\_\_\_ 3+ times per week (10)

1. Do you do shift work that requires you to stay up late at night?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

Total Score: \_\_\_\_\_

**You Are When You Eat**

1. Do you frequently skip meals?

\_\_\_\_\_ Yes (3)

\_\_\_\_\_ No (0)

1. How often do you typically go more than four hours without eating?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ 1-2 times per week (1)

\_\_\_\_\_ 3 times per week (2)

\_\_\_\_\_ 3+ times per week (3)

1. How often do you skip breakfast?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ 2 times per week (1)

\_\_\_\_\_ 3 times per week (5)

\_\_\_\_\_ 3+ times per week (10)

1. Do you avoid fats when eating?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. Do you frequently eat carbohydrates (i.e. breads, bagels, cookies, pasta, fruit, cereals, muffins, crackers, chocolate, or candy) by themselves?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. Do you often get hungry or crave sweets within two hours after eating a meal?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. How often do you consume drinks containing caffeine or sugar (i.e. coffee, tea, sodas, fruit juices with sucrose, corn syrup or added sugar)?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ 1 cup per day (1)

\_\_\_\_\_ 2 cups per day (3)

\_\_\_\_\_ More than 2 cups per day (5)

1. Have you tried diets to lose weight?

\_\_\_\_\_ No (0)

\_\_\_\_\_ Once (1)

\_\_\_\_\_ Twice (2)

\_\_\_\_\_ 3-5 times (5)

\_\_\_\_\_ More than five times (10)

1. Do you have difficulty burning fat around your belly, hips or thighs even with regular exercise?

\_\_\_\_\_ Yes (3)

\_\_\_\_\_ No (0)

1. Do you eat your largest meal in the evening?

\_\_\_\_\_ Yes (1)

\_\_\_\_\_ No (0)

Total Score: \_\_\_\_\_

**Digestion**

1. How often do you experience lower abdominal bloating?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ 1-2 times per week (3)

\_\_\_\_\_ 3 times per week (5)

\_\_\_\_\_ 3+ times per week (10)

1. Do you frequently have loose stools or diarrhea?

\_\_\_\_\_ No (0)

\_\_\_\_\_ Once a week (1)

\_\_\_\_\_ 3 or more times per week (5)

1. How often do you experience constipation or stools that are compact or hard to pass?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ 1-2 times per week (3)

\_\_\_\_\_ 3 or more times per week (5)

1. Do you find that you often burp after meals?

\_\_\_\_\_ Yes (3)

\_\_\_\_\_ No (0)

1. Do you frequently have gas?

\_\_\_\_\_ Yes (3)

\_\_\_\_\_ No (0)

1. Do you crave certain foods such as bread, chocolate, certain fruit, and red meat if you have not eaten them in a day or two?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. How often do you have a poor appetite or feel worse after eating?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ 1-2 times per week (3)

\_\_\_\_\_ 3 times per week (5)

\_\_\_\_\_ 3 or more times per week (10)

1. Do you have an excessive appetite and/or sweet cravings?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. Do you frequently (more than twice a week) experience abdominal pain, cramps or general abdominal discomfort?

\_\_\_\_\_ Yes (20)

\_\_\_\_\_ No (0)

1. How often do you have indigestion, heartburn or an upset stomach?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ 1-2 times per week (3)

\_\_\_\_\_ 3 times per week (5)

\_\_\_\_\_ 3 or more times per week (10)

1. How often do you get a headache after eating?

\_\_\_\_\_ Never or very rarely (0)

\_\_\_\_\_ 1-2 times per week (3)

\_\_\_\_\_ 3 or more times per week (5)

Total Score: \_\_\_\_\_

**Fungus & Parasites**

1. Have you ever been given general anesthesia?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. Have you ever taken antibiotics?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. Have you been or are you being treated for any condition requiring that you take medical drugs?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. In general, are your bowel movements loose, hard or foul smelling?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. Would you consider your life to be:

\_\_\_\_\_ Stress free (0)

\_\_\_\_\_ Mildly stressful (5)

\_\_\_\_\_ Very stressful (10)

1. Do you currently suffer from any digestive disorder or frequently have pain in the region above or below the navel?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. Do you have mercury amalgam fillings in your mouth?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. Do you have two different kinds of metal in your mouth; i.e., gold and silver or mercury amalgam and gold or silver?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. Do you experience itching in the ears, nose or rectum area?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. Do you have or have you had dandruff in the past year?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. Do you regularly eat or drink products containing sugar, white flour, processed dairy products?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. Do you crave sugar, fruit or milk if you don't have either of these items for more than three days?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. Do you find that regardless of how much you eat you get hungry quickly?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. In the past year, have you experienced athlete's foot (itching around the toes, soles or heel of the feet), jock itch or a fungal infection under a toenail (thickening of the toenail)?

\_\_\_\_\_ Yes (20)

\_\_\_\_\_ No (0)

1. Do you ever get a reddening around the mouth or nose area after eating or drinking?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. Do you experience muscle or joint aches on a regular basis?

\_\_\_\_\_ Yes (5)

\_\_\_\_\_ No (0)

1. Do you experience mood swings?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. Do you snack on sweets or drink coffee, soda pop or sports drinks most days to keep your energy up?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. Do you suffer from any kind of skin condition?

\_\_\_\_\_ Yes (10)

\_\_\_\_\_ No (0)

1. Have you ever had sex or close physical contact with anyone who you know had a fungal infection (including athletes foot, jock itch, dandruff) or parasite infection?

\_\_\_\_\_ Yes (20)

\_\_\_\_\_ No (0)

Total Score: \_\_\_\_\_

**Score Chart**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **You are What You Eat** | **Stress** | **Sleep/Wake Cycles** | **You are When You Eat** | **Digestion** | **Fungus & Parasites** | **Total Score** |
| **Zone** | **1, 2 and 3** | **4** |  | **3** | **1, 2 and 3** | **3 and 4** |  |
| **High Priority** | 130  60  50 | 81  60  40 | 90  70  50 | 50  35  20 | 90  81  40 | 195  120  60 | 627  426  260 |
| **Moderate Priority** | 40  30 | 30  20 | 40  30 | 15  10 | 30  20 | 50  40 | 205  150 |
| **Low Priority** | 15 | 10 | 15 | 5 | 15 | 20 | 80 |
| **Score 1 Date:** |  |  |  |  |  |  |  |
| **Score 2 Date:** |  |  |  |  |  |  |  |