

CLIENT NAME _____ DATE _____

DIRECTIONS: If any of the statements below apply to you, then place a 1 if the problem is minor or infrequent or a 2 if the problem is persistent or serious in the un-shaded box to the right of the statement. When you have finished, total each column and write the total at the bottom of the page. The category with the highest points is the one you need to focus on in your weight loss program, although any category with a score higher than five means that category may be a factor in your weight problem. Attention should always be paid to core nutrition and exercise in addition to addressing specific areas of concern.

Is your waist measurement (at the navel) larger than your hips (the widest part of your hip joints)?						
Do you eat simple carbohydrates (sugar, white flour, bread, potatoes) every day?						
Do you experience cravings for sugar?						
Do you experience fatigue or loss of energy when you haven't eaten in a few hours?						
Do you suffer from hypoglycemia or Type II diabetes?						
Men: Do you experience prostate problems? Women: Do you experience heavy menstrual bleeding or have uterine fibroids?						
Do you consume commercially-raised meat and dairy products regularly?						
Do you drink beverages from soft plastic containers (milk, juice, etc.) daily?						
Men: Do you have an enlarged breast area? Women: Do you experience PMS symptoms that include irritability, anxiety or nervous tension?						
Do you consume commercially-grown produce without washing it to remove pesticide residues?						
Do you have a tendency to a low body temperature (i.e., cold hands and feet, feeling cold when others are warm)?						
Do you experience fatigue or low energy levels?						
Do you have problems with dry skin?						
Do you have problems with depression or lack of sexual desire?						
Has a medical doctor diagnosed you with low thyroid?						
Do you feel like you are under an excessive amount of stress?						
Do you have problems with muscle tension, anxiety, and/or nervousness?						
Do you have high blood pressure?						
Is your weight primarily in the abdominal area?						
Do you toss and turn at night or experience restless sleep patterns?						
Do you have (or have you had in the past) problems with high cholesterol (over 275) or do you experience cravings for fats?						
Do you have skin problems (acne, rashes, hives, eczema, etc.)?						
Do you now work (or have you worked in the past) in a job where you were exposed to a lot of chemicals (examples: Dry Cleaners, Beauty Parlor, Laboratory, Hospital, Lawn Chemicals, Pesticides, etc.)?						
Do you suffer regularly from aches and pains such as arthritis, muscle stiffness, or frequent headaches?						
Do you have difficulty falling asleep at night and feel groggy and sluggish in the morning?						
Do you often have a stuffy or bloated feeling in your stomach or abdomen?						
Do you experience problems with your self image (i.e., feeling you are undesirable, unlovable, unworthy, etc.)?						
Are you always worrying about your weight or judging yourself as unattractive?						
Do you often find yourself eating, even when you aren't really hungry?						
Do you have compulsive cravings for certain "comfort" foods?						
Do you eat when you are unhappy or depressed to help yourself feel better?						
Total Your Results Here ----->	Category 1	Category 2	Category 3	Category 4	Category 5	Category 6