Male Symptom Assessment

Name: _____Birthdate: _____ Gender:_____

Email: _____ Phone: _____

General Health Assessment (Part 1)

Please indicate how frequently you experience the following symptoms according to these guidelines:

Never = 0% of the time
Rarely = Less than 30% of the time
Sometimes = About 50% of the time
Often = More than 70% of the time

Do you feel tired most of the time?	O Never	O Rarely	O Sometimes	O Often
Lifestyle-altering fatigue	O Never	O Rarely	O Sometimes	O Often
Intestinal gas	O Never	O Rarely	O Sometimes	O Often
Abdominal bloating	O Never	O Rarely	O Sometimes	O Often
Sugar cravings	O Never	O Rarely	O Sometimes	O Often
Bread or beer cravings	O Never	O Rarely	O Sometimes	O Often
Constipation and/or diarrhea	O Never	O Rarely	O Sometimes	O Often
Irritability and/or moodiness	O Never	O Rarely	O Sometimes	O Often
Brain fog and/or poor memory	O Never	O Rarely	O Sometimes	O Often
Feeling faint, dizzy, or lightheaded	O Never	O Rarely	O Sometimes	O Often
Muscle or body aches	O Never	O Rarely	O Sometimes	O Often
Itching or burning sensation in rectum or vagina	O Never	O Rarely	O Sometimes	O Often
Loss of sexual desire	O Never	O Rarely	O Sometimes	O Often
White thrush or yellow fuzzy tongue	O Never	O Rarely	O Sometimes	O Often
Athlete's foot, ringworm, or jock itch	O Never	O Rarely	O Sometimes	O Often
Fingernail or toenail fungus	O Never	O Rarely	O Sometimes	O Often
Sensitivity to perfumes, insecticides, or other chemical smells	O Never	O Rarely	O Sometimes	O Often
Weight gain and/or struggling to maintain a healthy weight	O Never	O Rarely	O Sometimes	O Often
Think your weight is out of control	O Yes	O Rarely	O Sometimes	O Often

General Health Assessment (Part 2)

Please indicate how frequently you've taken the following medications throughout your life.

Antibiotics	○ Never	○ Rarely	○ Sometimes	○ Often
Testosterone (prescribed by physician	○ Never	○ Rarely	○ Sometimes	○ Often
Steroids drugs (possibly for allergies, asthma, or injuries)	○ Never	○ Rarely	○ Sometimes	○ Often
Synthetic hormones (such as HRT or bioidentical)	○ Never	○ Rarely	○ Sometimes	○ Often

Thyroid Function Assessment

Please indicate to how frequently you experience the following symptoms and conditions according to these guidelines:

Never = 0% of the time
Rarely = Less than 30% of the time
Sometimes = About 50% of the time
Often = More than 70% of the time

Difficulty getting out of bed in the morning	O Never	O Rarely	O Sometimes	O Often
Need caffeine or other stimulants to get going	O Never	O Rarely	O Sometimes	O Often
Gain weight easily	O Never	O Rarely	O Sometimes	O Often
Difficulty losing weight	O Never	O Rarely	O Sometimes	O Often
Dry skin	O Never	O Rarely	O Sometimes	O Often
Mood swings	O Never	O Rarely	O Sometimes	O Often
Thinning hair	O Never	O Rarely	O Sometimes	O Often
Outer third of eyebrows missing or nothing	O Never	O Rarely	O Sometimes	O Often
Dry or brittle hair	O Never	O Rarely	O Sometimes	O Often
High cholesterol	O Never	O Rarely	O Sometimes	O Often
Low blood pressure	O Never	O Rarely	O Sometimes	O Often
Depression	O Never	O Rarely	O Sometimes	O Often
Yellow skin	O Never	O Rarely	O Sometimes	O Often
Do you have a family history of thyroid disease?	O Yes		O No	

Stress Assessment

Please indicate how frequently you experience the following situations according to these guidelines:

Never = 0% of the time

Rarely = Less than 30% of the time

Sometimes = About 50% of the time

Often = More than 70% of the time

Close support network of family and friends	O Never	O Rarely	O Sometimes	O Often
Happy with your current job/profession	O Never	O Rarely	O Sometimes	O Often
Exercise regularly	O Never	O Rarely	O Sometimes	O Often
Eat 3 meals and 0-2 snacks per day	O Never	O Rarely	O Sometimes	O Often
Consume caffeine, sugar, and/or refined carbohydrates	O Never	O Rarely	O Sometimes	O Often
Take time off work to recharge your batteries	O Never	O Rarely	O Sometimes	O Often
Take a multivitamin/mineral	O Never	O Rarely	O Sometimes	O Often
Worry about money and finances	O Never	O Rarely	O Sometimes	O Often
Satisfaction with your life and its direction	O Never	O Rarely	O Sometimes	O Often
8 hours of uninterrupted sleep at night	O Never	O Rarely	O Sometimes	O Often
Anxiety and/or panic attacks	O Never	O Rarely	O Sometimes	O Often
Think you're too stressed	O Never	O Rarely	O Sometimes	O Often
Suffer from allergies, arthritis, fibromyalgia, and/ or asthma	O Never	O Rarely	O Sometimes	O Often
Trouble falling asleep	O Never	O Rarely	O Sometimes	O Often
Feel exhausted after exercising	O Never	O Rarely	O Sometimes	O Often
Major life stressors such as death, divorce, etc.	O Never	O Rarely	O Sometimes	O Often
Catch colds and flu easily	O Never	O Rarely	O Sometimes	O Often

Hormone Assessment

Please indicate how frequently you experience the following symptoms according to these guidelines:

Never = 0% of the time

Rarely = Less than 30% of the time

Sometimes = About 50% of the time

Often = More than 70% of the time

Poor sleep quality	O Never	O Rarely	O Sometimes	O Often
Memory problems	O Never	O Rarely	O Sometimes	O Often
Puffiness/bloating	O Never	O Rarely	O Sometimes	O Often
Anxiety	O Never	O Rarely	O Sometimes	O Often
Insomnia	O Never	O Rarely	O Sometimes	O Often
Acne breakouts	O Never	O Rarely	O Sometimes	O Often
Brown age spots	O Never	O Rarely	O Sometimes	O Often
Inability to exercise	O Never	O Rarely	O Sometimes	O Often
Fatty breast	O Never	O Rarely	O Sometimes	O Often
Soft erections	O Never	O Rarely	O Sometimes	O Often
Loss of muscle	O Never	O Rarely	O Sometimes	O Often
Loss of stamina	O Never	O Rarely	O Sometimes	O Often
Headaches	O Never	O Rarely	O Sometimes	O Often
Enlarge prostate	O Never	O Rarely	O Sometimes	O Often
Night time urination	O Never	O Rarely	O Sometimes	O Often
Foggy thinking	O Never	O Rarely	O Sometimes	O Often

Toxic Burden Assessment (Part 1 - Consumption)

Please indicate how frequently you consume the following foods on daily and/or weekly basis according to these guidelines

Never = 0% of the time

Rarely = Less than 30% of the time

Sometimes = About 50% of the time

Often = More than 70% of the time

Organic, pesticide-free produce	O Never	O Rarely	O Sometimes	O Often
A wide variety of different colored fruits and vegetables	O Never	O Rarely	O Sometimes	O Often
Salads with dark leafy greens	O Never	O Rarely	O Sometimes	O Often
Flaxseeds and/or flaxseed oil	O Never	O Rarely	O Sometimes	O Often
Green juices or smoothies	O Never	O Rarely	O Sometimes	O Often
Organic, extra-virgin oils	O Never	O Rarely	O Sometimes	O Often
Fresh green herbs	O Never	O Rarely	O Sometimes	O Often
Coffee (including specialty)	O Never	O Rarely	O Sometimes	O Often
Tobacco and nicotine (including e-cigarettes)	O Never	O Rarely	O Sometimes	O Often
Alcohol (beer, wine, hard liquor, etc.)	O Never	O Rarely	O Sometimes	O Often
Soda (regular and or diet)	O Never	O Rarely	O Sometimes	O Often
“Diet foods” sweetened with aspartame, Splenda, or saccharin	O Never	O Rarely	O Sometimes	O Often
Vegetables oil, canola oil, and/ or margarine	O Never	O Rarely	O Sometimes	O Often
Foods flavored with MSG (monosodium glutamate)	O Never	O Rarely	O Sometimes	O Often
Foods that are artificially colored	O Never	O Rarely	O Sometimes	O Often
Foods microwaved in plastic containers	O Never	O Rarely	O Sometimes	O Often
Fast foods	O Never	O Rarely	O Sometimes	O Often
Processed foods(from a box, bag, or can)	O Never	O Rarely	O Sometimes	O Often

Toxic Burden Assessment (Part 2 - Supplementation)

Please mark how frequently you use the following supplements or medications on a daily and/or weekly basis:

Hormone and antibiotic-free whey protein	O Never	O Rarely	O Sometimes	O Often
Probiotic and/ or prebiotic supplements	O Never	O Rarely	O Sometimes	O Often
Digestive enzymes	O Never	O Rarely	O Sometimes	O Often
Prescription or over the counter (OTC) drugs	O Never	O Rarely	O Sometimes	O Often
Healthy oil supplements (like salmon, flaxseed, or evening primrose oil)	O Never	O Rarely	O Sometimes	O Often
Clean and 100% pure supplements (like the Solutions4 products that are sold in our office	O Never	O Rarely	O Sometimes	O Often

Toxic Burden Assessment (Part 3-Lifestyle and Habits)

Please mark how frequently you do the following:

Overeat	O Never	O Rarely	O Sometimes	O Often
Chew your food completely	O Never	O Rarely	O Sometimes	O Often
Experience lower bowel issues	O Never	O Rarely	O Sometimes	O Often
Exercise to induce a hard sweat	O Never	O Rarely	O Sometimes	O Often
Sit in a sauna	O Never	O Rarely	O Sometimes	O Often
Use a cell phone with a headset or hands free	O Never	O Rarely	O Sometimes	O Often
Live or work in an environment that recirculates the indoor air	O Never	O Rarely	O Sometimes	O Often
Use pesticides on your property	O Never	O Rarely	O Sometimes	O Often
Travel by plane	O Never	O Rarely	O Sometimes	O Often
Use a computer	O Never	O Rarely	O Sometimes	O Often
Lives with someone who smokes	O Never	O Rarely	O Sometimes	O Often
Use household cleaners (such as bleach, etc.)	O Never	O Rarely	O Sometimes	O Often
Keep green plants in your house	O Never	O Rarely	O Sometimes	O Often
Filter your water	O Never	O Rarely	O Sometimes	O Often
Use air purifiers in your home	O Never	O Rarely	O Sometimes	O Often
Drink half your body weight in ounces of water each day	O Never	O Rarely	O Sometimes	O Often

Frequency of Consumption

Please mark how many of each item(s) you consume on a daily and weekly basis.

	Daily	Weekly
Soda	❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6	❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9
Brewed Coffee	❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6	❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9
Specialty Coffee	❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6	❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9
Chips	❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6	❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9
Candy	❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6	❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9
Gum	❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6	❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9
Alcoholic Beverage	❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6	❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9
Cigarettes	❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6	❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9
Energy Drinks	❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6	❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9
Protein Bars	❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6	❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9
Bagels / Muffins / Donuts / Twinkies	❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6	❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9
Fast Food	❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6	❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9