Rejuvenation Evaluation

Are You Toxic?

Rate each of the following symptoms based on the past 3 months.

0 = ***never or almost never***.
1 = ***occasionally have it***, effect is ***not severe.***
2 = ***occassionally have it***, effect is ***severe.***
3 = ***frequently have it***, effect is ***not severe.***
4 = ***frequently have it***, effect is ***severe.***

DIGESTIVE
___ Nausea or vomiting
___Diarrhea
___Constipation
___Bloated feeling
___Belching, passing gas
___Heartburn
___TOTAL

EARS
___Itchy ears
___Earaches, or ear infection
___Drainage from ear
___Ringing from ears, hearing loss
___TOTAL

EMOTIONS
___Mood swings
___Anxiety, fear, nervousness
___Anger, irritability
___Depression/Despair
___Apathy/Lethargy
___TOTAL

ENERGY/ACTIVITY
___Fatigue, sluggishness
___Insomnia
___Hyperactivity
___Restlessness
___Startled at night
___TOTAL

HEAD
___Headaches
___Faintness
___Dizziness
___Pressure
___TOTAL

LUNGS
___Chest congestion
___Asthma, bronchitis
___Shortness of breath
___Difficulty breathing
___TOTAL

MIND
___Poor memory
___Confusion
___Poor concentration
___Poor coordination
___Difficulty making decisions
___Stuttering, stammering
___Slurred speech
___Learning disabilities
___TOTAL

MOUTH/THROAT
___Chronic coughing
___Gagging, frequent need to clear throat
___Sore throat, hoarse
___Swollen or discolored tongue, gums, lips
___Canker sores
___TOTAL

Continued

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NOSE
___Stuffy nose
___Sinus problems
___Hay fever
___Sneezing attacks
___Excessive mucus
___TOTAL

JOINTS/MUSCLES
___Pain or aches in joints
___Rheumatoid Arthritis
___Osteoarthritis
___Stiffness, limited movement
___Pains or aches in muscles
___Recurrent headaches
___Feeling of weakness or tiredness
___TOTAL

SKIN
___Acne
___Hives, rashes, dry skin
___Hair loss
___Flushing
___Excessive sweating
___TOTAL

HEART
___Skipped heartbeats
___Rapid heartbeats
___Chest pain
___TOTAL

WEIGHT
___Binge eating/drinking
___Craving certain foods
___Excessive weight
___Compulsive eating
___Water pretension
___Underweight
___TOTAL

EYES
___Watery, itchy eyes
___Swollen, reddened or sticky eyelids
___Dark circles under eyes
___Blurred, tunnel vision
___TOTAL

OTHER
___Frequent illness
___Frequent or urgent urination
___Leaky bladder
___Genital itch, discharge
___TOTAL

WOMEN ONLY
___PMS
___Menses Irregular or heavy
___Bloating, headaches with menses
___Craving sweets or chocolate
___TOTAL

_____GRAND TOTAL

___I'd like to register for the next Rejuvenation Course.
___I'd like information about consultations, please contact me.
___Please add me to the email newsletter list.

Name_____Phone_____

Address_____

City_____State_____Zip_____

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