



ABUNDA LIFE

Body Mind Spirit

Since 1964

Naturopathic Doctor's 1001



Nutritional Assessment Questionnaire

Abunda Life Medical Nutrition Testing Clinic

208 Third Avenue, Asbury Park, NJ 07712 *"Steps to the Ocean"*

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"I have come, that you may have life and have it more abundantly" (John 10:10)

www.abundalife.com



The Naturopathic Doctor's 1001 Nutritional Testing Questionnaire© is the most comprehensive computerized Medical Symptomology Test for nutritional assessment purposes, developed to date.

This test is not for everyone. It has been designed for health conscious, intelligent, motivated individuals seeking an alternative to orthodox drug medicine and who are also willing to become proactive and responsible for their personal wellness and future.

Degenerative disease takes many years to develop. Nutritional deficiencies manifest themselves by way of symptoms, body signs and signals, long before the disease process gets a foothold. When nutritional deficiencies remain unaddressed, they eventually develop into "full blown", named medical conditions. Because the human body was created from the dust of the ground, (it's minerals and nutrients), nutrition is essential to the preventative, regeneration and treatment process. No medical treatment is complete, nor can it achieve its full therapeutic potential without the implementation of proper nutrition. Nutritional Therapy is both primary and foundational to every known medical and human condition.

At one time in our medical history, medical doctors asked symptomological questions for one to two hours as part of their initial evaluation. In recent times, this detailed form of examination has become a lost art. The good news is, as a result of today's modern computerized technology, we are once again able to deliver the full benefits of the comprehensive evaluation of old, eliminate the chances of human error and improve on the analytical skills of the best doctors in history.

Alone though, it would be impossible for any scientist, doctor or technological device to be able to discover the physiological and psychological symptoms that you already know subconsciously about yourself.

The Naturopathic Doctor's 1001 Nutritional Testing Questionnaire© is designed to analyze and sequence over 2,500 symptoms that correlate to over 100 possible deficiency patterns. This data is then interpreted and presented in a clear, easy to understand report of findings.

Instructions:

1. **This test may take some people from 2 to 4 hours of "quite time" to complete.** This may require that you split the required time into 2 or more sessions.
2. **Focus.** Be sure to find a quite place free of intrusion and interruptions, television, radio, talking, door bells or cell phones.
3. **Each section addresses multiple symptoms.** Underline the most serious condition in the group and score it from 1 to 10 based on the intensity of the condition. *(See scoring chart below).*
4. **Total your scores in each section with a calculator** for accuracy and convenience. Place each section score in the respective box and your grand total of all section in the box at the end of the questionnaire.
5. **There is a space allocated at the end of the questionnaire** in the event that you feel you need to elaborate on any particular section or symptom. Also, feel free to use additional paper to address any health matter or personal concern, that may not have been addressed by the questionnaire.
6. **Some questions may appear repetitive.** This is all calculated into the master equation. Score each question to the best of your knowledge. In the event no condition exists in a section or if you simply don't know if it does exist, give it a score of "0" (zero score).
7. **Be sure you sign the "Non-Medical Agreement" on the back page.** We cannot process your test without a valid signature.

Score Definitions:

(Remember to underscore the most serious condition, then score it from 1 to 10 based on the level of intensity)

- | | |
|-----------------------------------|--|
| 👉 0 = Does not Exist/ Do not know | 👉 6 = Very Often |
| 👉 1 = Rarely | 👉 7 = Continuous |
| 👉 2 = Mild | 👉 8 = Intense |
| 👉 3 = Sometimes | 👉 9 = Very Intense |
| 👉 4 = Bothersome | 👉 10 = A Primary Complaint - Highest Intensity |
| 👉 5 = Often | |

PATIENT INFORMATION

NAME: _____ **DATE:** ____/____/____

Please Print Clearly, First Name, Middle Initial, Last Name

ADDRESS 1: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: (____) - ____ - ____ **BUSINESS PHONE:** (____) - ____ - ____

FAX: (____) - ____ - ____ **E-MAIL:** _____

OCCUPATION: _____

MEDICAL DOCTOR: _____ **PHONE:** (____) - ____ - ____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

CHIROPRACTOR: _____

NUTRITIONIST: _____

BLOOD TYPE: _____ **HEIGHT:** _____ **WEIGHT:** _____

WEIGHT AT AGE 20: _____ **BODY FAT:** _____ %

WAIST: _____" **HIPS:** _____" **CHEST/BUST:** _____" **ARM FLEXED:** _____"

LIST OPERATIONS AND DATES: _____

LIST DIAGNOSED ILLNESSES AND DATES: _____

LIST MEDICATIONS: _____

LIST VITAMINS AND SUPPLEMENTS: _____

Please place a check in the area next to "YES" or "NO" at the end of each of the following:

Do you drink coffee?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you been bed ridden for 1 wk or more in the past 2 yrs?	<input type="checkbox"/> YES <input type="checkbox"/> NO
- per day ___ cups		Chemotherapy in last 3 yrs?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you smoke?	<input type="checkbox"/> YES <input type="checkbox"/> NO	# of treatments: _____	
Smokes per day _____		Dates: _____	
Do you drink coke/diet coke or soda?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Radiation in last 3 yrs?	<input type="checkbox"/> YES <input type="checkbox"/> NO
- # per day _____		# of treatments: _____	
Do you consume wine, beer or alcohol?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Dates: _____	
- # per month _____		Major surgery in last 3 years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Colds, Flues per year: # _____		List Type/ Date: _____	
Do you sleep soundly?	<input type="checkbox"/> YES <input type="checkbox"/> NO	List Type/ Date: _____	
Sleep per night _____ hours		List Type/ Date: _____	
Have you done enemas?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Delivered a child in last 3 years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you had colonics?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Are you pregnant?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you had spinal adjustments?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If so, how many months: _____	
Do you fast (<i>no food</i>)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you desire to become pregnant?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Days per year? _____		Do you have children?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have a vegetable juicer?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If so, what are how many and their ages:	
Do you own a blender?	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	
Do you have a gym membership?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you been on calcium channel blockers in last 2 years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you exercise?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you taken Tetracycline type drugs in last 3 years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Types: _____		Have you taken anti-biotics?	<input type="checkbox"/> YES <input type="checkbox"/> NO
_____		When? _____ For how long a period? _____	
_____		Have you taken Cortisome or used Cortisome creams in last 2 years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
How often/ Hours per week: _____		Are you a vegetarian? (<i>no flesh products</i>)	
How long? _____		Do you avoid milk products?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Desire to improve eyesight?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you avoid sunshine?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Desire to stregnthen spine?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Glasses/ quarts of water drank per day?# _____	
Desire to stregnthen heart?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you consume "refined white sugar" in any form, more than 1 time per week?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Desire to stregnthen muscles?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you take aspirin or ibuprofen type products?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have a rebounder?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you take antacids?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you able to swallow pills?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Satisfied with your current weight?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Have you been on a supervised Nutrition Program previously?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Dates: _____			

List specific pains, complaints, problems and areas that you would like to address:

What is the "main" complaint you would like us to help you with?



Please check mark the Body, Mind, Spirit Services that you may be interested in/ and / or may like to receive more information on.

 **BODY SERVICES:**

- | | | | |
|--|--------------------------|--|--------------------------|
| 1. Male/ Female Hormone Testing?..... | <input type="checkbox"/> | 16. Foot Reflexology?..... | <input type="checkbox"/> |
| 2. Natural Hormone Replacement Therapy?..... | <input type="checkbox"/> | 17. 5 Day Boot Camp?..... | <input type="checkbox"/> |
| 3. Anti-Aging Testing?..... | <input type="checkbox"/> | <i>(in-patient detoxification, body fat loss, fitness vacation)</i> | |
| 4. Anti-Aging/ Optimal Aging Program?..... | <input type="checkbox"/> | 18. Hyperbaric Oxygen Therapy?..... | <input type="checkbox"/> |
| 5. Natural Growth Hormone (Anti-Aging Shots)?..... | <input type="checkbox"/> | 19. Ozone Therapy?..... | <input type="checkbox"/> |
| 6. Allergy/ Food Sensitivity Testing?..... | <input type="checkbox"/> | 20. Thermogenic Fat Burning and Internal Purification Room?..... | <input type="checkbox"/> |
| 7. Indican Testing (for malabsorption and bowel toxicity)?..... | <input type="checkbox"/> | 21. Medical Hypnotherapy?..... | <input type="checkbox"/> |
| 8. Medical Doctor appointment?..... | <input type="checkbox"/> | 22. Colon Hydrotherapy (colonics)?..... | <input type="checkbox"/> |
| 9. Non-Invasive Heart check-up?..... | <input type="checkbox"/> | 23. Urine Metabolic Testing?..... | <input type="checkbox"/> |
| 10. I.V. Super Nutrition?..... | <input type="checkbox"/> | 24. Comprehensive Blood Diagnostics for Metabolic and Nutritional Assessment?..... | <input type="checkbox"/> |
| 11. Spinal Adjustments?..... | <input type="checkbox"/> | 25. Comprehensive Gastro-Intestinal/ Stole Analysis?..... | <input type="checkbox"/> |
| 12. Spine Strengthening?..... | <input type="checkbox"/> | | |
| 13. Fitness Medicine and Personal Training?..... | <input type="checkbox"/> | | |
| 14. Massage Therapy?..... | <input type="checkbox"/> | | |
| 15. Hair/ Mineral Analysis for heavy metal and/or toxicity?..... | <input type="checkbox"/> | | |

 **MIND SERVICES:**

- | | | | |
|-----------------------------------|--------------------------|--|--------------------------|
| 1. Stop Smoking Program?..... | <input type="checkbox"/> | 4. Career Skills and Aptitude Evaluation?..... | <input type="checkbox"/> |
| 2. Medical Hypnotherapy for: | | 5. Personal Family and Professional Health, Nutrition and Nuturopathic Educational Programs leading to Certification?..... | <input type="checkbox"/> |
| Stress..... | <input type="checkbox"/> | 6. Self-Help Motivational Books?..... | <input type="checkbox"/> |
| Learning..... | <input type="checkbox"/> | 7. Nutritional/ Self-Help Books?..... | <input type="checkbox"/> |
| Weight/ Eating Disorders..... | <input type="checkbox"/> | 8. Motivational/ or Educational Health cassette tapes and videos?..... | <input type="checkbox"/> |
| Focus..... | <input type="checkbox"/> | 9. FREE online and e-mail subscriber Health Newsletters, and Self-Help Videos?..... | <input type="checkbox"/> |
| Motivation..... | <input type="checkbox"/> | Enter E-mail address: _____ | |
| Confidence..... | <input type="checkbox"/> | 10. Partime Income Opportunities as an Abunda Life Independent Product Distributor?..... | <input type="checkbox"/> |
| Emotional Trauma..... | <input type="checkbox"/> | | |
| Sexual Dysfunction..... | <input type="checkbox"/> | | |
| Personality Disorders..... | <input type="checkbox"/> | | |
| Immune Enhancement..... | <input type="checkbox"/> | | |
| Speeding the Healing Process..... | <input type="checkbox"/> | | |
| 3. Psycho-Visual Therapy?..... | <input type="checkbox"/> | | |

 **SPIRIT SERVICES:**

- | | | | |
|--|--------------------------|---|--------------------------|
| 1. Biblically based Spiritual Literature?..... | <input type="checkbox"/> | 5. Free trial Bible Study/ cassette tape membership?..... | <input type="checkbox"/> |
| 2. Biblically based cassette tapes and videos?..... | <input type="checkbox"/> | 6. Do you desire prayer?..... | <input type="checkbox"/> |
| 3. Christian Books?..... | <input type="checkbox"/> | 7. Do you care to pray for others?..... | <input type="checkbox"/> |
| 4. FREE membership via e-mail to spiritual literature and online sermon distribution?..... | <input type="checkbox"/> | | |
| Enter E-mail address: _____ | | | |

SECTION 1

- 1. Muscle cramps, leg cramps, hip/back pain, toes cramp? ___
- 2. Nervous, high strung, irritable, nervous habits, hyperactive, listless, complaining, difficult thinking, sighing? ___
- 3. Aching joints, carpal tunnel syndrome? ___
- 4. Brittle nails or kidney stones? ___
- 5. Spastic colon/stomach, colitis? ___
- 6. Cavities, tooth decay, loose teeth, dental fillings, crowded teeth, excessive saliva? . ___
- 7. PMS, osteoporosis, soft bones, menstrual pain/cramps excessive or lengthy? ___
- 8. Bell's Palsy, twitches, convulsions? ___
- 9. Arthritis symptoms? ___
- 10. Chronic headache or afternoon headaches? ___
- 11. Insomnia, sleeplessness? ___
- 12. Acne, eczema or slow healing soars? ___
- 13. Heart palpitations, enlarged heart, high blood pressure, heart cramps? ___
- 14. Chronic fatigue syndrome or fibromyalgia? ___
- 15. Panic attacks, discourage easily, anxiety, lack of courage, lack of will power? ___

Total

SECTION 2

- 1. Diabetes? ___
- 2. Hypoglycemia, pre-diabetes? ___
- 3. Episodes of shakiness and/or tremors? ___
- 4. Sugar or sweet cravings? ___
- 5. High or low triglycerides? ___
- 6. Manic depression, bipolar mental instability? ___
- 7. Mood/personality change, hyperirritability? ___
- 8. Do you have blurry vision, nausea, history of cataracts, or macular degeneration? . . ___
- 9. Depression, mental instability, lack of ambition, loss of creativity? ___
- 10. Obesity, 20 pounds or more overweight, difficulty losing weight? ___
- 11. High LDL or VLDL cholesterol? ___
- 12. Pre-mature aging, looking and/or feeling older than you are? ___
- 13. Undue fatigue, tiredness? ___
- 14. Asthma, allergies? ___
- 15. Easily angered, moody? ___
- 16. Craving for starches, tendency to gain weight after eating starch? ___

Total

SECTION 3

- 1. History of parasites, fungus infections, yeast overgrowth, eczema, discoloration around fingernails? ___
- 2. History of low blood pressure? ___
- 3. History of hypo/hyper thyroid? ___
- 4. Mal-absorption problem, require extra vitamin C? ___
- 5. Loss of skin pigmentation, muddy skin or wrinkled skin, loss of skin color, skin rashes? ___
- 6. History of anemia or chronic fatigue? ___
- 7. Mental instability or Jekyll and Hyde personality, forgetfulness? ___
- 8. Dry hair, graying hair, hair loss, brittle hair, alopecia? ___
- 9. Parkinson's disease, gulf war syndrome, osteoporosis, ruptured disc? ___
- 10. Bitter mouth taste, infertile? ___

Total

SECTION 4

- 1. Gain weight fast, lose weight slowly, puffy face, puffy body? ___
- 2. History of over or under active thyroid? ___
- 3. Severe PMS, cystic breast, cystic ovaries, heavy menstrual bleeding? ___
- 4. Cholesterol over 200, swelling of fingers and/or toes, dull headaches? ___
- 5. Cold hands or feet, feel cold, reduced body temperature, can't stand cold? ___
- 6. Tired in morning, energy improves as the day proceeds, chronic fatigue, or lethargy, mental sluggishness? ___
- 7. Chronic skin conditions, boils, acne, fungal infections, dry, scaly skin, coarse hair? . ___
- 8. Stuffy nose, sinuses, bronchitis, pneumonia, ear infections, strep throat, dislike for moisture or humidity? ___
- 9. High strung, frustration, depression, nervousness, inability to concentrate, mentally dull, loss of animation for life? ___
- 10. Inability to gain weight, constipation, sterility, miscarriages, infertility, appear dull and/or listless, slow moving? ___

Total

SECTION 5

- 1. Dizziness, light headedness, sensations of seeing spots before your eyes after sudden movement? ___
- 2. Pale skin, palms of hands pale? ___
- 3. Anemia, chronic headaches, easily fatigued? ___
- 4. Confusion, depression, slow mental reactions, inability to concentrate, forgetfulness, irritability, crying spontaneously? ___
- 5. Shortness of breath, difficulty swallowing, dull hearing? ___
- 6. Pains in heel and/or soles of feet, soles of feet burn, ice eating, craving for cold drinks? ___
- 7. Picky eater, lack of appetite, undue fatigue, mentally/emotionally hard to please? . . ___
- 8. Inflamed and/or sore tongue, heavy menstruation? ___
- 9. Sensitivity to cold, constipation, painful breathing, stinging pain in head, flattened fingernails? ___
- 10. Tingling of fingers or toes, rapid heart beat with minimal exercise? ___

Total

SECTION 6

- 1. Insomnia, PMS, excessive body odor? ___
- 2. Hypertension, rapid heart beat, heart disease, myocardial infraction, arrhythmia, irregular heart beat? ___
- 3. Kidney stones, gall stones, sluggish colon, chronic arthritis, gas and/or wind in intestines, inflated or bloated intestine? ___
- 4. Fibromyalgia, chronic pain, muscles tear or injure easily, aching neck and/or shoulder muscles? ___
- 5. Irritable Bowel Syndrome, spastic colon, constipation, colitis, allergies to wool, chilly after retiring? ___
- 6. Sensitive to noise, easily irritated, uncontrolled sweating, burning sensation in mouth, bedwetting? ___
- 7. Unexplainable ear noises, difficulty hearing, sudden episodes of loss of brain function, confusion, disorientation? ___
- 8. Jerky repeated tapping of hands and/ or feet, movements lack muscular coordination, muscle twitching, back pain, restless leg syndrome, restless movement of eyes and/or fingers, tremors? ___
- 9. Easily weakened by stress, depression, fears, grief, apprehension, grief suppression? ___

10. Muscle cramps in bottom of feet, nervous heart palpitations, teeth sensitive to cold water, tooth ache when nothing is wrong, muscle spasm?
- Total**

SECTION 7

1. Brain dysfunction, confusion, depression, irritability, nervousness, lack of concentration, crying spells, negative mental attitude, mental disagreement to most every statement, dislike of children, desire to be left alone?
 2. Hearing difficulties, tinnitus, deafness, eyes red and/or swollen?
 3. Stuttering, tooth grinding, convulsions, tremors?
 4. Stiff tendons, gout, carpal tunnel syndrome, glands swell easily?
 5. History of miscarriage, loss of libido, breast ailments, still birth, infertility, tenderness in nipples, enlargement of ovaries, womb falling and/or protruding?
 6. Creaking and/or clicking of joints, arthritis, joint pain?
 7. Sprain or injure joints easily, gripping sensation in limbs and body?
 8. Bone loss, thinning of bones, brittle bones?
 9. Chronic knee, hip and/or ankle pain, gripping sensation in limbs and body?
 10. History of ow levels of serum blood protein, globulin or albumin?
- Total**

SECTION 8

1. Loose teeth, teeth that crack or chip, chronic toothaches, cavities?
 2. Arthritis, chronic joint pain, bone pain, swollen joints, osteoporosis, paralysis, prone to bronchitis?
 3. Brain fog, slow thinking, sluggish mental function, can't get the words out in time?
 4. Tremors, nervousness, irritability, neuralgia, neuritis, general weakness, numbness in limbs, loss of muscle tone in arms and/or legs?
 5. Hardened wax in ear, afraid of tomorrow, fearful of the unknown?
 6. Muscular weakness, physically lazy, hard wax in ears?
 7. Sex indifference, infertility, low sperm count, enlarged prostate, sterility, dislike of the opposite sex?
 8. Asthma, sinus trouble, catarrh, bronchitis, frequent colds?
 9. Poor eyesight, prone to swollen glands, need for glasses (non-stigmatism)?
 10. Low red blood count, low hemoglobin?
- Total**

SECTION 9

1. Rapid heart beat, irregular heart beat, angina, heart disease, stroke, slow heart beat, poor circulation?
2. High blood pressure above 140/90 or low blood pressure under 100/70, or on blood pressure medication?
3. Muscle cramps, muscle weakness, muscle softness, intolerance to exercise, lack of desire to exercise?
4. Edema, fluid retention, swelling of ankles, salt retention, impaired kidney function?
5. Muscle twitches, tremors, bitter taste in mouth, tendency to blisters?
6. Acidosis, high acid urine, protein in urine, electrolyte imbalance, highly toxic, liver sluggishness, repeat of low grade infection?
7. Swollen glands, nausea, edema, thirst, chills, vomiting constipation, earaches, swollen ovaries or testicles, swollen ankles?
8. High cholesterol, headaches, dry throat, swollen ovaries or testicles, weakness in female system?
9. Acne, dry skin, itchy skin, eczema, dropsy, inability to digest sugar, pyorrhea, weak ligaments?

10. Inability to recover quickly, chronic fatigue, glucose intolerance, diabetes, distention of stomach?
- Total**

SECTION 10

1. Prematurely aging and/or looking older than your calendar years, nervous exhaustion, no ambition for brain work, lack of determination and/or mental strength?
 2. Hair thinning or falling out, brittle hair, premature graying?
 3. Acne, eczema, muddy skin, boils, psoriasis, dermatitis, itchy eyes?
 4. Highly toxic, autointoxication, biliousness, tendency to boils?
 5. Acid serum blood bio-chemistry, high or low serum calcium?
 6. Sinus trouble, bronchitis, frequent colds, catarrh, history of TB, smoking or lung trouble?
 7. Weak or swelling joints and/or ligaments, ear discharge, ulcerated gums and/or tongue, parched lips and/or finger nails?
 8. High blood pressure, osteoporosis, scleroderma, rheumatoid arthritis, lupus, fibromyositis?
 9. Brittle nails, slow wound healing, teeth sensitive to cold?
 10. Dry flaky skin, teeth sensitive to air, sties on eye lids, drug addiction?
- Total**

SECTION 11

1. Hypochlohydria, stomach, digestive, intestinal, and colon absorption problems? . .
 2. Unable to stand the heat, nauseous if over heated, eyes sensitive to bright lights, constipation, indigestion?
 3. Feel exhausted early in morning, general debility, decrease in strength or weight, mental depression, loss of temper over nothing, hysterical behavior?
 4. History of sun stroke, heat exhaustion, dehydration?
 5. Joint stiffness, dry tongue, craving for salt, excessive thirst?
 6. History of low serum platelets, cholesterol, or sodium, adrenal exhaustion, electrolyte imbalance, acid bio-chemistry, eyeglass prescription has to be changed often? . . .
 7. Heart palpitations, arteriosclerosis, low blood pressure hay fever?
 8. Vomiting , nauseated, diarrhea, loss of appetite, sourness of digestive tract, fowl breath, protein foods cause gas?
 9. History of high serum platelets, gout, seizures?
 10. Excessive perspiration, acidosis, autointoxication, highly toxic condition, use diuretics, bloating?
 11. Memory loss, mental or physical apathy, loss of smell?
- Total**

SECTION 12

1. History of chronic and/or severe allergies?
2. Respiratory congestion/inflammation, toxic condition?
3. Migraine headaches, nerve disorders, moodiness, difficulty speaking and/or singing, voice gives out easily?
4. Itching, skin disorders, acne, dry skin, desire to massage and knead the muscles of the arms and legs?
5. Joint pain, connective tissue pain, arthritis, backache, bone disorders, inflammation, sports injury?
6. Infection, allergies, joyless appearance and/or feelings, throat is whiter than rest of neck?
7. Muscle cramping, wrinkles, burning feet, disc trouble, fingernails thin and/or split, delayed and/or irregular menstruation, repeated women's ailments?

- 8. Stress, tension, tightness, worry, anxiety, uptight, appearance is unhappy or joyless, moodiness? _____
 - 9. Urinary tract disorders, alkaline urine or saliva, alkalosis? _____
 - 10 Stomach, reflux, acid stomach, inability to recuperate after illness, exercise, or overwork.? _____
- Total**

SECTION 13

- 1. Enlarged prostate, infertility, still births, impotency, low sperm count, loss of sex drive, lack of erection? _____
 - 2. Slow wound healing, slow hair growth, dry/brittle hair, slow nail growth, hair loss? . . _____
 - 3. Acne, dermatitis, stretch marks, sunburn easily, sun-induced rashes, canker sores? . _____
 - 4. Loss of smell, loss of taste, lack of appetite? _____
 - 5. Body odor, oral ulcerations? _____
 - 6. Weak immune system, recurring ear infections, susceptibility to colds or flu, recurring urinary tract infections, candida? _____
 - 7. Experienced a prolonged period of mental/emotional stress in the last 2 years? . . . _____
 - 8. White spots on fingernails? _____
 - 9. Slow growth, stunted growth, delayed sexual maturity? _____
 - 10. Diabetes, hypoglycemia, pancreatic disorders, thyroid disorders? _____
- Total**

SECTION 14

- 1. Excessive gas or indigestion, periods of constipation alternating with diarrhea? _____
 - 2. Constipation, poorly formed stools, greasy, pale or gray floating stool? _____
 - 3. Bloating, super bloating after meals, sour stomach, bad breath? _____
 - 4. Colitis, spastic colon, irritable bowel syndrome, chronic diarrhea, undigested food particles in stool? _____
 - 5. Stomach or bowel pain after eating, gastric distress while eating? _____
 - 6. History of diabetes, pancreatitis, hypochlorhydria, low stomach acid, history of stomach or intestinal cancer? _____
 - 7. History of overeating, been treated for anemia or other nutritional deficiencies? . . . _____
 - 8. Fatigued or tired after eating? _____
 - 9. White coated tongue? _____
 - 10. History of slow or sluggish digestion, incomplete assimilation of nutrients, feeling that food is not digesting fast enough, pieces of undigested food and/ or vitamins pills in stool? _____
- Total**

SECTION 15

- 1. Brittle hair, slow hair growth, hair loss, dry hair, split ends? _____
- 2. Brittle nails, slow growing nails, splitting or soft nails, cataracts, red lines in eyes? . . _____
- 3. Mood swings, nervousness, agitation, grouchy, diminished ability to handle stress, inability to recall dreams or insomnia? _____
- 4. Digestive disturbances, susceptibility to infection? _____
- 5. Anxiety, depression, panic attacks? _____
- 6. Dry skin, chronic pain, slow cut, burn, or wound healing, sore muscles, slow recovery after exercise? _____
- 7. History of hypoglycemia, diabetes, alcoholism, pancreatitis? _____
- 8. Low serum protein, BUN, albumin, globulin, or creatinine, low hormone levels? . . . _____
- 9. Chronic fatigue, muscular weakness, history of anemia, feeling of overall weakness? . _____

"At Abunda Life, we believe it is impossible to drug your body into health. Drugs only suppress symptoms; they do not nourish or build cellular health."

10. Difficulty losing fat weight, difficulty gaining muscle weight, difficulty digesting protein foods? Total

SECTION 16

- 1. Anxiety, rapid personality changes, depression, mood swings? ___
 - 2. Cracks in corner of mouth, sore tongue or mouth? ___
 - 3. Sugar intolerance and/or sensitivity? ___
 - 4. Blurred vision, dry, burning and/or itching of eyes, feeling of sand in eyes? ___
 - 5. Chronic fatigue, dizziness, muscular weakness, weight loss? ___
 - 6. Eczema, dandruff, patches of dry scaly or rough skin? ___
 - 7. Sleep apnea, insomnia,? ___
 - 8. Painful tongue, red or blue tongue, burning tongue, swollen tongue, tongue trenches? ___
 - 9. Agitation, irritability, anger, nervousness? ___
 - 10. Sugar and/or junk food craving and/or addiction? ___
 - 11. Mental dullness, poor concentration, attention deficit? ___
 - 12. Nausea, vomiting, loss of appetite, constipation, indigestion? ___
 - 13. Eye fatigue, eye twitches, macular degeneration, near sightedness, cataracts, constantly rubbing eyes? ___
 - 14. Confusion, fear of unknown origin, paranoia, phobias? ___
 - 15. MSG sensitive, dark circles under eyes? ___
 - 16. Vulnerability to insect bites? ___
 - 17. Compulsive behavior, emotional/mental instability, crying spells, jumpiness, shakiness? ___
 - 18. Hypochlorhydria, bloating, distension after eating? ___
 - 19. Dryness and/or scaling behind ears? ___
 - 20. Burning feet and/or heels, vague abdominal pains? ___
 - 21. Chapped lips, seborrhea dermatitis of face or nose? ___
 - 22. Inability to cope with stress, overwhelmed? ___
 - 23. Convulsions, epilepsy? ___
 - 24. Dry hair, loss of texture or shine of hair, oily hair? ___
- Total

SECTION 17

- 1. Attention deficit, mental dullness, inability to mentally focus, poor concentration, short attention span, alcoholism, listlessness? ___
 - 2. Anxiety, depression, nervousness, agitation, temper tantrums, quarrelsome, violent behavior or thoughts, argumentative, vague fears of unknown origin, emotionally unstable? ___
 - 3. Craving for sweets, headache, insomnia, constipation, excessive sweating, nightmares, sleep walking, lack of or excessive appetite, vulnerability to insect bites, nausea, constipation? ___
 - 4. Apathy, feeling of impending doom, find yourself feeling you would like to cry, noise sensitivity, heaviness, weakness, burning, or numbness of arms, feet, hands or toes, loss of muscle tone in arms and/or legs, slight paralysis? ___
 - 5. Undue fatigue, diastolic blood pressure over 90, irregular heartbeat, excessive heart beat after moderate exercise, rapid pulse above 80 beats per minute, loss of stomach and digestive acidity, loss of morale, loss of sense of humor, nerves on edge? ___
- Total

SECTION 18

- 1. Feeling of Sand in eyes, cataracts, eyes tear spontaneously, blurred vision blood

- shot eyes, conjunctivitis, light sensitivity, eye fatigue, eye twitches or spasms, nearsightedness, burning and/or itching of eyes, cracks in corner of eyes? ___
 - 2. Red or blue tongue, inflamed or swollen tongue, painful tongue, tongue bald spots or atrophy? ___
 - 3. Dandruff, chronic acne, chronic sinus problems, facial white heads, greasy facial skin or nose, oily hair, genitals itch, eczema, chronic dermatitis? ___
 - 4. Corners of mouth and/or lips cracked, swollen, inflamed, or chapped, loss in width fullness of upper lip, sore around or in mouth? ___
 - 5. Mood swings, nervousness, depression, low blood sugar type dizziness, anemia, vaginal itching,? ___
- Total**

SECTION 19

- 1. Patches of dry scaly skin, rough skin, dermatitis, brown blotches of skin? ___
 - 2. Serum cholesterol over 200, lack of appetite, thyroid or adrenal disorder, low hemoglobin, indigestion, constipation, nausea, diarrhea? ___
 - 3. Mood swings, lose of mental sharpness, memory loss, insomnia, chronic headaches, history of dementia, senility or Alzheimer's disease? ___
 - 4. Deep trenches or ulcerations in the tongue, sensitive, inflamed, or burning mouth or throat, red tongue? ___
 - 5. History of anxiety, irritability, manic depression, schizophrenia, recreational drug use or emotional instability, psychotic behavior, poor thinking, psychosis, nervous disorder? ___
- Total**

SECTION 20

- 1. Dull hair or dandruff, dry, dull, brittle or falling hair, scalp abscesses? ___
 - 2. Susceptibility to infections, sore nose, lungs, or throat, ear aches, colds, flu, pus in urine, pneumonia, bronchitis? ___
 - 3. Rough or dry skin, acne, warts, eczema, low serum platelets? ___
 - 4. Loss of sense of smell, sinusitis, stone formation in gallbladder and/or kidneys? ___
 - 5. Night blindness, conjunctivitis, redness in eyes, dry eyes, sties, eye inflammation, intolerance to bright lights, eye strain, impaired vision, itching or burning eyes? ___
 - 6. Loss of taste, loss of appetite, inability to lose weight, difficulty reading fine print, eye fatigue? ___
 - 7. Sore or inflamed gums, hoarseness, dry cough, dry or scanty saliva? ___
 - 8. History of hypothyroidism, defective tooth enamel problems? ___
 - 9. Calluses, corns, history of skin cancer? ___
- Total**

SECTION 21

- 1. Prone to motion sickness or morning sickness, nausea or vomiting, vaginal inflammation, low blood pressure, dizziness? ___
 - 2. Protein in urine, low serum hemoglobin, radiation exposure, leucopenia? ___
 - 3. Hands or feet sweat, dryness or scaling behind the ears, sore tip of tongue white heads? ___
 - 4. Personal or family history of chronic depression, psychosis, schizophrenia? ___
 - 5. Fluid retention, inability to digest protein, heartburn, constipation, bad breath? ___
 - 6. Nervousness, agitation, mood swings, confusion, depression, ear noises? ___
 - 7. Pre-mature aging of face, dry or scaly facial skin, lack of muscular tone, physical or mental exhaustion, extreme weakness, loss of weight? ___
 - 8. Skin cracks open easily, chapped lips, sensitive to MSG? ___
 - 9. History of MS, MD, Parkinson's, convulsions, epilepsy, brain disorder? ___
 - 10. Anemia, excessively oily skin and/or hair, heart disease, tongue ulcerations? ___
- Total**

SECTION 22

- 1. Extreme fatigue, thyroid and/or adrenal disorder? ___
 - 2. Inability to think clearly or rationally, irritability, tired of school/mental work? ___
 - 3. Pernicious anemia, weight loss, asthma? ___
 - 4. Ulcerated or sore mouth or tongue, loss of taste, burning tongue, loss of appetite, rosecea, burning pains? ___
 - 5. Low serum globulin, albumin, creatinine, bun or protein, hemoglobin? ___
 - 6. Anxiety, depression, confusion, paranoia, psychotic behavior, memory loss? ___
 - 7. Dark circles under eyes, pale complexion, lack of muscle tone? ___
 - 8. Chronic constipation, abdominal discomfort, digestive disturbances? ___
 - 9. Difficulty in walking, loss of balance and/or staggering, numbness or tingling of hands, legs or feet? ___
 - 10. Vegetarian, menstrual disturbances, hives, eczema, dry or scaly skin? ___
- Total**

SECTION 23

- 1. Oxygen deficiency, low serum, hemoglobin, mean corpuscular concentration MCH, MCV? ___
 - 2. History of cancer, alcoholism, smoking, or gangrene? ___
 - 3. History of rheumatic heart disease, angina pectoris, sclerosis of leg arteries and nerves? . ___
 - 4. Unusual stress (tramatic or sustained, last 2 years? ___
 - 5. History of asthma or anemia? ___
- Total**

SECTION 24

- 1. Personal and/or family history of baldness, dandruff, hair loss, cowlicks, hair stands on end, unmanageable? ___
 - 2. History of hardening of arteries? ___
 - 3. History of high triglycerides or high cholesterol? ___
 - 4. History of diabetes, poor appetite, or extreme fatigue? ___
 - 5. Sugar and/or sweets cravings and/or simple carbohydrate intolerance? ___
 - 6. Scales on scalp and/or skin, seborrhea, dry flaky skin, dermatitis, skin infections, itching eczema? ___
 - 7. Poor muscle tone, muscular soreness or pain, muscular atrophy? ___
 - 8. Chapped lips, essential fatty acid deficiency? ___
 - 9. Mental depression? ___
 - 10. Emaciated appearance, high or low serum insulin? ___
- Total**

SECTION 25

- 1. History of high blood pressure or iron deficiency, anemia? ___
 - 2. High serum cholesterol and/or triglycerides, or low serum iron? ___
 - 3. History of cirrhosis of liver, hepatitis, fatty liver, sluggish liver, liver disorders, spleen disorders? ___
 - 4. History of heart disorders, arteriosclerosis, muscular dystrophy? ___
 - 5. Dark yellow urine, yellow tint to eyes, yellow skin, diabetes? ___
 - 6. Obesity, excess "body fat"? ___
- Total**

SECTION 26

- 1. High serum cholesterol and/or triglycerides? ___
- 2. Overweight, excess body fat, obesity? ___
- 3. History of heart disease, arteriosclerosis, stroke, angina, hypertension? ___
- 4. Difficulty digesting fats? ___
- 5. Liver sluggishness, history of liver disease or alcoholism, gall bladder troubles? . . . ___

- 6. Tired after eating, constipation? ___
 - 7. High or low serum bilirubin? ___
 - 8. History of muscular dystrophy, MS, diabetes, cerebral palsy? ___
 - 9. Falling hair, balding? ___
 - 10. Eye disorders, nerve disorders? ___
- Total**

SECTION 27

- 1. History of chronic anemia or undue fatigue? ___
 - 2. History of abnormal pap smears, cervical dysplasia and/or cervical cancer? ___
 - 3. Born with a birth defect or gave birth to a child with a birth defect?. ___
 - 4. History of anxiety, depression, mania, schizophrenia, psychosis, mental illness? ___
 - 5. Bleeding gums, receding gums, pyorrhea or chronic gum infections? ___
 - 6. Mouth sores, canker sores, lack of resistance to infections or cracks in corners of mouth, eyes or nose? ___
 - 7. Inflammation and/or soreness of tongue, premature graying, ulcerated lips, sore throat, sprue? ___
 - 8. Low serum red blood count, protein, globulin, albumin, or whit blood count? ___
 - 9. Falling eyelashes and/or eyebrows? ___
 - 10. Slow healing, G I disorders, loss of skin pigmentation? ___
- Total**

SECTION 28

- 1. Insomnia, noise and/or light sensitivity, sleep apnea?. ___
 - 2. Hypoglycemia, low blood pressure, diabetes, extreme weakness?. ___
 - 3. Mental depression, panic attacks, anxiety, impaired memory?. ___
 - 4. Undue fatigue, sleepiness during the day or fall asleep spontaneously during the day? ___
 - 5. Sore tip of tongue, vitiligo, lack of skin pigmentation, burning sensation in feet? ___
 - 6. Low hemoglobin, thyroid disorder, allergies, sore throat, sensitivity to chemicals, susceptibility to infections, hives, eczema, asthma, cold sores, herpes? ___
 - 7. Restless leg syndrome, teeth grinding, clenching of jaw, jumpiness or shakiness? ___
 - 8. Mood swings, severe stress, agitation, temper tantrums, quarrelsome, compulsive behavior? ___
 - 9. Inability to handle stress, feeling of being overwhelmed, vague abdominal pains, pains in lower neck and/or upper back? ___
- Total**

SECTION 29

- 1. Low serum bun, albumin, globulin, calcium, creatine, protein, red blood count, iron? ___
 - 2. Graying hair, loss of skin pigmentation, balding, hair loss, slow growing hair or nails, dry hair? ___
 - 3. Eczema, dermatitis, constipation, digestive disorders, burn easily in the sun or sun sensitive, dry skin? ___
 - 4. Irritability, nervousness, headaches, mood swings, depression, anxiety, insomnia? ___
 - 5. Adrenal depletion, exhaustion, burning candle at both ends, thyroid or parathyroid disorders, inability to handle any more stress? ___
- Total**

SECTION 30

- 1. Adrenal or nervous exhaustion, general debility, undue fatigue, listlessness or apathy? ___
- 2. Gastric ulcers, slow wound healing? ___
- 3. Weak capillaries, liver spots, tiny red spots on skin? ___

4. Loose teeth, bleeding gums; soft, spongy or swollen gums; purple gums tooth tartar or plaque? ___
 5. Blood in urine, blood in stools? ___
 6. Bruises, low blood pressure, hay fever, heavy metal toxicity, environmental illness? . ___
 7. Nose bleeds, varicose veins, piles, hemorrhages, rheumatic fever, rhesus? ___
 8. Purple or swollen eyelids, cataracts, deterioration of vision? ___
 9. Low serum red blood count or high cholesterol? ___
 10. Excessive saliva, history of anemia? ___
 11. Frequent colds, changes in heart health? ___
 12. Canker sores, slow wound healing? ___
 13. Asthma, allergies, shortness of breath? ___
 14. History of heart attacks, stroke, or hardness of arteries? ___
 15. Weak, sore, inflamed or painful ligaments, bones, joints, connective tissue, arthritis? . . . ___
- Total**

SECTION 31

1. History of rickets, bow legs, osteomalacia, osteoporosis, TB, Osgood-shatter disease, bone cancer? ___
 2. Low serum calcium, phosphorus, or high serum calcium? ___
 3. Bone or tooth structural deformity, pigeon breast, soft teeth, chipping or cracking teeth? . ___
 4. Swollen or enlarged joints, frequent fractures, faulty jaw development, bow legged? ___
 5. Inability to gain weight, decrease in muscular size or weight, muscular weakness, retarded growth? ___
 6. Spinal curvature, twitching, cramps, scoliosis? ___
 7. Susceptibility to dental cavities or aching teeth? ___
 8. Insomnia, nervous, excitability, irritable? ___
 9. Lack of exposure of skin to sunlight? ___
 10. History of low cholesterol below 140, gall stones? ___
- Total**

SECTION 32

1. Dry or flaky skin, eczema, dermatitis, seborrhea, acne, psoriasis? ___
 2. Hot weather distress, undue fatigue, general weakness, muscle weakness? ___
 3. Tendency to overeat, history of asthma or emphysema, stomach ulcers, colitis? . . . ___
 4. Dry or lifeless hair, hair loss, oily hair, balding, unmanageable, hair sticks up on ends, split ends? ___
 5. Prostate gland problems or hormonal imbalance? ___
 6. History of kidney and/or gall bladder complaints? ___
 7. Slow recovery from exercise, slow healing? ___
 8. High serum cholesterol or calcium, low serum iron or platelets? ___
 9. Nose bleeds, Bleeding gums, easy bruising? ___
 10. Low fat or calorie count diet? ___
 11. Chapped lips? ___
 12. History of heart disease, stroke, lupus, hardening of arteries? ___
 13. Gritty feeling in eyes, dryness in eyes, lack of tearing? ___
 14. History of diabetes, arthritis, senility, crohn's disease, irritable bowel syndrome, cancer, infertility, alcoholism? ___
 15. Attention deficit, violent behavior, memory loss, autism, mental retardation, anxiety, seizures, headaches, depression? ___
- Total**

SECTION 33

- 1. History of sterility, miscarriage, reproductive difficulties, poor lactation, weak fertility, spontaneous abortion, weak sperm cells? ___
 - 2. High serum uric acid? ___
 - 3. Shortness of breath, cold hands or feet, leg or foot cramps? ___
 - 4. Circulatory problems, weak heart, swollen legs or ankles? ___
 - 5. Hormonal imbalance, tendency to form blood clots? ___
 - 6. History of heart attack, stroke, hardening of arteries, angina? ___
 - 7. Cross eyed, blurred or double vision, cataracts, macular degeneration? ___
 - 8. Impotence or frigidity? ___
 - 9. Retarded growth, muscular wasting? ___
 - 10. Sluggish liver, liver disease, intolerance to dietary fats? ___
- Total**

SECTION 34

- 1. Shoulder pain, joint pain, muscle pain, degenerative joint disease, low back pain? . ___
 - 2. Mental dullness, inability to concentrate, forgetfulness, brain fog? ___
 - 3. Arthritis, osteoporosis, carpal tunnel syndrome? ___
 - 4. Soft teeth, brittle bones, cavities, receding gums, weak cartilage? ___
 - 5. Female/male hormone imbalance, loss of libido, signs of calcium deficiency in spite of taking supplements? ___
- Total**

SECTION 35

- 1. Slow recovery, slow growth, slow muscle growth? ___
 - 2. Fibromyalgia, chronic fatigue, undue fatigue? ___
 - 3. High or low serum iron, B12 and/or iron deficiency? ___
 - 4. Nerve damage, brain fog? ___
 - 5. Digestive disorders or poor circulation? ___
- Total**

SECTION 36

- 1. Oxygen deficiency symptoms, anemia in extremities? ___
 - 2. History of cancer, stroke, leukemia? ___
 - 3. Toxicity, acidosis, autointoxication? ___
 - 4. Brain anemia, mental disorientation, lack of concentration, anxiety, confusion? ___
 - 5. Weak heart, circulatory problems? ___
 - 6. Blood pressure problems, cardiac insufficiency? ___
 - 7. Low red blood cell count, low hemocritin? ___
 - 8. Short winded, asthma? ___
 - 9. Viral infections, nephritis, frequent colds? ___
 - 10. Liver sluggishness, cirrhosis? ___
- Total**

SECTION 37

- 1. Desire to go on optimal aging/high level wellness program? ___
 - 2. History of cancer, joint inflammation, arthritis like symptoms? ___
 - 3. Seasonal Affective Disorders (SAD), melancholy, depression, mental anguish, fear of ill health, fear of old age, fear of failure, brain dysfunction? ___
 - 4. Sleeplessness, inability to sleep soundly, feeling down in the dumps? ___
 - 5. Drug use, alcohol addiction, need of stimulants, mood elevators and/or pick me uppers? ___
- Total**

SECTION 38

- 1. History of severe or clinical depression? ___

2. History of nervous breakdown, insanity? ___
 3. History of mental disorders, behavioral disorders, emotional instability? ___
- Total**

SECTION 39

1. Low libido, impotency, frigidity? ___
 2. History of liver sluggishness, hepatitis, cirrhosis, anemia? ___
 3. History of lime disease, Epstein bar virus? ___
 4. History of candidiasis, parasites, herpes, athletes foot, canker sores, ring worm? ___
 5. History of bell's palsy, MS.? ___
 6. History of prostate infection, bladder infection? ___
 7. Had a long-term battle with obesity, difficulty losing weight even when try to? ___
 8. History of cancer? ___
 9. Acidosis, high toxicity, acid urine or saliva? ___
 10. History of eczema, acne, gout, asthma? ___
- Total**

SECTION 40

1. History of cancer? ___
 2. PMS, insomnia? ___
 3. History of brain injury, neuralgia, nerve damage? ___
 4. Poor concentration, poor memory, headaches? ___
 5. Weak immune system, frequent colds, viral conditions, fungus conditions? ___
- Total**

SECTION 41

1. Feel you look older for your age, prematurely aging, history of heart disease? ___
 2. History of cancer? ___
 3. Infertility or age/liver spots? ___
 4. History of Parkinson's disease, muscular dystrophy, multiple sclerosis, cystic fibrosis, Alzheimer's? ___
 5. History of liver problems? ___
 6. Anemia, sickle cell, undue fatigue? ___
 7. Pancreatitis, pancreatic atrophy? ___
 8. Muscle weakness? ___
 9. Immune deficiencies, frequent colds? ___
- Total**

SECTION 42

1. History of candida, athlete's foot, E. coli, impetigo, ringworm, parasites, colds, flu, sore throat, influenza? ___
 2. History of infection, staph, tonsillitis, boils, meningitis, ear infections, impetigo? ___
 3. History of TB, whooping cough, pneumonia, shingles, impetigo, gonorrhea? ___
 4. Enlarged prostate, bladder irritation, cystitis, hemorrhoids? ___
 5. Colitis, dysentery, intestinal troubles? ___
- Total**

SECTION 43

1. Diabetic or insulin resistant, pancreatic dysfunction? ___
 2. Hypoglycemic? ___
 3. Chronic weight gain, excess body fat? ___
 4. High cholesterol or triglycerides, cardiovascular disease? ___
 5. Undue fatigue, excessive thirst, infertility, Jekyll/Hyde personality? ___
- Total**

SECTION 44

- 1. Presently diagnosed with cancer? ___
- 2. History of cancer now in remission? ___
- 3. Family history of cancer and/or exposed to carcinogens? ___
- 4. High CEA or AMAF or cancer antibody score on blood test? ___
- 5. Do you desire to go on a special cancer prevention protocol over and above personal nutritional program? ___

Total

SECTION 45

- 1. History of hemorrhages or inability for the blood to timely clot? ___
- 2. Low serum platelets? ___
- 3. Tendency to excessive bleeding from minor wounds? ___
- 4. Malfunction of the intestinal tract, liver or bile duct causing mal-absorption? ___
- 5. Use of sulfa drugs, x-rays, radiation, chemotherapy in last two years? ___

Total

SECTION 46

- 1. Extreme exhaustion, hot weather fatigue? ___
- 2. Obesity or recent sudden decrease in weight? ___
- 3. Cramps, sinus infection, pyorrhea, stiff joint? ___
- 4. Acne, pimples, eczema, boils, muddy skin? ___
- 5. Constipation, digestive disorders? ___
- 6. History of gall stones, gall bladder disorder? ___
- 7. History of jaundice, biliousness or spleen problem? ___
- 8. Weak voice or pyorrhea, bad body odor? ___
- 9. Goiter or thyroid deficiency? ___
- 10. History of electrolyte imbalance, high or low serum chlorine, high toxicity? ___

Total

SECTION 47

- 1. Tooth decay or spongy bleeding gums, weak tooth enamel, poor tooth structure? ___
- 2. Brittle fingernails, skin disorders, brown spots on skin, chapped hands? ___
- 3. Hard crusts form on nose, oily, yellowish skin pigmentation, varicose veins? ___
- 4. History of osteoporosis, silicon deficiency, calcium deficiency, TB? ___
- 5. History of cataracts, failing eyesight, murky color of eyes, backwardness in manners, great aversion to darkness, puffed, swollen lips, ankles, abdomen, and/or neck? ___

Total

SECTION 48

- 1. History of depressed mental state? ___
- 2. Pituitary gland imbalance? ___
- 3. Over age 50? ___

Total

SECTION 49

- 1. Vision failing, glaucoma? ___
- 2. History of stomach and/or duodenal ulcer, hemorrhages or excess bleeding? ___
- 3. Blood in stool or urine, hemorrhoids? ___
- 4. History of stroke, hardening of arteries, coronary artery disease, respiratory infections, poor circulation, weak heart? ___
- 5. Bleeding gums, nose bleeds, lose teeth? ___
- 6. Spider veins and/or varicose veins, tiny red spots on skin, weak capillaries? ___
- 7. History of fever blisters, shingles, genital herpes outbreaks, psoriasis? ___
- 8. History of miscarriage, heavy menstrual bleeding? ___

- 9. Arthritis, swelling or inflammation of joints, swollen extremities? ___
 - 10. Bruise easily, fragile blood vessels, black and blue marks? ___
- Total**

SECTION 50

- 1. Blood serum electrolyte imbalance, liver or kidney disorder? ___
 - 2. Urine, saliva acid/alkaline imbalance, mal-absorption, acidosis/alkalinosi,
indigestion, gall stones? ___
 - 3. Bad breath, body odor? ___
 - 4. Twitches, nervousness, hyper motion, hyperactivity, anxiety, insomnia? ___
 - 5. Heart disease, high blood pressure, poor circulation, rapid heart beat, arteriosclerosis? ___
 - 6. Gas, constipation, bloating, fluid retention, toxicity? ___
 - 7. PMS, cramps, weakness after sweating? ___
 - 8. Brain fog, depression, attention deficit? ___
 - 9. Sugar craving, hypoglycemia, diabetes? ___
 - 10. Overweight, fatigue? ___
- Total**

SECTION 51

- 1. History of heart disease, stroke, angina, coronary artery disease? ___
 - 2. History of cancer? ___
 - 3. Heart rhythm disturbances, high blood pressure, enlarged heart? ___
 - 4. Immune deficiency disorder, increased susceptibility to infections? ___
 - 5. Muscular weakness, chronic unrelenting fatigue? ___
 - 6. Chronic lung infection, shortness of breath, slow recovery after exercise, asthma? . ___
 - 7. Severe muscle pain, feel ill after exercise, unable to tolerate exercise, or have an
aversion to exercise? ___
 - 8. Obese or difficulty losing weight even when counting calories? ___
 - 9. Muscular atrophy, loss of muscle tone? ___
 - 10. Accelerated aging skin, prematurely aging, looking older than your years? ___
- Total**

SECTION 52

- 1. Inability to get or hold an erection? ___
 - 2. Infertile or low sperm count? ___
 - 3. Decreasing interest in sex or lack of sex drive? ___
 - 4. Loss of muscle size, tone or strength? ___
 - 5. Premature ejaculation or slow atrophy of the penis? ___
 - 6. More difficult remembering things, memory weakening, less patients for problem
solving and figuring things out, trouble focusing? ___
 - 7. Increase in fat weight, flab, hanging skin, stomach larger than hips? ___
 - 8. Increasing loss of physical and/or mental energy? ___
 - 9. Increasing loss of ambition, creativity, get up and go, animation of life, motivation
and manly drive? ___
 - 10. Loss of skin tone, wrinkles? ___
- Total**

SECTION 53

- 1. Difficulty urinating or increased straining with less flow? ___
- 2. History of prostatic infections? ___
- 3. Pain in rectum? ___
- 4. Ejaculation causes pain? ___
- 5. Discharge from penis? ___
- 6. Lack of sex drive? ___

- 7. Sense of bladder fullness? _____
- 8. Blood in urine or rose colored urine? _____
- 9. Dripping after urination? _____

Total

SECTION 54

Optional Female Hormone Replacement / Anti-Aging Medicine Questionnaire (by special request)

SECTION 55

- 1. History of low blood pressure? _____
- 2. Carvings and/or intolerance for sweets? _____
- 3. Constant fatigue? _____
- 4. Mood swings? _____
- 5. Alcohol intolerance? _____
- 6. Muscular weakness? _____
- 7. Nervousness? _____
- 8. Fainting spells, lightheaded? _____
- 9. Insomnia? _____
- 10. Low serum sodium, glucose, insulin, triglycerides? _____
- 11. Paranoia? _____
- 12. Migraines? _____
- 13. Heart palpitations? _____
- 14. Craving for salt? _____
- 15. Break out in hives or rashes? _____
- 16. Clenching and/or grinding of teeth? _____
- 17. Confusion, easily frustrated? _____
- 18. Inability to concentrate, easily distracted? _____
- 19. Compulsive behavior? _____
- 20. Can't stand hot humid weather? _____
- 21. Natural high after eating? _____
- 22. Extreme sensitivity to odors? _____
- 23. Difficulty relaxing? _____
- 24. Tendency to suffer from guilt feelings? _____
- 25. Can't stand noise? _____
- 26. Tendency to cry easily? _____
- 27. Cant's stand the stress? _____
- 28. Clumsiness? _____
- 29. Fine thin hair? _____
- 30. Index finger longer that ring finger? _____
- 31. Unusually small jaw bone? _____
- 32. Been on cortisone cream in last year? _____
- 33. Jumpy and/or easily startled? _____
- 34. Prefer hot drink to cold drinks and/or intolerant to cold drinks? _____

Total

SECTION 56

- 1. Rectal itching? _____
- 2. Intermittent fever and/or chills? _____
- 3. Constant belching? _____
- 4. Stomach pain after eating? _____
- 5. Rectal pressure? _____
- 6. Loss of muscular size and/or tone? _____

- 7. Uncontrollable appetite? ___
 - 8. Bloating after eating? ___
 - 9. Weight loss and/or inability to gain weight? ___
 - 10. Frequent or constant heartburn? ___
 - 11. Diarrhea? ___
 - 12. Mucus in stools? ___
 - 13. Insomnia? ___
 - 14. Night sweats? ___
 - 15. Severe fatigue? ___
 - 16. Nausea and/or vomiting? ___
 - 17. Poorly formed stools? ___
 - 18. Itch skin, worse at night? ___
 - 19. Dark circles under eyes? ___
 - 20. Digestive distress after eating fatty foods? ___
 - 21. House dogs that you pet or kiss? ___
 - 22. Eat sushi? ___
 - 23. Eat pork, ham, sandwich meats, prosciutto, sausages? ___
 - 24. Are you from a foreign country? ___
 What Country? _____
 - 25. Low serum red blood count, iron or RBC? ___
- Total**

SECTION 57

- 1. High serum cholesterol triglycerides, bilirubin, or liver enzymes? ___
 - 2. Persistent sleepiness? ___
 - 3. Upper abdominal pain on right side? ___
 - 4. Dark circles and/or bags under eyes? ___
 - 5. Consume alcohol weekly or more? ___
 - 6. History of hepatitis and/or cirrhosis? ___
 - 7. History of intestinal and/or hepatic parasites? ___
 - 8. Gall bladder removed and/or history of gallstones? ___
 - 9. Chronic constipation? ___
 - 10. Take one or more prescription medications? ___
 - 11. Recreational drugs in past or present? ___
 - 12. History of chemotherapy? ___
 - 13. Taken cholesterol medications? ___
 - 14. Sugar intolerance? ___
 - 15. Gain weight easily? ___
 - 16. Alcohol intolerance? ___
 - 17. History of blood sugar disturbances? ___
 - 18. Pale, greasy stools that float? ___
 - 19. Chronic indigestion? ___
 - 20. Intolerance to fatty foods? ___
 - 21. Foul smelling bowel gas? ___
 - 22. Low serum globulin or platelets? ___
 - 23. History of diabetes? ___
 - 24. History of giardia infection? ___
 - 25. Intestinal worms or amoebic dysentery? ___
- Total**

SECTION 58

- 1. Undigested food in stool and/or vitamin pills in stool? ___

- 2. Excessive weight loss or gain? _____
 - 3. Liver or pancreatic disease? _____
 - 4. Greasy foul smelling stools? _____
 - 5. Constipation? _____
 - 6. Diarrhea? _____
 - 7. Bloating and/or indigestion after meals? _____
 - 8. Belching after meals? _____
 - 9. Chronic heartburn? _____
 - 10. Dry flaky and/or chapped skin? _____
 - 11. Chronic fatigue? _____
 - 12. Blood sugar disturbances? _____
 - 13. Use antacids, zantac or tagament on a weekly basis? _____
 - 14. Use alcohol on a weekly basis? _____
 - 15. History of diabetes or hypoglycemia? _____
 - 16. Lactose or milk intolerance? _____
 - 17. History of stomach or intestinal ulcer? _____
 - 18. Gluten intolerance or celiac disease? _____
 - 19. History of Crohn's disease, ulcerated colitis? _____
 - 20. Irritable Bowel Syndrome? _____
 - 21. Psoriasis, eczema or dermatitis? _____
 - 22. Antibiotics in past year? _____
- Total**

SECTION 59

- 1. Itching vagina, penis, groin or rectum? _____
- 2. Abdominal comfort after eating sweet food? _____
- 3. Low body temperature? _____
- 4. Craving for sweets? _____
- 5. Burning urination? _____
- 6. Bloating after meals? _____
- 7. Rectal or vaginal burning? _____
- 8. Vaginal discharge, off white or cottage cheesy? _____
- 9. Skin and/or scalp itches after eating sweets? _____
- 10. Persistent indigestion and/or heartburn? _____
- 11. Itching ear canals and/or belly button? _____
- 12. Chronic sinus problems? _____
- 13. Intolerance to alcohol? _____
- 14. Sensitivity to chemicals, odors, cigarette smoke? _____
- 15. Heavy dandruff, seborrhea? _____
- 16. Itchy skin or scalp? _____
- 17. Ring worm? _____
- 18. Low serum white blood count? _____
- 19. Chronic constipation? _____
- 20. Feeling of being in a mental fog? _____
- 21. Chronic sore and/or scratchy throat? _____
- 22. Feel worse on damp, humid days? _____
- 23. Athlete's foot? _____
- 24. Toe nail and/or fingernail fungus? _____
- 25. History of fungal infections? _____
- 26. History of eczema and/or psoriasis? _____
- 27. Allergy or sensitivity to air born molds? _____

"At Abunda Life, we believe that symptoms are the cells ways and means of communication distress signals. Every symptom is a body signal that points to a potential nutritional deficiency."

- 28. History of oral, rectal, vaginal thrush? _____
- 29. Allergy or sensitivity to aged cheese, soy sauce, vinegar, yeast products? _____
- 30. Taken antibiotics in past two years? _____
- 31. Recurrent urinary tract infections? _____
- 32. Taken steroids, tetracycline, prednisone, cortisone in past two years? _____
- 33. Birth control pills? _____
- 34. Crave bread? _____
- 35. Crave alcoholic beverages? _____
- 36. Less than one bowel movement per day? _____
- 37. Belching? _____
- 38. Intestinal gas? _____
- 39. Dry mouth? _____
- 40. Bad breath? _____
- 41. Nasal itching? _____
- 42. Post nasal drip? _____
- 43. Burning or tearing eyes, failing vision? _____
- 44. Ear pain, loss of hearing, fluid in ears? _____
- 45. Wheezing or shortness to breath? _____

Total

SECTION 60

- 1. Mood swings? _____
- 2. Fatigued after sugar or desserts? _____
- 3. Insomnia? _____
- 4. Dizziness and/or fainting spells? _____
- 5. Headaches after missing a meal or going too long without eating? _____
- 6. Episodes of shakiness and/or tremors? _____
- 7. Legs feel rubbery and/or weak? _____
- 8. Episodes of agitation or temper tantrums? _____
- 9. Clumsiness? _____
- 10. Easily upset and/or frustrated? _____
- 11. Feelings of disorientation? _____
- 12. Episodes of cold sweats? _____
- 13. Episodes of nausea and/or upset stomach? _____
- 14. Sleepiness after eating a carbohydrate meal? _____
- 15. Bursts of violent or irrational behavior, fits of anger? _____
- 16. Behavior problems in school? _____
- 17. Forgetfulness and/or memory impairment? _____
- 18. Crying spells? _____
- 19. Paranoia or panic attacks, anxiety? _____
- 20. Episodes of blurry vision? _____
- 21. Sudden drop in energy levels during mid-morning and/or mid-day? _____
- 22. Nightmares? _____
- 23. Constant worrying? _____
- 24. Indecisiveness? _____
- 25. Feeling of insecurity? _____
- 26. Sensations of impending doom? _____
- 27. Poor concentration? _____
- 28. Heart rhythm disturbances? _____
- 29. Uncontrollable negative and/or self destructive thoughts? _____
- 30. Episodes of uncontrollable eating binges? _____

*"The brain, which occupies less than 2% of the body's total mass, requires up to 36% of its oxygen and nutrients.
We believe that most people lying on Psychiatrist's couches should be sitting in Nutritionist's offices."*

- 31. Accident prone? _____
 - 32. Episodes of mental shut down? _____
 - 33. Significant family history of diabetes? _____
 - 34. Craving for salty foods? _____
 - 35. Taken cortisone type drugs within past year? _____
- Total**

SECTION 61

- 1. Foul smelling stools? _____
 - 2. Foul smelling intestinal gas? _____
 - 3. Constipation, hard pebble like stools? _____
 - 4. History of colon cancer, lupus, Crohn's disease? _____
 - 5. History of diverticulitis, irritable bowel syndrome, ulcerated colitis, hepatitis? _____
 - 6. History of intestinal parasites, food poisoning, vulnerable to intestinal flu? _____
 - 7. Acne, psoriasis, eczema, seborrhea of the scalp? _____
 - 8. Chronic candidiasis? _____
 - 9. Acid reflux, bloating between meals, indigestion, mal-absorption syndrome, low gear, high gear, heart burn, acid stomach? _____
 - 10. Taken antibiotics within the past two years? _____
- Total**

SECTION 62

- 1. Basil Body Temperature: place mercury thermometer under the arm first time in the morning upon awaking before your feet hit the ground. Record temperature to the tenth of a degree (example 96.2) My Basal Temperature:?. _____
- 2. **Iodine test:** paint tincture of iodine on the inside of your arm the size of a penny. Record the time. How many hours does it take for the iodine to disappear. Record: hours? # _____ hrs _____
- 3. History of hypo/hyper thyroidism or synthoroid or thyroid medication? _____
- 4. High serum cholesterol or triglycerides? _____
- 5. Obesity, excess body fat percentage above 35%, difficult losing weight even when counting calories, chronic weight problems?. _____
- 6. Inability or lack of sweating? _____
- 7. Lethargy or weakness? _____
- 8. Slow or slurred speech? _____
- 9. Tired in morning and energetic at night? _____
- 10. Dry or coarse hair, brittle hair? _____
- 11. Cold hands and/or feet? _____
- 12. Bloating and/or indigestion after eating? _____
- 13. Hair loss from outer third of eyebrow? _____
- 14. Dry or coarse skin? _____
- 15. Short-term memory loss? _____
- 16. Swelling of hands and/or ankles? _____
- 17. Chronic headaches? _____
- 18. History of constipation and bowel problems? _____
- 19. PMS and/or other menstrual difficulties? _____
- 20. Infertility history? _____
- 21. History of emotional instability? _____
- 22. Hair loss, slow growing hair? _____
- 23. Heart palpitation? _____
- 24. Excess appetite? _____
- 25. Decrease in sexual desire? _____

- 26. Poor hand to eye coordination? _____
- 27. Hoarseness or coarse voice? _____
- 28. Inability to translate thoughts into action? _____
- 29. Slow reaction time? _____
- 30. Slow thinking? _____
- 31. Difficulty translating words into speech? _____
- 32. Depressed in cold weather? _____
- 33. History of ovary cysts? _____
- 34. Repeated breast inflammation and/or infection? _____
- 35. Received fluoride treatments from dentists? _____
- 36. Cracks on the bottom of your heels? _____
- 37. History of miscarriages? _____
- 38. History of carpal tunnel syndrome? _____
- 39. Cystic breast or lumpy breast history? _____
- 40. History of prematurely stopped periods? _____
- 41. Tendency to feel cold? _____

Total

SECTION 63

- 1. History of chronic, undue mental and/ or physical fatigue, adrenal depletion, nervous exhaustion, stress overwhelm, burn out, epstein barr, convalescence from illness, inability to recover or recuperate? _____
- 2. History of weak immune system, weak muscles, excess body fat, liver sluggishness, liver disease, male sterility, slow heart, delayed growth, diabetes, under active pituitary, low insulin, low T Cell count? _____
- 3. History of hardening of the arteries, rheumatoid arthritis, cancer, heavy metal toxicity, mucus, respiratory disorders, bronchitis, T.B., emphysema, chemotherapy, radiation, weak nails, aging skin, dull hair, smoking, autointoxication, high toxicity, sluggish liver, high blood iron, high or low white blood count? _____
- 4. History of poor fat metabolism, low energy, high triglycerides, weak muscles, neuromuscular disorders, confusion, heart pain, obesity, vegetarian, fatty and/ or sluggish liver, excess body fat, heart surgery? _____
- 5. History of anxiety, panic disorder, high strung, epilepsy, hypertension, enlarged prostate, attention deficit disorder, hyperactivity, tranquilizers, sleeping pills, inability to relax and let go, over firing nerve cells, nervous break down, frustration, burn out? _____
- 6. History of personality disorders, behavioral disorders, epilepsy, slow thinking, ulcers, diabetes, insulin complications, coma, severe hypoglycemia, severe mood swings, sugar and/ or alcohol cravings? _____
- 7. History of mental lethargy, lack of ambition, inability to think clearly, feeling of "jet lag", inability to focus or mentally concentrate, lack of enthusiasm, exaggerated mood swings, lack of mental energy, recent surgeries (2 years), arthritis, autoimmune disease, fibrosis, intestinal disorders, peptic ulcers, connective tissue problems, peptic ulcer, epilepsy, undue fatigue, schizophrenia, senility, recovering alcoholic? _____
- 8. History of lack of muscular coordination, tremors, difficulty maintaining balance, metal disorientation, confusion, pre-mature aging, liver sluggishness, poor fat metabolism, arteriolosclerosis related conditions? _____
- 9. History of rheumatoid arthritis, low sex drive, indigestion, weak immune system, heart burn, nerve deafness, radiation exposure, heavy metal toxicity, frigidity, high blood pressure, (women) inability to achieve orgasm, schizophrenia, poor appetite, nausea, lethargy, anger, allergies? _____

10. History of bi-polar, prostate problems, epilepsy, seizures, manic depression, muscle degeneration, weak stomach, poor digestion, slow healing, gall bladder troubles, poor fat metabolism? _____
11. High or low serum hemoglobin, blood sugar abnormalities, hypoglycemia symptoms, weak muscles, loss of strength? _____
12. History of low energy, weak bones and/ or muscles, slow healing, slow recovery after exercise, convalescing after an illness, slow healing skin, weak or thin skin, diabetes, high serum glucose, high blood sugar? _____
13. History of weak immune system, recovering from surgery or illness (2yrs.), cold sores, herpes, anemia, bloodshot eyes, hair loss, poor appetite, weight loss, irritability, enzyme disorders, inability to concentrate? _____
14. History of difficulty in the digestion of fats, heavy metal toxicity, brittle hair, radiation exposure, osteoporosis, chemical allergies, liver disease, liver sluggishness, auto intoxication, chronic constipation, kidney disorders, hardening of the arteries, muscle weakness, high triglycerides and/ or cholesterol, brain fog? _____
15. History of obesity, excess body fat, poor muscle tone, weak muscles, lack of muscle, weak immune response, sluggish liver, liver disease, slow healing, muscle, bone, joint or connective tissue injury convalescing from illness, low resistance, high toxic condition, chronic constipation? _____
16. History of depression, brain fog, negative mental attitude, anxiety, stress overwhelm, obesity, emotionally drained, hypothyroidism, overeating, adrenal exhaustion, tightness of feelings, undue fatigue, uncontrolled eating, mental dullness, Parkinson's disease, schizophrenia, migraines, menstrual cramps? _____
17. Need of a drugless pain control remedy? _____
18. History of weak connective tissue soft bones, bruise easily, weak and/ or inflamed joints, cartilage, tendons or connective tissue, bleeding gums? _____
19. History of weak immune system, unsaturated fatty acid deficiency, difficulty digesting fatty foods or dairy, dry skin? _____
20. History of high cholesterol and / or triglycerides, difficulty digesting fats, atherosclerosis, edema, heart disorders, clogged arteries, hypertension, hypoglycemia, electrolyte imbalances, cardiac arrhythmia, anxiety, epilepsy, seizures, dons syndrome, dystrophy, zinc deficiency, nervousness, breast cancer, high platelets, angina, candida, diabetes, facial twitches? _____
21. History of depression, insomnia, mood swings, hyperactivity, attention deficit disorders, stress overwhelm, nervous break down, feeling of not being able to "take it anymore", whipped out, migraine, coronary artery spasms? _____
22. History of stress overwhelm, mental and/ or physical fatigue, narcolepsy, anxiety, depression, allergies, headaches, drug medication, tobacco, alcohol and / or withdrawal, Parkinson's disease, thyroid troubles, excess body fat, uncontrollable appetite, slow metabolism? _____
23. Desire to build stronger, firmer muscles, desire to improve athletic performance, desire to increase energy? _____
24. History of alcoholism, junk food habit, undue mental and/ or physical fatigue, neurological and/ or brain disorders, confusion, inability to "get the words out on time", brain fog, low resistance, toxicity, liver disorders, liver sluggishness, autointoxication, lack of physical or mental energy, chronic constipation, (body builder, athlete) desire to increase energy, high serum bun, bilirubin, A/ G ratio, high or low liver enzyme? _____

Total

**You have completed the Naturopathic Doctor's 1001 Nutritional Assessment Questionnaire
PLEASE BE SURE TO SIGN THE NON-MEDICAL AGREEMENT ON BACK COVER**

Typically, what do you eat and drink each day?			
Breakfast Time:	Lunch Time:	Dinner Time:	Snacks Time:

Please use the space provided below to list any additional concerns or areas that you would care to elaborate on. Be sure to reference the section of the questionnaire and the number that you are addressing.

SECTION _____
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SECTION _____
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SECTION _____
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SECTION _____
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SECTION _____
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SECTION _____
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NON-MEDICAL AGREEMENT

(Please read and sign)

1. Abunda Life agree to render the high quality Holistic Health counseling of Body, Mind and Spirit, described in it's literature since 1964, at it's posted fees.
2. Although the clinic is staffed with a licensed Medical Doctor and other associates holding medically related licenses, this program will be administered by a "Natural Healing Practitioner. This is not a New Jersey State licensed profession because it is a distinct ministry of the Abunda Life Church. Appointments with affiliate Medical Personnel may be scheduled by separate appointment.
3. It is understood that Robert H. Sorge, although highly qualified and in private practice since 1964, is not a licensed medical doctor or primary care physician. He does not write prescription, render medical treatment or diagnose specific medical conditions.
4. The name of my medical doctor, clinic or hospital is:

who provides treatment for my medical problems from time to time. Because this program is designed to compliment, not substitute medical treatment, I intend to continue under this physician's care and not to discharge him while on this program.

5. In event a disagreement should ever arise involving the services being rendered, both parties agree to take the following steps:
 - a. Earnestly attempt to resolve the disagreement in writing
 - b. If for some reason, the matter is unable to be resolved promptly within 30 days, the dispute shall be settled by the membership committee or any mutually agreed on church court, minister, priest, rabbi, or spiritual counselor.
 - c. In the event the dispute cannot be settled by any of the above within 60 days, the dispute shall be settled by arbitration in accordance with the rules of the American Arbitration Association, whose decision shall be considered final.
6. If there are any additions to this agreement, please print in the space provided:

Client Signature/ Parent or Guardian's Signature (under 18 years old)

Signature of Natural Healing Practitioner



Abunda Life Medical Nutrition Testing Clinic

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"I have come, that you may have life and have it more abundantly" (John 10:10)

www.abundalife.com