STANDARD PROCESS **STRESS ASSESS™**

How well do you think you are handling stress? This assessment will help you and your health care professional design a personalized program to support your stress response and well-being.

Have you experienced any significant life events or changes in the last three months (illness, injury, job change, new baby, marriage, divorce, extreme training for a sporting event, major project at work, etc.)? If so, please list: ______________________________

Hours of sleep each night:	Hours exercised per week:	Alcoholic drinks per week: (1 drink = 12 oz. beer, 5 oz. wine, 1.5 oz. liquor)	Meals eaten out per week:
3-4 5-6 7-8 9+	0 1-2 3-5 6+	0 1-2 3-7 8+	0 1-2 3-5 6+

Do you have any downtime or participate in quiet mindfulness activities? (Pilates, yoga, meditation, quiet walks, personal hobbies) Yes No

Please answer the following questions based on your experience within the last month.	Not at All	Little Bit	Somewhat	Quite a Bit	Very Much
1. How stressful would you say your life is?	1	2	3	4	5
2. Dealing with daily stresses is negatively affecting my daily tasks.	1	2	3	4	5
3. I have a high intake of sugar and/or processed foods.	1	2	3	4	5
4. I feel worn down and/or burnt out.	1	2	3	4	5
5. I need caffeine or other energy drinks in the morning or afternoon to give me energy.	1	2	3	4	5
6. I seem to have lower than usual energy during the day.	1	2	3	4	5
7. I experience body aches and pains.	1	2	3	4	5
8. I have periods of low moods.	1	2	3	4	5
9. I feel more irritable.	1	2	3	4	5
10. My weight and metabolism have changed.	1	2	3	4	5
11. I can't seem to focus or concentrate.	1	2	3	4	5
12. I have feelings of anxiousness.	1	2	3	4	5
13. I feel totally exhausted most of the day and only have a few productive hours.	1	2	3	4	5
14. I find myself pushing through fatigue to get things done.	1	2	3	4	5
15. I seem to be sleeping a lot but never feel quite rested. I wake up feeling tired.	1	2	3	4	5
16. I have difficulty getting to sleep and/or wake up in the middle of the night.	1	2	3	4	5
17. I experience strong cravings for sweet or salty foods.	1	2	3	4	5
18. I feel overwhelmed with daily tasks and all that is on my plate.	1	2	3	4	5
19. I have a low sex drive.	1	2	3	4	5
20. I am unable to enjoy socializing with family and/or friends.	1	2	3	4	5

Add up your total score and mark where you fall on the stress scale below. Total: __________

Low Stress — High Stress

20 — 40 — 60 — 80 — 100

Stress is fairly well managed in your life. It may be important to support your body to continue its healthy response.

Your body's response to stress may be getting in the way of normal activities quite frequently, leaving you feeling depleted. Consult your health care professional for an individualized program to achieve your health goals.

You may have experienced prolonged stress, and your body's stress response can no longer adapt or successfully cope. Consult your health care professional for targeted support and strategies for improvement.

Standard Process.
WHOLE FOOD NUTRIENT SOLUTIONS

Name: ______________________________ Date: __________

Name: Date:

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a detoxification program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0 1 2 3 4
b. Diarrhea	0 1 2 3 4
c. Constipation	0 1 2 3 4
d. Bloated feeling	0 1 2 3 4
e. Belching and/or passing gas	0 1 2 3 4
f. Heartburn	0 1 2 3 4

Total: ____

2. EARS

a. Itchy ears	0 1 2 3 4
b. Earaches or ear infections	0 1 2 3 4
c. Drainage from ear	0 1 2 3 4
d. Ringing in ears or hearing loss	0 1 2 3 4

Total: ____

3. EMOTIONS

a. Mood swings	0 1 2 3 4
b. Anxiety, fear, or nervousness	0 1 2 3 4
c. Anger, irritability	0 1 2 3 4
d. Depression	0 1 2 3 4
e. Sense of despair	0 1 2 3 4
f. Uncaring or disinterested	0 1 2 3 4

Total: ____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0 1 2 3 4
b. Hyperactivity	0 1 2 3 4
c. Restlessness	0 1 2 3 4
d. Insomnia	0 1 2 3 4
e. Startled awake at night	0 1 2 3 4

Total: ____

5. EYES

a. Watery or itchy eyes	0 1 2 3 4
b. Swollen, reddened, or sticky eyelids	0 1 2 3 4
c. Dark circles under eyes	0 1 2 3 4
d. Blurred or tunnel vision	0 1 2 3 4

Total: ____

6. HEAD

a. Headaches	0 1 2 3 4
b. Faintness	0 1 2 3 4
c. Dizziness	0 1 2 3 4
d. Pressure	0 1 2 3 4

Total: ____

7. LUNGS

a. Chest congestion	0 1 2 3 4
b. Asthma or bronchitis	0 1 2 3 4
c. Shortness of breath	0 1 2 3 4
d. Difficulty breathing	0 1 2 3 4

Total: ____

8. MIND

a. Poor memory	0 1 2 3 4
b. Confusion	0 1 2 3 4
c. Poor concentration	0 1 2 3 4
d. Poor coordination	0 1 2 3 4
e. Difficulty making decisions	0 1 2 3 4
f. Stuttering, stammering	0 1 2 3 4
g. Slurred speech	0 1 2 3 4
h. Learning disabilities	0 1 2 3 4

Total: ____

9. MOUTH/THROAT

a. Chronic coughing	0 1 2 3 4
b. Gagging or frequent need to clear throat	0 1 2 3 4
c. Swollen or discolored tongue, gums, lips	0 1 2 3 4
d. Canker sores	0 1 2 3 4

Total: ____

10. NOSE

a. Stuffy nose	0 1 2 3 4
b. Sinus problems	0 1 2 3 4
c. Hay fever	0 1 2 3 4
d. Sneezing attacks	0 1 2 3 4
e. Excessive mucous	0 1 2 3 4

Total: ____

11. SKIN

a. Acne	0 1 2 3 4
b. Hives, rashes, or dry skin	0 1 2 3 4
c. Hair loss	0 1 2 3 4
d. Flushing	0 1 2 3 4
e. Excessive sweating	0 1 2 3 4

Total: ____

12. HEART

a. Skipped heartbeats	0 1 2 3 4
b. Rapid heartbeats	0 1 2 3 4
c. Chest pain	0 1 2 3 4

Total: ____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0 1 2 3 4
b. Stiffness or limited movement	0 1 2 3 4
c. Pain or aches in muscles	0 1 2 3 4
d. Recurrent back aches	0 1 2 3 4
e. Feeling of weakness or tiredness	0 1 2 3 4

Total: ____

14. WEIGHT

a. Binge eating or drinking	0 1 2 3 4
b. Craving certain foods	0 1 2 3 4
c. Excessive weight	0 1 2 3 4
d. Compulsive eating	0 1 2 3 4
e. Water retention	0 1 2 3 4
f. Underweight	0 1 2 3 4

Total: ____

15. OTHER:

a. Frequent illness	0 1 2 3 4
b. Frequent or urgent urination	0 1 2 3 4
c. Leaky bladder	0 1 2 3 4
d. Genital itch, discharge	0 1 2 3 4

Total: ____

Section I Total: ____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16. Circle the corresponding number for questions 16a-16f below.

0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily

a. How often are strong chemicals used in your home?
(disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.) 0 1 2 3 4

b. How often are pesticides used in your home? 0 1 2 3 4

c. How often do you have your home treated for insects? 0 1 2 3 4

d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office? 0 1 2 3 4

e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics? 0 1 2 3 4

f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes? 0 1 2 3 4

g. How often do you consume nonorganic foods? 0 1 2 3 4

Total: _____

17. Circle the corresponding number for questions 17a-17b below.

0	No	1	Mild Change	2	Moderate Change	3	Drastic Change

a. Have you noticed any negative change in your health since you moved into your home or apartment? 0 1 2 3

b. Have you noticed any change in your health since you started your new job? 0 1 2 3

Total: _____

18. Answer yes or no and circle the corresponding number for questions 18a-18d below.

	No	Yes
a. Do you have a water purification system in your home?	2	0
b. Do you have any indoor pets?	0	2
c. Do you have an air purification system in your home?	2	0
d. Are you a dentist, painter, farm worker, or construction worker?	0	2

Total: _____

Section II Total: _____

Grand Total (Section I & Section II) _____

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a detoxification program.