What SHAPE is Your Health In?

Name: _____ Date: _____ Assessment #: _____

Symptoms: Write the number that best describes how you have experienced each symptom over the last year:

0 = Never 3 = Sometimes 5 = Always

Acid reflux, heartburn		Eczema, psoriasis		Low blood sugar	
Acne		Erectile dysfunction		Low libido	
Anxiety		Excessive sweating		Mood swings	
Asthma		Excessive thirst/hunger		Muscle cramps, spasms	
Belching, passing gas		Fatigue, low energy		Muscle pain, aches, weakness	
Bleed or bruise easily		Food sensitivities/allergies		Nausea, vomiting	
Bloating		Frequent colds or flus		Nose bleeds	
Blurred or tunnel vision		Frequent need to clear throat		Painful or heavy periods	
Body odor		Gallbladder problems		Poor memory	
Breast masses or fibroids		Gout		Premenstrual syndrome (PMS)	
Brittle nails		Hair loss or thinning		Prostate problems	
Bronchitis		Hay fever, seasonal allergies		Rapid or pounding heartbeat	
Brown age/liver spots		Headaches, migraines		Skin rashes	
Chemical sensitivities		Hemorrhoids		Shortness of breath	
Chest congestion		High blood pressure		Sinus congestion or infection	
Chest pain or pressure		Hives		Sore throat, hoarseness	
Chronic coughing		Hot/cold intolerance		Stiffness, limited movement	
Cold/canker sores		Hyperactivity		Stuffy nose	
Constant sneezing		Incontinence		Swelling, edema	
Constipation		Indigestion		Swollen lymph nodes	
Cravings		Insomnia		Swollen tongue, gums or lips	
Cysts, boils		Intestinal or stomach pain		Tendonitis, bursitis	
Depression		Irregular, skipped heartbeat		Tinnitus, hearing loss	
Diarrhea		Irregular periods		Ulcers	
Difficulty breathing		Irritable when hungry		Urinary tract problems	
Difficulty concentrating		Itchy ears		Vaccine reactions	
Difficulty falling/staying asleep		Itchy skin, dermatitis		Vaginal discharge	
Difficulty losing weight		Joint pain		Varicose veins	
Dizziness, faintness		Kidney stones		Watery or itchy eyes	
Ear drainage		Low back pain		Weight gain	
Earaches, ear infections		Low blood pressure		Yeast infections	

Conditions: Have you ever been diagnosed with any of the following? Write Y/N (Count 5 points for every Y.)

ADD/ADHD		Diabetes		Hepatitis, liver disease	
Anxiety		Eczema, psoriasis		Hypoglycemia	
Arthritis		Fibromyalgia		Infertility	
Asthma		GERD		Insulin resistance	
Autoimmune conditions		Gout		Irritable bowel syndrome	
Celiac disease		Gouty arthritis		Restless leg syndrome	
Colitis, Crohn's disease		Hay fever, seasonal allergies		Seizure disorder, epilepsy	
Depression		Heart disease		Thyroid condition	

Total: _____

Below 50:	You're in good SHAPE
50-100:	Consider the SHAPE Program
100 or above:	It's time for the SHAPE Program

Notes: _____

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DR. TODD FRISCH

SHAPE ReClaimed