8770 Spring Brook Dr.
Coon Rapids, MN 55433
Phone: 763-571-9555

PATIENT INFORMATION

Name: ____

Address: ____

City: ___________________________ State: __________

Phone: ____

Email: ____

DETOXIFICATION QUESTIONNAIRE

Patient Name: ______________________ Date: ____________

Rate each of the following symptoms based on your typical health profile for the specified duration:

❒ Past month ❒ Past week ❒ Past 48 hours

Point Scale: 0—Never or almost never have the symptom 1—Occasionally have it, effect is not severe 2—Occasionally have it, effect is severe
3—Frequently have it, effect is not severe 4—Frequently have it, effect is severe

I. Medical Symptoms Questionnaire (MSQ)

HEAD
- _______ Headaches
- _______ Faintness
- _______ Dizziness
- _______ Insomnia TOTAL _______

EYES
- _______ Watery or itchy eyes
- _______ Swollen, reddened or sticky eyelids
- _______ Bags or dark circles under eyes
- _______ Blurred or tunnel vision TOTAL _______

EARS
- _______ Itchy ears
- _______ Earaches, ear infections
- _______ Drainage from ear
- _______ Ringing in ears, hearing loss TOTAL _______

NOSE
- _______ Stuffy nose
- _______ Sinus problems
- _______ Hay fever
- _______ Sneezing attacks
- _______ Excessive mucus formation TOTAL _______

MOUTH/ THROAT
- _______ Chronic coughing
- _______ Gagging, frequent need to clear throat
- _______ Sore throat, hoarseness, loss of voice
- _______ Swollen or discolored tongue, gums, lips
- _______ Canker sores TOTAL _______

SKIN
- _______ Acne
- _______ Hives, rashes, dry skin
- _______ Hair loss
- _______ Flushing, hot flashes
- _______ Excessive sweating TOTAL _______

HEART
- _______ Chest pain
- _______ Irregular or skipped heartbeat
- _______ Rapid or pounding heartbeat TOTAL _______

LUNGS
- _______ Chest congestion
- _______ Asthma, bronchitis
- _______ Shortness of breath
- _______ Difficulty breathing TOTAL _______

DIGESTIVE TRACT
- _______ Nausea, vomiting
- _______ Diarrhea
- _______ Constipation
- _______ Bloated feeling
- _______ Belching, passing gas
- _______ Heartburn
- _______ Intestinal/stomach pain TOTAL _______

JOINTS/ MUSCLE
- _______ Pain or aches in joints
- _______ Arthritis
- _______ Stiffness or limitation of movement
- _______ Feeling of weakness or tiredness
- _______ Pain or aches in muscles TOTAL _______

WEIGHT
- _______ Binge eating/drinking
- _______ Craving certain foods
- _______ Excessive weight
- _______ Water retention
- _______ Underweight
- _______ Compulsive eating TOTAL _______

ENERGY/ ACTIVITY
- _______ Fatigue, sluggishness
- _______ Apathy, lethargy
- _______ Hyperactivity
- _______ Restlessness TOTAL _______

MIND
- _______ Poor memory
- _______ Confusion, poor comprehension
- _______ Difficulty in making decisions
- _______ Stuttering or stammering
- _______ Slurred speech
- _______ Learning disabilities
- _______ Poor concentration
- _______ Poor physical coordination TOTAL _______

EMOTIONS
- _______ Mood swings
- _______ Anxiety, fear, nervousness
- _______ Anger, irritability, aggressiveness
- _______ Depression TOTAL _______

OTHER
- _______ Frequent illness
- _______ Frequent or urgent urination
- _______ Genital itch or discharge TOTAL _______

GRAND TOTAL TOTAL _______

II. Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
❐ Yes (1 pt.)
If yes, how many are you currently taking? ____ (1 pt. each)
❐ No (0 pt.)

2. Are you presently taking one or more of the following over-the counter drugs?
❐ Cimetidine (2 pts.) ❐ Acetaminophen (2 pts.) ❐ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
❐ Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
❐ Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)
❐ Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)
❐ Experience no side effects, drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?
❐ Yes (2 pts.) ❐ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine containing products?
❐ Yes (1 pt.) ❐ No (0 pt.) ❐ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
❐ Yes (1 pt.) ❐ No (0 pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
❐ Yes (1 pt.) ❐ No (0 pt.) ❐ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
❐ Yes (1 pt.) ❐ No (0 pt.) ❐ Don't know (0 pt.)

10. Do you have a personal history of
❐ Environmental and/or chemical sensitivities (5 pts.)
❐ Chronic fatigue syndrome (5 pts.)
❐ Multiple chemical sensitivity (5 pts.)
❐ Fibromyalgia (3 pts.)
❐ Parkinson's type symptoms (3 pts.) ❐ Alcohol or chemical dependence (2 pts.) ❐ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
❐ Yes (1 pt.) ❐ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?
❐ Yes (1 pt.) ❐ No (0 pt.) ❐ Don't know (0 pt.)

GRAND TOTAL: ____________

For Practitioner Use Only:

OVERALL SCORE TABULATION

Recommended protocols based on new detoxification questionnaire (MSQ and XTT)

MSQ SCORE ________ (High >50; moderate 15-49: Low <14)
XTT SCORE ________ (High >10; moderate 5-9: Low <4)

MSQ Score	XTT Score	Description	Functional Medicine Protocol		
			Medical Food	Diet	Additional Nutraceutical Support
50 or >	10 or >	High level of general symptoms and indicated symptoms of elevated toxic load	Medical food for imbalanced detoxifiers	28-day elimination diet	Bifunctional, antioxidant, and chlorophyllin nutraceuticals
15-49	5-9	Moderate level of general symptoms with moderate symptoms of toxic load	Medical food for imbalanced detoxifiers	10-day elimination diet	Consider bifunctional, antioxidant, and chlorophyllin nutraceuticals
14 or <	4 or <	Low level of general symptoms and minimal indicators of toxic load			Maintenance

Additional Symptom-Specific Support

Symptom	Nutraceutical Support
Water retention and/or frequent or urgent urination	Kidney support nutraceuticals
Heartburn and/or intestinal/stomach pain	Functional dyspepsia nutraceuticals
Diarrhea, constipation, and/or intestinal/stomach pain	Probiotics

Note: Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfuntion, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.

Identi-T Stress Assessment

Name ______________________________ Age __________ Sex __________ Date __________

Stress is a normal part of life. Every day, we're faced with stimuli, called stressors, which can elicit the body's "fight or flight" response, setting off a cascade of physiological reactions and resulting in emotions ranging from mild to intense. But while occasional stress is natural and even healthy, chronic or acute stress can be harmful.

Please take a few moments to discover your body's response to situations you perceive as stressful. By honestly assessing how you feel, your healthcare provider can create a natural stress relief program for your individual needs.

Directions:

Please read each statement and circle the number 0, 1, 2, or 3 that best describes your feelings or reactions throughout the course of the day. Determine the subtotal score for each section, then determine the total scores for sections A-C and C-E. Some questions may appear redundant between sections. There's a reason for each question. Don't spend much time on any one question.

0 = Never true 1= Seldom true 2= Sometimes true 3= Often true

When under stress for two weeks or longer, I…

Section A:

1. Get wound up when I get tired and have trouble calming down 0 1 2 3
2. Feel driven, appear energetic but feel "burned out" and exhausted........ 0 1 2 3
3. Feel restless, agitated, anxious, and uneasy 0 1 2 3
4. Feel easily overwhelmed by emotion........ 0 1 2 3
5. Feel emotional — cry easily or laugh inappropriately........ 0 1 2 3
6. Experience heart palpitations or a pounding in my chest 0 1 2 3
7. Am short of breath........ 0 1 2 3
8. Am constipated........ 0 1 2 3
9. Feel warm, over-heated, and dry all over 0 1 2 3
10. Get mouth sores or sore tongue 0 1 2 3
11. Get hot flashes 0 1 2 3
12. Sleep less than seven hours a night........ 0 1 2 3
13. Have trouble falling asleep and staying asleep........ 0 1 2 3
14. Worry about high blood pressure, cholesterol, and triglycerides........ 0 1 2 3
15. Forget to eat and feel little hunger 0 1 2 3

Total points: __________

Section B:

1. Find myself worrying about things big and small........ 0 1 2 3
2. Feel like I can't stop worrying, even though I want to........ 0 1 2 3
3. Feel impulsive, pent up, and ready to explode........ 0 1 2 3
4. Get muscle spasms 0 1 2 3
5. Feel aggressive, unyielding, or inflexible when pressed for time........ 0 1 2 3
6. See, hear, and smell things that others do not 0 1 2 3
7. Stay awake replaying the events of the day or planning for tomorrow........ 0 1 2 3
8. Have upsetting thoughts or images enter my mind again and again 0 1 2 3
9. Have a hard time stopping myself from doing things again and again, like checking on things or rearranging objects over and over 0 1 2 3
10. Worry a lot about terrible things that could happen if I'm not careful........ 0 1 2 3

Total points: __________

Section C:

1. Have muscle and joint pains........ 0 1 2 3
2. Have muscle weakness 0 1 2 3
3. Crave salt or salty things........ 0 1 2 3
4. Have multiple points on my body that when touched are tender or painful........ 0 1 2 3
5. Have dark circles under my eyes 0 1 2 3
6. Feel a sudden sense of anxiety when I get hungry........ 0 1 2 3
7. Use medications to manage pain........ 0 1 2 3
8. Get dizzy when rising or standing up from a kneeling or sitting position........ 0 1 2 3
9. Have diarrhea or bouts of nausea with or without vomiting for no apparent reason 0 1 2 3
10. Have headaches........ 0 1 2 3

Total points: __________

Section D:

1. Have trouble organizing my thoughts	0	1	2	3
2. Get easily distracted and lose focus	0	1	2	3
3. Have difficulty making decisions and mistrust my judgment	0	1	2	3
4. Feel depressed and apathetic	0	1	2	3
5. Lack the motivation and energy to stay on task and pay attention	0	1	2	3
6. Am forgetful	0	1	2	3
7. Feel unsettled, restless, and anxious	0	1	2	3
8. Wake up tired and unrefreshed	0	1	2	3
9. Experience heartburn and indigestion	0	1	2	3
10. Catch colds or infections easily	0	1	2	3

Total points: ___________

Section E:

1. Feel tired for no apparent reason	0	1	2	3
2. Experience lingering mild fatigue after exertion or physical activity	0	1	2	3
3. Find it difficult to concentrate and complete tasks	0	1	2	3
4. Feel depressed and apathetic	0	1	2	3
5. Feel cold or chilled - hands, feet, or all over - for no apparent reason	0	1	2	3
6. Have little or no interest in sex	0	1	2	3
7. Sweat spontaneously during the day	0	1	2	3
8. Feel puffy and retain fluids	0	1	2	3
9. Sleep more than nine hours a night	0	1	2	3
10. Have poor muscle tone	0	1	2	3
11. Have trouble losing weight	0	1	2	3
12. Wake up tired even though I seem to get plenty of sleep	0	1	2	3
13. Have no energy and feel physically weak	0	1	2	3
14. Am susceptible to colds and the flu	0	1	2	3
15. Feel dragged down by multiple symptoms, such as poor digestion and body aches	0	1	2	3

Total points: ___________

Add points from sections A, B & C	Total for A, B & C: ___________
Add points from sections C, D & E	Total for C, D & E: ___________

LIfestyle and Health Status:

1. Circle the level of stress you experience on the scale of 1-10, 10 being the worst:
   1 2 3 4 5 6 7 8 9 10
2. What do you consider to be the major causes of your stress (for example — spouse, family, friends, work, finances, wedding, pregnancy, legal, commute):
   ____
3. I eat breakfast _________ times a week. My typical breakfast is: ____
4. I take a multiple vitamin/mineral ___________ days per week. I take a fish oil supplement _____________ days per week.
5. I participate in 30 minutes of physical activity such as walking, aerobics (e.g., running), resistance training (e.g., weights, pilates), sports (e.g. biking), or yoga:
   Q Daily Q 5-6 times per week Q 3-4 times per week Q 1-2 times per week Q Less than once a week
6. I smoke ________ cigarettes daily.
7. I drink two or more 8 ounce cups of caffeinated coffee or other caffeinated beverages like energy/diet drinks, colas, or black or green teas:
   Q Daily Q 5-6 times per week Q 3-4 times per week Q 1-2 times per week Q Less than once a week
8. I drink two or more ounces of alcoholic beverages:
   Q Daily Q 5-6 times per week Q 3-4 times per week Q 1-2 times per week Q Less than once a week
9. List your current health problems and any over-the-counter or prescription medications that you are now taking:

Current health problem(s)	Date of onset	List all current medication(s)
______________________________	___________	____
______________________________	___________	____
______________________________	___________	____

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HEALTH HISTORY

Name ______________________________ Date of Birth ____________ Today's Date ____________

Occupation ______________________________ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Are you recovering from a cold or flu? __________ Are you pregnant? __________

Reason for office visit: Date began:

______________________________ ____________

______________________________ ____________

Date of last physical exam __________ Practitioner name and phone number______________________________

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

____

Outcome ______________________________

What types of therapy have you tried for this problem(s):

❑ diet modification ❑ fasting ❑ vitamins/minerals ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs

❑ other ______________________________

List current health problems for which you are being treated: ______________________________

____

Current medications (prescription or over-the-counter): ______________________________

____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
______	______________________	______________
______	______________________	______________

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): ______________________________

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right Your weight today _________

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? ______________

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)?

____

❑ Corrective lenses ❑ Dentures ❑ Hearing aid ❑ Medical devices/prosthetics/implants, describe: ______________________

Recent changes in your ability to: ❑ see ❑ hear ❑ taste ❑ smell ❑ feel hot/cold sensations

❑ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Strong dislike for any one of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Do you: ❑ Prefer warmth (i.e., food, drinks, weather, etc.) ❑ Prefer cold (i.e., food, drinks, weather, etc.) ❑ No preference

Is your sleep disturbed at the same time each night? ______ If yes, what time? ______

Time of day you feel the most energy or the least symptoms:

❑ 7 a.m. - 9 a.m. ❑ 9 a.m. - 11 a.m. ❑ 11 a.m. - 1 p.m.
❑ 1 p.m. - 3 p.m. ❑ 3 p.m. - 5 p.m. ❑ 5 p.m. - 7 p.m.
❑ 7 p.m. - 9 p.m. ❑ 9 p.m. - 11 p.m. ❑ 11 p.m. - 1 a.m.
❑ 1 a.m. - 3 a.m. ❑ 3 a.m. - 5 a.m. ❑ 5 a.m. - 7 a.m.

Time of day you feel the worst or your symptoms are aggravated:

❑ 7 a.m. - 9 a.m. ❑ 9 a.m. - 11 a.m. ❑ 11 a.m. - 1 p.m.
❑ 1 p.m. - 3 p.m. ❑ 3 p.m. - 5 p.m. ❑ 5 p.m. - 7 p.m.
❑ 7 p.m. - 9 p.m. ❑ 9 p.m. - 11 p.m. ❑ 11 p.m. - 1 a.m.
❑ 1 a.m. - 3 a.m. ❑ 3 a.m. - 5 a.m. ❑ 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

❑ Debilitating fatigue ❑ Shortness of breath ❑ Insomnia ❑ Constipation ❑ Chronic pain/inflammation
❑ Depression ❑ Panic attacks ❑ Nausea ❑ Fecal incontinence ❑ Bleeding
❑ Disinterest in sex ❑ Headaches ❑ Vomiting ❑ Urinary incontinence ❑ Discharge
❑ Disinterest in eating ❑ Dizziness ❑ Diarrhea ❑ Low grade fever ❑ Itching/rash

Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome ❑
- Kidney or bladder disease ❑
- Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other ______________________________

____

Medical (Men)

- ❑ Benign prostatic hyperplasia (BPH)
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ Sexually transmitted disease

Other ______________________________

____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ Premenstrual syndrome (PMS)
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ Sexually transmitted disease

Other ______________________________

Age of first period ______

Date of last gynecological exam ____

Mammogram ❑ + ❑ –

PAP ❑ + ❑ –

Form of birth control ______________

# of children ______________

# of pregnancies ______________

- ❑ C-section ______________
- ❑ Surgical menopause
- ❑ Menopause

Date of last menstrual cycle _________

Length of cycle _____ days

Interval of time between cycles ______ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) ______________________

Family Health History (Parents and Siblings)

- ❑ Arthritis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other ______________________________

Health Habits

❑ Tobacco:

Cigarettes: #/day ________________

Cigars: #/day ________________

❑ Alcohol:

Wine: #glasses/d or wk ___________

Liquor: #ounces/d or wk ___________

Beer: #glasses/d or wk ___________

❑ Caffeine:

Coffee: #6 oz cups/d ___________

Tea: #6 oz cups/d ___________

Soda w/caffeine: #cans/d _________

Other sources ______________

❑ Water: #glasses/d______________

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk
- ❑ Run, jog, jump rope
- ❑ Weight lift
- ❑ Swim
- ❑ Box
- ❑ Yoga

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs

❑ soy ❑ corn ❑ all gluten

Other ______________________

Food Frequency

Servings per day:

Fruits (citrus, melons, etc.) __________

Dark green or deep yellow/orange vegetables ______________

Grains (unprocessed) ______________

Beans, peas, legumes ______________

Dairy, eggs ______________

Meat, poultry, fish ______________

Eating Habits

- ❑ Skip breakfast
- ❑ Two meals/day
- ❑ One meal/day
- ❑ Graze (small frequent meals)
- ❑ Food rotation
- ❑ Eat constantly whether hungry or not
- ❑ Generally eat on the run
- ❑ Add salt to food

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source ______________
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe ____________
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveratrol, etc.)
- ❑ Herbs - teas
- ❑ Herbs - extracts
- ❑ Chinese herbs
- ❑ Ayurvedic herbs
- ❑ Homeopathy
- ❑ Bach flowers
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals

Other ______________________

Would you like to:

- ❑ Have more energy
- ❑ Be stronger
- ❑ Have more endurance
- ❑ Increase your sex drive
- ❑ Be thinner
- ❑ Be more muscular
- ❑ Improve your complexion
- ❑ Have stronger nails
- ❑ Have healthier hair
- ❑ Be less moody
- ❑ Be less depressed
- ❑ Be less indecisive
- ❑ Feel more motivated
- ❑ Be more organized
- ❑ Think more clearly and be more focused
- ❑ Improve memory
- ❑ Do better on tests in school
- ❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ❑ Stop using laxatives or stool softeners
- ❑ Be free of pain
- ❑ Sleep better
- ❑ Have agreeable breath ❑
- Have agreeable body odor ❑
- Have stronger teeth
- ❑ Get less colds and flus
- ❑ Get rid of your allergies
- ❑ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)