UNDERGROUND WELLNESS.COM

C.H.E.K. HOLISTIC LIFESTYLE QUESTIONNAIRE

Instructions: Please mark your answers by placing an "x" in the appropriate spaces. Save your work and send it back to me as an email attachment.

YOU ARE WHAT YOU EAT

1. **Do you shop less frequently than every four days?**
   ____ Yes (1) ____ No (0)

2. **Do you eat more packaged (frozen or canned) fruits and than fresh?**
   ____ Yes (3) ____ No (0)

3. **Do you eat more cooked vegetables than raw?**
   ____ Yes (3) ____ No (0)

4. **Do you eat vegetables with less than two meals daily?**
   ____ Yes (5) ____ No (0)

5. **Do you buy more non-organic vegetables than organic vegetables?**
   ____ Yes (5) ____ No (0)

6. **Do you use a microwave oven?**
   Yes (check option below) ____ No (0)
   ____ 1-2 times per week (2)
   ____ 3-4 times per week (5)
   ____ more than 4 times per week (10)

7. **Do you eat quick cook grains such as Rice-A-Roni, Quaker Oats or Minute Rice more often than slow cooked organic whole grains?**
   ____ Yes (5) ____ No (0)

8. **Do you eat white bread more often than whole grain breads?**
   ____ Yes (5) ____ No (0)

9. **How often do you drink pasteurized/homogenized milk, or eat cheeses frequently?**
   Yes (check option below) ____ No (0)
   ____ 1-2 times per week (1)
   ____ 3 times per week (3)
   ____ more than 3 times per week (5)

10. **How often do you eat non-organic yogurts that are low fat, presweetened or have fruit added (i.e. Yoplait Fat-Free Yogurt)?**
    Yes (check option below) ____ No (0)
    ____ 1-2 times per week (1)
    ____ 3 times per week (3)
    ____ more than 3 times per week (5)

11. **Do you eat typical store bought eggs from cage-raised chickens (as apposed to free range, grain fed eggs)?**
    ____ Yes (5) ____ No (0)

12. **Do you eat red meat more than once every four days?**
    ____ Yes (3) ____ No (0)

13. **Do you commonly eat meats (beef, chicken, turkey) from sources other than a free-range and hormone-free source?**
    ____ Yes (3) ____ No (0)

14. **Do you eat canned fish more frequently than fresh fish?**
    ____ Yes (3) ____ No (0)

15. **How often do you use commercial salad dressings?**
    Yes (check option below) ____ No (0)
    ____ once a week (1)
    ____ twice per week (2)
    ____ more than 2 times per week (3)

16. **Do you use mayonnaise or products containing hydrogenated oils (trans fats)?**
    Yes (check option below) ____ No (0)
    ____ once a week (1)
    ____ twice per week (2)
    ____ more than 2 times per week (5)

17. **Do you eat nuts and /or seeds that are roasted and/or salted?**
    ____ Yes (1) ____ No (0)

18. **Do you use white table sugar as a sweetener?**
    Yes (check option below) ____ No (0)
    ____ once a week (1)
    ____ 2-3 times per week (3)
    ____ more than 3 times per week (5)

19. **Do you drink diet sodas or use artificial sweeteners such as Sweet-n-Low, Splenda, Equal, Aspartame, or Nutrasweet?**
    Yes (check option below) ____ No (0)
    ____ once a week (1)
    ____ 2-3 times per week (5)
    ____ more than 3 times per week (10)

20. **Do you use standard white table salt?**
    ____ Yes (5) ____ No (0)

21. **Do you eat TV dinners or other highly processed foods more than three times a week?**
____ Yes (5) ____ No (0)

22. **Do you eat from fast food restaurants like McDonald's, Arby's, Wendy's, etc…?**
Yes (check option below) ____ No (0)
____ 1-2 times per week (2)
____ 3 times per week (5)
____ more than 3 times per week (10)

23. **How often do you eat from vending machines?**
Yes (check option below) ____ No (0)
____ 1-2 times per week (2)
____ 3 times per week (5)
____ more than 3 times per week (10)

24. **Do you drink tap water?**
____ Yes (10) ____ No (0)

25. **How often do you eat some form of store bought dessert, such as ice cream, cookies, donuts, cakes or pies after dinner most nights?**
Yes (check option below) ____ No (0)
____ once a week (1)
____ 2-3 times per week (3)
____ more than 3 times per week (5)

Total Score: _____

MENTAL/EMOTIONAL STRESS

1. **Do you eat more or less when stressed than when not stressed?**
____ Yes (10) ____ No (0)

2. **Do you worry over job, income or money problems?**
____ Yes (10) ____ No (0)

3. **Are any of your relationships causing you stress?**
____ Yes (10) ____ No (0)

4. **Do you often feel anxious?**
____ Yes (5) ____ No (0)

5. **Do you often feel upset when things go wrong or feel that things go wrong often?**
____ Yes (5) ____ No (0)

6. **Do you lash out at others?**
____ Yes (5) ____ No (0)

7. **Do you feel your sex drive is lower than normal for you?**
____ Yes (5) ____ No (0)

8. **Do you feel stressed due to lack of intimacy in one or more relationships?**
   ____ Yes (5) ____ No (0)

9. **Have you had reduced contact with friends (feeling antisocial) or an increase in contact because you feel you need to vent your frustrations or stresses to others?**
   ____ Yes (3) ____ No (0)

10. **Do you feel isolated or lonely?**
    ____ Yes (3) ____ No (0)

11. **Do you take any form of medication prescribed by a physician directly or indirectly related to stress in your life or a psychological disorder?**
    ____ Yes (15) ____ No (0)

12. **Do you lose more than two days of work a year due to illness?**
    ____ Yes (5) ____ No (0)

Total Score: _____

SLEEP/WAKE CYCLES

1. **Do you live in the same time zone you were born in?**
   ____ Yes (0) ____ No (5)

2. **Do you travel across time zones more than once a month?**
   ____ Yes (10) ____ No (0)

3. **Do you wake up feeling un-rested and in need of more sleep?**
   Yes (check option below) ____ No (0)
   ____ once a week (1)
   ____ 3 times per week (5)
   ____ more than 3 times per week (10)

4. **Do you commonly go to bed after 10:30PM?**
   ____ Yes (10) ____ No (0)

5. **Are the times you have bowel movements consistent and predictable on a daily basis?**
   ____ Yes (0) ____ No (5)

6. **Do you suffer from reduced memory since moving to a new time zone or since traveling across time zones?**
   ____ Yes (10) ____ No (0)

7. **Has your sense of hunger changed from being hungry at breakfast (upon rising), lunch (mid-day) and dinner times (sunset) since moving to a new time zone or traveling across time zones frequently (> 1 x Month)?**
   ____ Yes (10) ____ No (0)

8. **Do you wake up at night between 1:00AM and 4:00 AM and have a hard time falling back to sleep?**
   Yes (check option below) ____ No (0)
   ____ once a week (1)
   ____ 3 times per week (5)
   ____ more than 3 times per week (10)

9. **Do you tend to have a hard time staying awake in the afternoon after eating lunch?**
   Yes (check option below) ____ No (0)
   ____ once a week (1)
   ____ 3 times per week (5)
   ____ more than 3 times per week (10)

10. **Do you do shift work that requires you to stay up late at night?**
    ____ Yes (10) ____ No (0)

Total Score: _____

YOU ARE WHEN YOU EAT

1. **Do you frequently skip meals?**
   ____ Yes (3) ____ No (0)

2. **Do you typically go more than four hours without eating?**
   Yes (check option below) ____ No (0)
   ____ 1-2 times per week (1)
   ____ 3 times per week (2)
   ____ more than 3 times per week (3)

3. **Do you sometimes skip Breakfast?**
   Yes (check option below) ____ No (0)
   ____ 2 times per week (1)
   ____ 3 times per week (5)
   ____ more than 3 times per week (10)

4. **Do you avoid fats when eating?**
   ____ Yes (5) ____ No (0)

5. **Do you frequently eat carbohydrates (i.e. breads, bagels, cookies, pasta, fruit, cereals, muffins, crackers, chocolate, or candy) by themselves?**
   ____ Yes (5) ____ No (0)

6. **Do you get hungry or crave sweets within two hours after eating a meal?**
   ____ Yes (5) ____ No (0)

7. **Do you use caffeine and /or sugar containing drinks (i.e. coffee, tea, sodas, fruit juices with sucrose, corn syrup or added sugar)?**
   Yes (check option below) ____ No (0)
   ____ 1 cup a day (1)
   ____ 2 cups per day (3)
   ____ more than 2 cups per day (5)

8. **Have you tried diets to lose weight?**
   Yes (check option below) ____ No (0)
   ____ once (1)
   ____ twice (2)
   ____ three-five times (5)
   ____ more than five times (10)

9. **Do you have difficulty burning fat around your belly, hips or thighs even with regular exercise?**
   ____ Yes (3) ____ No (0)

10. **Do you eat your largest meal at night?**
    ____ Yes (1) ____ No (0)

Total Score: _____

DIGESTIVE SYSTEM HEALTH

1. **Do you experience lower abdominal bloating?**
   Yes (check option below) ____ No (0)
   ____ 1-2 times per week (3)
   ____ 3 times per week (5)
   ____ more than 3 times per week (10)

2. **Do you frequently have loose stools or diarrhea?**
   Yes (check option below) ____ No (0)
   ____ once week (1)
   ____ 3 or more times per week (5)

3. **Do you experience constipation or stools that are compact/hard to pass?**
   Yes (check option below) ____ No (0)
   ____ 1-2 times per week (3)
   ____ 3 or more times per week (5)

4. **Do you find that you often burp/belch after meals?**
   ____ Yes (3) ____ No (0)

5. **Do you frequently have gas?**
   ____ Yes (3) ____ No (0)

6. **Do you crave certain foods, such as bread, chocolate, certain fruit, and red meat, if you have not eaten them in a day or two?**
   ____ Yes (5) ____ No (0)

7. **Do you have a poor appetite and /or feel worse after eating?**
   Yes (check option below) ____ No (0)
   ____ 1-2 times per week (3)
   ____ 3 times per week (5)
   ____ more than 3 times per week (10)

8. **Do you have an excessive appetite and/or sweet cravings?**
   ____ Yes (5) ____ No (0)

9. **Do you frequently (more than twice a week) experience abdominal pain, cramps or general abdominal discomfort?**
   ____ Yes (20) ____ No (0)

10. **Do you have indigestion, heartburn or upset stomach?**
    Yes (check option below) ____ No (0)
    ____ 1-2 times per week (3)
    ____ 3 times per week (5)
    ____ more than 3 times per week (10)

11. **Do you get a headache after eating?**
    Yes (check option below) ____ No (0)
    ____ 1-2 times per week (3)
    ____ more than 3 times per week (10)

Total Score: _____

DETOXIFICATION SYSTEM HEALTH

1. **Are your eyes sensitive to bright light?**
   ____ Yes (3) ____ No (0)

2. **Do you suffer from irritability and have difficulty relaxing?**
   ____ Yes (10) ____ No (0)

3. **Do you often feel fatigued and sluggish?**
   ____ Yes (10) ____ No (0)

4. **Do you suffer from frequent headaches?**
   Yes (check option below) ____ No (0)
   ____ once a week (1)
   ____ 3 or more per week (5)

5. **Do you have dark circles and/or puffiness under eyes?**
   Yes (check option below) ____ No (0)
   ____ once a week (3)
   ____ 2-3 times per week (5)
   ____ more than 3 times per week (10)

6. **Are you sensitive to perfumes, paint fumes, traffic fumes, detergents or cigarette smoke?**
   Yes (check option below) ____ No (0)
   ____ mildly (3)
   ____ moderately (5)
   ____ very (10)

7. **Have you been unable to lose cellulite with diet and/or exercise?**
   ____ Yes (10) ____ No (0)

8. **Are you currently, or have you in the past, been frequently exposed to industrial or agricultural chemicals, such as solvents, cleaning fluids, paint fumes, plant sprays and fertilizers?**
   Yes (check option below) ____ No (0)
   ____ brief exposure (3)
   ____ more than once a week (5)
   ____ daily (10)

9. **Do you experience mental sluggishness, poor memory or poor concentration?**
   Yes (check option below) ____ No (0)
   ____ 1-2 times per week (3)
   ____ 3 times per week (5)
   ____ more than 3 times per week (10)

10. **Do you suffer from skin reactions such as rashes, itching or burning, for which the cause is unknown?**
    Yes (check option below) ____ No (0)
    ____ 1-2 times per month (3)
    ____ 3 times per month (5)
    ____ more than 3 times per month (10)

Total Score: _____

FUNGUS & PARASITES

1. **Have you ever been given general anesthesia?**
   ____ Yes (10)
   ____ No (0)

2. **Have you ever taken antibiotics?**
   ____ Yes (10)
   ____ No (0)

3. **Have you been or are you being treated for any condition requiring that you take medical drugs?**
   ____ Yes (10)
   ____ No (0)

4. **In general, are you bowel movements loose, hard, or foul smelling?**
   ____ Yes (10)
   ____ No (0)

5. **Would you consider your life to be:**
   ____ Stress free (0)
   ____ Mildly stressful (5)
   ____ Very stressful (10)

6. **Do you currently suffer from any digestive disorder or frequently have pain in the region above or below the navel?**
   ____ Yes (10)
   ____ No (0)

7. **Do you have mercury amalgam fillings in your mouth?**
   ____ Yes (10)
   ____ No (0)

8. **Do you have two different kinds of metal in your mouth; i.e., gold and silver or mercury amalgam and gold or silver?**
   ____ Yes (5)
   ____ No (0)

9. **Do you experience itching in the ears, nose, or rectum area?**
   ____ Yes (10)
   ____ No (0)

10. **Do you have or have you had dandruff in the last year?**
    ____ Yes (10)
    ____ No (0)

11. **Do you regularly eat or drink products containing sugar, white flour, and/or processed dairy products?**
    ____ Yes (5)
    ____ No (0)

12. **Do you crave sugar, fruit or milk if you don't have either of these items for more than three days?**
    ____ Yes (10)
    ____ No (0)

13. **Do you find that regardless of how much you eat you get hungry quickly?**
    ____ Yes (5)
    ____ No (0)

14. **In the past year, have you experienced athlete's foot (itching around the toes, soles or heel of the feet), jock itch or a fungal infection under a toenail (thickening of a toenail)?**
    ____ Yes (20)
    ____ No (0)

15. **Do you ever get a reddening around the mouth or nose area after eating or drinking?**
    ____ Yes (5)
    ____ No (0)

16. **Do you experience muscle or joint aches on a regular basis?**
    ____ Yes (5)
    ____ No (0)

17. **Do you experience mood swings?**
    ____ Yes (10)
    ____ No (0)

18. **Do you snack on sweets or drink coffee, soda pop or sports drinks most days to keep your energy up?**
    ____ Yes (10)
    ____ No (0)

19. **Do you suffer from any kind of skin condition?**
    ____ Yes (10)
    ____ No (0)

20. **Have you ever had sex or physical contact with anyone who you know had a fungal infection (including athlete's foot, jock itch, dandruff) or parasite infection?**
    ____ Yes (20)
    ____ No (0)

Total Score: _____

Overall Score: _____

SCREEN FOR FOOD ALLERGY AND FOOD INTOLERANCE

1. Do you feel lethargic soon after eating?
____ No (0)
____ Occasional or mild problems (2)
____ Frequent or severe problems (4)

2. Do you often feel better if you don't eat?
____ No (0)
____ Marginally better (2)
____ Much better (4)

3. Did you have problems such as colic, glue ear, ear infections, eczema, asthma or recurrent tonsillitis as a child?
____ No (0)
____ Yes, occasional problems (3)
____ Yes, frequent and/or severe problems (5)

4. Do you have recurrent, unexplained symptoms?
____ No (0)
____ Occasional or mild problems (2)
____ Frequent or severe problems (4)

5. Do you suffer from excess mucus or catarrh formation in the throat, nose, or sinuses?
____ No (0)
____ Occasional or mild problems (2)
____ Frequent or severe problems (4)

6. Do you feel particularly drawn to certain foods such as bread or cheese?
____ No (0)
____ Occasional or mild problems (2)
____ Frequent or severe problems (4)

7. Do you have dark circles under your eyes?
____ No (0)
____ Yes (2)
____ Frequent or severe problems (4)

8. Do you suffer from fluid retention? (Tight rings, puffy face or ankles and a weight, which fluctuates by two or more pounds from day to day, are classic signs)
____ No (0)
____ Occasional or mild problems (2)
____ Frequent or severe problems (4)

9. Do you suffer from Irritable Bowel Syndrome?
____ No (0)
____ Occasional or mild problems (2)
____ Frequent or severe problems (4)

Total Score: _____

ALMOST DONE! PLEASE WRITE A TYPICAL DAY OF EATING FOR YOU

Breakfast:

Snack (if applicable)

Lunch:

Snack (if applicable)

Dinner:

Late-Night Snack (if applicable):