Stream 1: The stream of being & becoming ~ In this stream we will assess & address all states of your metabolic makeup.

Stream 2: The stream of transforming the tattered into treasures ~ This stream focuses on healing your gut.

Stream 3: The stream of moving mountains ~ Accepting ownership of your life as it now is, as you grow into your more vibrant self.

Stream 4: The stream of inspiration sensation ~ Cellular inspiration sensation is the phase where we begin to really hone in on regenerating all the cells within your body.

Stream 5: The stream of motivation making ~ We can initially stay on the path of healthful rejuvenation with pure will power. However, shortly after, we must develop strong motivation techniques to KEEP us on that road.

Stream 6: The stream of you ~ Cracking your genetic code, and what to do with that information.

Stream 7: The stream of curious chemicals ~ Regenerate your metabolic hormones.

It is my passion to give you dynamic tools to defend yourself against becoming one of the statistics:

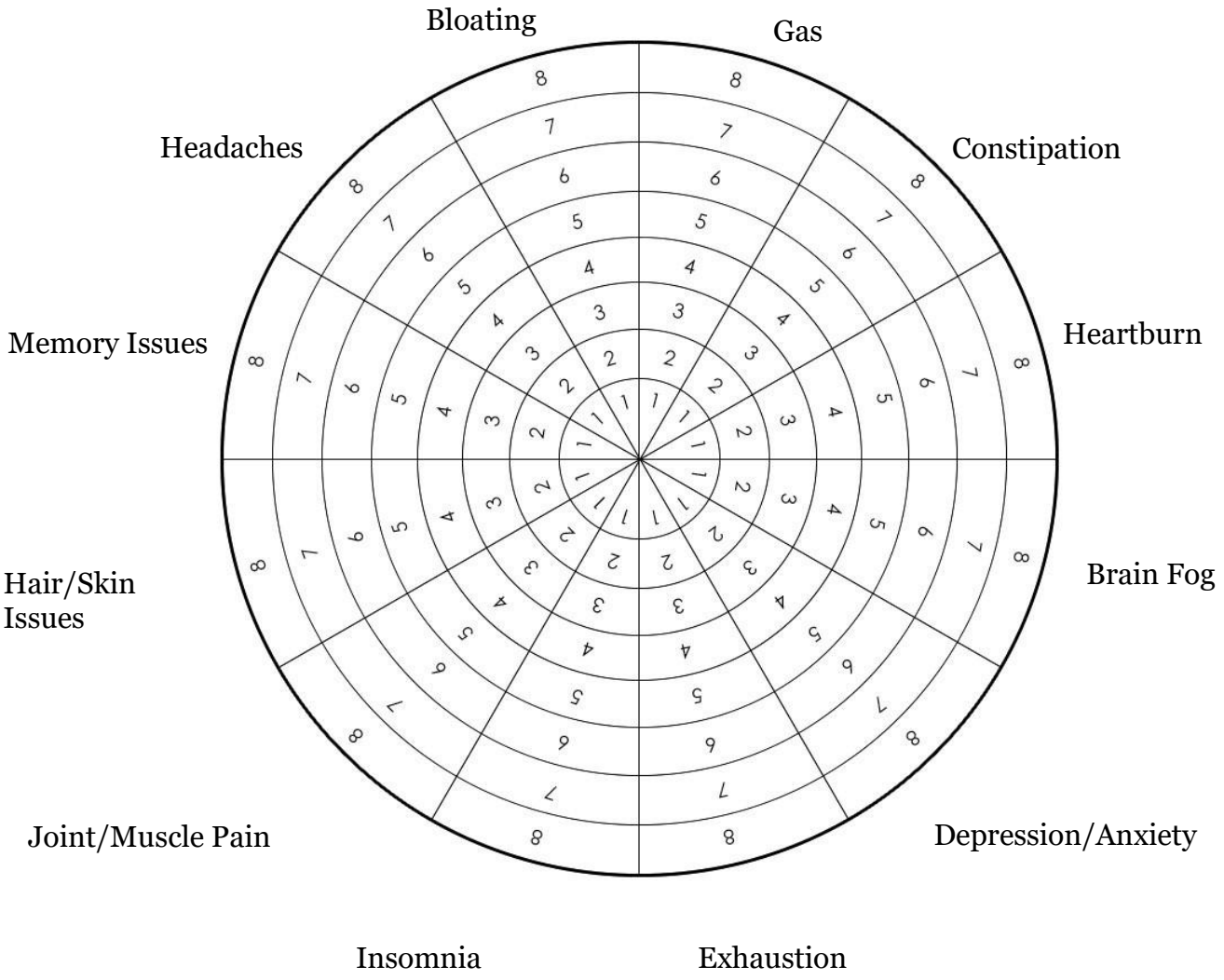
1. WHO - Cancer is projected to increase by 50% by 2020.
2. CDC - Death rate by Alzheimer's has risen by 55% over a 15 year period.
3. CDC - Autism has more than doubled from 2000 to 2012.

Physical Symptom Wheel for Getting Started

Date: _____

This exercise is intended to be used as a marker to show how you feel. To optimize health and wellness we must have a way to track our progress. It has twelve sections. Look at each section and place a dot on the line to designate how satisfied you are with the corresponding area of your health. A dot placed closer to the center (1, 2, 3) indicates dissatisfaction, while a dot placed on the periphery (6, 7, 8) indicates close-to-optimal wellness in that area. Connect the dots to see your physical symptom wheel of life. This will give you a clear visual of imbalances so that you can determine where you may wish to spend more time and energy to create balance within your body throughout our time together.

Make sure to print and date this. You will be filling it out again later as a marker of your progress based upon your perception of how you experience these symptoms.



Seven Streams to Wellness

Setting Intentions and Goals

Getting Clear on Outcomes

My top 3 areas of concern regarding my health are.

1.

2.

3.

How committed I am (on a scale of 1-10) to addressing these challenged areas.

What I would like to change by the end of this weekend.

My Big WHY:

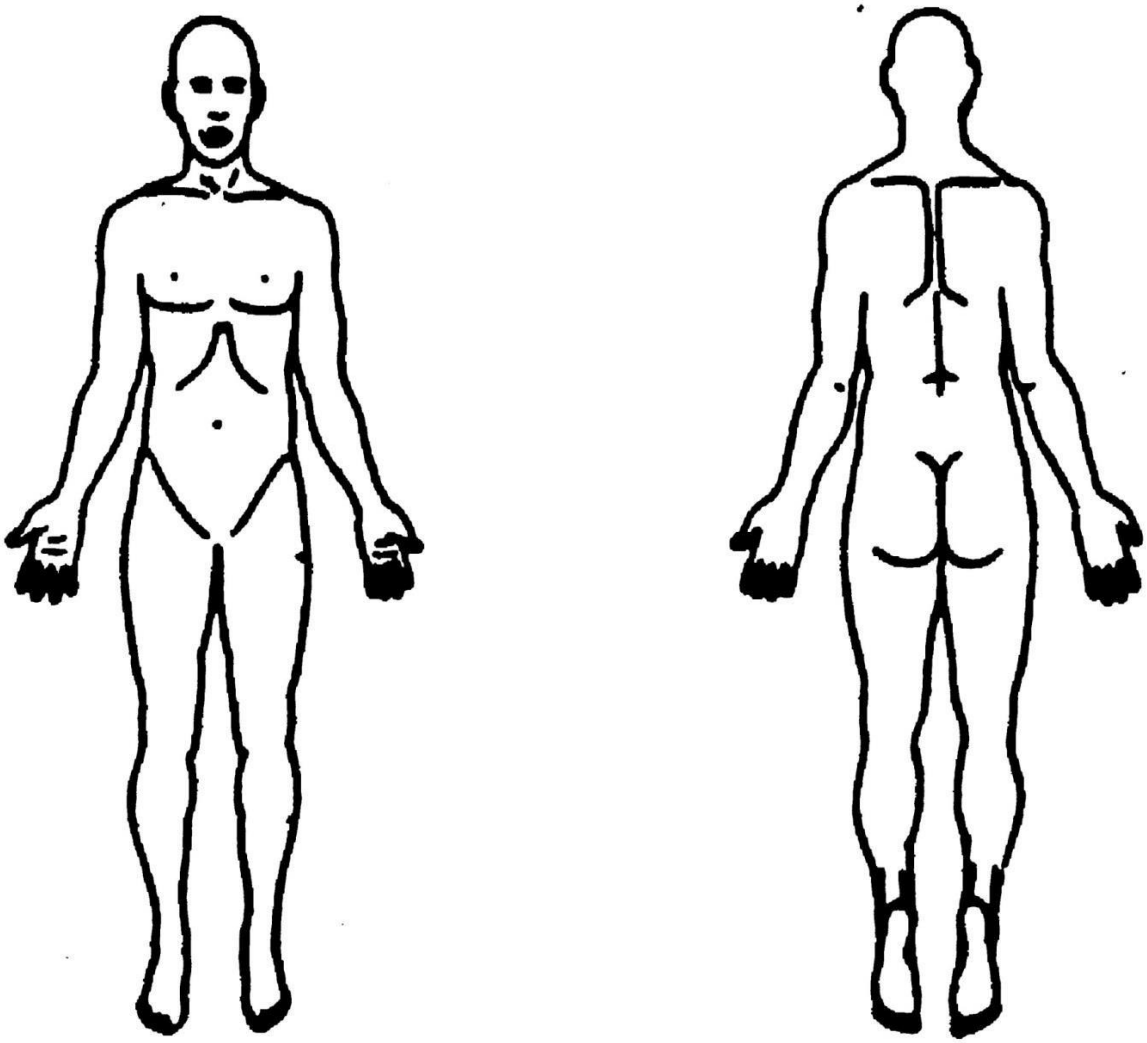
If there were no limitations, what would I aspire to?

What will change in my life when I take charge of my health and become energetic, focused and clear?

Body Scan for Signs of Toxicity

Mentally scan yourself from top to toe and pinpoint things that may be out of balance or not functioning as well as they could be. Scan your eyes, ears, nose, head, neck, chest, back, arms, and legs. Mentally scan and identify any areas that are bothering you in some way. A point of concern might be tight, painful, itchy, congested, or in some way not functioning as it should.

Mark areas you found on the diagram below. Also, note any areas of **rash, skin tag, discoloration, bumps, bruises, moles, or other abnormalities** of your skin.



Seven Streams to Wellness

The Cost of Your Health Challenges

What is your lack of energy, poor health, or physical challenges costing you in terms of your quality of life? Think about your relationships, your job, your social life and your recreational activities.

Jot down as many consequences as you can think of:

1.

2.

3.

4.

5.

6.

7.

8.

Visions and Goals – Waving My Magic Wand

If you could wave a magic wand and all your troubles would disappear, what would you be doing with your life?

Imagine that your health is perfect, that you have an unlimited energy supply, and that money is not an issue. Write whatever comes to mind. Don't filter or judge the thoughts as you write them. Allow yourself to write as if you are already in a state of perfect health and doing what you desire most. In other words, write in the present tense rather than the future tense. Say, "I am" rather than "I would."

I am…

Toxicity Self-Assessment

Name:_____ Date:_____

Rate each of the following symptoms based upon your health profile for the past 30 days:

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.

DIGESTIVE
___Nausea or vomiting
___Diarrhea
___Constipation
___Bloated feeling
___Belching, passing gas
___Heartburn
___Total

EARS
___Itchy ears
___Earaches, ear infection
___Drainage from the ear
___Ringing in the ears, hearing loss
___Total

EMOTIONS
___Mood swings
___Anxiety, fear, nervousness
___Anger, irritability
___Depression
___Total

ENERGY/ACTIVITY
___Fatigue, sluggishness
___Apathy, lethargy
___Hyperactivity
___Restlessness
___Total

HEAD
___Headaches
___Faintness
___Dizziness
___Insomnia
___Total

HEART
____Skipped heartbeats
____Rapid heartbeats
____Chest pain
____Total

JOINTS/MUSCLES
____Pain or aches in joints
____Arthritis
____Stiffness, limited movement
____Pain, aches in muscles
____Feeling of weakness or tiredness
____Total

LUNGS
___Chest congestion
___Asthma, bronchitis
___Shortness of breath
___Difficulty breathing
___Total

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.

EYES
____Swollen, reddened or sticky eyelids
____Dark circles under the eyes
____Blurred/tunnel vision
____Total

MIND
____Poor memory
____Confusion
____Poor concentration
____Poor coordination
____Difficulty making decisions
____Stuttering, stammering
____Slurred speech
____Learning disabilities
____Total

SKIN
____Acne
____Hives, rashes, dry skin
____Hair loss
____Flushing or hot flashes
____Excessive sweating
____Total

MOUTH/THROAT
____Chronic coughing
____Gagging, frequent need to clear throat
____Sore throat, hoarse
____Swollen or discolored retention tongue, gums or lips
____Canker sores
____Total

WEIGHT
____Binge eating/drinking
____Craving certain foods
____Excessive weight
____Compulsive eating
____Water
____Underweight
____Total

NOSE
____Stuffy nose
____Sinus problems
____Hay Fever
____Sneezing attacks
____Excessive mucus
____Total

OTHER
____Frequent illness
____Frequent or urgent urination
____Genital itch, discharge
____Total

_____GRAND TOTAL = TOXICITY SCORE (Add up the numbers to arrive at a total for each section, then add the totals for each section to arrive at the grand total.)

Toxicity Self-Assessment Interpretation

If any **individual section** is **10 or more,** or the **grand total** is **50 or more,** you are showing signs of toxicity

10 or less: Low Toxicity Category

Your liver is doing a decent job of detoxification and keeping you fairly healthy. You may be experiencing some irritating symptoms and possibly low energy, but relatively speaking, you should be feeling pretty good.

11 to 49: Mild to Moderate Toxicity Category

Your liver is unable to keep up with the toxic load and is not efficiently eliminating all the toxins you're putting in, on, or through your body, resulting in some uncomfortable and limiting symptoms like pain, bloating, discomfort and emotional irritability.

50 to 100: High Toxicity Category

It appears that your liver is overloaded and you're having significant health challenges related to toxicity. You may be experiencing severe fatigue and constant pain or discomfort.

Over 100: Extreme Toxicity Category

You are either experiencing or on your way towards serious health challenges. Your liver is overburdened and can't keep up with the toxic load.

Detoxification Capacity

Determining the Strength of Your Detox Capacity So You Can Choose the Best Cleansing Program for You

Part 1: Complete the chart.

There are certain environmental, dietary, and health history factors which affect your ability to detoxify your environment. The higher the score, the more likely you are to have uncomfortable reactions if you cleanse too rapidly, especially if you attempt to do a water-only fast or a juice-only diet.

You'll find a chart on the next two pages. For each statement, score 0 for a "no" answer and 1 for a "yes". Select ALL that apply.

For example, if you eat animal foods **daily**, you'd score **1 point each** for:

- "I eat animal protein more than 2 times a week"
- "I eat animal protein more than 3 times a week"
- "I eat animal protein more than 4 times a week"
- "I eat animal protein more than 5 times a week"

So you'd score **4 points** for animal protein consumption.

Part 1: Answer each of the following with a score (page 1 of 2):

"No" = 0; "Yes" = 1	SCORE
I eat animal protein (meat of any kind, dairy, cheese, eggs) more than 2 times a week.	
I eat animal protein (meat of any kind, dairy, cheese, eggs) more than 3 times a week.	
I eat animal protein (meat of any kind, dairy, cheese, eggs) more than 4 times a week.	
I eat animal protein (meat of any kind, dairy, cheese, eggs) more than 5 times a week.	
I have servings of animal protein greater than 4–6 ounces (the size of the palm of your hand) at a meal.	
I eat more than 1–2 foods a week with hydrogenated fats (margarine, shortening, processed or packaged foods).	
I eat less than 4 cups of dark-green leafy vegetables a day.	
I eat less than 3 cups of dark-green leafy vegetables a day.	
I eat less than 2 cups of dark-green leafy vegetables a day.	
I eat less than 1 cup of dark-green leafy vegetables a day.	
I eat fewer than 9 servings (1/2 cup = 1 serving) of fruits and vegetables a day.	
I have more than 1 alcoholic drink per week.	
I have more than 2 alcoholic drinks per week.	
I have more than 3 alcoholic drinks per week.	
I have a history of recreational drug use beyond experimentation on a few occasions.	
I have depression, depressed mood, or other mood or behavioral challenges.	
I have a history of a heart attack or other heart disease.	
I have a history of stroke.	
I have a history of cancer (especially colon, cervix, breast).	

"No" = 0; "Yes" = 1	SCORE
I have a history of abnormal PAP test (cervical dysplasia).	
I have a history of birth defects in offspring (neural tube defects or Down syndrome).	
I have a history of dementia.	
I have a loss of balance or sensation in feet.	
I have a history of multiple sclerosis or other diseases with nerve damage.	
I have a history of carpal tunnel syndrome.	
I do not take a multivitamin or whole food concentrate supplement.	
I have taken prescription drugs on and off over the past several years.	
I currently take prescription medication.	
I take over the counter medications more than once a month.	
I have taken prescription drugs on a regular basis for most of my life.	
I am over 65-years old.	
I get headaches and feel off balance when I fast or do cleanses.	
I am highly sensitive to fumes, perfume and chemicals.	
I have a family history of autism or ADHD.	
I've been told that I have mercury overload (hair analysis or urine test).	
I use pesticides or herbicides at home or live in a complex that gets regularly sprayed.	
I wear perfumes and/or use hairspray, nail polish or antiperspirant on a regular basis.	
Most of the food I eat is not organically grown.	
I drink soft drinks, diet or regular, more than 1 time per week.	
My job or hobby requires the use of toxic solvents or chemicals.	
I smoke cigarettes, cigars, or a pipe on a regular basis.	
I am an ex-smoker and quit less than 5 years ago.	
I am an ex-smoker and quit less than 10 years ago.	
TOTAL Score	

Part 2: Please answer the following questions as accurately as possible.

Where indicated, circle the best answer.

1. Have you ever fasted on water only for more than a day? **Yes or No**
2. If yes, how many times have you fasted on water-only for longer than a day?

   _____
3. What was the length of the longest fast you ever did?

   _____
4. If you have fasted for longer than a day on water only, how did you react?
   a. **Felt great the whole time.**
   b. **Felt bad for the first (fill in number)_____of days, then I felt great.**
   c. **Felt bad the whole time.**
   d. **Took a long time to recover my strength and stamina afterwards.**
   e. **Other:**
5. Have you ever done a juice only diet for more than a day? **Yes or No**

   If yes, how many times have you done a juice cleanse for longer than a day?

   _____

   What was the length of the longest juice cleanse you ever did?

   _____
6. If you have done a juice only diet for longer than a day, how did you react?
   a. **Felt great the whole time.**
   b. **Felt bad for the first (fill in number)_____of days, then I felt great.**
   c. **Felt bad the whole time.**
   d. **Took a long time to recover my strength and stamina afterwards.**
   e. **Other:**
7. Are you pregnant or nursing? **Yes or No**
8. Do you have serious blood sugar swings? **Yes, No, Sometimes**
9. Do you feel cranky, irritable, dizzy or unstable if you miss a meal or space meals longer than 3 hours apart? **Yes, No, Sometimes**

Part 3: Detox Capacity Interpretation

The higher the score, the more impaired your detoxification mechanisms are likely to be. Keep this in mind when selecting dosages for supplementary herbs and foods to support detoxification. You are also more likely to have strong cleansing reactions when you detoxify too rapidly.

Score	Interpretation
0	Your detoxification mechanisms are working well. You would likely do well with any detox strategies, unless you have tried fasting or juicing before and reacted negatively.
1 to 5	Your detoxification mechanisms are, overall, probably working well. You can most likely be comfortable fasting or juicing as a cleansing strategy, unless fasting or juicing in the past has caused adverse effects.
6 to 9	Your detoxification mechanisms appear to be mildly impaired. You may feel uncomfortable for a few days if you fast or juice, but are likely to feel good after that.
10 to 19	Your detoxification mechanisms are moderately impaired. You could benefit from a fast or juice cleanse, but you are likely to feel badly for the first few days. You would benefit from additional support from herbs and nutrients if you do attempt a juice or water cleanse. You would likely be better off doing a more slow and gentle, whole foods based cleanse, at least at first.
> 20	You most likely have very impaired detoxification mechanisms, and you will need quite a bit of extra support to successfully detoxify. Therefore it is recommended you do not attempt a fast or juice cleanse unless you are supervised and taking precautions to enhance your body's ability to cleanse and detoxify.

WARNING:

If you are pregnant or nursing DO NOT fast or do a juice-only diet.

You will cleanse too rapidly and may expose your baby to excessive toxicity.

Adrenal Health "Score Card" Self-Assessment

Based upon your health profile for **the past 30 days**, please select the appropriate number, from '0 - 3' on all questions (0 as least/never/no and 3 as most/always/yes). Circle the number you feel best applies, then add the numbers to create your score.

POINT SCALE: (Please adjust your understanding as needed for health questions that are NOT symptom related.)

0 = NEVER (also: least, no, never tried/experienced)
1 = MILD (also: occasionally; symptom occurs rarely - i.e. a couple of times a month at most)
2 = MODERATE (also: some severity/intensity, and/or frequency, often; symptom occurs weekly)
3 = SEVERE/ABSOLUTE (also: frequent, intense, most, always, yes)
For all yes/no questions, 0=no and 3=yes

Adrenal Assessment

1. **0 1 2 3** Are there nights when you cannot stay asleep?
2. **0 1 2 3** Do you experience afternoon headache(s)?
3. **0 1 2 3** Do you crave salt?
4. **0 1 2 3** Are you a slow starter in the morning?
5. **0 1 2 3** Do you experience afternoon fatigue?
6. **0 1 2 3** Do you experience dizziness when standing up quickly?
7. **0 1 2 3** Do you experience headache(s) with exertion or stress?
8. **0 1 2 3** Do you tend to be a "night person"?
9. **0 1 2 3** Do you have difficulty falling asleep?
10. **0 1 2 3** Do you tend to be keyed up, and/or have trouble calming down?
11. **0 1 2 3** Is your blood pressure above 120/80?
12. **0 1 2 3** Do you experience headache(s) after exercising?
13. **0 1 2 3** Do you feel wired or jittery after drinking coffee?
14. **0 1 2 3** Do you clench or grind your teeth?
15. **0 1 2 3** Are you calm on the outside, but troubled on the inside?

16. **0 1 2 3** Do you have chronic low back pain that worsens with fatigue?
17. **0 1 2 3** Do you have difficulty maintaining manipulative correction?
18. **0 1 2 3** Do you experience pain after manipulative correction?
19. **0 1 2 3** Do you have arthritic tendencies?
20. **0 1 2 3** Do you crave salty foods?
21. **0 1 2 3** Do you salt foods before tasting?
22. **0 1 2 3** Do you perspire easily?
23. **0 1 2 3** Do you have chronic fatigue and/or get drowsy often?
24. **0 1 2 3** Do you have bouts of afternoon yawning?
25. **0 1 2 3** Do you have asthma, wheezing, and/or difficulty breathing?
26. **0 1 2 3** Do you experience pain on the medial or inner side of the knee?
27. **0 1 2 3** Do you tend to sprain ankles or experience "shin splints"?
28. **0 1 2 3** Do you tend to need sunglasses?
29. **0 1 2 3** Do you have allergies and/or hives?
30. **0 1 2 3** Do you ever suffer from weakness and/or dizziness?

TOTAL:_____/90

0-10% - Overall good balance. Sound nutrition and healthy habits will maintain good balance.

11-20% - In need of a tune up to restore balance before serious illness sets in. Diet and lifestyle improvements should shift to normal.

21-35% - Things are out of balance and need attention.

36-50% - Very compromised and likely to significantly affect your state of health, well-being, and energy level.

51-100% - Severely compromised and requires immediate attention.

Menu Planner Template | Name ____

Breakfast	
Lunch	
Dinner	