1. Do you sleep fewer than 7 hours a night? ____
2. Do you get to bed after 11:00 p.m.? ____
3. Do you have trouble falling asleep? ____
4. Do you have trouble staying asleep? ____
5. Are you a "night owl," feeling more awake in the evening hours? ____
6. Do you have sleep apnea? ____
7. Do people say you look tired? ____
8. Do numerous anxious thoughts jump around your brain at night? ____

Number of yes responses ____

Section 2 — *Food and Digestion*

1. Do you have fewer than one bowel movement a day? _____
2. Does your digestive system bother you in some way (constipation, diarrhea, bloat, gas, pain, reflux) most days? _____
3. Do you get angry or irritable if you miss a meal (do you feel hungry plus angry, aka "hangry")? _____
4. Do you have days when you don't eat green plant foods? _____
5. Do you drink less than 40 ounces of water a day? _____
6. Do you purchase larger-size clothes and/or put on a pound or more every year or two? _____
7. Is most of your food cooked in someone else's kitchen? _____
8. Do you eat foods cooked at high temperature (e.g., chips or fried foods) every day? _____

Number of yes responses _____

Section 3 — Move in Your Glow Zone

1. Do you avoid exercise or anything that involves breaking a sweat? ____
2. Are some parts of your body much weaker than others? ____
3. Do you carry excess fat around your stomach, upper arms, butt, or thighs? ____
4. Is walking up steps a chore? ____
5. Is it hard to get up off a couch or chair? ____
6. Are you unable to do a push-up? ____
7. Is your home on one level, with no steps? ____
8. Do you sit for the majority of the day? ____

Number of yes responses ____

Section 4 — Relaxation and Inner Peace

1. Do you feel negative or anxious most of the time and/or do you hate your work or daily life? ____
2. Do you feel a deep disconnect from other people that makes you feel alone and/or do you consistently feel you are not "good enough"? ____
3. Do you have zero exposure to a park or outdoor space with trees and plants once a day? ____
4. Is meditation, acupuncture, or massage absent from your regularly scheduled life? ____
5. Do you get together with friends, a religious group, or other community less than once a week? ____
6. Is there no time in your life to help other people? ____
7. If someone else is doing well, do you feel there's less for you? ____
8. Do you consider your body "not good looking" and/or will you not look at your naked body in the mirror? ____

Number of yes responses ____

Section 5 — *Detoxification*

1. Do perfumes and aromas bother you? ____
2. Does a cup of coffee or alcoholic drink make you feel pretty bad or keep you up at night? ____
3. Have you had or do you have regular exposure to pollution and/or chemicals such as those in hair products? ____
4. Do you have age/liver spots on your skin? ____
5. Do you smoke or take medications regularly? ____
6. Do you look older or weigh more than you think you should? ____
7. Does every day involve eating some form of cow's milk, gluten, or meat? ____
8. Do you think you don't sweat, no matter how hard you exercise? ____

Number of yes responses ____

Section 6 — Glowing Supplements and Hormonal Harmony

1. Do you take a quality multiple vitamin fewer than five days a week? ____
2. Do you take essential fatty acids fewer than five days a week? ____
3. Do you take a probiotic supplement fewer than five days a week? ____
4. Do you have menstrual irregularity or perimenopausal/menopausal symptoms? ____
5. Do you miss a rainbow color (red, orange, yellow, green, blue, violet) in your regular diet? ____
6. Does your skin have no shine or luster or is your tongue coat patchy or a little swollen? ____
7. Do you swell or have mood changes, terrific hunger, or insomnia that is affected by your menstrual cycle? ____
8. Are your nails soft, thin, brittle, or furrowed or do you have dry mouth corners? ____

Number of yes responses ____