



Nutritional Self Evaluation

General Information

Name: _____ Date of Birth: _____
 Email Address: _____
 Current Address: _____
 City: _____ Province/State: _____ Zip Code: _____
 Daytime Phone Number: _____ Evening Phone Number: _____
 ViralScore™ Referred By: _____
 List all Vitamins or Supplements that you are currently taking: _____

Medications (Check all current medications or conditions)

Antacids	Hormones	Steroids	Chemotherapy
Antibiotics	Pain Medication	Laxatives	Oral Contraceptives
Antidepressants	Heart Medications	Thyroid	High Blood Pressure
Radiation	Water Retention	Ulcer	Anti-Inflammatory Medications

Family History (Check all that apply)

Diabetes	Heart Disease	Hypertension	Hepatitis/Liver Disease
Stroke	Cancer	Alcohol Problems	Emotional/Mental Disorders

Childhood History (Check all that apply)

Measles	Dry Cough	Sinus Problems	Slow Learner	Mono
Mumps	Skin Breakouts	Chickenpox	Antibiotics(received)	
Strep Throat	Ear Infections	Received all standard vaccinations		

Personal History

___ Tobacco Products (est. daily use)	___ Number of Alcoholic Drinks per Day
___ Number of Amalgam Fillings	___ Personal Stress (1-10)
___ Number of 8oz Glasses of Water per Day	___ How Many Pounds Overweight
___ Number of Caffeinated Products per Day	___ Daily Minutes on Cell Phone
___ Daily Sugar Servings	___ Number of Hours on Computer (daily)



Nutritional Self Evaluation

Current Conditions (All items affecting health must be answered)

- | | |
|------------------------------------|---|
| 1. Acne | 29. Grave's Disease |
| 2. ADHD | 30. Hair Loss (Alopecia) |
| 3. Allergies (Airborne) | 31. Hair Loss (Crown) |
| 4. Allergies (Food) | 32. Hair Loss (Overall Thinning) |
| 5. Anemia (Macrocytic) | 33. Hashimoto's Disease |
| 6. Anemia (Microcytic Hypochromic) | 34. Headaches/Migraines |
| 7. Arthritis (Osteo) | 35. Heart Disease |
| 8. Arthritis (Rheumatoid) | 36. Hiatal Hernia |
| 9. Asthma - Acute (Crisis) | 37. Hyperactivity/ADD |
| 10. Asthma (Chronic) | 38. Infections |
| 11. Autism | 39. Insomnia |
| 12. Auto Immune Disease | 40. Liver Conditions |
| 13. Cancer | 41. Lupus |
| 14. Candida | 42. Menopause |
| 15. Cholesterol (need to lower) | 43. Multiple Sclerosis |
| 16. Chronic Active Hepatitis | 44. Pain Identification (Chronic) |
| 17. Colic (Bottle-Fed Babies) | 45. Pain Identification - Trauma (Accident) |
| 18. Colic (Nursing Babies) | 46. Pancreatitis |
| 19. Colitis | 47. Post War Syndrome |
| 20. Crohn's Syndrome | 48. P.M.S. |
| 21. Depression | 49. Scleroderma |
| 22. Diabetes (Type I) | 50. Surgery (Recent) |
| 23. Diabetes (Type II) | 51. Stroke |
| 24. Disc-Invertebral (Acute) | 52. Thyroid Condition |
| 25. Disc-Invertebral (Chronic) | 53. Triglycerides (elevated) |
| 26. Fibromyalgia | 54. Urinary Tract Inflammation |
| 27. Gastritis | 55. Vasculitis |
| 28. Gout | 56. Vitiligo |

List any conditions not listed above: _____



Personal Questions (All items must be answered)

Section 1:

1. Do you experience bloating?
2. Do you feel sleepy after eating?
3. Do you have uncomfortable reactions after eating?
4. Does your diet consist of processed and cooked foods?
5. Do you have diarrhea after eating?
6. Do you feel flushed after eating?
7. Do you have difficulty breathing after eating?
8. Does your food pass through undigested?
9. Do you get indigestion after eating?
10. Do you have premature graying of the hair?
11. Do you have trouble sleeping?
12. Do you experience weakness or faintness between meals?
13. Do you have the inability to gain or lose weight?
14. Do you have pain in the upper right quadrant of the stomach?

Total

Section 3:

1. Do you persistently have a low level of energy?
2. Are you depressed?
3. Do you have trouble with your short term memory?
4. Do you have low energy after eating?
5. Do you have poor stamina?
6. Do you experience excessive fatigue during workouts?
7. Have you experienced heartburn after eating?
8. Do you have trouble thinking clearly?
9. Are you still tired after a full night of sleep?
10. Do you feel too full after eating?
11. Do you crave fatty foods?
12. Do you eat an unbalanced diet?
13. Do you feel tired after performing your usual daily activities?

Total

Section 2:

1. Do you have age spots?
2. Do you have hemorrhoids?
3. Do you get bloody noses?
4. Do you have varicose veins?
5. Do you bruise easily?
6. Do you have deteriorating eye sight?
7. Do you experience excessive nervousness?
8. Do you have bleeding gums?
9. Do you have excessive wrinkling of the skin?
10. Do you Smoke?
11. Are you exposed to second hand smoke?
12. Are you exposed to smog?
13. Are you constantly around computers, electrical appliances, etc.?
14. Do you spend most of you time in a City environment?

Total

Section 4:

1. Are you taking or have you taken antibiotics within the last 90 days?
2. Have you undergone any surgery in the last 90 days?
3. Do you have persistent diarrhea?
4. Do you get sick often?
5. Do you have frequent cold sores?
6. Do you have a history of food poisoning?
7. Do you consume alcohol or carbonated beverages?
8. Have you done any foreign travel within the last 90 days?
9. Do you have persistent flatulence or gas?
10. Do you consume dairy products?
11. Do you have bad breath?
12. Do you suffer from migraine headaches?

Total



Questions

Neurological

- Chronic or Frequent Headaches
- Numbness or Tingling anywhere
- Dizziness
- Ringing or noises in the ear
- Tremors in hands, feet, lips, eyelids

Psychological

- Irritability
- Nervousness
- Shy or Timid
- Loss of memory
- Inability to concentrate
- Mood changes
- Attention Deficit Syndrome
- Decline of intellect
- Loss of self-confidence
- Anger or loss of self-control
- Depression
- Crying spells
- Anxiety
- Drowsiness
- Insomnia

Inflammatory and Immunological

- Chronic Fatigue Syndrome
- Fibromyalgia
- Rheumatoid Arthritis
- Allergies
- Sinusitis
- Asthma

Digestive

- Abdominal cramps
- Constipation or diarrhea
- Irritable bowel syndrome
- Colitis
- Nausea
- Loss of appetite and obesity
- Excessive thirst

Cardiovascular

- Irregular heartbeat
- Alterations in blood pressure
- Arterial plaquing

Oral Cavity

- Bleeding Gums
- Bone loss and loosening of teeth
- Foul breath
- Excessive salivation
- Metallic taste
- Chronic inflammation of gums
- Burning in the mouth or throat
- Black pigmentation of mouth tissue

Other Problems

- Excessive perspiration without fever
- Low body temperature/clamminess
- Skin rashes, especially around face/neck
- Dim or double vision
- Hypoxia (lack of oxygen)

Disclaimer: The following information is provided for nutritional information. The information being sought is of a nutritional nature and not a medical diagnosis, treatment, disease prevention, or health assessment. I hereby certify that I am not an employee, agent, or otherwise affiliated with the Federal Drug Administration, Health-Canada, or a related agency. I further understand: According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "Drug" is defined to mean; Articles intended for the use in the DIAGNOSIS, CURE, MITIGATION, or PREVENTION of disease. In other words, to "say" that vitamin, mineral, trace or amino acids will have any effect on disease or symptoms thereof, that a particular nutrient then becomes a DRUG under the law as written. Therefore, any suggested nutrition is not intended as primary therapy for any disease or symptom, but is provided solely to upgrade the quality of foods delivered through the diet.

By providing information, you are aware that you are consenting for information to be used under the name ViralScore-Nutritional Self-Evaluation and it's partners. Information shared will be used for this evaluation and no confidential information obtained will be used for any other purpose.

I have read and agree to the Disclaimer

Signature

Date



Viral Score Instructions

- A. Fill out the Viral Score (Answer all Questions that relate to you.)
- B. Sign the form. If your are E-Mailing the form, sign the form using a digital signature.
How do I use a digital signature?
Click the Signature Box, Adobe will then walk you through the digital signature process.
- C. Submit the form. This can be accomplished two different ways:
 1. E-Mail the Viral Score (must have Adobe 9.0 or higher)
 - Desktop E-Mail applications
Click the "E-Mail Form" button located under the signature line.
Adobe will open instructions for you to follow.
 - Internet E-Mail
Choose the save button.
Save the Viral Score to your Desktop.
Open your Internet E-Mail account.
Attach the saved Viral Score.
E-Mail to reports@viralscore.com
 2. Print the form and fax to: 1-866-850-7619