UMI Determination Questionnaire

Directions: This questionnaire asks you to assess how you have been feeling during the past two months. This information will help us determine your present underlying metabolic imbalances as well as how these change as you progress with your program.

For each question, place an "X" on the number that best describes your symptoms:

0 = No or Rarely – You have never experienced the symptom or the symptom is familiar to you but you perceive it as insignificant.

1 = Occasionally – Symptom comes and goes and is linked in your mind to stress, diet, fatigue or some other identifiable trigger

4 = Often – Symptom occurs 2-3 times per week and /or with a frequency that bothers you enough that you would like to do something about it

8 = Frequently – Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularly on a monthly or cyclical basis

Some questions require a YES or NO response: 0 = NO, 8 = YES

Section 1	No/Rarely	Occasionally	Often	Frequently
1. Crave sweets, eat them, get a temporary boost, then crash	0	1	4	8
2. Have trouble burning off fat	0	1	4	8
3. Get irritable, jittery, anxious, tired or develop headaches if go more than 3-4 hours without food	0	1	4	8
4. Eat a carbohydrate-rich breakfast (i.e., muffin, bagel, cereal, pancakes, toast, donut, etc.)	0	1	4	8
5. Hard to stop eating carbohydrates	0	1	4	8
6. Have heart palpitations after eating sweets	0	1	4	8
7. Get moody, impatient or anxious	0	1	4	8
8. Poor memory or concentration	0	1	4	8
9. Feel more calm after eating	0	1	4	8
10. Take medication or supplements for blood sugar control	0	1	4	8
11. Diagnosed with diabetes, polycystic ovarian syndrome (PCOS), or metabolic syndrome	0 (No)		8 (Yes)	
12. Get infections or illness (i.e., regular colds/flus) or poor wound healing	0 (No)		8 (Yes)	
13. Tired most of the time	0	1	4	8
14. Chronic fungal infections (i.e., yeast infections, jock itch, athlete's foot; dry, scaly patches of skin)	0	1	4	8
15. Drink soda (diet or regular)	0	1	4	8
16. Use artificial sweeteners	0	1	4	8

17. Skip meals during the day	0	1	4	8
18. Does your weight seem to be mainly around your waistline?	0 (No)		8 (Yes)	
19. Do you have high blood pressure?	0 (No)		8 (Yes)	
20. Is your waist 35” or greater for women or 40” or great for men?	0 (No)		8 (Yes)	
21. Low HDL levels (<40 mg/dl for men; <50 mg/dl for women)	0 (No)		8 (Yes)	
22. High triglycerides (>100 mg/dl)	0 (No)		8 (Yes)	
23. Triglyceride:HDL ratio greater than 3:1	0 (No)		8 (Yes)	
24. Abnormal liver function tests (AST, ALT, GGT) or fatty liver	0 (No)		8 (Yes)	
25. Fasting blood sugar level >100 mg/dl	0 (No)		8 (Yes)	
26. Hemoglobin A1c greater than 5.5	0 (No)		8 (Yes)	
27. Is your body fat percentage greater than 37% for a woman or 29% for a man?	0 (No)		8 (Yes)	
Total points:				

Section 2	No/Rarely	Occasionally	Often	Frequently
1. Need caffeine , sugar or other stimulants to keep you going during the day	0	1	4	8
2. Gain or hold weight primarily around your midsection	0	1	4	8
3. Need alcohol to relax	0	1	4	8
4. Feel overwhelmed or stressed out	0	1	4	8
5. Are you anxious or depressed	0	1	4	8
6. Trouble falling asleep or staying asleep	0	1	4	8
7. Low sex drive	0	1	4	8
8. Irritable, angry or upset	0	1	4	8
9. Experienced a major life stressor in the past year (i.e., death of a loved one, divorce, marriage, birth of a child, move, change of job, financial change, medical diagnosis of a loved one or self, etc.)	0 (No)		8 (Yes)	
10. Catch colds, flu or get sick	0	1	4	8
11. Crave carbohydrates/sweets and/or salt	0	1	4	8
12. “Need” aerobic exercise to stay sane	0	1	4	8
13. Can’t shut off your mind at night	0	1	4	8
Total points:				

Section 3	No/Rarely	Occasionally	Often	Frequently
1. Nausea or vomiting	0	1	4	8
2. Ever taken antibiotics	0 (No)		8 (Yes)	
3. Eat sugar or refined carbohydrates	0	1	4	8
4. Have loose stools or diarrhea	0	1	4	8
5. Have constipation (less than one bowel movement per day)	0	1	4	8
6. Have gas or bloating	0	1	4	8
7. Eat the same foods on a daily basis	0	1	4	8
8. Do you have or suspect you have food allergies/sensitivities/intolerance	0 (No)		8 (Yes)	
9. Have bad breath	0	1	4	8
10. Heartburn	0	1	4	8
11. Belching/burping	0	1	4	8
12. Rashes, skin eruptions or skin disorders	0	1	4	8
13. Joint pain	0	1	4	8
14. Diagnosis of or suspect gastrointestinal illness or disease (i.e. IBS, Crohn's disease, Ulcerative colitis, GERD, etc.)	0 (No)		8 (Yes)	
15. Diagnosis of autoimmune disease (i.e., rheumatoid arthritis, Grave's disease or Hoshimoto's thyroiditis, Lupus, etc.)	0 (No)		8 (Yes)	
16. Use of aspirin and/or NSAIDs (non-steroidal anti-inflammatories like ibuprofen, naproxen, etc.)	0	1	4	8
Total points:				

Section 4	No/Rarely	Occasionally	Often	Frequently
1. Crave sweets or carbohydrates, especially in the afternoon or evening	0	1	4	8
2. Binge eat	0	1	4	8
3. Have a large appetite or rarely feel full	0	1	4	8
4. Have migraine headaches or take medications for migraines	0 (No)		8 (Yes)	
5. Have depression or anxiety or being treated for depression or anxiety	0 (No)		8 (Yes)	
6. Are you currently or have you taken amphetamines or diet drugs	0 (No)		8 (Yes)	
7. Have a hard time focusing or paying attention or take medications for ADD/ADHD	0	1	4	8
8. Have poor quality sleep or take medications for sleep	0	1	4	8
9. Have hot flashes or experience fluctuations in body temperature	0	1	4	8

10. Feel cold often or vacillate between hot and cold	0	1	4	8
11. Have obsessive thoughts	0	1	4	8
12. Have a poor memory	0	1	4	8
Total points:				

Section 5	No/Rarely	Occasionally	Often	Frequently
1. Take longer than 15 minutes to fall asleep	0	1	4	8
2. Have trouble falling asleep at night or waking up during the night	0	1	4	8
3. Difficulty waking up in the morning	0	1	4	8
4. Sleep less than 8-9 hours a night	0	1	4	8
5. Wake up more than once during the night	0	1	4	8
6. Wake up feeling tired	0	1	4	8
7. Go to bed later than 11 PM	0	1	4	8
8. Need to nap or feel the need to nap during the day	0	1	4	8
9. Use medications (over the counter or prescription) or supplements for sleep	0	1	4	8
10. Work odd hours, change shifts often or work nights	0	1	4	8
Total points:				

Section 6	No/Rarely	Occasionally	Often	Frequently
1. Unpleasant PMS or menstrual symptoms	0	1	4	8
2. Hot flashes or night sweats	0	1	4	8
3. Infertility	0	1	4	8
4. Irregular periods	0	1	4	8
5. Migraines	0	1	4	8
6. Vaginal Dryness	0	1	4	8
7. Hair Loss	0	1	4	8
8. Fibroids or cysts (uterine or ovarian) – past or present	0 (No)		8 (Yes)	
9. Endometriosis – past or present	0 (No)		8 (Yes)	
10. Depression or anxiety	0	1	4	8
11. Acne	0	1	4	8
12. Osteoporosis	0	1	4	8

13. Low sex drive	0	1	4	8
14. Dry skin	0	1	4	8
15. Water retention	0	1	4	8
17. Poor weight loss	0	1	4	8
18. Family history of breast or endometrial cancer	0 (No)		8 (Yes)	
19. Current or past hormone-dependent cancer (breast, ovarian, uterine, prostate)	0 (No)		8 (Yes)	
20. Currently take or have taken birth control or hormone replacement in past 3 years	0 (No)		8 (Yes)	
Total points:				

Section 7	No/Rarely	Occasionally	Often	Frequently
1. Pain or aches in joints	0	1	4	8
2. Joint swelling	0	1	4	8
3. Muscles stiff, sore, tense or achy	0	1	4	8
4. Burning, throbbing, shooting or stabbing muscle pain	0	1	4	8
5. Muscle cramps or spasms	0	1	4	8
6. Don’t feel refreshed upon waking	0	1	4	8
7. Stiffness or limitation of movement	0	1	4	8
8. Feeling of weakness or tiredness	0	1	4	8
9. Cramps in legs	0	1	4	8
10. Routine exercise such as daily walking, causes your knees or ankles to swell or hurt	0	1	4	8
11. Injure, strain or sprain easily	0	1	4	8
12. Do you have arthritis?	0 (No		8 (Yes)	
13. Do you have acne or other skin disorder?	0 (No		8 (Yes)	
14. Use pain relievers (over-the-counter, prescription or supplements)	0	1	4	8
Total points:				

Section 8	No/Rarely	Occasionally	Often	Frequently
1. Severe fatigue or low energy	0	1	4	8
2. Easy to gain weight	0	1	4	8
3. Difficult to lose weight	0	1	4	8

4. Family history of thyroid disease	0	1	4	8
5. Diagnosed with hypothyroidism or being treated for hypothyroidism	0	1	4	8
6. Dry Skin	0	1	4	8
7. Constipation	0	1	4	8
8. Hair or eyebrows thinning	0	1	4	8
9. Menstrual irregularities	0	1	4	8
10. Dry or brittle hair	0	1	4	8
11. Low sex drive	0	1	4	8
12. Mood swings or depression	0	1	4	8
13. Forgetful	0	1	4	8
14. High cholesterol	0	1	4	8
15. Low blood pressure	0	1	4	8
Total points:				

Section 9	No/Rarely	Occasionally	Often	Frequently
1. Do you eat out?	0	1	4	8
2. Do you consume ‘diet foods’ or foods with artificial sweeteners?	0	1	4	8
3. Do you eat packaged or processed foods?	0	1	4	8
4. Drink soda/pop	0	1	4	8
5. Consume alcohol	0	1	4	8
6. Use over the counter medication	0	1	4	8
7. Smoke or use tobacco or live with someone that does	0	1	4	8
8. Take prescription medication daily	0	1	4	8
9. Do you live or work in places where pesticides are used?	0	1	4	8
10. Do you travel in planes?	0	1	4	8
11. Exposed to household or industrial cleaners or solvents	0	1	4	8
12. Use fluorinated toothpaste or mouthwash	0	1	4	8
13. In traffic more than 10 minutes/day	0	1	4	8
Total points:				