The Thyroid Cure

The Functional Mind-Body Approach to Reversing Your Autoimmune Condition and Reclaiming Your Health!

Functional Mind-Body Personal Assessments

Client Name:_____ Date:_____

These assessments will help you and your practitioner determine where to begin looking for the "splinters" that may be triggering your autoimmune or other chronic condition.

The Functional Mind-Body assessments are designed to evaluate the following:

Emotional Stress – GI Stress – Adrenal Stress – Infectious Stress – Inflammatory Stress – Toxic Stress – Hormonal Stress

The key to these assessments is as follows:

0 – Never/Symptoms do not apply/Disagree
1 – Occasionally/Symptoms are mild/Somewhat agree
2 – Regularly/Symptoms are moderate in intensity/Agree
3 – Frequent/Symptoms are severe and intense/Strongly Agree

Score each assessment as follows:

Score	Splinter Level
0–6	This may be a splinter for you.
7–10	This is most likely a splinter for you.
10 +	This is very likely a splinter

Emotional Stress Assessment

Please examine your life and experience and determine to what degree each issue affects you. Pay extra attention to the questions that impact your life strongly. Look for patterns.

If you find yourself agreeing with numerous questions in this section, it's a signal that emotional stress is a big splinter for you.

1. I have recently lost my spouse or a loved one.
2. I am recently divorced.
3. I am in an unhappy marriage or relationship.
4. I do not have loving, fulfilling relationships that nurture me.
5. I have recently lost a pet.
6. I don't love my vocation or feel very stressed at work.
7. I work far from home and deal with traffic every day.
8. I have recently moved or changed careers.
9. I did not grow up in a happy family environment.
10. I worry a lot.
11. I have significant financial stress.
12. I over-commit and find it difficult to say, "No."
13. I have a difficult time keeping my commitments.
14. I don't feel supported emotionally by my spouse/partner.
15. I feel guilty a lot.
16. I feel shame a lot.
17. I don't have a fulfilling sex life.
18. I don't have friends I can laugh with and confide in.
19. I don't get adequate sleep.
20. I anger easily.
21. I feel frustrated a lot.
22. I don't have a spiritual practice.
23. My home is cluttered and I find it difficult to manage my household duties.
24. I have unfinished business.
25. I don't have healthy relationships with my parents and/or siblings.
26. I have a hard time speaking my truth.
27. I tend to be a martyr—I have a difficult time asking for help.
28. I don't have a creative outlet such as painting, writing, gardening, etc.
29. I don't have time to play.
30. I rarely feel grateful.
31. I don't feel understood or loved.

Please list anything else you feel is relevant to this assessment and assign a number 1–3 reflecting whether this is occasional, moderate or severe.

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Your Score _____

GI Stress Assessment

Please read the following questions and enter the appropriate response.

1. I have been diagnosed with IBS (Irritable Bowel Syndrome).
2. I have been diagnosed with GERD.
3. I take antacids such as Maalox, Mylanta, Gelusil, Rolaids, or Tums regularly.
4. I take Tagamet, Pepcid, Axid, or Zantac regularly.
5. I take Prevacid or Prilosec regularly.
6. I have taken antibiotics for two weeks or longer recently or in the past.
7. I have taken prednisone or other steroid drugs for two weeks or longer.
8. I am on the birth control pill.
9. I take over-the-counter painkillers regularly.
10. I experience food allergies, hay fever, or skin rashes.
11. I have often have cramps or intestinal pain.
12. I have a white/yellowish or dark coating on my tongue.
13. My gums bleed when I brush my teeth or floss.
14. I have incomplete bowel movements.
15. I often feel gassy and bloated after eating.
16. I experience anal itching.
17. I have undigested food in my stool.
18. I often feel nauseous after eating.
19. I am constipated more often than not.
20. I have diarrhea.
21. I have foul-smelling stools.
22. I often have a spacey feeling after eating.
23. I'm prone to acne or breakouts.
24. I crave alcohol, sugar or bread.
25. I drink more than 8 oz. of alcohol or coffee daily.
26. I tend to feel sick in moldy or damp places.
27. I have experienced food poisoning.
28. I drink more than one cup of coffee daily.
29. I eat sushi or undercooked meat.
30. I eat at restaurants regularly.
31. My sexual partner has one or more of these conditions. Please list:_____
_____
_____

Please list anything else you feel is relevant to this assessment and assign a number 1–3 reflecting whether this is occasional, moderate or severe._____
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Your Score _____

Adrenal Stress Assessment

Please read the following questions and enter the appropriate response.

1. I always feel stressed-out.
2. I need caffeine to start the day.
3. I get panic attacks.
4. I'm easily startled.
5. I frequently have cold hands and feet.
6. I'm frequently constipated.
7. I am easily frustrated and angry—the littlest things bug me.
8. I don't have the patience I used to.
9. I often feel wired but tired.
10. I often resist going to bed even when I'm tired.
11. I have trouble falling and staying asleep.
12. I get heart palpitations.
13. I'm hypoglycemic.
14. I retain water—my feet and hands swell.
15. I wake up feeling not refreshed.
16. I get dizzy when I stand up.
17. I have dark circles under my eyes.
18. I crave salt.
19. I crave sweets.
20. I have trouble concentrating or have brain fog.
21. I catch everything that goes around.
22. I have low blood pressure.
23. I've gained weight around my midsection and it won't budge.
24. I don't have the energy to work out.
25. I have weak muscles.

Please list anything else you feel is relevant to this assessment and assign a number 1–3 reflecting whether this is occasional, moderate, or severe._____
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Your Score _____

Infectious Stress Assessment

Please read the following questions and enter the appropriate response.

1. I have had pneumonia.
2. I have had mononucleosis.
3. I have had or have hepatitis.
4. I have had Candida or other fungal infections.
5. I have had chlamydia.
6. I have had tuberculosis.
7. I have had a mycoplasma infection.
8. I have herpes.
9. I have the Epstein-Barr virus.
10. I have HIV.
11. I have been diagnosed with an STD.
12. I have had a staphylococcus aureus infection.
13. I have Lyme disease.
14. I have dental bone loss.
15. I have gum infections.
16. I have chronic sinusitis.
17. I have chronic UTI infections.
18. I have chronic yeast infections.
19. I have chronic ear infections.
20. I have athlete's foot, jock itch, or other fungal infections of the skin.
21. I have a low-grade fever.
22. I have swollen lymph glands.
23. I have experienced a period of illness that lasted two weeks or longer—the doctors did not know what I had, but I have never felt the same since then.
24. I have or have had Gulf War Syndrome.
25. I have or have had a serious infection not on this list: _____
26. My sexual partner has one or more of the above conditions/symptoms. Please list:_____
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    _____
    _____

    Please list anything else you feel is relevant to this assessment and assign a number 1–3 reflecting whether this is occasional, moderate, or severe._____
    _____
    _____
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    _____
    _____

    Your Score _____

Inflammatory Stress Assessment

Please read the following questions and enter the appropriate response.

1. I am totally stressed-out most of the time.
2. I have toxic exposure at work and home (toxins, quantum toxins).
3. I catch everything that goes around.
4. I work out for less than 30 minutes, three times a week.
5. I never go in the sun without sunblock, and I don't take vitamin D.
6. I have allergies and sensitivities.
7. I have food allergies or sensitivities.
8. I am dependent on sugar and/or alcohol.
9. I have had a difficult time recovering from an injury or surgery.
10. I have chronic infections—fungal, bacterial, or viral.
11. I have chronic pain.
12. I have sore joints.
13. I have carpal tunnel syndrome
14. I have asthma or bronchitis.
15. I have heart disease.
16. I have diabetes, insulin resistance or metabolic syndrome.
17. I have chronic skin conditions such as dermatitis, acne, eczema, or psoriasis.
18. I experience chronic digestive symptoms, such as GERD, IBD, IBS, or Crohn's disease.
19. I am overweight/obese.
20. I have arthritis (osteoarthritis/degenerative arthritis).
21. I retain water (edema).
22. I have high blood pressure.
23. I have high cholesterol.
24. I have periodontal disease.
25. I have osteopenia.
26. I have hepatitis.
27. I have chronic fatigue or fibromyalgia.
28. I experience interstitial cystitis.
29. I have tendonitis.

Please list anything else you feel is relevant to this assessment and assign a number 1–3 reflecting whether this is occasional, moderate, or severe._____
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Your Score _____

Toxic Stress Assessment

Please read the following questions and enter the appropriate response.

1. I never or rarely sweat.
2. I'm frequently constipated, have hard, difficult-to-pass bowel movements, or only go every other day or so.
3. I produce low-volume, dark, or strong-smelling urine.
4. I have allergies and sensitivities.
5. I have frequent headaches.
6. I experience fatigue that is not caused by obvious reasons such as staying up late or strenuous exercise.
7. I am obese.
8. I am sensitive to MSG.
9. I am sensitive to sulfites (wine, dried fruit).
10. I am sensitive to chocolate.
11. I am sensitive to alcohol.
12. I have silver amalgam fillings.
13. I am sensitive to perfumes.
14. I am sensitive to tobacco smoke.
15. I am sensitive to soaps, detergents, or dryer sheets.
16. I am sensitive to chlorine and bromine.
17. I am sensitive to household cleaning products.
18. I am sensitive to room spray or candles.
19. I am sensitive to new clothes, dressing rooms, and fabric stores.
20. I am sensitive to other strong odors, such as:_____
21. I have trouble concentrating.
22. I drink water from or cook in plastic containers.
23. I drink tap water.
24. I drink unfiltered well water.
25. I have my living space treated for pests.
26. I use pesticides and garden chemicals.
27. I have my clothes dry-cleaned.
28. I live in a city or large urban area.
29. I live in a space with poor ventilation or windows that do not open.
30. I have mold in my home.
31. I regularly take over-the-counter medications, such as Tylenol, cold medications, allergy medications, etc. Please list: _____
32. I take the following prescription medications:_____
33. I get the flu vaccine.
34. I have had a liver condition. Please list:_____
35. I have an autoimmune condition. Please list:_____
36. I have or have had cancer.
37. I have gone through chemotherapy.
38. I have had a major chemical exposure. Please list:_____

Please list anything else you feel is relevant to this assessment and assign a number 1–3 reflecting whether this is occasional, moderate, or severe._____
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Your Score _____

Hormonal Stress Assessment for Women

Please read the following questions and enter the appropriate response.

1. I use birth control pills or HRT.
2. I have irregular cycles, cramping, or heavy bleeding.
3. I experience PMS.
4. I have breast tenderness or fibrocystic breasts.
5. I experience fluid retention, swelling, or puffiness.
6. I have dry skin/hair.
7. I have vaginal dryness.
8. I get hot flashes.
9. I have lost interest in sex.
10. I have gained weight around the middle and it won't budge.
11. I get migraines/headaches before my period.
12. I experience mood swings.
13. I feel anxious.
14. I feel depressed.
15. I have been diagnosed with polycystic ovarian syndrome.
16. I have uterine fibroid tumors.
17. I have experienced or am experiencing infertility.
18. I have facial hair on my upper lip and or chin.
19. I have hair on my breasts.
20. I have memory problems.
21. I have insomnia.
22. I experience cramping at ovulation.
23. I get acne around the time of my period.
24. I am experiencing perimenopausal or menopausal symptoms.
25. I have had a toxic or chemical exposure. Please list:_____

Please list anything else you feel is relevant to this assessment and assign a number 1–3 reflecting whether this is occasional, moderate, or severe.

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Your Score _____

Hormonal Stress Assessment for Men

Please read the following questions and enter the appropriate response.

1. I have lost interest in sex.
2. I have impotence or a weak erection.
3. I have lost my drive or sense of purpose.
4. I have fatigue.
5. I have a low sperm count.
6. I have decreased muscle mass.
7. I have "man boobs."
8. I am losing the hair on my arms, legs, and chest.
9. I have increased abdominal fat.
10. I have bone loss.
11. I have high cholesterol.
12. I have insulin and blood sugar imbalances.
13. I feel depressed.
14. I have trouble remembering things.
15. I experience frequent urination and prostate problems.
16. I have had a toxic or chemical exposure. Please list:_____

Please list anything else you feel is relevant to this assessment and assign a number 1–3 reflecting whether this is occasional, moderate, or severe.

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Your Score _____

What are Your Splinters?

The results of your assessments will give you an idea of where to begin looking for the underlying triggers in your autoimmune thyroid condition.

If you find that a particular area *may be* a splinter for you, then it is most likely not the first place you should address.

If you find that a particular area is *most likely* a splinter for you, then while it may not be the primary cause, there is a good chance that it is a contributing factor in your condition.

If you find that a particular area is *very likely* a splinter for you, then this is where you will want to begin looking first.

You may find that you have several areas that are tied together or overlapping, in which case I invite you to use your intuition and enlist the assistance of a qualified practitioner to help you determine where to begin.

Please make a note of which areas may be, most likely are, and very likely are splinters for you.

Emotional Stress _____

GI Stress _____

Adrenal Stress _____

Infectious Stress _____

Inflammatory Stress _____

Toxic Stress _____

Hormonal Stress _____

How do you think you got your condition?

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