MENTAL STRESS ASSESS

		NEVER	MILD	MODERATE	SEVERE
1.	Did you experience a death or illness of a spouse or child?	0	1	2	3
2.	Did you get separated or divorced?	0	1	2	3
3.	Did you lose your home or experience financial hardship?	0	1	2	3
4.	Did you or partner unexpectedly lose a job?	0	1	2	3
5.	Are you depressed or anxious?	0	1	2	3
6.	Any difficulties with children or grandchildren?	0	1	2	3
7.	Do you have trouble handling the stress in your life?	0	1	2	3
8.	Do you have family stress with your siblings or parents?	0	1	2	3
9.	Are you having problems with your spouse or partner?	0	1	2	3
10.	Have you had a major life change, such as marriage, moving to a new community, or a new job?	0	1	2	3

SECTION TOTAL: _____

PHYSICAL HEALTH ASSESS

		ALWAYS	MOSTLY	SOMETIMES	HARDLY
1.	Do you sleep through the night?	0	1	2	3
2.	Do you go to sleep before 11:00?	0	1	2	3
3.	Do you sleep at least 7 hrs a night?	0	1	2	3
4.	Do you eat probiotic foods or supplements daily?	0	1	2	3
5.	Do you eat at least 5 servings produce/day?	0	1	2	3
6.	Do you avoid alcohol and smoking?	0	1	2	3
7.	Do you exercise 3 or more times a week?	0	1	2	3
8.	Do you meditate, yoga, or do another form of relaxation?	0	1	2	3
9.	Do you get acupuncture, massage, or other body treatments?	0	1	2	3
10.	Do you makve time to spend with friends?	0	1	2	3

SECTION TOTAL: _____

IMMUNITY ASSESS

		NEVER	SOMETIMES	OFTEN	ALWAYS
1.	Do you feel tired when you wake up, even after sleeping?	0	1	2	3
2.	Do you feel exhausted in the afternoon?	0	1	2	3
3.	Are you depressed feeling no energy to do anything?	0	1	2	3
4.	Do you get irritable or sleepy when you don't eat for 4-5hr?	0	1	2	3
5.	Do you crave salty or sweet foods?	0	1	2	3
6.	Do you have pain in your muscles or joints?	0	1	2	3
7.	How often do you get sick or catch the flu?	0	1	2	3
8.	Do you have an inflammatory disease?* 0-No 3- Yes	0	1	2	3
9.	Do you have constipation, gas, or bloating?	0	1	2	3
10.	Do you stress easily?	0	1	2	3

SECTION TOTAL: _____