CLASSIC PROGRAM
CARDIO-METABOLIC RISK REPORT

PRIMAL MD™
Bringing Health to Life

STEP 1 MEASURE

PART A. HISTORY

MEDICAL SYMPTOM QUESTIONNAIRE

Answer each question on a scale of 0 to 4:
0 = I never experience this symptom.
1 = I occasionally experience this symptom, but it's not severe.
2 = I occasionally experience this symptom, and it is severe.
3 = I often experience this symptom, but it's not severe.
4 = I often experience this symptom, and it is severe.

Head
Do you have headaches? ___
Do you feel faint? ___
Do you feel dizzy? ___
Do you suffer from insomnia? ___
Subtotal =

Digestion
Do you feel nauseous or have bouts of vomiting? ___
Do you have diarrhea? ___
Do you have constipation? ___
Do you feel bloated? ___
Do you frequently burp or pass gas? ___
Do you have heartburn? ___
Do you have stomach or intestinal pain? ___
Subtotal =

Muscle and Joints
Do you have pain or aches in your joints? ___
Do you have arthritis? ___
Do you feel stiff or feel limited in your movements? ___
Are your muscles stiff, painful, or achy? ___
Do you feel physically weak? ___
Subtotal =

Emotions
Do have mood swings? ___
Are you anxious, fearful or nervous? ___
Are you angry, aggressive, or irritable? ___
Are you depressed? ___
Subtotal =

Eyes
Are your eyes itchy or watery? ___
Are your eyelids swollen, sticky, or reddened? ___
Do you have bags or dark circles under your eyes? ___
Do you ever have blurry or tunnel vision? ___
Subtotal =

Ears
Do your ears feel itchy on the inside? ___
Do you suffer from earaches or infections? ___
Do you have drainage from your ears? ___
Do you experience ringing in your ears? ___
Subtotal =

Nose
Do you have a stuffy nose? ___
Do you have sinus problems? ___
Do you suffer from hay fever? ___
Do you have sneezing attacks? ___
Do you have excessive mucus formation? ___
Subtotal =

General Health
Do you get sick frequently? ___
Do you feel the need to urinate urgently or frequently? ___
Do you suffer from any genital itch or discharge? ___
Subtotal =

Eating and Weight
Do you indulge in binge eating or drinking? ___
Do you crave particular foods? ___
Are you overweight? ___
Are you underweight? ___
Do you retain water? ___
Do you eat compulsively or mindlessly? ___
Subtotal =

Energy Level
Do you feel fatigued or sluggish? ___
Do you feel apathetic or lethargic? ___
Do you feel hyperactive? ___
Do you feel restless? ___
Subtotal =

Mind
Is your memory short or faulty? ___
Do you have trouble comprehending information? ___
Do have trouble concentrating? ___
Are you uncoordinated? ___
Do you find it difficult to make decisions? ___
Do you stutter or stammer? ___
Do you slur your speech? ___
Do you suffer from any learning disabilities? ___
Subtotal =

Mouth and Throat
Do you have chronic cough? ___
Do you frequently feel the need to clear your throat? ___
Do you have a sore throat, hoarseness, or loss of voice? ___
Are your lips, tongue, or gums swollen or discolored? ___
Do you have canker sores? ___
Subtotal =

Skin
Do you have acne? ___
Do you get hives, rashes, or patches of dry skin? ___
Do you have hair loss? ___
Do you suffer from flushing or hot flushes? ___
Are you excessively sweaty? ___
Subtotal =

Heart Health
Do you ever experience an irregular or skipped heartbeat? ___
Do you ever experience a rapid or pounding heartbeat? ___
Do you ever experience chest pain? ___
Subtotal =

Respiratory System
Do you have chest congestion? ___
Do you suffer from asthma or bronchitis? ___
Do you have shortness of breath? ___
Do you have difficulty breathing? ___
Subtotal =

Adapted from The Institute of Functional Medicine

GRAND TOTAL

INFLAMMATION CONTROL

CARDIAC RISK ASSESSMENT

CIRCLE THE RIGHT ALTERNATIVE

1. HAVE YOU EVER BEEN FOUND TO HAVE A HIGH BLOOD SUGAR (DIABETES)?

   NO 0pts YES 5pts

2. BODY FAT PERCENT **
   (<20%) 0pts, (20-26%) 2pts, (>26% Fat) 5pts

3. DO YOU EAT A PREDOMINATELY WESTERN DIET/PROCESSED FOODS?

   OFTEN 2pts ALWAYS 5pts

4. HAVE YOU EVER BEEN FOUND TO HAVE HIGH BLOOD PRESSURE (HYPERTENSION)?

   NO 0pts YES 3pts

5. ARE YOU PHYSICALLY INACTIVE (SITTOSIS)?
   NO 0pts YES 3pts

6. DO YOU SMOKE?

   NO 0pts YES 3pts

7. DO YOU DRINK MORE THAN A GLASS OF ALCOHOL A DAY?

   NO 0pts YES 3pts

8. DO YOU HAVE A FAMILY HISTORY OF HEART DISEASE (GENETICS)?

   NO 0pts YES 3pts

9. DO YOU HAVE MODERATE OR HIGH STRESS IN YOUR LIFE?

   NO 0pts YES 3pts

10. HAVE YOU EVER BEEN FOUND TO HAVE HIGH BLOOD FATS (DYSLIPIDEMIA)?

    NO 0pts YES 2pts

TOTAL RISK SCORE OF DEVELOPING HEART DISEASE WITHIN THE NEXT 10 YEARS.
0 – 10 LOW
11 – 20 MODERATE
21 – 35 HIGH

* Modified from the Global InterHeart Study

DIABETES RISK ASSESSMENT

CIRCLE THE RIGHT ALTERNATIVE

1. AGE

   UNDER 45 YEARS 0pts 45-54 YEARS 2pts
   55-64 YEARS 3pts OVER 64 YEARS 4pts

2. BODY FAT PERCENT**

   LOWER THAN 20% 0pts 20-26% 1pt
   HIGHER THAN 26% 3pts

3. WAIST CIRCUMFERENCE MEASURED BELOW THE RIBS
   (USUALLY AT THE LEVEL OF THE NAVEL)

   LESS THAN 94CM (38") 0pts
   94-102CM (38-41") 3pts
   MORE THAN 102CM (>41") 4pts

4. DO YOU USUALLY HAVE DAILY AT LEAST 30 MINUTES OF PHYSICAL ACTIVITY AT WORK AND/OR DURING LEISURE TIME (INCLUDING NORMAL DAILY ACTIVITY)?

   NO 2pts YES 0pts

5. HOW OFTEN DO YOU EAT VEGETABLES, FRUIT OR SALADS?

   EVERY DAY 0pts NOT EVERY DAY 1pt

6. HAVE YOU EVER TAKEN MEDICATION FOR HIGH BLOOD PRESSURE ON A REGULAR BASIS?

   NO 0pts YES 2pts

7. HAVE YOU BEEN FOUND TO HAVE HIGH BLOOD GLUCOSE (EG IN A HEALTH EXAMINATION, DURING ILLNESS, DURING PREGNANCY)?

   NO 0pts YES 5pts

8. HAVE ANY OF THE MEMBERS OF YOUR IMMEDIATE FAMILY OR OTHER RELATIVES BEEN DIAGNOSED WITH DIABETES (TYPE 1 OR TYPE 2)?

   NO: 0pts

   YES GRANDPARENT, AUNT, UNCLE OR FIRST COUSIN (BUT NO PARENT, BROTHER, SISTER OR CHILD) 3pts

   YES PARENT, BROTHER, SISTER OR OWN CHILD 5pts

TOTAL RISK SCORE OF DEVELOPING DIABETES WITHIN THE NEXT 10 YEARS.
0 – 10 LOW
11 – 20 MODERATE
21 – 35 HIGH

* Modified from the Finnish Diabetes Association

NUTRITION
AND METABOLIC BALANCE

	NUTRITION ASSESSMENT	YES	NO
1	I FREQUENTLY EAT BREAD		
2	I FREQUENTLY EAT CEREALS AND PACKAGED FOODS		
3	I FREQUENTLY EAT RICE OR PASTA		
4	I FREQUENTLY EAT POTATOES OR FRENCH FRIES		
5	I FREQUENTLY EAT WHEAT BASED PRODUCTS		
6	I FREQUENTLY EAT PASTRIES, COOKIES OR DOUGHNUTS		
7	I FREQUENTLY EAT CANDIES		
8	I FREQUENTLY EAT TROPICAL FRUITS (BANANAS, MANGOS, MELONS)		
9	I FREQUENTLY USE VEGETABLE OILS LIKE SUNFLOWER, CANOLA, CORN, COTTON SEED TO COOK		
10	I DRINK MILK (COWS) OFTEN SKIM OR LOW FAT MILK		
11	I DRINK SODAS (REGULAR OR DIET)		
12	I FREQUENTLY DRINK JUICE AND / OR ALCOHOLIC DRINKS		
	TOTAL:		

I EAT: A PALEO DIET ☐ A VEGETARIAN DIET ☐ A MILK, EGG, VEGETARIAN DIET ☐

I EAT ANOTHER TYPE OF DIET _____

TOXIN AND CANCER REDUCTION

Scoring
0 = Never
1 = Occasionally (Yes)
2 = Frequently
(Some exposures are so damaging, you'll need to add extra points where indicated)

Cleaners
Do you use conventional chemical cleaners (furniture polish; disinfecting sprays; scrubs or glass, surface or metal cleaners) In any of these rooms? ___

- Living room ___
- Bed room ___
- Kitchen ___
- Bathroom ___

Do you use conventional detergents, bleaches or softeners for Laundry? ___
Do you use conventional soap for dishwashing? ___
Do you use nonorganic room deodorizers like aerosols or plug-ins? ___
Is your shower curtain liner made of vinyl or plastic? ___
Do you use a conventional dry cleaner and remove the clothing from the plastic wrap less than 12 hours before wearing? ___
Subtotal=

Outdoors
Do you use chemical weed killers or herbicides on your lawn or landscape? ___
Do you use chemical fertilizers? ___
Have you treated your home or yard chemically for insect infestation? (Ants, termites, etc) ___
Does your outdoor area feature older treated wood in decking, play structures, or landscaping? ___
Subtotal=

Occupation
Does your work involve exposure to inhaled or skin-contact chemical agents (dentist, dry cleaner, shoe repairman, welder, industrial worker etc)? ___
Subtotal=

Electromagnetic Fields (EMFs)
Do you use an electrical blanket? ___
Do you use a mobile phone next to your ear more than 15 minutes a day? ___
Do you keep your mobile phone in a pocket or clipped to your body? ___
Is there powered electric device within 2 feet of your bed? ___
Do you live within 50 feet of mobile phone tower or high power line? ___
Subtotal=

Air Quality
Have you renovated your home using any of the following? ___

- Conventional paints ___
- Plasterboard ___
- Polyurethane (1+) ___
- Sanding ___
- Glues for carpet of flooring (+1) ___

Are there outdoor-air-quality alerts where you live? ___
Are you often exposed to automotive exhaust? ___
Do you spend more than 2 hours a day in a car? ___
Do you tend to travel by air? ___
Do you own new furniture –purchased less than 2 years ago? ___
Does your home contain cabinets made of pressed wood composites? ___
Is there paint in your house that's cracking and more than 20 years old? ___
Is there heavy accumulation of dust on furniture or drapes? ___
Do you have wall-to-wall carpet? ___
Do you have a damp or musty basement? ___
Is there visible mold in your home? ___
Does anyone in your household smoke? (2+) ___
Subtotal=

Water
Does your home have old pipes? ___
Do you drink from untested well water? ___
Do you live in a building with a roof tank? ___
Do you have heavy water discoloration in the morning? ___
Subtotal=

Ingested Therapies and Over-the-Counter Medicines
Do you use antibiotics more than twice a year? ___
Do you use nicotine patches, gum or spray more than twice a week? ___
Do you use acetaminophen (aka Tylenol) more than 4 days a week? ___
Do you use NSAIDs (such as aspirin or ibuprofen) more than 4 days a week? ___
Do you use antihistamines (like Diphenhydramine) daily? ___
Do you use decongestants daily? ___
Do you use stomach acid-suppressing medications daily? (+1) ___
Do you use nutritional or herbal supplements that are produced with no ostensible quality assurance? ___
Do you drink grapefruit juice (6 ounces) with your prescription medication? ___
Do you have silver mercury fillings in teeth? ___
Subtotal=

Adapted from The Detox Prescription by Woodson Merrell MD

TOTAL

TOXIN AND CANCER REDUCTION

Daily Prescription Medications

Do you use inhaled steroids? or oral steroids? (1+) ___
Do you take anti convulsing or antipsychotic medication? ___
Do you use tranquilizers, sleeping pills, or antidepressants? ___
Are you on hormone therapy? ___
Are you undergoing chemotherapy? (+1) ___
Are you on a biologic agent (e.g, TNF blocker)? ___
Are you on other medications? (+1 for each additional beyond 2) ___
Subtotal = ___

Personal Care

How often do you use conventional (read: not specifically organic nor free of synthetic preservatives, fragrances, or sudsing agents) versions of the following beauty and personal care products?

- Soap(perfumed) ___
- Antibacterial ___
- Perfume ___
- Moisturizers ___
- Shampoo ___
- Hair dye ___
- Sun block ___
- Nail posh ___
- Deodorant/ antiperspirant ___
- Conditioner ___
- Hairspray ___
- Foundation ___
- Eye and cheek colour ___
- Lipstick ___

Subtotal = ___

Food Quality and Quantity

Do you eat a lot (3 or 4 days a week) of fried food? (+1) ___
Do you eat a lot (3 or 4 days a week) of red meat? ___
Do you eat a lot (3 or 4 days a week) of cheese or other dairy? ___
Do you eat tuna, swordfish, or other large predatory fish? ___
Do you eat a lot of sugar or refined carbohydrates? (+1) ___
Do you charboil your meat? (+1) ___
Do you usually subject your vegetables to long cooking times? ___
Do you eat foods that contain high-fructose corn syrup (such as sodas or salad dressings)? (+1) ___
Do you eat foods (such as drinks or processed foods) that contain preservatives or colorants? (+1) ___
Do you eat less than 50 grams of protein a day? ___
Do you eat less than 25 grams of fibre a day? ___
Do you eat less than eight servings of fruits and vegetables a day? (+1) ___
Subtotal = ___

Drinking

Do you drink less than 8 cups of water a day? ___
Do you drink more than 4 cups of coffee a day? ___
Do you use artificial sweeteners such as aspartame, saccharin, or sucralose? ___
Do you drink more than two alcoholic drinks a day? (+2) ___
Do you drink alcohol more than 5 days a week? ___
Subtotal =

Grocery Shopping

Do you usually buy conventional rather than organic produce? (+1) ___
Do you buy meat, eggs or milk that is not labeled antibiotic or RBGH free? ___
Do you buy fish that may contain mercury/heavy metals? (+1) ___
Do you accept and handle paper shopping receipts? (+1) ___
Subtotal = ___

Cooking

Do you use Teflon-coated nonstick pans? ___
Do you store food in plastic containers?
Do you reheat food in plastic containers? (+1) ___
Do you use plastic wraps? ___
Do you use canned foods? ___
Do you microwave popcorn in prepared bags? (+1) ___
Subtotal =

Exercise and Rest

Do you sleep less than 7 hours a day? ___
Do you wake more than twice a night? ___
Do you have a job that requires you to sit more than 4 hours a day? ___
Do you exercise 3 hours a week? ___
Do you exercise more than 2 hours a day? ___
Do you fail to take one rest day a week away from exercise? ___
Subtotal =

Stress

Do you experience continuous daily stress? (+1) ___
Do you have episodic, high–intensity stress? (+1) ___
Do you suffer from chronic anxiety? (+1) ___
Are you depressed, or do you have a feeling of hopelessness? (+1) ___
Are you caregiver for someone who is chronically ill? (+1) ___
Do you smoke? (+2) ___
Subtotal =

Adapted from The Detox Prescription by Woodson Merrell MD

GRAND TOTAL

EXERCISE AND SLEEP

	EXERCISE ASSESSMENT	YES	NO
1	I enjoy exercise		
2	I am a regular member of my health club		
3	I use exercise equipment at home		
4	I have a personal trainer		
5	I exercise at least 3 days a week		
6	The intensity of my exercise is moderate to heavy		
7	I walk, run or jog on a regular basis		
8	I am free of any injury that inhibits me from exercise		
9	I do aerobic exercise at least twice a week		
10	I do resistance exercise at least twice a week		
	Total:		

	LUNG ASSESSMENT	YES	NO
1	Do you or have you ever smoked?		
2	I smoke (d) over a pack per day.		
3	I smoked for more than 5 years.		
4	I have not smoked for over 5 years.		
5	I have been diagnosed with chronic lung disease.		
6	I am short of breath with mild exercise.		
7	I am short of breath at rest.		
8	I take medication for my lungs.		
9	I get frequent chest colds.		
10	I use antibiotics frequently.		
	Total:		

	SLEEP ASSESSMENT	YES	NO
1	Have you ever been told that you stop breathing while you are sleeping?		
2	Do you feel excessively sleepy during the day?		
3	Has anyone ever told you that you snore while you're sleeping?		
4	Do you awaken suddenly with shortness of breath, gasping or with your heart racing?		
5	Have you ever fallen asleep or nodded off while driving?		
6	Have you had weight gain and found it difficult to lose?		
7	Have you taken medication for or been diagnosed with high blood pressure?		
8	Do you wake up with headache during the night or morning?		
9	Do you have trouble falling asleep?		
10	Do you have trouble staying asleep once you fall asleep?		
	Total:		

GUT MICROBIOME

	GUT MICROBIOME CHECK	YES	NO
1	Did your mother take antibiotics while she was pregnant with you?		
2	Did your mother take steroids like prednisone while she was pregnant with you?		
3	Were you born by C-section?		
4	Were you breast-fed for less than one month?		
5	Did you suffer from frequent ear and/or throat infections as a child?		
6	Did you require ear tubes as a child?		
7	Did you have your tonsils removed?		
8	Have you ever needed steroid medications for more than one week, including steroid nasal or breathing inhalers?		
9	Do you take antibiotics at least once every two to three years?		
10	Do you take acid-blocking drugs(for digestion or reflux)?		
11	Are you gluten-sensitive?		
12	Do you have food allergies?		
13	Are you extra sensitive to chemicals often found in everyday products and goods?		
14	Have you been diagnosed with an autoimmune disease?		
15	Do you have type - 2 diabetes?		
16	Are you more than 20 pounds overweight?		
17	Do you suffer from irritable bowel syndrome?		
18	Do you have diarrhea or loose bowel movements at least once a month?		
19	Do you require a laxative at least once a month?		
20	Do you suffer from depression?		
	Total:		

Note: Adapted from BRAIN MAKER by David Perlmutter MD

RESTORATION OF HORMONES

	TESTOSTERONE	YES	NO
1	I'm often tired		
2	I have fewer early morning erections		
3	I have lost a lot of strength		
4	My mind feels less sharp		
5	I think about sex less often		
6	My belly has much more fat		
7	I feel more down and sad at times		
8	My orgasms are less satisfying		
9	My erections are less hard		
10	I feel less confident		
	Total:		

	IODINE/ IODIDE	YES	NO
1	Benign Prostatic Hypertrophy (BPH)		
2	Goiter Bulge or Band Around the Neck		
3	Slow Speech		
4	Enlarged Tongue/ Teeth Impressions		
5	Puffy Face/ Puffy Hands		
	Total:		

	THYROID	YES	NO
1	Tiredness, Sluggishness, Lethargic		
2	Dryer Hair or Skin (Thick, Dry, Scaly)		
3	Sleep More than Usual		
4	Weaker Muscles		
5	Constant Feeling of Cold (Fingers/ Hands/ Feet)		
6	Poorer Memory		
7	Frequent Muscle Cramps		
8	More Depressed (Mood Changes Easily)		
9	Slower Thinking		
10	Puffier Eyes		
11	Difficulty with Math		
12	Hoarser or Deeper Voice		
13	Constipation		
14	Coarse Hair/ Hair Loss/ Brittle Hair		
15	Low Sex Drive		
16	Puffy Hands and Feet		
17	Unsteady Gait (Bump Into Things)		
18	Gain Weight Easily		
19	Outer Third of Eyebrows Thin		
20	Muscle/joint pain		
	Total:		

***- Use with history and lab tests to diagnose hormonal scoring**

ADVANCED SUPPLEMENTATION

(Answer 1 – 11 only)

	MICRONUTRIENT ASSESSMENT	LOW (1)	MEDIUM (2)	HIGH (3)
1	I eat locally grown food	Often	Sometimes	Never
2	I eat organic food	Often	Sometimes	Never
3	I eat my food raw	Often	Sometimes	Never
4	I peel my fruits and vegetables	Often	Sometimes	Never
5	I eat out less than twice a week	Often	Sometimes	Never
6	I take prescription (OTC) meds	Never	Sometimes	Often
7	I keep processed food to a minimum	Often	Sometimes	Never
8	I eat 5 servings of fruits and vegetables daily	Often	Sometimes	Never
9	My Body Fat Percentage	< 20	20 - 26	> 26
10	I take daily multivitamins	Often	Sometimes	Never
11	I eat primarily a Paleo (HFLC) Diet	Often	Sometimes	Never

	CARDIOMETABOLIC RISKS	LOW (1)	MEDIUM (2)	HIGH (3)
12	Medical Symptoms Risk	< 70	70 - 100	> 100
13	Cardiac Risk	0 - 10	11 - 20	21 - 35
14	Diabetes Risk	0 - 10	11 - 14	15 - 20
15	Nutrition Risk	< 4	4 - 6	> 6
16	Toxin Risk	< 45	45 - 60	> 60
17	Exercise Risk	> 7	3 - 7	< 3
18	Gut Microbiome Risk	< 5	5 - 12	> 12
19	Hormone Risk	< 10	10 - 20	> 20
20	Stress Risk	< 3	3 - 7	> 7
	TOTAL			

LIFELONG MINDFULNESS AND STRESS REDUCTION

	MINDFULNESS	YES	NO
1	Mind is infinite, indestructible and immortal		
2	Every thought i have affects my health		
3	Mind can travel across time and space		
4	Mind (consciousness) is evolving		
5	Systems thinking can make the world a better place		
6	Mindfulness (awareness) is key to longevity		
7	I often listen to my “inner voice”		
8	There is little to fear in my life		
9	I have a rich “interior life”		
10	My life is productive and full of meaning		
	Total:		

	STRESS ASSESSMENT	YES	NO
1	Appetite or weight change		
2	Insomnia- trouble sleeping		
3	Anxiety		
4	Pounding heart		
5	Feel constant pressure		
6	Apathy – little joy		
7	Poor memory		
8	Work hard – little satisfaction		
9	Chronic fatigue		
10	Low sex drive		
11	Unable to discuss feelings		
12	Isolation		
	Total:		

SELF-HEALTH ASSESSMENT

Circle the number that best represents your health!

Very Unhealthy	1	2	3	4	5	6	7	8	9	10	Very Healthy

PART B. EXAMINATION

VITAL SIGNS										
BP			HR		RR		TEMP			

MEASUREMENTS			
1	Height	4	Hip (widest point below waist)
2	Weight	5	Waist/Hip Ratio (< 0.95)
3	Waist (at navel)	6	Waist/Height Ratio (< 53)

EXAMINATION			
Head			
Neck			
Chest			
Abdomen			
Extremities			
Comments:			

OVERALL ASSESSMENT
Good ☐ Fair ☐ Poor ☐

PART C. DIAGNOSTICS

TEST	YOUR VALUES	NORMAL RANGE
Body Fat Percent		< 20%
Vascular Age		Vasc < chron age
Oxygen Saturation		> 95%
Thyroflex:		
• Reflex Time =		50 – 120
• RMR* =		2,750
* Will show reading 400cal below baseline before treatment		

BLOOD TESTS	YOUR VALUES	NORMAL RANGE
Cardio-Metabolic:		
• Fasting Glucose		< 80
• HbA1C		< 5
• Triglycerides		< 100
• HDL		> 55
• TG/ HDL Ratio		< 2
• Cholesterol		< 200
• LDL-Cholesterol		< 100
• Uric Acid		< 5
• CBC		Hb 11.2 – 15.7
Hormones:		
• Testosterone (Total)		700 - 850
• DHEA's		250 – 350
• TSH		< .4
• PSA		< 4
• Vitamin D3		70 – 100

Metabolic Syndrome Risk:		Yes	No
• Waist size increased	> 40" (100cm)		
• High blood sugar	> 100		
• High blood pressure	> 130/85		
• High triglycerides	> 150		
• Low HDL cholesterol	< 40		
	Total:		

*Positive if 3 or more YES answers.

CARDIO-METABOLIC SCORING

	TEST	Low (1)	Medium (2)	High (3)
	Medical symptoms	< 70	70 - 100	> 100
1	Inflammation	< 4	4 - 5	> 5
2	Nutrition	< 4	4 - 6	> 6
3	Toxins	< 45	45 - 60	> 60
4	Exercise	> 7	3 - 7	< 3
5	Gut microbiome	< 5	5 - 12	> 12
6	Restore hormones	< 10	10 - 20	> 20
7	Advanced supplements	< 25	25 - 40	< 40
8	Mindfulness and stress	< 3	3 - 4	> 4
9	Overall physical examination	Good	Fair	Poor
10	Waist/ height ratio	< 53	53 - 58	>58
11	Blood pressure	120/80	120/80 - 140/90	> 140/90
12	Heart rate	< 68	68 - 74	> 74
13	Body fat percent	< 20	20 - 26	> 26
14	Vascular age	Younger	Same	Older
15	Thyroflex	< 120	120 - 135	> 135
16	TSH	< .5	.5 - 1.5	> 1.5
17	LDL cholesterol	< 100	100 - 150	> 150
18	TG/HDL ratio	< 2	2 - 4	> 4
19	Uric acid	< 5	5 - 6	> 6
20	Vitamin D3	> 70	40 - 70	< 40
	Total:			

Your overall cardio-metabolic risk is:

Low	Medium	High
< 3 0	30 - 45	> 45

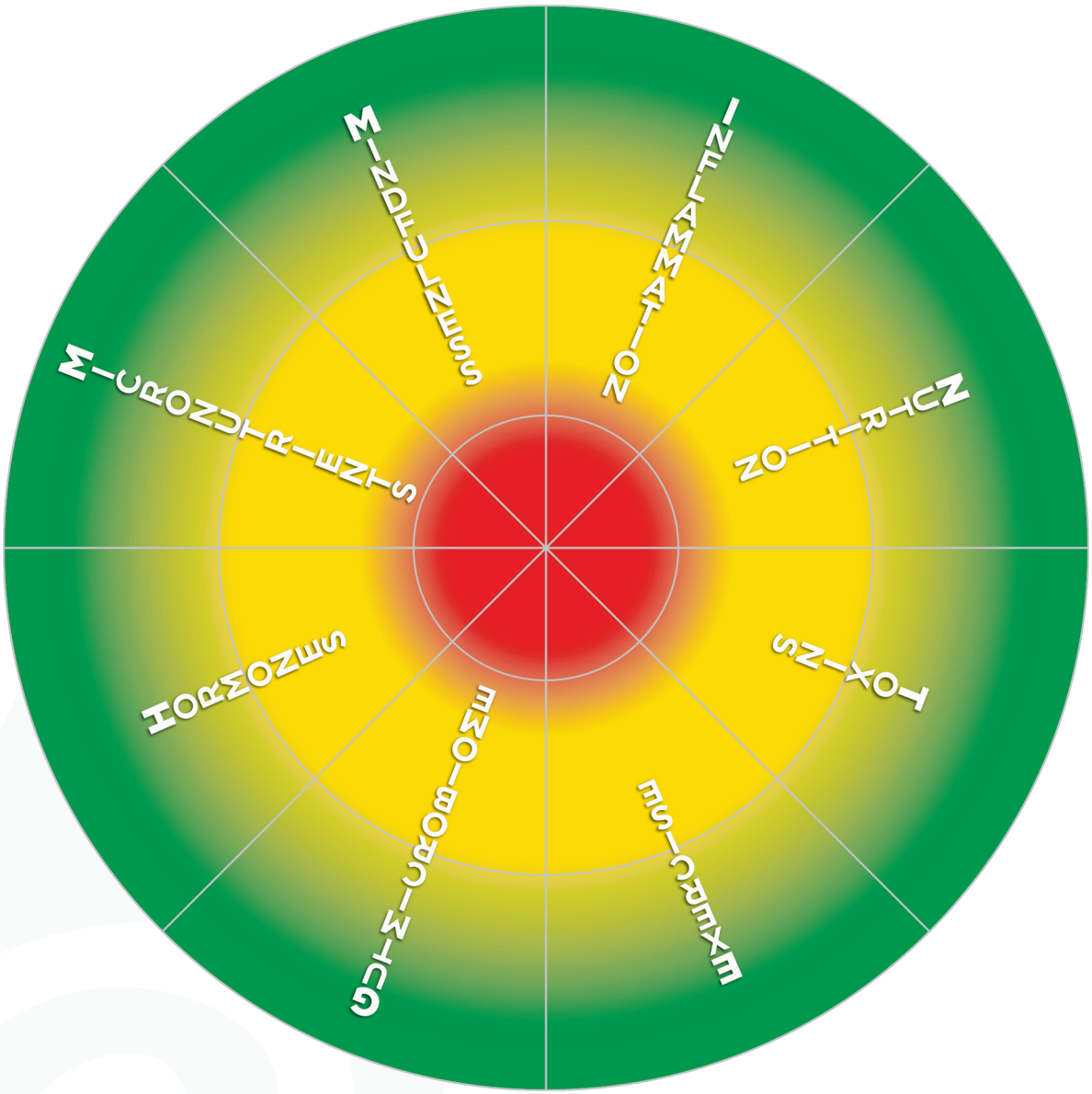
This means that you have / do not have insulin resistance and that you have/ do not have increased inflammation in the endothelium (blood vessels) of your body. Inflammation will increase your risk of developing chronic disease like diabetes, metabolic syndrome, heart attack, stroke, Alzheimer's, cancer and will increase your rate of aging.

Low Risk Paleo Diet and Core Nutraceuticals

Moderate Risk Paleo Diet, Nutraceuticals, BHRT and Lifestyle Modification

High Risk Paleo Diet, Nutraceuticals, Pharmaceuticals and Refer to an MD for Intensive Lifestyle Modification

WHOLE PERSON
INTEGRAL HEALTH APPROACH



YOUR OVERALL CARDIOMETABOLIC RISK IS:

Low	Medium	High
<30	30-45	>45