



**essential balance**  
*Build Another Lifestyle... A New Changing Experience*

**Please read before completing your Dysbiosis Questionnaire**

This questionnaire is designed for adults and the scoring system is not as appropriate for children. It lists factors in your medical history which are known to contribute to the disruption of normal healthy gastrointestinal bacteria, directly or indirectly promoting the overgrowth of yeast, fungi and other pathogens.

Filling out and scoring this questionnaire should help you and your practitioner evaluate the possible role of Dysbiosis in contributing to your health problems. Yet will not provide and automatic "Yes" or "No" answer.

**Note:** *Dysbiosis refers to the condition where the normal healthy population of beneficial bacteria in the intestines had been disrupted, leaving it open to the over growth of yeast, fungi, parasites and potentially harmful strains of bacteria. This intestinal imbalance in turn adversely effects other important systems via toxic stress and interfering with nutrient absorption and utilization.*

**For each "yes" answer in Section A, circle the point score for that question. Total your score and record it in the box at the end of the section. The move to sections B and C and score them as directed.**

**\*Add sections A, B, and C for your Grand Total on the last page.**

**\*Please bring completed questionnaire to your first appointment.**

**\*Take your time and go with your first instinct.**



SECTION A: HISTORY

Score Point

1. Have you taken tetracyclines (Sumycin, Panmycin, Vibramycin, Minocin, etc.) or other antibiotics for skin, acne or anything else for 1 month (or longer)? 25

2. Have you, at any time in your life, taken other "broad spectrum" antibiotics for respiratory, urinary or other infections in shorter courses 4 or more times in a one-year period? 20

3. Have you taken a broad spectrum anti-biotic drug - even a single course? 6

4. Have you, at any time in your life, been bothered by recurrent or persistent prostatitis, vaginitis or other problems affecting your reproductive organs? 25

5. Have you taken birth control pills... For more than 5 years? 25
For more than 2 years? 15
For 6 months to 2 years? 8

6. Have you been pregnant... 2 or more times? 5
One time? 3

7. Have you taken Prednisone, Decadron or other cortisone type drugs... For more than 6 months? 25
For more than 2 weeks? 15
For 2 weeks or less? 6

8. Does exposure to perfumes, insecticides, fabric shop odors and other chemicals provoke... Moderate to severe symptoms? 20
Mild symptoms? 5

List symptoms:

Text input box for listing symptoms

9. Are your symptoms worse on damp, muggy days or in moldy places? 20

List symptoms:

10. Have you had athlete's foot, ring worm, "jock itch" or other chronic fungus infections of the skin or nails? Yes
Have such infections been... No



- Severe or persistent? 20
- Mild to moderate? 10
- 11. Do you crave sugar? 10
- 12. Do you crave breads? 10
- 13. Do you crave alcoholic beverages? 10
- 14. Does tobacco smoke really bother you? 10
- 15. Have you ever had parasitic infection, dysentery or unexplained episode of prolonged diarrhea and or intestinal distress? 15
- 16. Have you ever consumed chlorinated (or chemically treated) drinking water for 3 or more months? 15
- 17. Do you consume commercially raised flesh foods (antibiotic fed) on a regular basis? 15
- 18. Do you eat processed foods regularly? 20
- 19. Do you drink alcohol or consume coffee daily? 20
- 20. Do you have or have you ever had an ulcer, colitis, crohn's disease or diverticulitis? 35

**Total Score, Section A**

**SECTION B: MAJOR SYMPTOMS** If a symptom is occasional or mild, score 3 points  
frequent and/or moderate, score 6 points.  
severe or disabling, score 9 points.

- 1. Fatigue or lethargy 3  6  9
- 2. Feeling of being "drained" 3  6  9
- 3. Poor memory 3  6  9
- 4. Feeling "spacey" or "unreal" 3  6  9
- 5. Depression 3  6  9



- |  |                            |                            |                            |
|--|----------------------------|----------------------------|----------------------------|
| 6. Numbness, burning or tingling                 | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 7. Muscle aches                                  | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 8. Muscle weakness or paralysis                  | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 9. Pain and/or swelling in joints                | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 10. Abdominal pain                               | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 11. Constipation                                 | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 12. Diarrhea                                     | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 13. Bloating                                     | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 14. Troublesome vaginal discharge                | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 15. Persistent vaginal burning or itching        | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 16. Prostatitis                                  | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 17. Impotence                                    | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 18. Loss of sexual desire                        | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 19. Endometriosis                                | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 20. Cramps and/or other menstrual irregularities | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 21. Premenstrual tension                         | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 22. Spots in front of eyes                       | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 23. Erratic vision                               | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |
| 24. Eczema, dermatitis, psoriasis                | 3 <input type="checkbox"/> | 6 <input type="checkbox"/> | 9 <input type="checkbox"/> |

**Total Score, Section B**

**SECTION C: OTHER SYMPTOMS** If a symptom is occasional or mild score 1 point.  
If a symptom is frequent and/or moderately severe score 2 points.  
If a symptom is severe and/or disabling score 3 points.

- |                                |                            |                            |                            |
|--------------------------------|----------------------------|----------------------------|----------------------------|
| 1. Drowsiness                  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 2. Irritability or jitteriness | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 3. In-coordination             | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |



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- |  |                            |                            |                            |
|--|----------------------------|----------------------------|----------------------------|
| 4. Inability to concentrate                                    | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 5. Frequent mood swings  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 6. Headache  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 7. Dizziness/loss of balance                                   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 8. Pressure above ears...feeling of head swelling and tingling | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 9. Itching   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 10. Abdominal pain   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 11. Heartburn  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 12. Indigestion  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 13. Belching and intestinal gas                                | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 14. Mucus in stools  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 15. Hemorrhoids  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 16. Dry mouth  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 17. Rash or blisters in mouth                                  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 18. Bad breath   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 19. Nasal congestion or discharge                              | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 20. Joint swelling or arthritis                                | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 21. Postnasal drip   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 22. Nasal itching  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 23. Sore or dry throat   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 24. Cough  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 25. Pain or tightness in chest                                 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 26. Wheezing or shortness of breath                            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 27. Urgency or urinary frequency                               | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 28. Burning on urination                                       | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 29. Failing vision   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |



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30. Burning or tearing of eyes      1       2       3
31. Recurrent infection or fluid in ears      1       2       3
32. Ear pain or hearing loss      1       2       3

**Total Score, Section C**

**GRAND TOTAL SCORE:**

### Key to Scoring

The grand total score will help you and your practitioner decide if your health problems are dysbiosis related.

Scores in women will run higher as 7 items apply exclusively to women, & 2 to men.

Dysbiosis related health problems are almost certainly present in women with scores over 180, and in men with scores over 140.

Dysbiosis related health problems are probably present in women with scores over 120 and in men with scores over 80.

With scores of less than 60 in women and 40 in men, dysbiosis is unlikely to be contributing to your health challenges.

**Congratulations...**  
**you have completed the Dysbiosis Questionnaire 😊**