health audit

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ACUPUNCTURE

How to use

1. Answer yes to all the true statements. Each yes gets 1 point.
2. Tally up totals in each section. The more points, the more that area needs focus.
3. Put all section scores in the summary table at the bottom.
4. Compare month to month to see what changes occur in your health or if the same problem areas remain the same.

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Energy & Sleep

	Yes = 1 point
I regularly have low energy or afternoon slumps	
I do not have a good balance in life across work/family/friends/rest	
I struggle to fall asleep regularly	
I wake regularly during the night	
I get less than 7-8 hours of sleep regularly	
I feel tired when I wake in the morning	
I still feel tired in the morning even if I have had enough sleep	
I do not exercise regularly	
I don't do any active mindfulness to keep my mind calm	
	Total ___ / 9

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Digestion, Gut Health & Urination

	Yes = 1 point
I lack an appetite in the morning	
I regularly skip meals	
I experience bloating, reflux, wind	
I suffer from constipation regularly	
I regularly have looser stools or diahhroea	
My stools alternate between being on the looser side, then more formed	
What I drink (the input of liquid) does not match what comes out (may be more or less)	
My urine is regularly cloudy or very dark	
I regularly get UTIs	
	Total ___ / 9

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Period / Peri & Menopause

	Yes = 1 point
My period does not come at the same time each month (eg every 30 days)	
I get PMS symptoms every month	
I get blood clots	
I get pain with most or every cycle	
I have a light period	
I have a heavy period	
My blood colour differs from fresh red colour throughout my entire bleed	
When my period starts I feel so much better	
I do not get a regular period	
I experience perimenopausal symptoms	
My period has stopped for 12 consecutive months and I am in Menopause and still get menopausal symptoms	
	Total ___ / 11

Emotions

Do you experience regular or prolonged:	Yes = 1 point
Stress	
Anxiety or excessive worry	
Anger/irritability/impatience	
Grief/sadness/letting go	
Moments of overjoy / then flatness	
Fear or significant sudden fright	
	Total ___ / 6

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Other Symptoms

Do you experience regularly:	Yes = 1 point
Cold hands and feet	
Dizziness / Vertigo	
Brain fog	
Dry skin, hair or nails	
Dry or red eyes, floaters	
Palpitations	
Issues with memory & concentration	
Night sweats or hot flushes	
Feel body temperature is extra cold in general	
Feel body temperature is extra hot in general	
Headaches or migraines	
Areas of body tension or pain	
	Total ___ / 12

SUMMARY TABLE

Add totals in from each section, under the date you audited your health.
Example entry in red

TOTALS	Eg Mar 24	Date:	Date:	Date:	Date:	Date:	Date:
Energy & Sleep	Eg 7 / 9	..... / 9	..... / 9	..... / 9	..... / 9	..... / 9	..... / 9
Digestion, Gut Health & Urination	Eg 7 / 9	...../ 9	...../ 9	...../ 9	...../ 9	...../ 9	...../ 9
Periods, Peri/Menopause	Eg 5/ 11	...../ 11	...../ 11	...../ 11	...../ 11	...../ 11	...../ 11
Emotions	Eg 2 / 6	...../ 6	...../ 6	...../ 6	...../ 6	...../ 6	...../ 6
Other Symptoms	Eg 4 / 12	...../ 12	...../ 12	...../ 12	...../ 12	...../ 12	...../ 12

Enter your monthly problem areas under the relevant date you audited them and track how it changes

Eg. Need to work on Energy & Sleep, Digestion.						

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