

Test Kit Assessment Form

Name: _____

Date: _____

All of the following are muscle testing energies and not diagnostic disease claims.

									<u>Other Areas</u>	<u>Solution</u>
<input type="checkbox"/>	Lyme Mix	Brain _____	Thyroid _____	Heart _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Bartonella Mix	Brain _____	Thyroid _____	Heart _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Babesia Mix	Brain _____	Thyroid _____	Heart _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Mycoplasma Mix	Brain _____	Thyroid _____	Heart _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Ehrlichia Mix	Brain _____	Thyroid _____	Heart _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Virus Mix	Brain _____	Sinuses _____	Lungs _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Mixed Candida	Brain _____	Sinuses _____	Lungs _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Mold/Fungal Toxin	Brain _____	Sinuses _____	Lungs _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Bacteria Mix	Brain _____	Sinuses _____	Lungs _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Cestode	Brain _____	Sinuses _____	Lungs _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Trematode	Brain _____	Sinuses _____	Lungs _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Nematode	Brain _____	Sinuses _____	Lungs _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Stronglyoides	Brain _____	Sinuses _____	Lungs _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Protozoa	Brain _____	Sinuses _____	Lungs _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Sporozoa	Brain _____	Sinuses _____	Lungs _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Ropeworm	Brain _____	Sinuses _____	Lungs _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Ammonia	Brain _____	Thyroid _____	Heart _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Toxic Metals	Brain _____	Thyroid _____	Heart _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Radiation	Brain _____	Thyroid _____	Heart _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Radon	Brain _____	Thyroid _____	Heart _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Pesticide	Brain _____	Thyroid _____	Heart _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Herbicide	Brain _____	Thyroid _____	Heart _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Glyphosate	Brain _____	Thyroid _____	Heart _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Indust/Env Mix	Brain _____	Thyroid _____	Heart _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		
<input type="checkbox"/>	Neg Emotion Mix	Brain _____	Thyroid _____	Heart _____	Liver _____	Sm. Intest. _____	L. Intest. _____	Joints _____		

		Mitochondrial Support:
MG-ATP - Skeletal	_____	Drainage Support:
MG-ATP - Heart	_____	Binder Support:
MG-ATP - Brain	_____	Emotional Support:

Product Dosing Form

Name: _____

Protocol Duration: _____

Products	Dose and Frequency	*Empty	Upon	With	Mid	With	Mid	With	Evening	Bedtime
		Stomach	Rising	Breakfast	Morning	Lunch	Afternoon	Dinner		
Advanced TUDCA	___ capsules ___ per day	<input type="checkbox"/>								
BioToxin Binder	___ capsules ___ per day	<input type="checkbox"/>								
Bowel Mover	___ capsules ___ per day	<input type="checkbox"/>								
Carboxy	___ scoops ___ per day	<input type="checkbox"/>								
Collagen Renew		<input type="checkbox"/>								
CT-Biotic	___ capsules ___ per day	<input type="checkbox"/>								
CT-Iodine	___ capsules ___ per day	<input type="checkbox"/>								
CT-Minerals	___ drops ___ squirts ___ per day	<input type="checkbox"/>								
CT-Zyme	___ capsules ___ per day	<input type="checkbox"/>								
GCO: Gluco Optimizer	___ capsules ___ per day	<input type="checkbox"/>								
HM-ET	___ capsules ___ per day	<input type="checkbox"/>								
HydrOxygen	___ drops ___ per day	<input type="checkbox"/>								
IFC: Inflamma Control	___ capsules ___ per day	<input type="checkbox"/>								
IS-BAB	___ drops ___ squirts ___ per day	<input type="checkbox"/>								
IS-BART	___ drops ___ squirts ___ per day	<input type="checkbox"/>								
IS-BOOST	___ drops ___ squirts ___ per day	<input type="checkbox"/>								
IS-BORR	___ drops ___ squirts ___ per day	<input type="checkbox"/>								
KL Support	___ capsules ___ per day	<input type="checkbox"/>								
LymphActiv	___ capsules ___ per day	<input type="checkbox"/>								
MES	___ drops ___ per day	<input type="checkbox"/>								
MitoATP	___ drops ___ squirts ___ per day	<input type="checkbox"/>								
Para 1	___ capsules ___ per day	<input type="checkbox"/>								
Para 2	___ capsules ___ per day	<input type="checkbox"/>								
Para 3	___ drops ___ squirts ___ per day	<input type="checkbox"/>								
Para 4	___ capsules ___ per day	<input type="checkbox"/>								
ViRadChem	___ capsules ___ per day	<input type="checkbox"/>								
		<input type="checkbox"/>								
		<input type="checkbox"/>								

*Empty Stomach means that this supplement is best taken on an empty stomach which is a minimum of 20-30 minutes before food or 2 hours after a meal