INE INSTITUTE OF NUTRITIONAL ENDOCRINOLOGY

CHANGING LIVES WITH ROOT CAUSE HEALTH CARE

Nutrient Balance Assessment Scorecard

Name:

Point Scale:
0 = **No, Never/Rarely** or almost never
1 = **Mild/Sometimes** experiences/effects
2 = **Moderate/Frequent** experiences/effects
3 = **Yes, Severe/Daily** experiences/effects

Section 1: Essential Fatty Acids	**0**	**1**	**2**	**3**
Do you experience pain relief with aspirin?	0	1	2	3
Do you crave fatty or greasy foods?	0	1	2	3
Do you have a history of following a low or reduced-fat diet? *0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months*	0	1	2	3
Do you experience tension headaches at the base of your skull?	0	1	2	3
Do you get headaches when out in the hot sun?	0	1	2	3
Do you sunburn easily or suffer sun poisoning?	0	1	2	3
Do your muscles easily fatigue?	0	1	2	3
Do you have dry, flaky skin?	0	1	2	3
Do you ever experience "goose flesh/goose bumps"?	0	1	2	3
Do you have ridged, cracked, and/or peeling nails?	0	1	2	3
Do you have magnesium or vitamin B6 deficiencies that don't respond to supplements?	0			3
Do you have dandruff?	0	1	2	3
Do you have areas of inflamed soft tissue?	0	1	2	3
Do you have inflamed joints?	0	1	2	3
Do you have cracks in your heels?	0	1	2	3
Do you have red cuticles?	0	1	2	3
Do you have acne?	0	1	2	3
Do you have breast cysts?	0	1	2	3
Do you suffer from diarrhea?	0	1	2	3
Do you have dry hair?	0	1	2	3
Do you have Eczema?	0	1	2	3
Do you have excess ear wax?	0	1	2	3
Do you have gall stones?	0	1	2	3
Have you experienced hair loss?	0	1	2	3
Do you suffer from any immune impairment?	0	1	2	3
Do you have a history of liver degeneration? *0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months*	0	1	2	3
Do you have a history of infertility?	0			3
Are you prone to poor wound healing?	0	1	2	3
Are you prone to premenstrual syndrome? (males select "0")	0	1	2	3
Do you have sores around your mouth?	0	1	2	3
Do you have dry lips?	0	1	2	3
Do you have split cuticles?	0	1	2	3
Do you ever notice splitting nails?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Essential Fatty Acids (Max 99)				

Section 2: Amino Acids	0	1	2	3
Do you have a history of ADHD? *0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months*	0	1	2	3
Do you ever experience depression?	0	1	2	3
Do you ever experience difficulty building muscle mass?	0	1	2	3
Do you ever experience an inability to concentrate?	0	1	2	3
Do you ever experience insomnia?	0	1	2	3
Do you ever experience a lack of motivation?	0	1	2	3
Do you struggle with any learning disabilities?	0	1	2	3
Do you ever experience mood swings?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Amino Acids (Max 24)				

Section 3: Vitamin A	0	1	2	3
Do you have poor night vision?	0	1	2	3
Do you have "chicken skin" on the backs of your arms?	0	1	2	3
Do you have acne?	0	1	2	3
Do you suffer from dry eyes?	0	1	2	3
Do you have food allergies?	0	1	2	3
Do you notice any loss of appetite?	0	1	2	3
Are you prone to infections and colds?	0	1	2	3
Have you noticed reduced hair growth?	0	1	2	3
Do you have a history of ulcers?	0	1	2	3
Have you experienced any hair loss?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Vitamin A (Max 30)				

Section 4: B Vitamins	0	1	2	3
Do you ever feel an afternoon slump in energy?	0	1	2	3
Do you have cold hands and feet?	0	1	2	3
Do you suffer from chronic fatigue?	0	1	2	3
Do you have issues trying to focus?	0	1	2	3
Do you have "geographic tongue" (discolored regions of taste buds)?	0	1	2	3
Are you prone to moodiness?	0	1	2	3
Do you experience poor digestion?	0	1	2	3
Do you have issues with splitting nails?	0	1	2	3
Are there vertical ridges on your nails?	0	1	2	3
Do you have flaky cuticles?	0	1	2	3
Is there splitting skin in the corners of your mouth?	0	1	2	3
Do you have thin hair?	0	1	2	3
Do you ever have tongue and/or mouth pain?	0	1	2	3
Have you experienced any hair loss?	0	1	2	3
Do you suffer from canker sores?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total B Vitamins (Max 45)				

Section 5: Vitamin B1	0	1	2	3
Do you ever experience anxiety?	0	1	2	3
Do you ever experience depression?	0	1	2	3
Do you ever experience hysteria?	0	1	2	3
Have you noticed a loss of appetite?	0	1	2	3
Do you experience muscle cramps?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Vitamin B1 (Max 15)				

Section 6: Vitamin B2	0	1	2	3
Do you have cracks and sores around your mouth and nose?	0	1	2	3
Do you ever have visual problems?	0	1	2	3
Do you suffer from low energy?	0	1	2	3
Do your eyes tire easily and/or are they sensitive to light?	0	1	2	3
Do you ever have sore lips?	0	1	2	3
Do you have a sensitive tongue?	0	1	2	3
Do you suffer from insomnia?	0	1	2	3
Do you ever experience trembling?	0	1	2	3
D you have itching around your eyes, ears, mouth, scrotum, forehead, and/or scalp?	0	1	2	3
Do you have blood sugar imbalances?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Vitamin B2 (Max 30)				

Section 7: Vitamin B3 (Niacin)	0	1	2	3
Do you have bad breath?	0	1	2	3
Do you ever have canker sores?	0	1	2	3
Do you ever experience confusion?	0	1	2	3
Do you ever experience depression?	0	1	2	3
Do you ever experience dermatitis?	0	1	2	3
Do you ever experience diarrhea?	0	1	2	3
Do you ever experience emotional instability?	0	1	2	3
Do you ever experience fatigue?	0	1	2	3
Do you ever experience irritability?	0	1	2	3
Do you ever experience loss of appetite?	0	1	2	3
Do you ever experience memory impairment?	0	1	2	3
Do you ever experience muscle weakness?	0	1	2	3
Do you ever experience nausea?	0	1	2	3
Do you ever experience skin eruptions and inflammation?	0	1	2	3
Do you ever experience puffy gums?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Vitamin B3 (Max 45)				

Section 8: Vitamin B5 (Pantothenic Acid)	0	1	2	3
Do you ever experience abdominal pains?	0	1	2	3
Do you ever experience burning feet?	0	1	2	3
Do you ever experience gas or constipation?	0	1	2	3
Do you ever experience depression?	0	1	2	3
Do you ever experience Eczema?	0	1	2	3
Do you ever experience fatigue?	0	1	2	3

Section 8: Vitamin B5 (Pantothenic Acid) - continued	0	1	2	3
Have you noticed any hair loss?	0	1	2	3
Do you suffer from any immune impairment?	0	1	2	3
Do you ever experience insomnia?	0	1	2	3
Do you ever experience irritability?	0	1	2	3
Do you have low blood pressure?	0	1	2	3
Do you ever have muscle spasms?	0	1	2	3
Do you ever experience nausea?	0	1	2	3
Do you have seasonal allergies?	0	1	2	3
Do you ever experience "beefy tongue" (reddish lesions outlined in yellow?"	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Vitamin B5 (Max 45)				

Section 9: Vitamin B6	0	1	2	3
Do you have a history of anemia? *0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months*	0	1	2	3
Do you have a history of breast cysts? *0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months*	0	1	2	3
Do you have a history of carpal tunnel syndrome? *0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months*	0	1	2	3
Do you ever experience convulsions?	0	1	2	3
Do you have dandruff?	0	1	2	3
Do you have excess ear wax?	0	1	2	3
Do you ever experience irritability?	0	1	2	3
Do you have patches of itchy, scaling skin?	0	1	2	3
Do you ever experience PMS? (males select "0")	0	1	2	3
Do you ever experience poor dream recall?	0	1	2	3
Do you have stiff fingers in the morning?	0	1	2	3
Do you have water retention in the morning?	0	1	2	3
Do you ever experience "scalloped tongue" (swollen tongue with impression of surrounding teeth of the lower jaw)?	0	1	2	3
Do you have tooth decay?	0	1	2	3
Do you have breaking nails?	0	1	2	3
Do you have an essential fatty acid deficiency that doesn't respond to taking fats?	0	1	2	3
Do you have a magnesium deficiency that doesn't respond to taking magnesium?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Vitamin B6 (Max 51)				

Section 10: Vitamin B7 (Biotin)	0	1	2	3
Do you have dermatitis?	0	1	2	3
Do you have any eye inflammation?	0	1	2	3
Have you experienced any hair loss?	0	1	2	3
Do you ever experience insomnia?	0	1	2	3
Do you ever experience a loss of muscle control?	0	1	2	3
Do you ever experience dry lips?	0	1	2	3
Do you ever experience breaking nails?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Vitamin B7 (Max 21)				

Section 11: Vitamin B9 (Folate)	0	1	2	3
Do you ever experience anemia?	0	1	2	3
Do you ever experience apathy?	0	1	2	3
Do you ever experience diarrhea?	0	1	2	3
Do you ever experience fatigue?	0	1	2	3
Do you ever experience gastrointestinal upsets?	0	1	2	3
Do you ever experience headaches?	0	1	2	3
Have you ever been told you have impaired cell division?	0			3
Do you ever experience insomnia?	0	1	2	3
Do you ever experience loss of appetite?	0	1	2	3
Have you ever been told you had neural tube defects as a fetus?	0			3
Do you ever experience paranoia?	0	1	2	3
Do you ever experience shortness of breath?	0	1	2	3
Do you ever experience weakness?	0	1	2	3
Do you ever experience puffy gums?	0	1	2	3
Do you ever experience your tongue being sore/tender?	0	1	2	3
Do you ever experience canker sores?	0	1	2	3
Do you have "geographic tongue" (discolored regions of taste buds or sometimes even cracks in the surface of the tongue)?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Vitamin B9 (Max 51)				

Section 12: Vitamin B12	0	1	2	3
Do you ever experience your tongue being sore/tender?	0	1	2	3
Do you have "geographic tongue" (discolored regions of taste buds or sometimes even cracks in the surface of the tongue)?	0	1	2	3
Do you have pale skin?	0	1	2	3
Do you ever experience shortness of breath?	0	1	2	3
Do you ever experience fatigue?	0	1	2	3
Do you ever experience dizziness?	0	1	2	3
Do you ever experience headaches?	0	1	2	3
Do you ever experience cold hands and feet?	0	1	2	3
Do you ever experience heart palpitations?	0	1	2	3
Do you ever experience chest pain?	0	1	2	3
Do you ever experience nausea?	0	1	2	3
Do you ever experience vomiting?	0	1	2	3
Do you ever experience heartburn?	0	1	2	3
Do you ever experience abdominal gas?	0	1	2	3
Do you ever experience constipation?	0	1	2	3
Do you ever experience diarrhea?	0	1	2	3
Do you ever experience loss of appetite?	0	1	2	3
Do you ever experience weight loss without trying to lose weight?	0	1	2	3

Section 12: Vitamin B12 - continued	0	1	2	3
Do you ever experience numbness and tingling in the hands and feet?	0	1	2	3
Do you ever experience unsteadiness?	0	1	2	3
Do you ever experience difficulty walking?	0	1	2	3
Do you ever experience confusion?	0	1	2	3
Do you ever experience depression?	0	1	2	3
Do you ever experience hallucinations?	0	1	2	3
Do you ever experience memory loss?	0	1	2	3
Are there vertical ridges on your nails?	0	1	2	3
Do you ever experience bloating?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Vitamin B12 (Max 81)				

Section 13: Vitamin C	0	1	2	3
Do you bruise easily?	0	1	2	3
Do you ever experience hemorrhoids?	0	1	2	3
Do you have a history of joint injuries? *0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months*	0	1	2	3
Do you ever experience muscle weakness? *0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months*	0	1	2	3
Do you ever experience puffy, bleeding, and/or red gums?	0	1	2	3
Do you have varicose veins?	0	1	2	3
Do you have issues with a weakened immune system?	0	1	2	3
Do you ever experience raw and/or bleeding mucus membranes?	0	1	2	3
Do you ever experience spongy and bleeding gums?	0	1	2	3
Do you have varicose veins?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Vitamin C (Max 30)				

Section 14: Vitamin D	0	1	2	3
Do you experience muscle pain?	0	1	2	3
Do you have osteoporosis or osteopenia?	0	1	2	3
How often have you fractured bone?	0	1	2	3
Do you experience depression?	0	1	2	3
Do you experience mood swings?	0	1	2	3
Do you experience sleep disturbances?	0	1	2	3
Do you experience irritable bowel?	0	1	2	3
Do you catch colds or flus easily?	0	1	2	3
Have you been told you have leaky gut?	0			3
Have you been told you have an autoimmune condition?	0			3
Total for Each Column (number of checkmarks x value)				
Total Vitamin D (Max 30)				

Section 15: Vitamin E	0	1	2	3
Do you experience mild anemia?	0	1	2	3
Do you have age spots?	0	1	2	3
Do you have cataracts?	0	1	2	3
Do you experience decreased sex drive?	0	1	2	3
Do you experience infertility?	0	1	2	3
Do you experience numbness or tingling of your extremities, or other neurologic disturbances?	0	1	2	3
Do you have LDL cholesterol?	0	1	2	3
Have you noticed a decline in memory?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Vitamin E (Max 24)				

Section 16: Vitamin K	0	1	2	3
Do you experience blood clotting problems?	0	1	2	3
Do you bruise and or bleed easily?	0	1	2	3
Do you have osteoporosis or osteopenia?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Vitamin K (Max 9)				

Section 17: Calcium	0	1	2	3
Do you ever experience anxiety?	0	1	2	3
Do you have brittle nails?	0	1	2	3
Do you ever experience cramps?	0	1	2	3
Do you ever experience delusions?	0	1	2	3
Do you ever experience depression?	0	1	2	3
Do you ever experience insomnia?	0	1	2	3
Do you ever experience irritability?	0	1	2	3
Do you ever experience nervousness?	0	1	2	3
Do you have a history of Osteoporosis? *0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months*	0	1	2	3
Do you ever experience palpitations?	0	1	2	3
Do you have Periodontal Disease?	0	1	2	3
Do you have Rickets?	0	1	2	3
Do you ever experience a tendency towards headaches?	0	1	2	3
Do you have any tooth decay?	0	1	2	3
Do you ever experience twitches?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Calcium (Max 45)				

Section 18: Chromium	0	1	2	3
Do you have adult-onset diabetes?	0			3
Do you have insulin resistance?	0			3
Do you ever experience anxiety?	0	1	2	3
Do you ever experience fatigue?	0	1	2	3
Do you ever experience irritability or moodiness if a meal is skipped?	0	1	2	3
Do you ever experience hunger shortly after eating?	0	1	2	3

Section 18: Chromium - continued	0	1	2	3
Do you ever experience cravings for sweets?	0	1	2	3
Do you ever experience sudden decreases in energy levels?	0	1	2	3
Do you ever experience sudden and abrupt rises in anxiety?	0	1	2	3
Do you ever experience mood swings?	0	1	2	3
Do you ever experience slow healing after injuries or surgery?	0	1	2	3
Do you have high cholesterol?	0	1	2	3
Do you have high blood pressure?	0	1	2	3
Do you have blood sugar fluctuations?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Chromium (Max 42)				

Section 19: Copper	0	1	2	3
Do you ever experience anemia?	0	1	2	3
Do you ever experience depression?	0	1	2	3
Do you ever experience diarrhea?	0	1	2	3
Do you ever experience fatigue?	0	1	2	3
Are your bones fragile?	0	1	2	3
Have you ever experienced hair loss?	0	1	2	3
Do you have hyperthyroidism?	0			3
Do you ever experience weakness?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Copper (Max 24)				

Section 20: Iodine	0	1	2	3
Were you born with Cretinism (decreased/no thyroid hormone production in a newborn)?	0	1	2	3
Do you ever experience fatigue?	0	1	2	3
Do you have unwanted weight gain?	0	1	2	3
Do you have Hypothyroidism?	0			3
Do you have a history of exposure to radiation?	0	1	2	3
Do you drink tap water?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Iodine (Max 18)				

Section 21: Iron	0	1	2	3
Do you ever experience anemia?	0	1	2	3
Do you have brittle nails?	0	1	2	3
Do you ever experience confusion?	0	1	2	3
Do you ever experience constipation?	0	1	2	3
Do you ever experience depression?	0	1	2	3
Do you ever experience dizziness?	0	1	2	3
Do you ever experience fatigue?	0	1	2	3
Do you ever experience headaches?	0	1	2	3
Do you ever experience having an inflamed tongue?	0	1	2	3
Do you have any mouth lesions?	0	1	2	3
Do you ever experience spooning nails (when the nail curves upwards)?	0	1	2	3
Do you ever experience having pale, blue nails?	0	1	2	3

Total for Each Column (number of checkmarks x value)				
Total Iron (Max 36)				
Section 22: Magnesium	**0**	**1**	**2**	**3**
Do you ever experience anxiety?	0	1	2	3
Do you have breast cysts?	0	1	2	3
Do you ever experience confusion?	0	1	2	3
Do you ever experience constipation?	0	1	2	3
Do you ever experience chronic stress?	0	1	2	3
Do you ever experience cramps?	0	1	2	3
Do you ever experience dandruff?	0	1	2	3
Do you ever experience depression?	0	1	2	3
Do you ever experience excess ear wax?	0	1	2	3
Have you ever had a heart attack?	0			3
Do you ever experience Hyperactivity?	0	1	2	3
Do you ever experience insomnia?	0	1	2	3
Do you ever experience irregular heartbeats?	0	1	2	3
Do you ever experience irritability?	0	1	2	3
Do you have a history of Irritable Bowel Syndrome? *0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months*	0	1	2	3
Do you ever experience muscle weakness and nausea?	0	1	2	3
Do you ever experience nervousness?	0	1	2	3
Do you ever experience noise sensitivity?	0	1	2	3
Do you ever experience PMS? *(males select "0")*	0	1	2	3
Do you ever experience restlessness?	0	1	2	3
Do you ever experience spasms?	0	1	2	3
Do you ever experience twitching?	0	1	2	3
Do you ever experience sores around your mouth?	0	1	2	3
Do you ever experience breaking nails?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Magnesium (Max 72)				
Section 23: Manganese	**0**	**1**	**2**	**3**
Do you have Atherosclerosis?	0			3
Do you ever experience dizziness?	0	1	2	3
Do you have elevated cholesterol levels?	0			3
Do you have sugar intolerance?	0	1	2	3
Do you suffer from hearing loss?	0	1	2	3
Do you ever experience loss of muscle control?	0	1	2	3
Do you ever experience ringing in your ears?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Manganese (Max 21)				

Section 24: Phosphorus	**0**	**1**	**2**	**3**
Do you have a history of Anorexia? *0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months*	0	1	2	3
Do you ever experience bone pain?	0	1	2	3
Do you ever experience weakness?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Phosphorus (Max 9)				

Section 25: Potassium	**0**	**1**	**2**	**3**
Do you have a history of Anorexia? *0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months*	0	1	2	3
Do you ever experience irritability?	0	1	2	3
Do you ever experience muscle cramps?	0	1	2	3
Do you ever experience muscle weakness?	0	1	2	3
Do you ever experience nausea?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Potassium (Max 15)				

Section 26: Zinc	**0**	**1**	**2**	**3**
Do you ever experience acne?	0	1	2	3
Do you ever experience a decreased sense of taste?	0	1	2	3
Do you form scars easily?	0	1	2	3
Do you have a history of Crohn's disease? *0 = never, 1 = years ago, 2 = within last year, 3 = within past 3 months*	0	1	2	3
Are you prone to an over consumption of sweets?	0	1	2	3
Do you ever experience a poor perception of sweet taste?	0	1	2	3
Do you ever experience rashes?	0	1	2	3
Did you experience retarded growth and delayed sexual development as a child?	0			3
Are you prone to slow wound healing?	0	1	2	3
Are you prone to having smelly feet?	0	1	2	3
Do you have a tendency towards infections?	0	1	2	3
Do you have white spots on your fingernails?	0	1	2	3
Do you ever experience puffy gums?	0	1	2	3
Do you ever experience cracked finger tips?	0	1	2	3
Total for Each Column (number of checkmarks x value)				
Total Zinc (Max 42)				

Percent score is calculated by dividing your score by the max score and multiplying by 100. Look up the % score in the chart below to determine priority.

Nutrient	Max Score	Your Score	Your % Score	Priority: 1=low (green) 2=medium (blue) 3=high (yellow) 4=very high (red)
Essential Fatty Acids	99			
Amino Acids	24			
Vitamin A	30			
B Vitamins	45			
Vitamin B1	15			
Vitamin B2	30			
Vitamin B3 (Niacin)	45			
Vitamin B5 (Pantothenic Acid)	45			
Vitamin B6	51			
Vitamin B7 (Biotin)	21			
Vitamin B9 (Folate)	51			
Vitamin B12	81			
Vitamin C	30			
Vitamin D	30			
Vitamin E	24			
Vitamin K	9			
Calcium	45			
Chromium	42			
Copper	24			
Iodine	18			
Iron	36			
Magnesium	72			
Manganese	21			
Phosphorus	9			
Potassium	15			
Zinc	42			

Score Interpretation:

0-10%: Overall good balance. Sound nutrition and healthy habits will maintain good balance.

11-25%: In need of a tune up to restore balance before serious illness sets in. Diet and lifestyle improvements should shift to normal.

26-50%: Your nutrient balance is compromised and likely to significantly affect your state of health, well-being, and energy level.

51-100%: Your nutrient balance is severely compromised and requires immediate attention. Take steps now to restore balance to your health, well-being, and energy level.