Parasite Questionnaire
Para Kit

NAME _____ DATE _____

	Never	Occasionally	Often	Regularly
Do you experience restless sleep (toss or turn, or wake up often)?	0	1	2	3
Do you have acne, eczema, hives, itching, rashes, skin issues?	0	2	4	6
Do you have frequent diarrhea or loose stools?	0	1	2	3
Do you have alternating constipation and diarrhea?	0	1	2	3
Do you have SIBO (small intestinal bacterial overgrowth), or feel bloated or gassy?	0	1	2	3
Do you have bowel urgency or occasional accidents?	0	1	2	3
Do you experience abdominal pains, burning, or cramps?	0	1	2	3
Do you have rectal and/or anal itching?	0	2	4	6
Do you have anal fissures (small, painful tears or cracks)?	0	2	4	6
Do you have stomach or small intestinal ulcers or lesions?	0	1	2	3
Do you grind your teeth when sleeping?	0	2	4	6
Do you pick your nose, or have excess boogers in your nose or scab-like boogers?	0	2	4	6
Do you bite your fingers?	0	2	4	6
Do you have headaches/migraines?	0	1	2	3
Are you irritable for no apparent reason?	0	2	4	6
Do you have a mood disorder, anxiety, depression, or suicidal thoughts?	0	1	2	3
Do you have hyperactive tendencies (nervousness)?	0	1	2	3
Do you have dark circles under your eyes?	0	1	2	3
Do you need extra sleep and wake up unrefreshed?	0	2	4	6
Do you have allergies and/or food sensitivities?	0	1	2	3
Do you get fevers of unknown origin?	0	2	3	4
Do you experience night sweats (not menopausal)?	0	1	2	3
Do you kiss your pets or allow pets to lick your face?	0	1	2	3
Do you sleep with pets on your bed?	0	1	2	4
Do you experience an increase of symptoms around a full moon?	0	2	6	8
Do you have anemia (low iron/hemoglobin on blood test)?	0	1	2	4
Do you have iron deficiency?	0	2	4	6
Do you have vitamin B6 deficiency?	0	2	4	6
Do you have zinc deficiency and/or white spots on nails?	0	2	4	6
Do you have frequent colds, flu, or sore throats?	0	1	2	3

	Never	Occasionally	Often	Regularly
Do you travel in developing nations?	0	2	4	6
Do you eat pork products?	0	1	2	3
Do you eat sushi and raw fish?	0	2	4	6
Do you sleep with pets on the bed?	0	1	2	3
Do you experience bed-wetting?	0	1	2	3
Do you frequently vomit?	0	1	2	3
Do you have a loss of appetite?	0	1	2	6
Are you hungry all the time, bottomless pit, hungry after meals?	0	2	4	6
Do you have strong sugar and processed food cravings?	0	1	2	3
Do you have asthma or breathing problems?	0	2	4	6
Do you have pain in belly button area (umbilicus)?	0	1	2	4
Do you have blurry, unclear vision?	0	1	2	3
Do you have eye floaters?	0	2	4	6
Do you have lethargy and apathy (disinterest)?	0	1	2	3
Do you have menstrual problems?	0	1	2	3
Do you have dry lips?	0	1	2	3
Do you drool while asleep?	0	1	2	3
Do you have occult blood in stool (from lab test)?	0	1	2	3
Do you swim in creeks, lakes, or rivers?	0	2	4	6
Do you have a history of giardia, pinworms, or other parasites?	N	Y	(6)	
Do you work in childcare?	N	Y	(6)	
Do you have a history of or currently have cancer?	N	Y	(20)	

Parasite Infection Total _____

GREEN	YELLOW	RED
0-46	47-96	97-242

Instructions

Rate each of the questions to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number provided next to your answer. Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.