

MY OWN TESTING

Answer the questions in MOT (My Own Testing) and discover your health status. The MOT is designed to evaluate your general health and well-being. Poor health can lead to illness over a period of time. So please take your time to think and make a honest assessment of the symptoms given below.

ENERGY

	Yes	Sometimes	No
Do you have chronic (long term) fatigue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When do you feel most tired?			
When waking up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After lunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from a "jet lag" type of fatigue?			
Tired during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Awake at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel tired in crowded and stuffy places or when you smell wet paint or petrol fumes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get a postnasal drip down your throat? Do you get pain in your forehead or cheeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you sensitive to strong light ? Do the eyelids feel heavy, indicating you are tired? <small>Note: these are common symptoms of fatigue due to congested sinuses, which often cause eye fatigue and drowsiness</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you anemic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you a vegan or strict vegetarian and do not eat any protein of animal origin? (e.g. egg, meat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel tired immediately after eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel tired an hour after eating bread, pizza or other yeast containing products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel tired shortly after drinking white wine or champagne or beer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel tired when you haven't drunk much water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ACHES & PAINS

Do you get general body ache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get pain in other parts of the body?			
In the neck and shoulder area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the lower back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the joints (if yes)			
Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get headache? <small>(Has it been diagnosed as migraine i.e. one sided, periodic, severe in nature accompanied by nausea, sensitivity to sound or light, often around the time of periods)</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get acidity or indigestion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have bloating especially after a meal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get flatulence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get constipation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get alternating diarrhea and constipation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you burp a lot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get abdominal cramps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get pain in the upper part of the abdomen shortly after eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get frequent mouth ulcers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you eat fast?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SLEEP

Do you wake up at 3 or 4 am sharp?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up 2-3 hours after falling sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have sleeplessness over 3 days per week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your daytime performance (concentration, memory, power of decision making, physical stamina) get affected by lack of sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PSYCHOLOGICAL STATE

Do you suffer from depression?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from anxiety or panic attacks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have memory problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SKIN CONDITION

Do you suffer from any skin rash?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get red cheeks or rash on either side of the nose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get fungal toes or athletes foot or alopecia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you itch when you are resting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get dry skin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your feet or soles crack?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get dark patches around your forehead or cheeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from acne?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have patches on the face where beard is missing or growing poorly? (for men)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get thick facial hair? (for women)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

WOMEN'S HEALTH

Are you in reproduction age (13-50 years)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get regular periods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have shorter or longer periods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get severe period pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get periods for more than 7 days and heavy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If in menopause, do you get hot flushes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you infertile?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GENERAL HEALTH

Are you over weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get fat / cellulite in your upper arm or thighs or below the belly bottom? (for women)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you sweat a lot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get swollen fingers and feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you crave for sugar?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you snore loudly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems with libido?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GENERAL HEALTH (following)

Do you get frequent (over 6 times a year) colds or coughs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink less than 4 glasses or 1 liter of water (including tea) per day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol more than 4 times a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink more than 3 glasses of wine or 1 liter of beer at a time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you eat a lot of cheese or mushrooms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink a lot of coffee (more than 3 cups a day)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you eat a lot of yeast containing food stuffs like bread, pizza, yeast spread, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you eat a lot of chilly (hot food) or nuts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you pray or meditate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you spend time in nature or fresh air for less than twice a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a lot of gadgets in your bedroom (computers, music system, TV, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get enough sunshine (more than one day per week) during the year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you travel frequently on planes (more than once a fortnight)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel stressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from raised blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get cold hands and feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get hot and red cheeks in a warm environment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you take a lot of supplements (more than 6 per day) or prescription / medication (more than 3) per day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you exercise more than thrice a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent mood swings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TOTAL*

* 2 points for all the "yes" answers, 1 for "sometimes" answers and 0 for "No" answers.

- Below 80 You don't need to worry. You are overall healthy.
- 80-120 You are in the borderline health category. Its strongly advised to follow The Healthier Younger You Program.
- Over 120 It is recommended than you consult a Functional Medicine Practitioner or your doctor immediately and have blood tests, physical examinations etc.