4 DOCTOR READINESS ASSESSMENT

Name: _____ **Age:** _____

Current Challenge: _____

_____

Please mark each question with a YES or NO as appropriate, then total each column.

Dr. Happiness	Yes	No
1. Do you have an overarching dream/legacy for your life?	0	20
2. Do you have clearly defined goals to achieve your dream?	0	10
3. Do you have a clear definition of what "happiness" is for you?	0	10
4. Do you Love yourself?	0	20
5. Can you look into your own eyes in the mirror and honestly say, "I love you" to yourself?	0	20
6. Do you have clearly defined core values regarding your needs for rest, inner spiritual practice, food, exercise and movement?	0	10
7. Do you need/use any form of stimulants or drugs to feel happy about yourself or your life?	0	10
8. Do you make time for unbound play, art or unstructured activities each day?	0	20
9. If you were to die today, would you die knowing that you have lived fully?	0	20
10. Are you doing what you love to do to make a living?	0	20
Total		

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Please mark each question with a YES or NO as appropriate, then total each column. (Note that there are two questions that pertain to either men or women – only answer those that are appropriate to your gender.)

Dr. Quiet	Yes	No
1. Do you get eight hours of sleep each night?	0	10
2. Do you have your head on the pillow by 10:00pm most nights?	0	5
3. Upon rising, are you "quick" to get with it?	0	5
4. Men: Do you have a healthy erection most mornings?	0	10
5. Men: Is your sexual performance optimal; can you bring a woman to orgasm without losing your erection?	0	10
6. Women: Are you free of menstrual irregularities or vaginal dryness?	0	10
7. Women: Do you have a healthy interest / desire for sex most days?	0	10
8. Do you find yourself able to function well without coffee, tea, chocolate (cacao) or the use of stimulants throughout your day?	0	10
9. Can you work and play throughout your day without feeling the need to sleep/nap?	0	20
10. Do you make adequate time for introspection, self-reflection and spiritual practice each day?	0	10
Total		

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Please mark each question with a YES or NO as appropriate, then total each column.

Dr. Diet	Yes	No
1. Is your diet composed of mostly organic produce (vegetables and fruits)?	0	10
2. Do you eat primarily free-range organic meats?	0	20
3. Do you include wild caught fish in your diet?	0	10
4. Do you eat a variety of foods each day during the week and as the seasons change?	0	10
5. Is your diet composed primarily of unprocessed whole foods?	0	10
6. Do you change how much flesh foods you eat, based on your body-mind needs day-to-day?	0	10
7. Do you eat in a calm quiet atmosphere and taste and thoroughly chew your food?	0	10
8. Do you move at least 12 inches (30cm) of feces daily and feel a sense of complete elimination?	0	10
9. Is your digestion, assimilation and elimination optimal?	0	10
10. Is your skin healthy?	0	10
11. Are you drinking approximately half your bodyweight in ounces of high quality water each day?	0	10
12. Do you feel satiated after eating?	0	10
13. Do you feel energized after eating?	0	10
14. Are you free of food cravings such as chocolate or cacao, sugary treats, grains or fats?	0	10
15. Do your bodily odors (breath, armpits, etc.) smell neutral?	0	10
16. Do your bowl movements have a healthy earthy smell?	0	10
17. Do you tend to eat three meals a day at regular times?	0	10
18. Are your teeth and gums healthy?	0	10
19. Are you rotating your foods and drinks (water not included) so that you are not eating the same basic foods more than once every three to four days?	0	20
20. Is either breakfast or lunch the largest meal of your day?	0	10
Total		

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Please mark each question with a YES or NO as appropriate, then total each column.

Dr. Movement	Yes	No
1. When you take a deep breath, does your belly expand before your chest moves?	0	10
2. Do you get at minimum of 30 minutes of exercise each day?	0	10
3. Can you exercise regardless of current body and movement challenges?	0	10
4. Do you consider yourself at optimal weight and body fat for your body?	0	10
5. Is your metabolism functioning optimally?	0	20
6. Co you easily put on muscle mass/strength with resistance exercise?	0	10
7. Do you consider yourself emotionally stable?	0	10
8. Can you maintain mental focus easily and naturally?	0	10
9. Do you stretch and mobilize your body to maintain structural balance and energy flow regularly?	0	10
10. Does your body look and feel younger than your actual age?	0	10
11. Is your body-mind healthy and fit enough to effectively support the creation of your dreams?	0	10
12. Can you exercise easily without the use of stimulants or performance enhancements?	0	10
13. Do you find that your thoughts and beliefs support your overarching dreams and goals?	0	10
14. Do you warm up quickly and feel good and fully functional to begin exercise?	0	10
Total		

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4 DOCTOR SCORE GRAPH

Please write your scores from the individual 4 Doctor questionnaires into the corresponding column on the bottom row. Now place a mark on the column corresponding to your score. Then add all four totals together and write this total in the bottom of the 4 Doctor Total column and place a mark on this column equal to your overall score.

Suggested Use of Exercise	4 Doctor Total	Dr Happi-ness	Dr. Quiet	Dr. Diet	Dr. Move-ment
Work-In	650	150	110	230	150
	580	140	100	200	140
	510	130	90	180	120
	410	100	80	130	100
	310	70	70	100	70
Caution In – Out Balance?	280	60	60	90	60
	250	-	-	80	-
	240	-	50	70	-
	230	-	-	60	-
	200	50	40	50	50
Workout To Ability	150	40	30	40	40
	100	30	20	30	30
	80	20	-	20	20
	60	10	10	10	10
	40	0	0	0	0
Your Totals					

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4 DOCTOR PROBLEM SOLVING

(Nutrition - Hydration - Sleep - Thinking - Breathing - Movement)

Work In? ~ Work Out?

Name: _____ **Date:** _____

Dr. Quiet +/-

My Dream / Goal:

Dr. Happiness +/-

1.
2.
3.
4.
5.

Issue:

1.
2.
3.
4.
5.

Dr. Diet +/-

1.
2.
3.
4.
5.

Dr. Movement +/-

1.
2.
3.
4.
5.

Notes:

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