ELIMINATION PATHWAYS SELF-ASSESSMENT

The body's elimination pathways, including the Bowels, Liver, Gallbladder/Bile, Lymphatic system, Lungs, Kidneys, and Skin, play a vital role in maintaining our overall health. This questionnaire is designed to help you evaluate the health of these pathways.

Be sure to revisit this self-assessment regularly, ideally every few weeks, to monitor any changes and shifts in your elimination pathways.

How It Works

Select YES or NO to the questions below.

If you answered 'YES' to 2 or more questions related to a particular pathway, it may be an indicator that this pathway could benefit from additional support and attention.

BOWELS/COLON:

		YES	NO
01	Do you have more or less than 1 to 3 easy to pass, well-formed bowel movements per day?	☐	☐
02	Are your stools regularly loose and/or hard and difficult to pass?	☐	☐
03	Do you regularly experience abdominal pain or cramps?	☐	☐
04	Do you regularly feel bloated/distended or gassy?	☐	☐
05	Do you have a history of parasites?	☐	☐

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LIVER:

		YES	NO
01	Are you easily intoxicated or hung over if you drink alcohol?	☐	☐
02	Does caffeine or drinking coffee make you anxious or lightheaded?	☐	☐
03	Do you have haemorrhoids or varicose veins?	☐	☐
04	Are you sensitive to tobacco smoke and chemicals (perfume, cleaning agents, etc)	☐	☐
05	Do you regularly experience nausea and headaches?	☐	☐
06	Do you have unresolved anger?	☐	☐

GALLBLADDER/BILE:

		YES	NO
01	Do you experience pain between your shoulder blades?	☐	☐
02	Does eating fried and greasy foods upset your stomach?	☐	☐
03	Are your stools greasy or shiny? Do they float?	☐	☐
04	Do you experience pain under the right side of your rib cage?	☐	☐
05	Do you experience a bitter taste in your mouth, especially after meals?	☐	☐
06	Has your gallbladder been removed?	☐	☐

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LYMPHATIC SYSTEM:

		YES	NO
01	Do you frequently experience swollen lymph nodes, particularly without an apparent infection or illness?	☐	☐
02	Are you prone to unexplained or chronic swelling, especially in the extremities (arms, legs)?	☐	☐
03	Have you noticed persistent skin conditions or rashes that don't seem to improve with treatment?	☐	☐
04	Are you experiencing frequent infections, particularly respiratory or sinus infections?	☐	☐
05	Do you often feel fatigued or suffer from unexplained aches and pains?	☐	☐

LUNGS/RESPIRATORY TRACT:

		YES	NO
01	Do you frequently experience shortness of breath, even during light physical activities or at rest?	☐	☐
02	Are you prone to persistent coughing or wheezing, especially when not associated with a known respiratory infection or allergy?	☐	☐
03	Have you noticed a reduction in your ability to engage in physical activities or exercises due to breathing difficulties?	☐	☐
04	Are you experiencing unexplained chest pain or discomfort, or have you been diagnosed with a lung condition like asthma or chronic obstructive pulmonary disease (COPD)?	☐	☐
05	Do you have a history of smoking or exposure to environmental toxins such as mold & mycotoxins that could affect lung health?	☐	☐
06	Do you breathe from your mouth?	☐	☐
07	Do you have unresolved sadness or grief?	☐	☐

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KIDNEYS/URINARY TRACT:

01	Do you drink enough water daily? (about half of your bodyweight (in pounds) in ounces. For example, 100 lb person should drink ~ 50oz of water. 1kg = 2.2 lbs and 1 oz = 30mL)	YES ☐	NO ☐
02	Do you notice increased or decreased urinary frequency, pain during urination, a noticeable change in urine color or odor, or foam in the urine?	YES ☐	NO ☐
03	Do you experience the feeling of incomplete emptying?	YES ☐	NO ☐
04	Are you aware of any history of urinary tract infections (UTIs), kidney stones, or other urinary tract conditions?	YES ☐	NO ☐
05	Do you experience any lower back pain, lower abdominal or pelvic pain?	YES ☐	NO ☐
06	Do you live in fear and don't feel safe?	YES ☐	NO ☐

SKIN:

01	Do you sweat easily with physical activity?	YES ☐	NO ☐
02	Are you prone to persistent coughing or wheezing, especially when not associated with a known respiratory infection or allergy?	YES ☐	NO ☐
03	Do you experience excessive sweating, particularly in situations when others do not seem to sweat as much?	YES ☐	NO ☐
04	Are you prone to skin issues like acne, eczema, or other persistent skin conditions?	YES ☐	NO ☐
05	Do you notice unusual body odor that isn't related to your hygiene or diet?	YES ☐	NO ☐
06	Do you have sensitive skin to certain chemicals, environmental toxins, or specific skincare products?	YES ☐	NO ☐

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