

Radioactive Elements Questionnaire

RAD Support Protocol



	Never	Occasionally	Often	Regularly
Do you have a history of or currently have cancer?	N	Y	20	
Do you have a suppressed immune system?	N	Y	6	
Do you have osteoporosis or an osteopenia diagnosis?	N	Y	6	
Are you unable to clear infections, despite following pathogen protocols?	N	Y	6	
Do you have a chronic candida infection?	0	2	4	6
Do you experience fatigue?	0	2	4	6
Do you have anemia?	0	2	4	6
Do you experience skin reactions(dry, red, itchy, or color changes)?	0	1	2	3
Do you struggle with hair loss?	0	2	4	6
Do you have a loss of appetite?	0	1	2	3
Do you experience nausea and vomiting?	0	1	2	3
Do you have a low blood cell count?	0	1	2	3
Do you have seizures?	0	1	2	3
Do you get earaches or have difficulty hearing?	0	1	2	3
Do you have hormone problems?	0	1	2	3
Do you have a sore or dry mouth?	0	1	2	3
Does your sense of taste change?	0	1	2	3
Do you have difficulty swallowing?	0	2	4	6
Do you experience voice changes or hoarseness?	0	1	2	3
Do you get dry eyes?	0	1	2	3
Do you get a stiff jaw?	0	1	2	3
Do you have tooth decay?	0	1	2	3
Do you experience soreness or swelling of the breast?	0	1	2	3
Do you have an irregular heartbeat?	0	2	4	6
Do you experience heart palpitations?	0	1	2	3
Do you get stomach ulcers?	0	2	4	6
Do you have kidney problems?	0	1	2	3
Do you get bladder infections (cystitis)?	0	2	4	6
Do you feel burning or pain during urination?	0	1	2	3
Do you experience loss of bladder control?	0	1	2	3
Do you have fertility problems?	0	1	2	3
Do you experience sexual problems (both male and female)?	0	1	2	3

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.

Radioactive Elements Total

GREEN	YELLOW	RED
0-16	17-40	41-146