CONFIDENTIAL

# 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 feel happy about yourself and your life without needing to use or take any form of stimulants or drugs? | 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** | | |

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 or 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** | | |

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 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 bowel 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** | | |

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 a 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. Do 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** | | |

# 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 Happiness | Dr. Quiet | Dr. Diet | Dr. Movement |
|---|---|---|---|---|---|
| **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** | | | | | |