



HAVE YOU
GOT THE GUTS
TO BE REALLY
HEALTHY?

DON CHISHOLM

Audio Workbook

INTRODUCTION

*Thank you for purchasing the audio version of **Have You Got The Guts To Be Really Healthy?** by Don Chisholm. To enhance your learning and audio experience this mini workbook contains activities that correspond with the topics in the audio.*

THE HEALTH SCALE

Before listening to the audio, it is a good idea to have a look at the *Health Scale* on page 3. The concept is to see where you actually sit on the health chart now, and then try to imagine what it would be like if you moved one or two rungs higher up the chart. Then listen to the audio and see what changes you could implement to make your life an improvement on what it is today.

STRESS AND NO STRESS CHART

What side of the chart do you mostly live in? The concept on page 6 is to illustrate the benefits of living with less stress.

SELF-CHECK QUESTIONNAIRE

Before reading or starting any programs, why not fill out where you are today on the *Self-Check Questionnaire* on page 4. We have found it invaluable for anyone

looking to monitor their progress. By spending 15 minutes at the end of each month filling out the questionnaire you can monitor what areas are working and what is lagging behind. We've included a second copy for you to fill out after 30 days from starting a new health product or regime.

If a certain area does not improve, then that can become a focal point instead of simply guessing what to do next. Having a plan does work, but you need to know what plan to take. Hopefully you will find the truth to your own situation as you listen to the audio.

PERSONAL JOURNEY

Page 7 is for you to take notes as you listen. Note down which ideas and concepts resonate with you, keep all these ideas as a starting point for your own health research and discoveries.

THE HEALTH SCALE

Where do you fit on the health scale below? Answer as honestly as you can so you can get the most out of this book. Remember, you are attempting to define how you feel most of the time, not when you are at your peak.

Vital	Only need 4 hours sleep and can work an 18 hour day; tire but never get exhausted. Physically and mentally vital.
Really Healthy	Just loving life and all it offers; full of zest with only 6 hours sleep. Can work a long day with good memory and a sense of wellbeing.
Healthy	Eat well; fit; feel good most of the time. Wake up fresh on 8 hours sleep. Exercise regularly.
OK	Feel OK, just get a bit tired in the afternoon; that extra coffee helps. Could exercise more. Reasonably active.
Just OK	Feel OK some of the time, but then get a little sluggish. Bowel movement could improve. Not that active.
Sluggish	Don't feel too bad, but a bit sluggish; takes a lot to get going.
Very Sluggish	Hard to get started; days take forever; drained most of the time.
Poor	Life is a struggle; living in a brain fog.
Very Poor	Catch everything going around, feel uncomfortable and depressed. Use medication.
Extremely Poor	Need medication on a continual basis.
Seriously Ill	Medications and tests are on the increase; conditions are worsening.
Terminally Ill	Disease has reached a stage of no return; it's only a matter of time before death takes over.

SELF-CHECK QUESTIONNAIRE

DAY 1

Rate your symptoms on a scale of 10 (extreme) down to 1 (minimal).
Place your score in the right hand column and add up your total.

DATE / /

SYMPTOM	SCALE											SCORE	
		10	9	8	7	6	5	4	3	2	1		
TIRE D	Extremely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Never	<input type="text"/>
TEMPERAMENT	Racy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Calm	<input type="text"/>
A LITTLE SNAPPY	Very Bad Tempered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Placid	<input type="text"/>
A LITTLE EMOTIONAL	Highly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Balanced	<input type="text"/>
FOOD DOESN'T DIGEST	Uncomfortable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No Problem	<input type="text"/>
SHORT TERM MEMORY	Forget Easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Great Memory	<input type="text"/>
SUGAR CRAVINGS	Love Sweets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Don't Need Sugar	<input type="text"/>
LIBIDO	Very Low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High	<input type="text"/>
COLD HANDS OR FEET	Very Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Normal	<input type="text"/>
FEELING OF HOPELESSNESS	Depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Life is Good	<input type="text"/>
MIGRAINES	Extreme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No Headaches	<input type="text"/>
THRUSH	Frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Never	<input type="text"/>
BOWEL MOVEMENTS	Irregular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent/Normal	<input type="text"/>
CONSTIPATION	10 Days Apart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Every Day	<input type="text"/>
WEIGHT	Need to Lose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slim	<input type="text"/>
APPETITE	Always Snacking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Never Hungry	<input type="text"/>
ACNE	Extreme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nil	<input type="text"/>
VOICE	Very Deep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soft	<input type="text"/>
HIGHLY STRUNG	Volatile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Calm	<input type="text"/>
IRRITABLE BOWEL SYNDROME	Bad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No	<input type="text"/>
SLEEP PATTERNS	Poor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Very Good	<input type="text"/>
NUMBER OF HOURS OF SLEEP	10 or More	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 to 8	<input type="text"/>
RESTLESS LEGS	Often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Never	<input type="text"/>
LOWER BACK PAIN	Extreme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Never	<input type="text"/>
WIND / BLOATING	Often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Never	<input type="text"/>
YOUR PERSONAL CONDITION		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="text"/>
	Extreme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Minimal	<input type="text"/>
OTHER		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="text"/>
	Extreme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Minimal	<input type="text"/>

SUPPORT
Phone Mon to Fri (07) 554 66 086
Email info@probioticfoods.com.au

**CURRENT
WEIGHT**

**SCORE
TOTAL**

SELF-CHECK QUESTIONNAIRE

DAY 30

Rate your symptoms on a scale of 10 (extreme) down to 1 (minimal).
Place your score in the right hand column and add up your total.

DATE / /

SYMPTOM	SCALE											SCORE	
		10	9	8	7	6	5	4	3	2	1		
TIRED	Extremely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Never	<input type="text"/>
TEMPERAMENT	Racy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Calm	<input type="text"/>
A LITTLE SNAPPY	Very Bad Tempered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Placid	<input type="text"/>
A LITTLE EMOTIONAL	Highly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Balanced	<input type="text"/>
FOOD DOESN'T DIGEST	Uncomfortable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No Problem	<input type="text"/>
SHORT TERM MEMORY	Forget Easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Great Memory	<input type="text"/>
SUGAR CRAVINGS	Love Sweets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Don't Need Sugar	<input type="text"/>
LIBIDO	Very Low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High	<input type="text"/>
COLD HANDS OR FEET	Very Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Normal	<input type="text"/>
FEELING OF HOPELESSNESS	Depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Life is Good	<input type="text"/>
MIGRAINES	Extreme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No Headaches	<input type="text"/>
THRUSH	Frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Never	<input type="text"/>
BOWEL MOVEMENTS	Irregular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent/Normal	<input type="text"/>
CONSTIPATION	10 Days Apart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Every Day	<input type="text"/>
WEIGHT	Need to Lose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slim	<input type="text"/>
APPETITE	Always Snacking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Never Hungry	<input type="text"/>
ACNE	Extreme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nil	<input type="text"/>
VOICE	Very Deep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soft	<input type="text"/>
HIGHLY STRUNG	Volatile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Calm	<input type="text"/>
IRRITABLE BOWEL SYNDROME	Bad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No	<input type="text"/>
SLEEP PATTERNS	Poor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Very Good	<input type="text"/>
NUMBER OF HOURS OF SLEEP	10 or More	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 to 8	<input type="text"/>
RESTLESS LEGS	Often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Never	<input type="text"/>
LOWER BACK PAIN	Extreme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Never	<input type="text"/>
WIND / BLOATING	Often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Never	<input type="text"/>
YOUR PERSONAL CONDITION		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="text"/>
	Extreme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Minimal	<input type="text"/>
OTHER		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="text"/>
	Extreme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Minimal	<input type="text"/>

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**CURRENT
WEIGHT**

**SCORE
TOTAL**

STRESS OR NO STRESS

The Fight or Flight response is helpful in crisis situations which threaten human survival. However, today, we are seldom in such situations—at least not on a daily basis. Yet, our Fight or Flight instincts are still in us. Why? Because of one main trigger: stress.

STRESS

Fight or Flight Response

Sympathetic

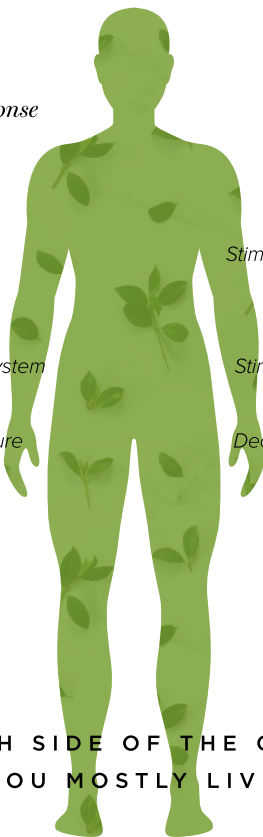
*Stimulates cortisol
Insomnia
Suppresses saliva
Suppresses immune system
Speeds up heartbeat
Increases blood pressure
Suppress digestion
Secretes adrenaline
Cold, clammy hands
Cause constipation
Causes tremors
Raises blood sugar*

NO STRESS

Relaxation Response

Parasympathetic

*Stimulates growth hormone
Deep sleep
Secretes saliva
Stimulates immune system
Slows heart rate
Decreases blood pressure
Improves digestion
Reduces adrenaline
Warm, dry hands
Favours regularity
Relaxes muscles
Lowers blood sugar*



**WHICH SIDE OF THE CHART
DO YOU MOSTLY LIVE IN?**

YOUR JOURNEY

EDUCATION IS KEY

There is a myriad of resources—websites, literature and products at your fingertips, but it is important to remember these words—*do not believe everything you hear*. If you find a comment far-fetched, astonishing or you simply don't believe it, don't necessarily write it off. At the very least conduct a quick Google search to see if the comment has value. Often we dismiss the very thing that could assist us because it is not in our belief system. Over the years I have had to challenge many issues because I couldn't see how they could be anywhere near the truth. In that process I discovered even more and much of what I have learned is in this audio book.

Enjoy the audio and to enhance your learning even more, challenge my comments. Because what you discover might just be life saving for yourself or someone close to you.

I have never seen a condition that cannot be improved, and if it can be improved, could it be cured?



To enhance your learning and audio experience this mini workbook contains activities that correspond with the topics in the audio.



Don Chisholm

T. (07) 554 92 554

E. don@donchisholm.com.au

 /donchisholmevents

WWW.DONCHISHOLM.COM.AU