TAKE THE QUIZ!

The Metabolic Approach to Cancer

Integrating Deep Nutrition, the Ketogenic Diet, and Nontoxic Bio-Individualized Therapies

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Jess Higgins Kelley, MNT

Foreword by Kelly Turner, author of Radical Remission

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TABLE 2.1. GENETICS AND EPIGENETICS

Question	Yes	No
1. Have you tested positive for *BRCA1* and/or *BRCA2*?	Yes	No
2. Have you tested positive for any other type of gene mutation, including: *EPCAM*, *MLH1*, *MSH2*, *MSH6*, *PMS2*, *RB*, or *TP53*? If you don't know, circle "No"	Yes	No
3. Are you either heterozygous or homozygous for a *MTHFR* mutation?	Yes	No
4. Are you heterozygous or homozygous for a *VDR*, *COMT*, and/or *CYP1B1* mutation?	Yes	No
5. Do you have a family history of cancer?	Yes	No
6. Were your grandparents affected by the Great Depression, or any other type of famine, natural disaster, or major stressful period?	Yes	No
7. Were your parents exposed to large amount of stress and/or environmental toxins?	Yes	No
8. Did your mother smoke or take any types of drugs or medications while she was pregnant with you?	Yes	No
9. Did you experience any type of trauma in your childhood?	Yes	No
10. Are you on any pharmaceutical drugs, including over-the-counter medications?	Yes	No
Total number of "Yes" answers		

If you scored highest in this section, please focus on chapter 3.

TABLE 2.2. BLOOD SUGAR BALANCE

Question		
1. Do you have a sweet tooth?	Yes	No
2. Do you find it difficult to fall asleep without an evening or late-night snack, and/or awaken hungry during the night?	Yes	No
3. Do you get "hangry" (irritable because of hunger) if meals are skipped or delayed?	Yes	No
4. Do you regularly skip breakfast?	Yes	No
5. Are sugar-based foods (e.g., candy, cookies, cake, soda, bread, waffles) what you crave the most, and/or consider your "comfort foods"?	Yes	No
6. Do you consume more than 25 grams of added sugar a day (more than one soda, candy bar, or flavored yogurt)?	Yes	No
7. Is your body-fat content over 25 percent?	Yes	No
8. Do you feel tired or crave sugar after a meal?	Yes	No
9. Do you or any family member have a history or diagnosis of metabolic syndrome, hypoglycemia, prediabetes, insulin resistance, polycystic ovarian syndrome (PCOS), pancreatitis, pancreatic cancer, or type 1 or 2 diabetes?	Yes	No
10. Do you consume alcoholic beverages more than 3 times a week?	Yes	No
Total number of "Yes" answers		

If you scored highest in this section, please focus on chapter 4.

TABLE 2.3. TOXIC BURDEN

1. Do you currently live (or were you raised) near a toxic waste or factory site, military base, industrial complex, agricultural area, or airport?	Yes	No
2. Do you have any known environmental sensitivities, such as to odors like perfume or diesel fuel?	Yes	No
3. In total, do you use a microwave, cell phone, or laptop computer more than 3 hours a day?	Yes	No
4. Do you use pesticides or herbicides in or around your home or garden or on your pets?	Yes	No
5. Do you use any nonorganic body care or household cleaning products (e.g., shampoo or laundry detergent) and/or have your hair professionally dyed?	Yes	No
6. Do you have your clothes dry-cleaned, use nonstick cookware, drink unfiltered water, or either drink from or store food in plastic containers?	Yes	No
7. Do you have a history of first-, second-, or thirdhand cigarette smoke exposure?	Yes	No
8. Do you have any mercury fillings, work in the dental industry, eat fish more than 3 times a week, and/or have you ever been exposed to heavy metals, including lead?	Yes	No
9. Do you have an occupational history with known exposure to toxic chemicals, such as asbestos or heavy metals?	Yes	No
10. Do you find it difficult to sweat?	Yes	No
Total number of “Yes” answers		

If you scored highest in this section, please focus on chapter 5.

TABLE 2.4. MICROBIOME AND DIGESTIVE FUNCTION

Question		
1. Were you born via cesarean delivery?	Yes	No
2. Were you fed infant formula before the age of 1 year?	Yes	No
3. Have you ever, or do you now, use hand sanitizer and/or antimicrobial soap?	Yes	No
4. Have you been diagnosed with small intestine bacterial overgrowth (SIBO), ulcerative colitis, Crohn's disease, or colon cancer? Or do you have digestive symptoms such as gas, bloating, diarrhea, or constipation?	Yes	No
5. In your lifetime have you ever taken more than one course of antibiotics? Or have you ever completed the recommended prep for a colonoscopy? *(Answer yes if either is true.)*	Yes	No
6. Do you eat nonorganic meat and/or dairy products?	Yes	No
7. Have you had chemotherapy?	Yes	No
8. Do you take nonsteroidal anti-inflammatory drugs (NSAIDs)—such as acetaminophen (Tylenol), aspirin, or ibuprofen (Motrin or Advil)—or antacids more than a couple of times a year?	Yes	No
9. Do you typically eat fewer than 6 servings of different vegetables a day?	Yes	No
10. Do you eat processed, nonorganic grains such as pasta, bread, or cookies more than once a month?	Yes	No
Total number of "Yes" answers		

If you scored highest in this section, please focus on chapter 6.

TABLE 2.5. IMMUNE FUNCTION

Question		
1. Have you been told that your vitamin D level is below 50 ng/mL?	Yes	No
2. Do you have a personal or family history of any autoimmune disease such as rheumatoid arthritis?	Yes	No
3. Do you use over-the-counter medications to suppress a fever?	Yes	No
4. Do you have a history of any of the following: Epstein-Barr virus (can cause infectious mononucleosis); human papillomavirus (HPV); cytomegalovirus (CMV); a sexually transmitted infection (STI or STD); herpes zoster (shingles); Lyme disease; yeast infection; or infection with a parasite?	Yes	No
5. Is either of the following true: (1) You are *never* sick, or (2) you catch every cold and flu that comes your way?	Yes	No
6. Do you have allergies (i.e., seasonal allergies, asthma, hives, and/or allergies to certain foods)?	Yes	No
7. Have you been diagnosed with celiac disease or gluten intolerance?	Yes	No
8. Have you ever received any vaccinations (including against seasonal influenza or herpes zoster, and vaccines needed for travel), or been prescribed any type of immunotherapies?	Yes	No
9. Have you ever taken steroids?	Yes	No
10. Do any children younger than 5 years live in your house? And/or do you work in a school, hospital, or medical setting?	Yes	No
Total number of “Yes” answers		

If you scored highest in this section, please focus on chapter 7.

TABLE 2.6. INFLAMMATION

Question		
1. Do you have a history of eczema, psoriasis, acne, flushing, or rashes?	Yes	No
2. Have you ever been diagnosed with arthritis, or do you suspect that you have it?	Yes	No
3. Do you have any physical pain patterns, including back or hip pain, that is either constant or intermittent?	Yes	No
4. Do you have inflammatory bowel disease (i.e., Crohn's disease or ulcerative colitis)?	Yes	No
5. Do you ever eat fried or fast foods?	Yes	No
6. Do you have any known food allergies or do you experience gastric reflux?	Yes	No
7. Do you rely on NSAIDs for pain management?	Yes	No
8. Have you ever or do you now experience high amounts of stress?	Yes	No
9. Do you engage in high-intensity exercise more than 5 days a week?	Yes	No
10. Are you overweight, do you consume alcohol, and/or do you eat fewer than 6 different vegetables a day?	Yes	No
Total number of "Yes" answers		

If you scored highest in this section, please focus on chapter 8.

TABLE 2.7. BLOOD CIRCULATION AND ANGIOGENESIS

1. Do you bruise easily?	Yes	No
2. Have you ever been diagnosed with a clotting disorder?	Yes	No
3. Have you ever been diagnosed with hemochromatosis or elevated ferritin level (high iron storage)?	Yes	No
4. Do you have a history of deep vein thrombosis (DVT)?	Yes	No
5. Do you have a history of pulmonary embolism (PE)?	Yes	No
6. Do you have high or low blood pressure?	Yes	No
7. Do you drink less than 2 quarts of water a day?	Yes	No
8. Do you take any pharmaceutical anticoagulants (e.g., warfarin [Coumadin] or enoxaparin [Lovenox])?	Yes	No
9. Are you on medication to control your blood pressure? And/or do you take a daily aspirin?	Yes	No
10. Do you exercise less than 30 minutes 3 times a week?	Yes	No
Total number of “Yes” answers		

If you scored highest in this section, please focus on chapter 9.

TABLE 2.8. HORMONE BALANCE

Question		
1. Do you have a history of birth control pills, bioidentical or standard hormone replacement therapy, steroid use, fertility treatments, and/or hormone blockade therapies?	Yes	No
2. (Women) Do you have a history of premenstrual syndrome (PMS), irregular cycles, fibrous breasts, and/or menopausal symptoms?	Yes	No
3. (Men) Have you had a change in sexual function and/or been diagnosed with erectile dysfunction?	Yes	No
4. Do you have a low libido (sex drive)?	Yes	No
5. Do you have a history of fertility problems, including miscarriage?	Yes	No
6. Have you ever been diagnosed with a thyroid disorder?	Yes	No
7. Have you ever been diagnosed with adrenal fatigue and/or low cortisol levels?	Yes	No
8. Do you experience weight fluctuations of more than 10 pounds on a regular basis?	Yes	No
9. Do you handle store receipts, drink out of plastic bottles, have exposure to paraben-containing products, or eat nonorganic animal protein more than once a month?	Yes	No
10. Do you now or have you ever followed a low-fat diet?	Yes	No
Total number of “Yes” answers		

If you scored highest in this section, please focus on chapter 10.

TABLE 2.9. STRESS AND BIORHYTHMS

Question		
1. Did any of your symptoms or lab results worsen after a stressful period? And/or, if you have a cancer diagnosis, was the diagnosis made following a stressful period?	Yes	No
2. Are you a night owl? And/or have you ever had a job working at night or caring for a small child who kept you up late?	Yes	No
3. Do you often travel back and forth across many time zones?	Yes	No
4. Are there lights on while you sleep during the night (e.g., streetlights or a TV)?	Yes	No
5. Do you feel you are you easily fatigued?	Yes	No
6. Do you often crave salt?	Yes	No
7. Do you sleep fewer than 8 hours a night and/or go to bed after 11 p.m.?	Yes	No
8. Do you have screen time (i.e., watch TV or use an electronic device) after 5 p.m.?	Yes	No
9. Do you spend less than 15 minutes outdoors every day?	Yes	No
10. Do you feel that you experience high levels of stress every day?	Yes	No
Total number of “Yes” answers		

If you scored highest in this section, please focus on chapter 11.

TABLE 2.10. MENTAL AND EMOTIONAL HEALTH

Question		
1. Do you experience irritability, mood swings, and/or unstable emotions?	Yes	No
2. Have you been diagnosed with a mental disorder (e.g., bipolar disorder, depression, anxiety)?	Yes	No
3. Are you easily offended?	Yes	No
4. Are you sensitive to other people's energy and reactions?	Yes	No
5. Do you ever experience racing, repetitive thoughts?	Yes	No
6. Do you find it difficult to speak your truth in certain situations?	Yes	No
7. Have you ever used drugs or alcohol, sex, shopping, TV, gambling, gaming, or time on the internet to self-medicate?	Yes	No
8. Do you feel that you lack a good support system (e.g., supportive spouse, friends, and/or spiritual community?)	Yes	No
9. Do you feel you lack purpose?	Yes	No
10. Do you find it difficult to feel gratitude and joy?	Yes	No
Total number of "Yes" answers		

If you scored highest in this section, please focus on chapter 12.