

Diagnos-Techs, Inc.

Clinical & Research Laboratory
 PO BOX 389662, Tukwila, WA 98138-0662
 Tel: (425) 251-0596
 CLIA License # 50D0630141

Accession # 06-92144

Received : 11/11/2006
 Completed: 11/16/2006
 Reported : 11/16/2006

NATURAL CHOICES HEALTH CLINIC
 KIM
 12270 SW 2ND ST

BEAVERTON OR 97005
 USA Tel: 1(503)520-8859 Fax: 1(503)627-0919

Results For:

ANNA

Age: 54

Gender: Female

Patient's Tel:

Specimen Collected: 11/07/2006

Test	Description	Result	Ref Values
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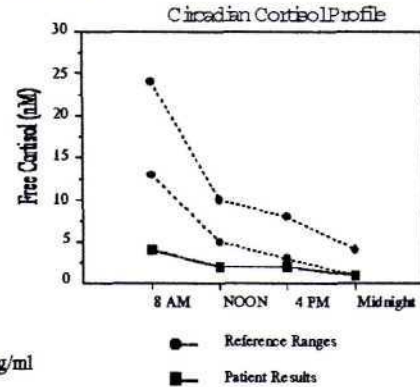
NLASI CUSTOM ASI

TAP Free Cortisol Rhythm

07:00 - 08:00 AM	4	Depressed	13-24 nM
11:00 - Noon	2	Depressed	5-10 nM
04:00 - 05:00 PM	2	Depressed	3-8 nM
11:00 - Midnight	1	Normal	1-4 nM
Cortisol Burden:	9		23 - 42

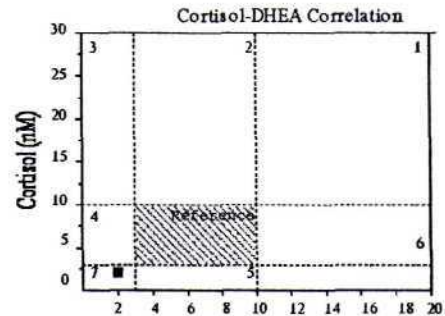
DHEA Dehydroepiandrosterone

2 Depressed DHEA Adults (M/F): 3-10 ng/ml



KEY: CORTISOL-DHEA CORRELATION

1. Adapted to stress.
2. Adapted with DHEA slump.
3. Maladapted Phase I.
4. Maladapted Phase II.
5. Non-adapted, Low Reserves.
6. High DHEA.
7. Adrenal Fatigue.



Patient Result Interpretations

Depressed morning cortisol, < 13 nM, is suggestive of marginal HPA performance.

Normal rhythms exhibit highest cortisol value for the day at 7 - 8 AM.

Morning cortisol augmentation, or 11 Beta HSD inhibitors, as in licorice, worth consideration.

Minimal cortisol rhythm, cortisol augmentation and anabolic support suggested.

Diagnosis Code: 780.79

Please Note: All examples of patient treatment or therapy are for illustrative and/or educational purpose. Use this report in context of the clinical picture before initiating hormone or other therapies.

COURTESY INTERPRETATION of test and technical support are available upon request, to Physician Only

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ANNA
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 Patient's Tel:
 Specimen Collected: 11/07/2006

Code	Test Name	Result / Notes	Reference Values/Key
ISN	Insulin	Fasting: <3 Post-prandial: <3 Depressed	Normal: 3-12 uIU/mL Optimal: 5-20 uIU/mL Low: < 5 uIU/mL High: > 20 uIU/mL

Depressed Post-prandial insulin within four hours after meal. This may be caused by a small carbohydrate load in the preceding challenge meal or a reduction in pancreatic insulin release or synthesis. Consider a closer examination of challenge meal composition to rule out pre-diabetic tendencies.

Why Test for Insulin?

Insulin activity is affected by the stress and cortisol responses. Chronic stress with cortisol elevation antagonizes insulin, and may cause functional insulin resistance. Furthermore, chronic hypercortisol causes hyperinsulin responses to carbohydrate intake. Chronic insulin resistance and overproduction lead to pancreatic exhaustion.

General information about insulin values.

Fasting: This insulin value is elevated in cases of insulin resistance.

Post Prandial: This insulin value varies with type of meal and time of sample collection. See figure 1b. Adapted, Br. J. Nutr. 2003, 90:853

To obtain the most meaningful results, instruct patient to eat 50g of carbohydrate or what is equivalent to 200 calories about 45-90 minutes before noon sample collection. Examples: 2 slices of white bread and 1 cup of orange juice OR 1 cup of cooked oatmeal and 1 cup of orange juice OR 2 ounces of corn flakes snack.

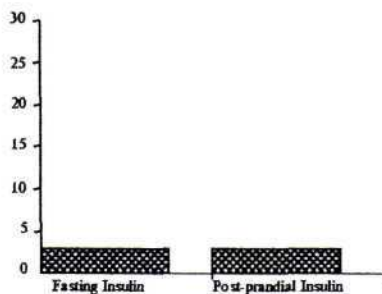


Figure 1a. Insulin Levels

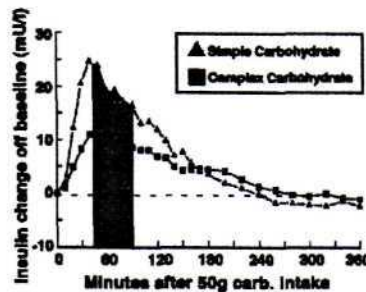


Figure 1b. Serum Insulin - Time Curve

Shaded area is optimal period of post-prandial collection.

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Subject:
ANNA
Age: 54 Gender: Female

Patient's Tel:
Specimen Collected: 11/07/2006

Code	Test Name	Values	Provisional Ranges
STP Saliva Thyroid Study			
ftSH	Thyroid stimulating hormone	55 Normal	Borderline Low : 20-25 nIU /ml Normal: 26-85 nIU/ml Borderline High: 86-120 nIU/ml
ft4	L-Thyroxine	0.20 Normal	Normal: 0.17-0.42 ng/dl
ft3	Triiodo-thyronine	0.36 Normal	Borderline Low: 0.21-0.27 pg/ml Normal: 0.28-1.10 pg/ml
TPO	Thyroid Microsomal Ab, SIgA	Negative	Normal: Negative

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PHP1. Postmenopausal Hormone panel -- Short

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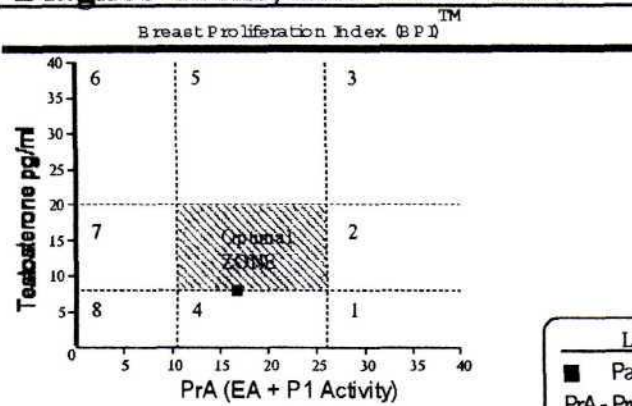
Hormone	Result	Notes	Reference Ranges
TTF - Testosterone	8	Normal	Borderline: 5-7 pg/ml Normal: 8-20 pg/ml
E1 - Estrone	19		Normal for Age 50-59: 26-64 pg/ml
E2 - Estradiol	9		Postmenopause-No HRT: 1-4 pg/ml HRT Target Range: 5-13 pg/ml Follicular: 5-13 pg/ml Luteal: 7-20 pg/ml
E3 - Estriol	13		Postmenopause-No HRT: 7-18 pg/ml HRT Target Range: 14-38 pg/ml Cycling Female: 12-25 pg/ml
P1 - Progesterone	34		Postmenopause-No HRT: 5-95 pg/ml HRT Target Range: 100-300 pg/ml Follicular: 20-100 pg/ml Luteal: 65-500 pg/ml

More interpretation and the action plan on following pages.

Diagnosis Code: 780.79

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COURTESY INTERPRETATION/Technical support available upon request, to Physicians Only



Legend
 ■ Patient
 PrA - Proliferative Activity
 EA - Estrogenic Activity

- | | |
|----------------------------------|-------------------------------|
| 1. Enhanced Proliferation. | 5. Mild Androgen Dominance. |
| 2. High Proliferative Potential. | 6. Frank Androgen Excess. |
| 3. Hormone Overload. | 7. Female Hormone Deficit |
| 4. Pro-Proliferative. | 8. Hypogonadism with Atrophy. |

Your hormone values are in Zone 4.

Explanation:

ZONE 4: PRO-PROLIFERATIVE

Zone 4 represents a normal physiologic activity of the proliferative estrogens and progesterone hormones, not opposed or counter-balanced by a sufficient amount of the anti-proliferative androgenic hormones. This unbalanced state favors proliferative activity and reduced anabolic potential resulting in possible weight gain, lower tolerance to physical activity, anxiety, low libido...

What Next?

Monitored anabolic enhancement worth consideration. Androgen precursor or hormone supplementation, when applicable, can restore the metabolic balance and moderate the proliferative activity.

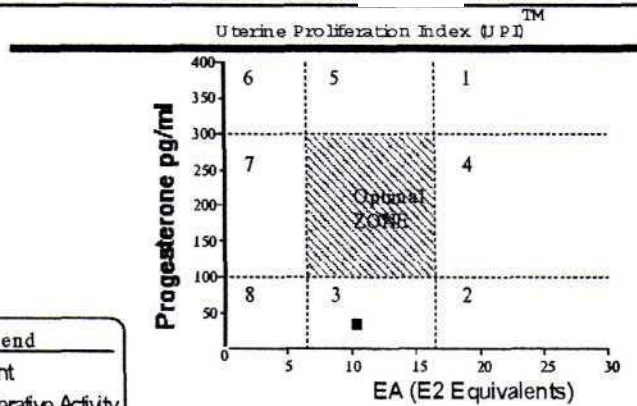
Examples below reflect ranges of intake and may require customization based on the patient's clinical history and symptoms which include Adrenal status, age, lean body mass, existing pathologies, the hormone preparations, and the method of administration.

- I. DHEA: 5-25 mg/day in one or more doses
- II. Androstenedione: 10-30 mg/day
- III. Testosterone: topical application, 1-3 mg on alternate days

Dose information is only a generalized example. We highly recommend retesting hormone levels in androgen supplemented patients.

Typical Action Plans

1. Select one of the androgen supplementation regimens shown above.
2. Monitor hormone levels with a re-test in 6 - 8 weeks.
3. If estrogen activity (EA) shows an increase reduce androgen dose or switch to another.
4. Re-test in 6 - 8 weeks.
5. If EA is normal, fine tune dosing, otherwise go back to step 3.
6. Follow up testing recommended annually.



- | | |
|-----------------------------------|--------------------|
| 1. Enhanced Proliferation. | 5. Mild Imbalance. |
| 2. High Proliferative Potential. | 6. Pre-Atrophic. |
| 3. Potentially Proliferative. | 7. Pro-Atrophic. |
| 4. Accentuated Hormone Imbalance. | 8. Atrophic. |

Your hormone values are in Zone 3.

Explanation:

ZONE 3: POTENTIALLY PROLIFERATIVE

Zone 3 represents normal estrogenic activity not counteracted by sufficient amounts of progesterone resulting in a relatively proliferative environment. This state favors:

- I. Mild target tissue proliferation: endometrial thickening, uterine bleeding, fibroids, infertility etc.
- II. Somatic: Mild increase in body fat deposition, weight gain and water retention.
- III. Nervous system (CNS) dysfunction which includes cognitive changes, headaches, anxiety, panic attacks, insomnia and depression with mood swings.

What Next?

Consider the restoration of Progesterone (Progesterone + Pregnenolone)

**Need a more complete explanation of the indexes?
 See respective sections on the following page.**

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AND	Androstenedione	220	Borderline Low: 75-124 pg/ml Normal: 125-274 pg/ml Borderline High: 275-400 pg/ml
FSH	Follicle Stimulating Hormone	213	Pre-menopause: <125 uIU/mL Postmenopause: 90-500 uIU/mL
LH	Luteinizing Hormone	83	Pre-menopause: 8-30 uIU/mL HRT: 8-30 uIU/mL Postmenopause-No HRT: 25-200 uIU/mL
P17-OH	17-OH Progesterone	<15	Adults Optimal: 22-100 pg/ml Borderline: 101-130 pg/ml Elevated: >130 pg/ml