



NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____ @ _____

May I send health info to your email address? Y N

DAY PHONE:(____) _____ FAX:(____) _____

Preferred time to follow-up with you: _____ am pm

MY THREE GREATEST HEALTH CONCERNS ARE:

1. _____

2. _____

3. _____

Please turn to the other side to complete the survey...

Personal Health Profile (Please check all that apply)

- | | | | |
|--|--------------------------|--|--------------------------|
| I am interested in Anti-Aging Products..... | <input type="checkbox"/> | Fibromyalgia..... | <input type="checkbox"/> |
| I am interested in Children's Health..... | <input type="checkbox"/> | Foot Fungus..... | <input type="checkbox"/> |
| I am interested in Cleansing & Detoxifying..... | <input type="checkbox"/> | Gum Disease..... | <input type="checkbox"/> |
| I am interested in Healthy Snacks..... | <input type="checkbox"/> | Hands (cracked, red, chapped, rough, etc)..... | <input type="checkbox"/> |
| I am interested in Meal Replacement..... | <input type="checkbox"/> | Heartburn..... | <input type="checkbox"/> |
| I am interested in Skin Care..... | <input type="checkbox"/> | Heart Disease..... | <input type="checkbox"/> |
| I am interested in Sports Nutrition..... | <input type="checkbox"/> | Hemorrhoids..... | <input type="checkbox"/> |
| I am interested in a Water Purifier..... | <input type="checkbox"/> | Hiatal Hernia..... | <input type="checkbox"/> |
| I would like to look and feel younger..... | <input type="checkbox"/> | High Blood Pressure..... | <input type="checkbox"/> |
| I would like to lose Weight..... | <input type="checkbox"/> | Hot Flashes..... | <input type="checkbox"/> |
| I am interested in natural alternatives to
medications I am taking..... | <input type="checkbox"/> | Hyperactivity..... | <input type="checkbox"/> |
| Acid Indigestion..... | <input type="checkbox"/> | Hypertension..... | <input type="checkbox"/> |
| Acne..... | <input type="checkbox"/> | Hypoglycemia..... | <input type="checkbox"/> |
| A.D.D./A.D.H.D..... | <input type="checkbox"/> | Immune System..... | <input type="checkbox"/> |
| Allergies..... | <input type="checkbox"/> | Indigestion..... | <input type="checkbox"/> |
| Alzheimer's Disease..... | <input type="checkbox"/> | Infection..... | <input type="checkbox"/> |
| Angina..... | <input type="checkbox"/> | Insomnia..... | <input type="checkbox"/> |
| Anti-Inflammatory..... | <input type="checkbox"/> | Intestinal Health..... | <input type="checkbox"/> |
| Anxiety..... | <input type="checkbox"/> | Irritable Bowel Syndrome (IBS)..... | <input type="checkbox"/> |
| Arteriosclerosis..... | <input type="checkbox"/> | Jet Lag..... | <input type="checkbox"/> |
| Arthritis..... | <input type="checkbox"/> | Joint Function..... | <input type="checkbox"/> |
| Asthma..... | <input type="checkbox"/> | Joint & Muscle Sprains..... | <input type="checkbox"/> |
| Autism..... | <input type="checkbox"/> | Laryngitis..... | <input type="checkbox"/> |
| Backache..... | <input type="checkbox"/> | Libido (low)..... | <input type="checkbox"/> |
| Bleeding/Sensitive Gums..... | <input type="checkbox"/> | Macular Degeneration..... | <input type="checkbox"/> |
| Bone Spurs..... | <input type="checkbox"/> | Memory & Mental Alertness..... | <input type="checkbox"/> |
| Cancer Prevention..... | <input type="checkbox"/> | Menopause..... | <input type="checkbox"/> |
| Candida..... | <input type="checkbox"/> | Menstrual Cramps..... | <input type="checkbox"/> |
| Cardiovascular Problems..... | <input type="checkbox"/> | Migraine Headaches..... | <input type="checkbox"/> |
| Cataracts..... | <input type="checkbox"/> | Mood Balancing..... | <input type="checkbox"/> |
| Chapped Lips..... | <input type="checkbox"/> | Muscle Aches and Pains..... | <input type="checkbox"/> |
| Cholesterol (High)..... | <input type="checkbox"/> | Nervous Tension..... | <input type="checkbox"/> |
| Chronic Fatigue..... | <input type="checkbox"/> | Nicotine Addiction..... | <input type="checkbox"/> |
| Chronic Illnesses..... | <input type="checkbox"/> | Night Vision..... | <input type="checkbox"/> |
| Circulatory Problems..... | <input type="checkbox"/> | Osteoarthritis..... | <input type="checkbox"/> |
| Cold & Flu Risk..... | <input type="checkbox"/> | Osteoporosis..... | <input type="checkbox"/> |
| Congestive Heart Failure..... | <input type="checkbox"/> | Parasites..... | <input type="checkbox"/> |
| Constipation..... | <input type="checkbox"/> | Periodontal Disease..... | <input type="checkbox"/> |
| Coronary Artery Disease..... | <input type="checkbox"/> | PMS..... | <input type="checkbox"/> |
| Cough..... | <input type="checkbox"/> | Poor Circulation..... | <input type="checkbox"/> |
| Depression..... | <input type="checkbox"/> | Post Partum Depression..... | <input type="checkbox"/> |
| Dehydration..... | <input type="checkbox"/> | Prostate Health..... | <input type="checkbox"/> |
| Diabetes..... | <input type="checkbox"/> | Psoriasis..... | <input type="checkbox"/> |
| Diaper Rash..... | <input type="checkbox"/> | Rosacea..... | <input type="checkbox"/> |
| Diverticulitis..... | <input type="checkbox"/> | Sexual Performance..... | <input type="checkbox"/> |
| Eczema..... | <input type="checkbox"/> | Sinusitis..... | <input type="checkbox"/> |
| Energy..... | <input type="checkbox"/> | Sports Injuries..... | <input type="checkbox"/> |
| Environmental Toxins..... | <input type="checkbox"/> | Stomachache..... | <input type="checkbox"/> |
| Epstein Barr Virus..... | <input type="checkbox"/> | Stress..... | <input type="checkbox"/> |
| Eye Health..... | <input type="checkbox"/> | Sunburn..... | <input type="checkbox"/> |
| Fever Blisters..... | <input type="checkbox"/> | TMJ..... | <input type="checkbox"/> |
| Fibrocystic Breast Disease..... | <input type="checkbox"/> | Vision Problems..... | <input type="checkbox"/> |
| | | Other..... | <input type="checkbox"/> |