INITIAL EVALUATION

PLEASE COMPLETE THE FOLLOWING QUESTIONAIRRE **THOROUGHLY**. INFORMATION DISCLOSED IN THIS DOCUMENT WILL BE USED TO COMPILE A NUTRITIONAL PROGRAM SPECIFICALLY FOR YOU. **NOTE**: INFORMATION DETAILED IN **THIS DOCUMENT IS CONFIDENTIAL** AND WILL NOT BE SHARED WITH OTHERS WITHOUT PROPER CONSENT.

TODAY'S DATE _____ **REFERRED BY** _____

NAME _____ **M** ○ **F** ○ **DOB** _____ **AGE** _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

EMAIL _____ **PHONE** _____

HEIGHT _____ **WEIGHT** _____ **OCCUPATION** _____

MARITAL STATUS S ☐ M ☐ D ☐ W ☐ **NO. OF CHILDREN** _____

PLEASE DO NOT TAKE ANY NUTRITIONAL SUPPLEMENTS FOR 2 MEALS (OR 24 HOURS) BEFORE YOUR FIRST NUTRITIONAL EVALUATION.

COMPLAINTS PLEASE LIST YOUR CURRENT COMPLAINTS AND RATE THEIR SEVERITY (SCALE OF 1 - 10). SEVERE IS 10!

_____

_____

_____

_____

OTHER INFO PLEASE LIST ADDITIONAL INFORMATION, HISTORY OR CONCERNS ABOUT YOUR HEALTH

_____

_____

_____

MEDICATIONS PLEASE LIST CURRENT MEDICATIONS TAKEN AND THE DURATION (INCLUDING BIRTH CONTROL, ASPIRIN, NSAID'S, STEROIDS, ETC)

_____

_____

_____

_____

ALLERGIES PLEASE LIST ANY KNOWN ALLERGENS AND/OR SENSITIVITIES

_____

_____

_____

_____

SMOKING DO YOU CURRENTLY SMOKE? Y ☐ N ☐

IF YES, HOW MUCH? _____

IF YES, HOW LONG HAVE YOU SMOKED? _____

DO YOU FREQUENTLY BREATH SECOND-HAND SMOKE (WORK/HOME)? _____

DRUGS **STRICTLY CONFIDENTIAL INFORMATION**

DO YOU CURRENTLY USE/HAVE USED RECREATIONAL DRUGS? Y ☐ N ☐

IF YES, HOW MUCH? _____

IF YES, HOW OFTEN/LONG? _____

LIST ALL THAT APPLY (IE-MARIJUANA, COCAINE, HEROIN)? _____

_____

SURGERIES PLEASE LIST ANY SURGERIES, OPERATIONS, TRAUMAS, ACCIDENTS THAT YOU'VE HAD (INCLUDING ELECTIVE/COSMETIC SURGERY)?

_____

_____

_____

_____

LIST ANY IMPLANTS OR PROSTHESES: _____

_____

LIST ANY METAL OR PLASTIC INSIDE THE BODY (PINS, CLAMPS, PLATES, ETC):

_____

HAVE YOU HAD FULL BODY ANESTHESIA (IE- TONSIL REMOVAL, WISDOM TEETH, ETC)?

_____

LIST ANY PIERCINGS: _____

_____

LIST ANY TATTOOS: _____

_____

_____

SCARS PLEASE LIST & DESCRIBE ANY SCARS ON THE BODY (MAJOR & MINOR)

PLEASE LIST & DESCRIBE ANY HEAD TRAUMA/SCARS (MAJOR & MINOR)

STRESS PLEASE RATE YOUR CURRENT STRESS LEVEL & LIST MAJOR REASONS CONTRIBUTING TO YOUR STRESS (1 THROUGH 10)

DENTAL EVALUATION

PLEASE CHECK OFF ALL THAT APPLY TO YOUR DENTAL HISTORY.

- ☐ SILVER FILLINGS
- ☐ COMPOSITES (TOOTH COLORED)
- ☐ EXTRACTIONS
- ☐ BRIDGEWORK
- ☐ PARTIAL OR FULL DENTURES
- ☐ GOLD CROWNS/INLAYS
- ☐ STAINLESS STEEL CROWNS/INLAYS
- ☐ PORCELAIN CROWNS/INLAYS
- ☐ DEGUSSA PORCELAIN CROWNS/INLAYS
- ☐ VENEERS
- ☐ ROOT CANALS
- ☐ ROOT CANALS WITH ENDOCAL
- ☐ POSTS
- ☐ IMPLANTS
- ☐ TEMPORARIES
- ☐ DNA APPLIANCE
- ☐ RETAINERS/INVISALINE
- ☐ BRACES
- ☐ BLEEDING GUMS
- ☐ SENSITIVE TEETH
- ☐ BAD BITE
- ☐ NEW CAVITIES
- ☐ RECURRENT CANKER SORES
- ☐ (MOUTH ULCERS)

HAVE YOU HAD TEETH EXTRACTED?

LIST ANY DENTAL SURGERIES:

LIST ANY FUTURE DENTAL WORK PLANNED (IF NEEDED):

LIFESTYLE EVALUATION

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY AND/OR HONESTLY.

SLEEP HOW IS YOUR SLEEP (CHECK ALL THAT APPLY)?

- RESTFUL ☐
- RESTLESS ☐
- HARD TO GET TO SLEEP ☐
- WAKE UP OFTEN ☐
- GET UP DURING THE NIGHT (BATHROOM) ☐
- BAD DREAMS ☐

OTHER SLEEP SYMPTOMS NOT LISTED?

USUAL TIME FOR BED?

NUMBER OF HOURS OF SLEEP PER NIGHT:

DIGESTION HOW IS YOUR DIGESTION (CHECK ALL THAT APPLY)?

- ADEQUATE ☐
- POOR ☐
- ACID REFLUX ☐
- BURP OFTEN ☐
- BLOATING/GAS ☐
- BURNING/PAIN IN STOMACH ☐
- TIRED AFTER EATING ☐

OTHER DIGESTION SYMPTOMS NOT LISTED?

URINATION HOW IS YOUR DAILY URINE (CHECK ALL THAT APPLY)?

- EVERY 2 TO 3 HOURS ☐
- TOO FREQUENT ☐
- SENSE OF URGENCY ☐
- TOO SMALL AMOUNT ☐
- TOO LARGE AMOUNT ☐
- BURNING WHILE URINATING ☐
- DRIBBLING ☐
- AWAKE AT NIGHT TO URINATE ☐

OTHER URINATION SYMPTOMS NOT LISTED?

DO YOU USUALLY SUFFER FROM RECURRENT URINARY TRACT INFECTIONS?

BOWELS HOW ARE YOUR ELIMINATIONS (CHECK ALL THAT APPLY)?

HOW OFTEN?
- ☐ 3 TIMES/DAY
- ☐ ONCE/DAY
- ☐ SKIP DAYS

AMOUNT?
- ☐ NORMAL
- ☐ TOO LITTLE
- ☐ TOO LARGE

CONSISTENCY?
- ☐ NORMAL
- ☐ TOO HARD
- ☐ VERY SOFT
- ☐ DIARRHEA

COLOR?
- ☐ BROWN
- ☐ BLACK
- ☐ WHITE/LIGHT

OTHER CONSIDERATIONS?
- ☐ LOTS OF MUCOS IN STOOL
- ☐ LOTS OF GAS
- ☐ HORRIBLE SMELL
- ☐ FLOATING STOOL

IF YOU HAVE DIFFICULTY GOING TO THE BATHROOM, BRIEFLY EXPLAIN YOUR ISSUE BELOW.

_____

_____

_____

WOMEN ONLY! CHECK OFF ALL THAT APPLY.

- ☐ CURRENTLY PREGNANT
- ☐ CURRENTLY BREAST-FEEDING
- ☐ HAVING MONTHLY PERIODS
- ☐ CURRENTLY GOING THROUGH MENOPAUSE
- ☐ MY PERIODS HAVE STOPPED
- ☐ HAD A HYSTERECTOMY

WHEN WAS THE LAST MENSTRAL PERIOD?_____ IF YES, WHEN?_____

MENSTRAL CYCLE

ARE YOUR PERIODS REGULAR (28 DAY CYCLES)?_____

HOW LONG DOES YOUR MENSTRAL FLOW LAST?_____

LIST ANY OTHER MENSTRAL SYMPTOMS

_____

_____

CHECK OFF ALL THAT APPLY:
- ☐ CRAMPING
- ☐ BLOATING
- ☐ FEELING WEAK
- ☐ MOOD SWINGS
- ☐ CRAVINGS
- ☐ HEAVY BLEEDING
- ☐ BACK PAIN
- ☐ HEADACHES
- ☐ BRIGHT RED BLOOD
- ☐ DARK CLOTTY BLOOD

EXERCISE DO YOU REGULARLY EXERCISE?_____

WHICH TYPE OF EXERCISE DO YOU DO?_____

HOW OFTEN IS THE EXERCISE AND HOW LONG DOES A SESSION LAST?_____

SUNLIGHT AMOUNT OF SUNLIGHT YOU RECEIVE DAILY OUTSIDE?_____

AMOUNT OF SUNLIGHT YOU RECEIVE DAILY INDOORS OR THROUGH WINDOWS?_____

HOURS SPENT DAILY UNDER FLUORESCENT LIGHTS?_____

WHICH TYPE OF LIGHTBULB DO YOU USE AT HOME?_____

WHICH TYPE OF LIGHTBULB IS USED AT WORK OR SCHOOL?_____

ARE YOU AFFECTED BY SEASONAL TIME-CHANGE?_____

DO YOU USE E-LUX OR "HAPPY" LAMPS?_____

EYEWEAR CHECK OFF ALL THAT APPLY.

- ☐ WEARS GLASSES
- ☐ WEARS CONTACT LENSES
- HOURS/DAY THEY'RE WORN?_____
- ☐ GLASSES ARE TINTED
- ☐ GLASSES HAVE ANTI-GLARE COATING
- ☐ WEARS COMPUTER/GAMING GLASSES

ELECTROMAGNETIC EXPOSURE HOW MANY HOURS ARE SPENT DAILY (ONLY ANSWER WHAT APPLIES):

WATCHING TV _____

ON/NEAR COMPUTERS _____

ON/NEAR CELL PHONE/TABLET_____

TALKING ON CELL PHONE _____

WEARING BLUTOOTH HEADPHONES _____

WEARING WATCHES (INCLUDING SMART WATCHES, APPLE WATCH, ETC) _____

WEARING HEARING AIDS _____

RIDING IN CAR/COMMUTE _____

NEAR ELECTRICAL EQUIPMENT (POWER LINES, SMART METERS, ETC) _____

IS YOUR HEAD WITHIN 10 FEET OF A CELL PHONE, COMPUTER AND/OR OTHER ELECTRONICS WHILE IN BED? _____

DO YOU SLEEP BY A WIFI ROUTER? _____

DO YOU SLEEP BY A SMART METER? _____

DO YOU USE ANY EMF REDUCTION PRODUCTS? IF SO, WHICH?_____

_____

PERSONAL CARE CHECK ALL THAT WERE/ARE USED.

- ☐ SHAMPOO
- ☐ SHAVING CREAM
- ☐ DEODERANT
- ☐ DISH WASHING POWDER/LIQUID
- ☐ TOOTHPASTE
- ☐ TEETH WHITENING PRODUCTS
- ☐ ACTIVATED CHARCOAL PRODUCTS
- ☐ LAUNDRY SOAP
- ☐ HAND SOAP
- ☐ HAND SANITIZER
- ☐ HAIR DYE
- ☐ HAIR PERMANENT (PERMS)
- ☐ KERATIN TREATMENTS
- ☐ TUB/TILE CLEANER
- ☐ CLOROX/BLEACH
- ☐ HAND/BODY LOTION
- ☐ SUNSCREEN (WITH SPF)
- ☐ GLASS CLEANER
- ☐ FACIAL CLEANSER./MOISTURIZER
- ☐ ACNE MEDICATION/CREAM
- ☐ ALL-PURPOSE CLEANER
- ☐ HAIR SPRAY/GEL/STYLING PRODUCTS
- ☐ NAIL POLISH
- ☐ FACE & EYE MAKE-UP
- ☐ FALSE EYE LASHES WITH GLUE
- ☐ CHAPSTICK/LIPSTICK
- ☐ LIP/CHEEK/EYE INJECTIONS
- ☐ COLOGNE/PERFUME
- ☐ PERSONAL/SEX LUBRICANT
- ☐ ROACH/ANT/BUG SPRAY
- ☐ CONTRACEPTIVE GEL/SPERMICIDE
- ☐ BATHROOM FRESHENER

APPLIANCES CHECK ALL THAT ARE USED.

- ☐ GAS STOVE
- ☐ ELECTRIC STOVE
- ☐ ELECTRIC HEATER
- ☐ MICROWAVE
- ☐ AIR PURIFIER
- ☐ WATER PURIFIER
- ☐ HIGH SPEED BLENDER
- ☐ JUICER

COOKWARE CHECK ALL THAT ARE USED.

- ☐ STAINLESS STEEL
- ☐ ALUMINUM
- ☐ IRON
- ☐ TEFLON-COATED
- ☐ GLASS
- ☐ CERAMIC-COATED

PETS CHECK ALL THAT APPLY.

- ☐ DOG(S)
- ☐ CAT(S)
- ☐ REPTILE(S)
- ☐ BIRD(S)

HOW MANY PETS? _____

ALLOWED ON BED? _____

WHAT KIND OF FOOD ARE THEY GIVEN? _____

CLOTHING CHECK ALL THAT APPLY.

- ☐ SYNTHETIC/POLYESTER
- ☐ WOOL
- ☐ COTTON
- ☐ HEMP
- ☐ ELASTICS/SPANDEX
- ☐ UNDERWIRE BRAS

DIET & NUTRITION

CHECK OFF EACH FOOD REGULARLY EATEN DURING A WEEKLY PERIOD.

PROCESSED/PRE-MADE FOODS

- ☐ CANNED/BOXED FOOD
- ☐ CEREALS
- ☐ FROZEN FOODS/DINNERS
- ☐ BOTTLED/FROZEN JUICE
- ☐ TAKE-OUT FOOD
- ☐ SNACKS (CONVENTIONAL & ORGANIC)

RED MEAT (BEEF, PORK, LAMB)

- ☐ CONVENTIONAL
- ☐ NATURALLY RAISED/ORGANIC
- ☐ ORDERED AT RESTAURANTS

POULTRY (CHICKEN/TURKEY)

- ☐ CONVENTIONAL
- ☐ NATURALLY RAISED/ORGANIC
- ☐ ORDERED AT RESTAURANTS

FISH & SEAFOOD

- ☐ CANNED SEAFOOD
- ☐ FARM RAISED (FROZEN)
- ☐ WILD CAUGHT (FROZEN)
- ☐ FRESH CAUGHT (DIRECT FROM FISHER)
- ☐ CRUSTACEANS/CRAW/CRAYFISH
- ☐ ORDERED AT RESTAURANTS

VEGETABLES

- ☐ CONVENTIONAL
- ☐ ORGANIC (STORE BOUGHT)
- ☐ ORGANIC (DIRECTLY FARM BOUGHT)

FRUITS

- ☐ CONVENTIONAL
- ☐ ORGANIC (STORE BOUGHT)
- ☐ ORGANIC (DIRECTLY FARM BOUGHT)

WHOLE GRAINS

- ☐ CONVENTIONAL
- ☐ ORGANIC (STORE BOUGHT)
- ☐ ORGANIC (DIRECTLY FARM BOUGHT)

WHOLE BEANS

- ☐ CONVENTIONAL
- ☐ ORGANIC (STORE BOUGHT)
- ☐ ORGANIC (DIRECTLY FARM BOUGHT)

EGGS/BUTTER

- ☐ CONVENTIONAL EGGS
- ☐ ORGANIC EGGS
- ☐ CONVENTIONAL BUTTER
- ☐ ORGANIC BUTTER

MILK

- ☐ CONVENTIONAL MILK
- ☐ ORGANIC/PASTEURIZED
- ☐ ORGANIC GOAT'S MILK
- ☐ RAW WHOLE MILK

CHEESE

- ☐ CONVENTIONAL CHEESE
- ☐ ORGANIC CHEESE
- ☐ AGED CHEESE

CONDIMENTS

- ☐ CONVENTIONAL SALT/PEPPER
- ☐ PINK SALT/ ORGANIC SALT OR PEPPER
- ☐ ARTIFICIAL SWEETENERS (PLUS COFFEE CREAMERS)
- ☐ CONVENTIONAL KETCHUP/MUSTARD/SAUCES
- ☐ ORGANIC KETCHUP/MUSTARD/SAUCES
- ☐ CONVENTIONAL VEGETABLE OILS
- ☐ ORGANIC VEGETABLE OILS
- ☐ CONVENTIONAL VINEGARS
- ☐ ORGANIC VINEGARS

PLANT BASED/NON-DAIRY/VEGAN PRODUCTS

- ☐ NON-DAIRY CHEESE
- ☐ NON-DAIRY BUTTER/MARGIARINE
- ☐ MEATLESS PRODUCTS

POTENTIAL STRESSORS PLEASE INDICATE HOW MANY TIMES/WEEK YOU CONSUME THE FOLLOWING FOODS.

- ☐ AMERICAN COFFEE (INCL. DECAF)
- ☐ BLACK TEA, CAFFEINE DRINKS
- ☐ SOFT DRINKS/SODAS
- ☐ DRINKS WITH NUTRASWEET
- ☐ ALCOHOL
- ☐ CHOCOLATE
- ☐ CANDIES/SWEETS/PASTRIES
- ☐ FRIED FOODS
- ☐ FAST FOODS
- ☐ POTATO OR CORN CHIPS
- ☐ ROASTED NUTS
- ☐ MAYONNAISE
- ☐ MARGARINE
- ☐ PEANUT BUTTER
- ☐ CONVENTIONAL COW'S MILK
- ☐ YOGURT
- ☐ ICE CREAM
- ☐ COTTAGE CHEESE
- ☐ SOUR CREAM
- ☐ CONVENTIONAL CHEESES
- ☐ CURED/DELI MEATS
- ☐ WHITE FLOUR
- ☐ CONVENTIONAL BREADS
- ☐ BAGELS
- ☐ TRADITIONAL PASTA
- ☐ MUFFINS
- ☐ COOKIES

DIET HABITS

EATING OUT

DO YOU EAT OUT AT RESTAURANTS, AND IF SO, HOW OFTEN USUALLY? _____

GENERALLY, WHICH FOODS ARE EATEN WHILE OUT? _____

DO YOU AVOID FOOD/DRINKS THAT LIST "NATURAL FLAVORS" (HIDDEN MSG) ON THE LABEL? _____

EATING AT HOME

HOW OFTEN DO YOU EAT MEALS AT HOME? _____

GENERALLY, WHICH FOODS ARE EATEN WHILE HOME? _____

DO YOU GENERALLY:

☐ SKIP MEALS OFTEN ☐ HAVE RANDOM EATING TIMES ☐ EAT PAST 7/8PM

WATER

DO YOU DRINK TAP WATER? _____

WHICH BRAND OF WATER DO YOU USE? _____

IF YOU HAVE A HOME WATER FILTER, WHICH TYPE OF FILTER DO YOU HAVE AND WHEN WAS THE LAST CARTRIDGE CHANGED? _____

TYPICAL WEEKLY DIET

PLEASE EXPLAIN YOUR TYPICAL DIET FOR AN AVERAGE DAY. THIS ONLY REFLECTS THE LAST FEW WEEKS. BE SPECIFIC WITH YOUR DESCRIPTIONS, INCLUDE BRAND NAMES, COOKING STYLE (RAW, BAKED, PAN SEARED, ETC), AND THE INGREDIENTS USED. ANSWER THIS SECTION HONESTLY AND THOROUGHLY.

BREAKFAST TYPICAL TIME EATEN: _____

DINNER TYPICAL TIME EATEN: _____

LUNCH TYPICAL TIME EATEN: _____

SNACKS TYPICAL TIME EATEN: _____

OTHER CONSIDERATIONS PLEASE ANSWER AS HONESTLY AND BEST AS POSSIBLE

BEDDING MATERIALS

WHICH TYPE OF BED SHEETS/BLANKETS DO YOU USE? (IE-POLYESTER, COTTON, SILK) _____

WHICH KIND OF PILLOW DO YOU USE? _____

MATTRESS

WHICH TYPE OF MATTRESS DO YOU USE?

_____

HEAD DIRECTION

WHICH DIRECTION DOES THE TOP OF YOUR HEAD POINT WHILE SLEEPING? _____

DARKNESS

IS THERE CONSIDERABLE LIGHT IN THE ROOM WHEN YOU SLEEP? _____

ELECTRICAL APPLIANCES

IS THERE A COMPUTER, TV, ALEXA, GOOGLE HOME, CLOCK RADIO, ETC NEAR YOUR BED? _____

ARE ANY OF THE ABOVE ITEMS KEPT ON WHILE SLEEPING? _____

WINDOWS

DO YOU SLEEP NEAR A WINDOW? _____

IF YES, WHICH DIRECTION DOES THE WINDOW FACE OUT TOWARDS? _____

ALARM/HOME SECURITY

DO YOU SLEEP WITH A WHOLE HOUSE ALARM SYSTEM ON (SENSORS/INFRARED BEAMS)? _____

EMF(S)

DO YOU SLEEP WITH YOUR HEAD AT LEAST A FOOT AWAY FROM A WALL? _____

PREVIOUS TREATMENTS

IF APPLICABLE, HOW MANY ACUPUNCTURE TREATMENTS HAVE YOU HAD? _____

ELECTRICAL DEVICES WORN ON BODY

IF YOU WEAR HEARING AIDS, WHICH EARS ARE THEY USED ON? _____

IF YOU WEAR A (SMART) WATCH, WHICH WRIST IS IT USUALLY ON? _____

DO YOU WEAR A PACEMAKER? _____

DO YOU WEAR ANY OTHER ELECTRICALLY-POWERED DEVICES ON YOUR BODY? _____

MORE EMF EXPOSURE

DO YOU LIVE OR WORK WITHIN A 1/2 MILE RADIUS OF A CELL PHONE TOWER? _____

DO YOU LIVE OR WORK LESS THAN 100 FT FROM A POWER TRANSFORMER (ON A TELEPHONE POLE)? _____

DO YOU WEAR EXERCISE TECH FREQUENTLY (LIKE A FIT-BIT)? _____

OTHER EXPOSURE

DID/DO YOU WEAR NAIL POLISH (FINGERS/TOES)? _____

HAVE YOU EVER HAD TOXIC CHEMICALS SPILL ON YOUR BODY (GASOLINE, BENZENE, MERCURY, BLEACH)? _____

IMMUNIZATIONS

WERE YOU IMMUNIZED AGAINST SMALLPOX? _____

HAVE YOU TAKEN ORAL POLIO VACCINE? _____

DID YOU RECEIVE 1 OR MORE DOSES OF HPV VACCINE? _____

GOALS PLEASE ANSWER AS HONESTLY AND BEST AS POSSIBLE

DO YOU WANT TO LOSE ANY WEIGHT?_____
IF YES, WHAT IS YOUR IDEAL WEIGHT?_____

HOW IMPORTANT IS YOUR HEALTH TO YOU (SCALE 1-10, 10 BEING HIGHEST/MOST IMPORTANT)**?** _____

HOW MUCH CONFIDENCE DO YOU HAVE IN YOUR PREVIOUS/CURRENT HEALTH TREATMENT (IF APPLICABLE) (SCALE 1-10, 10 BEING HIGHEST)**?**_____

HOW MUCH CONFIDENCE DO YOU HAVE IN YOUR BODY'S ABILITY TO HEAL ITSELF, IF GIVEN THE PROPER NUTRIENTS/NATURAL CHOICES (SCALE 1-10, 10 BEING HIGHEST)**?**_____

WHICH SUPPLEMENTS DO YOU REGULARLY TAKE (NOT PRESCRIPTION MEDICATIONS)?

_____
_____
_____
_____
_____
_____

WHAT BEST DESCRIBES YOUR DIET LIFESTYLE OVERALL? CHECK ALL THAT APPLY

- ☐ MOSTLY EAT OUT (FAST FOOD)
- ☐ MOSTLY EAT OUT (BUT TRY TO EAT HEALTHIER)
- ☐ EAT WHATEVER IS AVAILABLE
- ☐ OCCASIONAL BINGES
- ☐ WOULD NEVER GIVE UP MEATS
- ☐ EAT A LOT OF FRESH FOOD (VERY LITTLE PACKAGED)
- ☐ MOSTLY HOMEMADE MEALS
- ☐ VEGETARIAN
- ☐ VEGAN
- ☐ EAT MOSTLY ORGANIC
- ☐ EAT A LOT OF RAW FOOD
- ☐ RAW VEGAN
- ☐ IN TRANSITION TO EATING BETTER

WHAT ARE YOUR SPECIFIC HEALTH GOALS (WHAT DO YOU <u>REALLY</u> WANT) **?**

_____

HOW COMMITTED ARE YOU TO YOUR HEALTH AND REACHING YOUR HEALTH GOALS?

- ☐ DON'T REALLY WANT TO CHANGE
- ☐ WILLING TO MAKE MINOR CHANGES
- ☐ WILLING TO MAKE SUBSTANTIAL CHANGES
- ☐ WILLING TO DO WHAT IT TAKES TO REACH MY BEST HEALTH

HOW MUCH DO YOU USUALLY SPEND PER MONTH ON YOUR HEALTH OUT OF POCKET?

_____

HOW LONG IS AN IDEAL LIFE FOR YOU TO LIVE IN YOUR OPINION?

- ☐ AGE 60-70
- ☐ AGE 70-80
- ☐ AGE 80-90
- ☐ AGE 90-100
- ☐ AGE 100+
- ☐ AS LONG AS I'M HEALTHY
- ☐ AS LONG AS I HAVE BEEN GRANTED
- ☐ UNTIL I COMPLETE MY MISSION OR PURPOSE ON THIS PLANET
- ☐ ONLY IF MY SIGNIFICANT OTHER IS STILL ALIVE ALSO
- ☐ FOREVER
- ☐ IT'S ALREADY ENOUGH HONESTLY