

# Health *Awareness* Survey

The *Health Awareness Survey* is an effort to gather information through a series of questions designed to indicate areas of need concerning lifestyle, health and diet. Please complete this survey in its entirety and return it at your earliest convenience. Your efforts will allow us to help you achieve optimal health.

You have our assurance that we will treat any information you supply on this survey with complete confidentiality. Your specific information will be used only to provide you with the results of your *Health Awareness Survey* and will not be sold, forwarded, or revealed in any way to any outside source.

Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Gender: \_\_\_\_\_

Best day/time to contact you: \_\_\_\_\_

1. Do you take vitamins of any kind? Yes  No  Sometimes
2. Do you currently take any nutritional or herbal supplements? Yes  No  Sometimes
3. Are you familiar with antioxidants? Yes  No  Somewhat
4. Do you know how antioxidants can benefit your health and well-being? Yes  No  Somewhat
5. Are you concerned about any of the following health issues?

Please mark any responses that apply to you, a family member/relative, or a friend.

Condition	Yourself	Relative	Friend
Circulation			
Joint Flexibility			
Headaches/Migraines			
Fat Formation/Cellulitis			
Cellular Health			
Artery/Vein Health			
Constipation			
Memory/Concentration			
Weight Gain			
Normal Wrist Flexibility			
Muscular Coordination			
Ulcer Formation			
Uric Acid Levels			
Menopausal Symptoms			
PMS/Cramps			
Allergies/Hay Fever			
Premature Aging			
LDL/HDL Levels			

Condition	Yourself	Relative	Friend
Respiratory Inflammation			
Bruising			
Healthy Blood Pressure			
Hemorrhoids			
Prostate Health			
Varicose Veins			
Blood Sugar Maintenance			
Skin Problems			
Cataracts/Glaucoma			
Frequent Fatigue			
Liver Function			
Macular			
Sinus/High Histamine			
Auto Immune			
Digestive System			
Muscle Pain			
Syndrome X			

6. Are you familiar with free radicals? Yes  No  Somewhat
7. Did you know that more than 60 medical conditions can be associated with free radicals and their effects on our bodies? Yes  No
8. Do you take prescription drugs or use over-the-counter medications? Yes  No  Sometimes
9. Do you eat a diet high in fat and/or ingest a lot of fried foods? Yes  No  Sometimes
10. Do you smoke cigarettes, cigars, a pipe or use other tobacco products? Yes  No  Sometimes
11. Do you drink alcoholic beverages, coffee or tap water? Yes  No  Sometimes
12. Are you exposed to X-rays. Tanning Beds or excessive sunlight? Yes  No  Sometimes
13. Are you ever exposed to (or do you work or live near) hazardous chemicals? Yes  No  Sometimes
14. Would you be willing to take a safe and effective nutritional supplement (or an additional supplement if you are already taking supplements) if you knew it could greatly benefit your health and well-being? Yes  No
15. What health benefits would you like to receive from a nutritional supplement program?

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