Health Survey

Name:_____

Street, City, State, Zip: _____

Home: (___)____-___ Times: ____-____Work: (___)____-____(____)_ Times: _____-_____

E-mail: _____@_____.com **Web Site:** www._____.com

Business: _____ **Type:** _____

Own Interests: _____

Spouse/Significant Other: _____**Interests:** _____

Business: _____ **Type:** _____

Birthday: Own: ____/___/___ Spouse/Sign.Other.: ____/___/___ Anniversary: ____/___/___

Child's Name: _____ **DOB: ___/___/___ Interests:** _____

Child's Name: _____ **DOB: ___/___/___ Interests:** _____

Child's Name: _____ **DOB: ___/___/___ Interests:** _____

Child's Name: _____ **DOB: ___/___/___ Interests:** _____

Child's Name: _____ **DOB: ___/___/___ Interests:** _____

Child's Name: _____ **DOB: ___/___/___ Interests:** _____

Family Relationships/Dynamics: _____

PLEASE CHECK ALL HEALTH CONDITIONS THAT APPLY TO YOU

Blood pressure ___/___ Pulse: _____ Respiration's: ____ Weight:_____(__actual/__stated)
Blood pressure ___/___ Pulse: _____ Respiration's: ____ After Treatment

___ Acne, skin irritations, rashes
___ Allergies
___ Anemia
___ Arthritis pain
___ Asthma or other respiratory ailments
___ Back pain
___ Bladder infections
___ Blood Diseases: ___ aides ___ hepatitis ___ type ___ other
___ Caffeine consumption: _____ cups/day
__ coffee __ cappachino __ soft drinks __ other
___ Calcium deficiency (osteoporosis)

Would you like to:
_____ LOSE WEIGHT
How many lbs. & sizes?
_____

_____ GAIN WEIGHT
How many lbs. & sizes?
_____

_____ MAINTAIN HEALTH & WEIGHT

___ Cancer-type: _____
___ Cellulite accumulation
___ Cholesterol ___ high Triglycerides ___ high
___ Circulation problems
___ Constipation or other digestive ailments
___ Diabetes Mellitus
___ Fatty-food consumption (eat out often?)
___ Gall Bladder problems
___ Heartburn &/or indigestion
____ Heart: ___ Pacemaker ___ Fast/ ___ Slow/ Rate
___ Attack ___ Surgery ___ Other (Below)
___ Hypoglycemia (low) ___ Hyperglycemia (high)
___ Immune System Problems _____ Type
___ Insomnia (Problems with sleep)
___ Low energy, tiredness
___ Low stamina or endurance
___ Nervous System Problems ___ Other (Seizures, etc.)
___ Brain Injury ___ Multiple Sclerosis ___ Stroke
___ Menstrual problems ___ PMS ___ Other
___ Migraine headaches
___ Pregnant/Lactating
___ Smoking: _____ packs/day _#____ /day
___ Stress related tension Cause: _____
___ low ___ medium ___ high
___ Suicidal Tendencies
___ Ulcers ___ Bowel Problems ___ Stomach Problems
___ Urinary Problems ___Water retention/bloating
___ Other Problems/
Further Information/Illnesses/Diseases/Surgeries:
_____

INTERESTS:
___ Better Health
___ Less Stress
___ More Energy
___ Balanced Nutrition
___ Secondary Income
___ Financial Freedom
___ Restful Sleep
___ Personal Fulfillment
___ Increase Income
$_____ Monthly Increase
Other Interests:
_____
_____
_____
_____
_____
_____
_____
ABILITIES: _____
_____
_____
_____
_____
_____
_____
Comments/Explanations:
_____
_____
_____

If money we no object, what would you do with:

Your Life? _____
_____
Your Business? _____
_____
Your Family? _____
_____
Your Friends? _____
_____
Your Favorite Non-Profit? _____
_____
Your Neighbors? _____
_____
Your Enemies? (Just kidding) _____
_____
Others? _____
_____

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