# Health Survey

*All information is private and confidential.*

If there was one thing you could change about your health today, what would it be?

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| Please fill in all the boxes and un-check all boxes that do NOT apply: | You | Family & Friends | Name |
|---|---|---|---|
| Energy and/or healthy alternatives to energy drinks | | | |
| Weight Loss | | | |
| Joint and ligament flexibility | | | |
| Heart health | | | |
| Respiratory health | | | |
| Digestive health | | | |
| Improved sense of well-being | | | |
| Joint support | | | |
| Foot and muscle maintenance | | | |
| Healthy immune function | | | |
| Skin health | | | |
| Sleep quality | | | |

Other health concerns: ____________________

| | | | |
|---|---|---|---|
| Do you take vitamins or herbals of any kind? | | | |
| Are you under the supervision of a health professional? | | | |
| Do you take prescription medication? | | | |

Is there any reason why you would not be willing to use a product related to these concerns?

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Name: ____________________ Age: __________

Address: ____________________

Phone #: ____________________ Email: ____________________

**Once this form is complete, save it as "Your Name" Health Survey, and email it back. Thank you!**