Health Survey

All information is private and confidential.

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

_____

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?

_____

_____

Name: _____ Age: _____

Address: _____

Phone #: _____ Email: _____

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