

PERSONAL HEALTH SURVEY

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|---|---|---|
| 1. Do you often wake up feeling tired, even after 8 hours of sleep? | Y | N |
| 2. Do you regularly experience fatigue during the day? | Y | N |
| 3. Do you feel that you should be more energetic? | Y | N |
| 4. Do you suffer from frequent headaches? | Y | N |
| 5. Do you have a family history of cancer, heart disease or stroke? | Y | N |
| 6. Has anyone in your family died prematurely from these diseases? | Y | N |
| 7. Are you more than 10 pounds overweight? | Y | N |
| 8. Does you weight fluctuate often? | Y | N |
| 9. Do you experience lack of mental clarity or memory loss? | Y | N |
| 10. Are you a cigarette smoker, or do you use tobacco in any form? | Y | N |
| 11. Do you diet frequently? | Y | N |
| 12. Do you eat fewer than 5-9 servings of fresh, raw, uncooked fruits and vegetables daily? | Y | N |
| 13. Do you eat foods like red meat, processed meat, eggs, butter or margarine, cheese, or other whole dairy products regularly? | Y | N |
| 14. Do you have frequent indigestion? | Y | N |
| 15. Are your bowel habits regular? | Y | N |
| 16. Do you experience shortness of breath? | Y | N |
| 17. Do you have allergies? If so, to what? _____ | Y | N |
| 18. Do you get frequent colds, sinus congestion or flu-like symptoms? | Y | N |
| 19. Do you experience bouts of depression? | Y | N |
| 20. Do you exercise less than 3-4 hours per week? | Y | N |
| 21. Do you have an arthritic condition? | Y | N |
| 22. Do you have aching or stiff, swollen joints? | Y | N |
| 23. Do you have trouble sleeping? | Y | N |
| 24. Have you noticed changes in the color and/or texture of you skin? | Y | N |
| 25. Do you retain water in you legs or hands? | Y | N |
| 26. Do you frequently experience food cravings? | Y | N |
| 27. Do you regularly overeat? How often? _____ | Y | N |
| 28. Do you frequently eat when you're not hungry? | Y | N |
| 29. Do you often feel stressed out? | Y | N |
| 30. Do you eat out often? | Y | N |
| 31. Do you experience abdominal discomfort or bloating? | Y | N |
| 32. Are you interested in improving your general health? | Y | N |
| 33. Do you have any other concerns? If so, what are they? _____ | Y | N |

Name _____

Date _____