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| HEALTH QUESTIONNAIRE | | | | | |
| NAME: | | | | | |
| DATE: | | | | | |
| REFERRED BY: | | | | | |
| DRINKS– how many 8 oz servings of the following do you consume per day? | | | | | |
| Regular Coffee |  | Decaffeinated Coffee | |  |  |
| Regular Tea |  | Herbal Tea | |  |  |
| Brewed Tea |  | Bottled Tea | |  |  |
| Tap Water |  | Bottled Water | |  |  |
| Filtered Water |  | Alcohol | |  |  |
| Energy / Sports drinks |  | Regular Pop | |  |  |
| Diet Pop |  |  |  |  |  |
| LIFESTYLE | | | | | |
| How many hours per day do you spend indoors? | | | | |  |
| How many hours per day do you spend outdoors? | | | | |  |
| Do you work with chemicals? | | | | |  |
| Do you presently smoke? If yes, how many cigarettes per day? | | | | |  |
| Were you a smoker in the past? It yes for how long and how many cigarettes per day? | | | | |  |
| If applicable, what was the date of your last cigarette? | | | | |  |
| FOOD | | | | | |
| How many times per week do you eat fast food? | | | | |  |
| How many times per week do you eat processed foods? | | | | |  |
| Do you eat organic food? | | | | |  |
| Do you have cravings? If yes, for what type of food? | | | | |  |
| MEDICAL QUESTIONS | | | | | |
| How many bowel movements do you have per day? | | | | |  |
| Have you ever had bowel problems? If yes, what and when? | | | | |  |
| Have you ever had stomach problems? If yes, what and when? | | | | |  |
| Have you ever had cancer? | | | | |  |
| If yes, have you had radiation or chemo? When? | | | | |  |
| What other nutritional programs or diets have you tried? | | | | |  |
| Have you ever tried cleansing? | | | | |  |
| Do you currently exercise? If yes, how often? | | | | |  |
| If no, have you exercised in the past? | | | | |  |
| What is your overall health goal? | | | | |  |
| On a scale of 1-10 (10 being the highest), how would you rate your overall health? | | | | |  |
| On a scale of 1-10 (10 being the highest), how would you rate your overall energy? | | | | |  |
| Do you have any medical conditions? | | | | |  |
| Are you on any medications? If yes, please list? | | | | |  |
| Do you have any allergies? | | | | |  |
| Do you have asthma? | | | | |  |
| Do you have trouble concentrating or staying focussed? | | | | |  |
| Do you have any issues with your joints? | | | | |  |
| Do you have trouble sleeping? | | | | |  |
| How many hours of sleep do you receive per night? | | | | |  |
| What are your typical hours of sleep? | | | | |  |
| Do you have a skin care regime? | | | | |  |

Please feel free to use the space below if you require additional space to answer the above questions or if there are issues that you believe could be beneficial in assisting your sponsor help you achieve your goals with ISAGENIX.