HEALTH SURVEY FORM

First Name ________________________**Last Name** ______________________________________
Age _____**Birthday** _________________**E-Mail**____
Facebook ______________________________________ **Twitter** ___________________________
Cell ____ **Today's Date** _______________________

What is the most important issue to you concerning your health & wellness today?
____

How much weight do you want to lose or gain? ______lbs
What other programs/products have you tried in the past?
____

Why do you feel that these other program(s) did not work?
____

How many meals and snacks do you have daily? (Circle) 1-2 3-4 5 or more
What do you usually have for breakfast? ____
Do you have a problem with snacking? (Circle) YES/NO What is your favorite snack?_______________
If yes, at what time of the day or evening is snacking hardest to control?__________________________
Do you take vitamins or any type of nutritional supplements? (Circle) YES/NO
How much water do you drink daily? ______ glasses *-or-* ______ standard water bottles
How often do you eat out weekly? _________
Where is your energy level, on a scale of 1-10 ___________
On a scale of 1-10, how committed are you on achieving your health and wellness goals?_____________
If you are taking any prescription medications what conditions do you take them for? _______________
____

CHECK ALL THE HEALTH CONDITIONS BELOW THAT APPLY AND/OR ARE OF CONCERN TO YOU

_Acne
_Attention Deficit disorder/ ADHD
_Alcohol Consumption
_Allergies
_Alzheimer's Disease
_Anemia
_Anxiety
_Arthritis
_Asthma
_Back Pain
_Bladder Infections
_Bruise Easily
_Caffeine Consumption
_Calcium Deficiency
_Cancer-Type
____
_Cellulite Accumulation
_Chronic Constipation

_Chronic Fatigue
_Circulation (poor) cold hands or feet
_Depression
_Diabetes Mellitus-Diet, Oral or Insulin
_Fatty Food Consumption
_Gall Bladder Disease/ Gall Stones
_Gall Bladder Removed
_ Gout
_Headaches
_Heartburn
_Heart Disease
_High Blood Pressure
_High Cholesterol
_High Triglycerides
_Insomnia

_Kidney Disease
_Low Energy (Fatigue)
_Low Sexual Stamina
_Lupus
_Menopausal
_Multiple Sclerosis
_Nursing Mother
_Osteoporosis
_Pregnant
_Skin Disorder
_Sleep Disorder
_Smoking
_Stress Level
_Low Medium High
_Stretch Marks
_Ulcers
_Water Retention/Bloating
_Wrinkles

Weight _________
Height _________

Body Fat ______% ______ **lbs**

BMI ______
Protein Factor ______
Resting Metabolic Rate (RMR) ______

Meal Plan _________
Daily Caloric Intake _________

IAM NEWBODY

MEASUREMENTS

	Date	Weight	Neck	Shoulders	Chest	Waist 1	Waist 2	Hips	Glutes	Quad L/R	Bicep L/R
Week 1											
Week 2											
Week 3											
Week 4											
Week 5											
Week 6											
Week 7											
Week 8											
Week 9											
Week 10											
Week 11											
Week 12											