

Your Personal Health and Fitness Check

- | | Yes | No |
|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Do you have problems with stomach, bowels or digestion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are there certain foods that you cannot eat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you prone to bad skin? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you susceptible to colds and infections? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you regularly troubled by allergies such as hay fever? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you often feel tired and exhausted? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Is it difficult for you to concentrate over a longer period of time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you often suffer from headaches and/or migraine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you sometimes feel depressed without any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are you nervous and irritable from time to time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have trouble falling asleep? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you sometimes wake up not feeling rested? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you often have muscle cramps or stiff joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you suffer from osteoporosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you often feel stressed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Are you unhappy with your skin, your hair, and/or your nails? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are you over 40 years of age? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you drink alcohol regularly (3 days per week or more)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have to take medications regularly? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you drink more than 1 liter (34 fl.oz) of coffee and/or black tea per day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you eat less than 5 portions of fresh fruits, vegetables and salads each day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you drink less than 2 liters (68 fl.oz) of clear, calorie-free liquids per day?
(Do not count coffee, tea, alcohol, milk, Coke) | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you often eat ready-to-serve meals, fast-food or in a cafeteria? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you like to spent time in the sun or a tanning salon? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you often diet? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Are you content with your weight? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you know your body mass index or your body fat percentage? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you know your fat burning range? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you exercise regularly?
If YES, what kind of exercise do you? How often? At what intensity level? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Do you have kids? | <input type="checkbox"/> | <input type="checkbox"/> |

Please fill out the form and send me back your Check for a free analysis

Last Name _____ First Name _____ Age _____

Street _____ Zip + City _____ Phone _____

E-Mail _____

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