Name: _____ **Address:** _____
Tel: ____ - _____ - _____ _____

HEALTH SURVEY

What Are Your Health Concerns? Please check all that apply:

[ ] Nutrition	[ ] Immunity Building	[ ] Disease Prevention
[ ] Children's Health	[ ] Anti-Aging	[ ] Women's Health
[ ] Weight Management	[ ] Pet Health	[ ] Men's Health
	[ ] Other:	

Your Family's Health History. Please check all that apply:

[ ] Cancer	[ ] Heart Disease	[ ] Stroke
[ ] High Blood Pressure	[ ] High Cholesterol	[ ] Obesity
[ ] Diabetes	[ ] Other:	

How Many Fruits and Vegetables do you eat on a daily basis?

___ Fruits ___ Vegetables

Do you think it's very important to eat 5 – 9 servings of raw fruits and vegetables every day? (circle one) **Yes No**

Do you take vitamins and/or other supplements? (circle one) **Yes No**

Do you exercise at least 3 times a week for a ½ hour or more? (circle one) **Yes No**

Do you have children?	Boys ___	Girls ____	Ages: _____
Grandchildren?	Boys ___	Girls ____	Ages: _____

Are you interested in finding a convenient way to add more fruits and vegetables to your family's diet every day? (circle one) **Yes No**

Thank You For Your Participation!