Name:_______________________________________________ Date:____________________

8. Do you eat vegetables? (**Please circle: Yes or No**)

If Yes please list:________________________________________________________________________

_____________________________________________________________________________________

9. Do you take Vitamin C supplements? ( **Please circle: Yes or No**)

If Yes what is the dose?__________________

10. Do you take Vitamin B or Niacin? ( **Please circle Yes or No**)

If Yes what is the dose?__________________

11. Do you have an Auto-Immune disease? (**Please circle Yes or No**)

Please list types:________________________________________________________________________

12. How often do you have a bowel movement?_______________________________________________

_____________________________________________________________________________________

13. Please rate your satisfaction with your life in the following areas.

Circle the appropriate number:

**(1= dissatisfied, 2=somewhat dissatisfied, 3= not sure, 4= somewhat satisfied, 5= satisfied)**

| | | | | | |
|---|---|---|---|---|---|
| Physical Health | **1** | **2** | **3** | **4** | **5** |
| Mental Health | **1** | **2** | **3** | **4** | **5** |
| Financial Situation | **1** | **2** | **3** | **4** | **5** |
| Environment/Home Life | **1** | **2** | **3** | **4** | **5** |
| Sexuality/Pleasure | **1** | **2** | **3** | **4** | **5** |
| Creativity | **1** | **2** | **3** | **4** | **5** |
| Spirituality | **1** | **2** | **3** | **4** | **5** |
| Work/Life Purpose | **1** | **2** | **3** | **4** | **5** |
| Relationships | **1** | **2** | **3** | **4** | **5** |
| Emotions | **1** | **2** | **3** | **4** | **5** |