



Health Profile

Name: _____ D.O.B _____

Address: _____ City: _____

Postal/Zip Code: _____

Home #: _____ Work #: _____

Cell #: _____ Email: _____

Occupation: _____

Physical Profile

Weight: _____ Height: _____

Waist Measurement: _____

Is this your first experience with Nu-Life? Yes No

If "no," please explain _____

Daily Habits

How frequently do you consume the following?

	Never	Sometimes	Always		Never	Sometimes	Always
Coffee				Tea			
Tobacco				Alcohol			
Sugar				Salt			
Sugar Substitutes				Carbonated Beverages			
Beef				Poultry			
Pork				Fish			
Seafood				Candy			
Pasta				Bread			
Fruits				Vegetables			

When answering the Health Profile please place an "x" in the that best describes your answer/ condition.

Please describe your health/physical complaint(s):

How long have you been dealing with your health/physical issues? _____

What treatments/methods have you done to try and rectify this health/physical issue?

Have you ever been hospitalized? Yes No

If "yes," for what reason? _____

Do you suffer from anxiety? yes no

If "yes," how often? _____

Do you suffer from other mental illnesses? Yes No

If "yes" what specific illnesses? _____

What percentage is consumed daily? Cooked Food ____% Raw Food ____%

Do you use prescription drugs? Yes No

If "yes," please list: _____

How many times per day is the prescription taken? _____

Do you microwave? Yes No

Do you drink tap water? Yes No

Do you have silver mercury amalgam fillings in your teeth? Yes No

In order to evaluate you, it is important that we know about any symptoms/ diagnoses you have experienced in the past or those that you are currently experiencing. Please place an "x" next to any that apply to you.

Allergies		Food/Drug Addictions	
Anal Itching		Headaches	
AIDS		Heart Disease	
Arthritis		Hemorrhoids	
Backache		Herpes	
Bad Breath		Hormonal Problems	
Baldness		HIV	
Body Odors		Hypoglycemia	
Bowel Disease		Impotence	
Cancer		Infertility	
Candidiasis		Menopause	
Chronic Fatigue Syndrome		Migraines	
Coated Tongue		MS	
Colitis		Obesity	
Communicable Disease		Parkinson's	
Constipation		PMS	
Crohn's Disease		Poor Digestion	
Depression		Pregnancy	
Diabetes		Skin Problems	
Diarrhea		Sleep Disorders	
Digestive Disorders		Thyroid Imbalance	
Fainting		Ulcers	
Fatigue		Other	
Fear			

If "other," please explain _____

Is there a familial history of any of the above issues? Yes No

If "yes" please explain in detail _____
