Complete and return to:

L.I.F.E. Questionnaire

Lifestyle Inquires for Evaluation

SSN#: ______________________________

Name ______________________________ Date ______________________________

Phone (   )______________________________ Fax Number (   )______________________________

E-mail______________________________

Address ______________________________ City______________________________ State ________ Zip ____________

Age ____________ Birth date ____________________ Male ________ Female ________ Height ______________ Weight____________

Chief Complaint ______________________________

PRESCRIPTION DRUG USAGE - Please check if you use any of the following:

A. ❑Antacids, Zantac, Pepcid AC, Rolaids, etc.
   ❑Chemotherapy

B. ❑Laxatives
   ❑Ulcer Medications
   ❑Antibiotic/Antifungal

C. ❑Anti-diabetic/Insulin

D. ❑Oral Contraceptives

E. ❑Hormones

F. ❑Relaxants/Sleeping Pills
   ❑Thyroid
   ❑Radiation
   ❑Antidepressants

G. ❑Aspirin/Acetaminophen
   ❑Cortisone/Anti-Inflammatory
   ❑Heart Medications
   ❑High Blood Pressure Medicine

*Note: If you are taking OTC medications, prescription drugs, and/or nutritional supplementation, consult your Physician for possible drug interactions.

`

Check if you are currently taking any OHS supplements:

❑Digestion
❑Vitamin/Mineral
❑Fat/Sugar/Trim
❑Acute
❑Chronic
❑Liver/Kidney

❑Flora
❑Iron
❑Oxy-Pure
❑Complete Nutrition +
❑Calcium
❑Opti-Force

❑Male +T
❑Female +B
❑BonePlus
❑Opti-Cleanse
❑Whole B
❑Rem Sleep

❑Adrena Boost
❑Whole C
❑Defense
❑Natural Vitality
❑Essential Fatty Acids
❑

❑Muscle Rx
❑Longevi-D

List any other supplements you are currently taking:______________________________

____

DIETARY HABITS: Describe the foods you normally eat:

BREAKFAST:______________________________

LUNCH:______________________________

DINNER: ______________________________

2015 OHS FOR LIFE

SNACKS: ____ **Client Name:**_________________ **Date:** ___________

Please circle YES or NO **Health Professional:** ________________________

Do you consume:

1.	Soda or carbonated beverages of any kind including carbonated water?	YES	NO	1.
2.	White flour products?	YES	NO	2.
3.	Fried foods?	YES	NO	3.
4.	Fast foods regularly?	YES	NO	4.
5.	Fifty percent of your food in its raw form?	YES	NO	5.
6.	Sugars other than fructose, sucanat, stevia, or raw organic honey?	YES	NO	6.
7.	Artificial sweeteners?	YES	NO	7.
8.	Candy?	YES	NO	8.
9.	Red meat or pork?	YES	NO	9.
10.	Tap water? If no, what type? _________________________	YES	NO	10.
11.	Eight to ten glasses of water daily?	YES	NO	11.
12.	Coffee?	YES	NO	12.
13.	Alcoholic beverages?	YES	NO	13.
14.	Artificial colors, flavoring, MSG or preservatives (BHT, etc.)	YES	NO	14.
15.	Hydrogenated or partially hydrogenated oils?	YES	NO	15.
16.	Any tobacco products?	YES	NO	16.
17.	Real butter as opposed to margarine?	YES	NO	17.
18.	Oils in the form of extra virgin olive oil and safflower or canola oil daily?	YES	NO	18.
19.	One Tbsp. of flax seeds daily?	YES	NO	19.
20.	Are you a vegetarian?	YES	NO	20.
21.	At least six servings of whole grains daily? (Serving size: 1 piece of bread or ¾ c. oatmeal)	YES	NO	21.
22.	At least three servings of fresh fruit daily? (Serving size is ½ c. chopped)	YES	NO	22.
23.	At least three servings of vegetables daily? (Serving size is ½ c. chopped)	YES	NO	23.
24.	Two to three servings of protein daily (eggs, raw nuts, legumes, beans, lean meats)?	YES	NO	24.
25.	Two servings daily of dairy (low-fat milk, cottage cheese, yogurt, etc.)?	YES	NO	25.
26.	Mainly grains, some fruits and vegetables, a small amount of dairy and protein and sparingly fats, oils and sweets daily	YES	NO	26.

27. Are you currently involved in an aerobic exercise program? ❑Yes ❑No How many days per week?________

28. Are you currently involved in a strength-training program? ❑Yes ❑No How many days per week?________

*Refer to **21 Day Challenge** to make positive lifestyle changes.*

2015 OHS FOR LIFE

Client Name:_________________ **Date:** ___________

Health Professional: _______________________

INSTRUCTIONS:
Circle the best answer that describes the intensity of your symptoms.
If you do not know the answer to a question, leave it blank.
Repeated questions should be answered as they appear.

N-0 = NO Y-2 = YES S-1 = SOMETIMES

**Questions marked by these asterisks are to be completed by your Health Professional. Do NOT total the sections.

Section 1: Digestion

Question			
Do you experience bloating?	N-0	Y-2	S-1
Fullness for extended time after meals?	N-0	Y-2	S-1
Sleepy or low energy after eating?	N-0	Y-2	S-1
Do you experience indigestion or take antacids?	N-0	Y-2	S-1
Uncomfortable/adverse reactions to food?	N-0	Y-2	S-1
**Additional lifestyle questions.	N-0	Y-2	S-1
**Testing: Indican	0 1	2	3

Total Score ________________

Section 2: Vitamin/Mineral/Antioxidants

Question			
Do you have varicose veins/ bruise easily?	N-0	Y-2	S-1
Do you have poor stamina?	N-0	Y-2	S-1
Do you have persistent leg cramps?	N-0	Y-2	S-1
Are you nervous/ have poor concentration?	N-0	Y-2	S-1
Is your vision failing rapidly?	N-0	Y-2	S-1
**Additional lifestyle questions.	N-0	Y-2	S-1
**Testing:	0 1	2	3

Total Score ________________

Section 3: Essential Fatty Acids

Question			
Do you have dry skin?	N-0	Y-2	S-1
Do you experience grinding in your joints?	N-0	Y-2	S-1
Days without eating avocados, raw nuts, flax seeds(oil) etc.?	N-0	Y-2	S-1
Do you suffer from learning disabilities or poor concentration?	N-0	Y-2	S-1
Are you overweight?	N-0	Y-2	S-1
**Additional lifestyle questions.	N-0	Y-2	S-1
**Testing:	0 1	2	3

Total Score ________________

Notes: ____

Section 4: Fat/Sugar/Trim

Question			
Do you crave sweets and sugars?	N-0	Y-2	S-1
Do you feel weak/faint between meals?	N-0	Y-2	S-1
Do you crave a lot of foods for no reason?	N-0	Y-2	S-1
Are you unable to lose or gain weight?	N-0	Y-2	S-1
Family history of diabetes?	N-0	Y-2	S-1
**Additional lifestyle questions.	N-0	Y-2	S-1
**Testing: Lipid Panel	0 1	2	3

Total Score ________________

Section 5: Acute

Question			
Have you been on a high-protein diet or eat more than 6 oz. of protein a day?	N-0	Y-2	S-1
Are your injuries slow to heal?	N-0	Y-2	S-1
Do you have frequent fevers or infections?	N-0	Y-2	S-1
Do you have muscle cramps or pain?	N-0	Y-2	S-1
Have you been injured within last 3 months?	N-0	Y-2	S-1
**Additional lifestyle questions.	N-0	Y-2	S-1
**Testing:	0 1	2	3

Total Score ________________

Section 6: Chronic

Question			
Do you have chronic pain?	N-0	Y-2	S-1
Do you have bursitis?	N-0	Y-2	S-1
History of joint injury?	N-0	Y-2	S-1
Do you have swollen joints/arthritis?	N-0	Y-2	S-1
Do you have increased flexibility in your joints? (double-jointed)	N-0	Y-2	S-1
**Additional lifestyle questions.	N-0	Y-2	S-1
**Testing:	0 1	2	3

Section 7: Liver/Kidney

Question			
Are the whites of your eyes yellowish?			
Do you experience back pain over kidneys?			
Do you have strong-smelling urine?			
Do you take anti-inflammatory drugs?			
Do you have age spots?			
**Additional lifestyle questions.	N-0	Y-2	S-1
**Testing: Lipid Panel	0 1	2	3

2015 OHS FOR LIFE

Total Score ________________

Client Name:__________________ Date: ____________
Health Professional: ________________________

"The Doctor of the future will give no medicine,
but will interest his patients in the care of the human body,
in diet, and in the cause and prevention of disease."

- Thomas Edison

Section 8: Iron

Do you have anemia?	N-0	Y-2	S-1
Is your skin clammy?	N-0	Y-2	S-1
Do you have frequent headaches?	N-0	Y-2	S-1
Do you experience low energy or fatigue?	N-0	Y-2	S-1
Do you exercise over 6 hours a week?	N-0	Y-2	S-1
**Additional lifestyle questions.	N-0	Y-2	S-1
**Testing:	0 1	2	3

Total Score ________________

Section 9: Flora

Do you consume dairy products, meat and/or poultry?	N-0	Y-2	S-1
Are you taking or have taken antibiotics within the last 90 days?	N-0	Y-2	S-1
Do you have a history of food poisoning?	N-0	Y-2	S-1
Have you traveled overseas in the last 3 mos?	N-0	Y-2	S-1
Do you have persistent gas?	N-0	Y-2	S-1
**Additional lifestyle questions.	N-0	Y-2	S-1
**Testing:	0 1	2	3

Total Score ________________

Section 10: OxyPure

Do you get fungal/yeast infections?	N-0	Y-2	S-1
Do you seem to get sick easily?	N-0	Y-2	S-1
Do you have food allergies?	N-0	Y-2	S-1
Do you experience anal itching?	N-0	Y-2	S-1
Do you experience congestion?	N-0	Y-2	S-1
**Additional lifestyle questions.	N-0	Y-2	S-1
**Testing:	0 1	2	3

Total Score ________________

Section 11: BonePlus

Have you had any hormonal problems?	N-0	Y-2	S-1
Do you have osteoporosis?	N-0	Y-2	S-1
Days without eating raw leafy green vegetables?	N-0	Y-2	S-1
Are you over 50?	N-0	Y-2	S-1
Do you have a small frame or low weight?	N-0	Y-2	S-1
**Additional lifestyle questions.	N-0	Y-2	S-1
**Testing: Bone Density	0 1	2	3

Total Score ________________

Section 12 - MALES ONLY:

Does your bladder always feel full?	N-0	Y-2	S-1
Do you experience inconsistent pressure or pain during urination?	N-0	Y-2	S-1
Does ejaculation cause pain?	N-0	Y-2	S-1
Do you experience low sex drive?	N-0	Y-2	S-1
Do you have premature ejaculation?	N-0	Y-2	S-1
**Additional lifestyle questions.	N-0	Y-2	S-1
**Testing:	0 1	2	3

Total Score ________________

Section 13 - FEMALES ONLY:

Do you experience depression, moodiness/irritability?	N-0	Y-2	S-1
Do you have heavy menstrual bleeding?	N-0	Y-2	S-1
Do you have monthly cramps?	N-0	Y-2	S-1
Do you have tender breasts?	N-0	Y-2	S-1
Are you postmenopausal?	N-0	Y-2	S-1
**Additional lifestyle questions.	N-0	Y-2	S-1
**Testing:	0 1	2	3

Total Score ________________

Section 14: Opti-Cleanse

Are you ever constipated?	N-0	Y-2	S-1
Do you ever experience diarrhea?	N-0	Y-2	S-1
Do you take laxatives?	N-0	Y-2	S-1
Day or days without a bowel movement?	N-0	Y-2	S-1
Have you been exposed to metal toxicity?	N-0	Y-2	S-1
**Additional lifestyle questions.	N-0	Y-2	S-1
**Testing:	0 1	2	3

Total Score ________________

Section 15: Whole B

Are you using antibiotics?	N-0	Y-2	S-1
Do you have red lips or cracks at the corners of your mouth?	N-0	Y-2	S-1
Do you suffer from mental disorders?	N-0	Y-2	S-1
Are you a vegan?	N-0	Y-2	S-1
Eyes: burn, red, itch or sensitive to light?	N-0	Y-2	S-1
**Additional lifestyle questions. (Females: are you pregnant?)	N-0	Y-2	S-1
**Testing:	0 1	2	3

Total Score ________________

2015 OHS FOR LIFE

Client Name:________________ Date: ___________
Health Professional: ________________________

Section 16: Vitamin C

Do you experience bleeding gums? N-0 Y-2 S-1
Do you experience frequent colds
or flu like symptoms? N-0 Y-2 S-1
Days without fresh fruit? N-0 Y-2 S-1
Do you currently take a synthetic Vitamin C
Supp
Do you
**Add
**Test

Client Name:________________ Date: ___________
Health Professional: ________________________

Section 17: Adrenal (adrena-boost herbal or opti-adrenal)

Do you experience light headedness
when standing up? N-0 Y-2 S-1
Do you rely on coffee, tea or soda
to make it through the day? N-0 Y-2 S-1
Do you experience high stress levels? N-0 Y-2 S-1
Are you an adrenaline junkie? N-0 Y-2 S-1
Is it difficult for you to maintain or gain
weight? N-0 Y-2 S-1
**Additional lifestyle questions. N-0 Y-2 S-1
**Testing: Adrenal Sufficiency 0 1 2 3

Total Score _______________

Section 18: Defense

Do you have prolonged exposure to sun? N-0 Y-2 S-1
Do you consume alcohol? N-0 Y-2 S-1
Are you exposed to toxic substances? N-0 Y-2 S-1
(fumes, chemicals, smoke, etc.)
Are you currently being treated
with medications? N-0 Y-2 S-1
Do you partake in strenuous activities
for more than 1 hour at a time? N-0 Y-2 S-1
**Additional lifestyle questions. N-0 Y-2 S-1
**Testing: 0 1 2 3

Total Score _______________

Section 19: Longevi-D

Experience heartburn after meals? N-0 Y-2 S-1
Under stress, do you experience
stomach pains? N-0 Y-2 S-1
Drink alcohol or sodas? N-0 Y-2 S-1
Do you take over the counter antacids? N-0 Y-2 S-1
Ever been diagnosed with an ulcer? N-0 Y-2 S-1
**Additional lifestyle questions. N-0 Y-2 S-1
**Testing: 0 1 2 3

Total Score_______________

Section 20: Calcium

Do you eat a lot of processed fatty foods? N-0 Y-2 S-1
Eat more than 3 oz. servings of protein daily? N-0 Y-2 S-1
When you grab your wrist, does your
finger and thumb easily touch? N-0 Y-2 S-1
Do you salt your foods? N-0 Y-2 S-1
Drink caffeinated drinks (coffee,sodas)? N-0 Y-2 S-1
**Additional lifestyle questions. N-0 Y-2 S-1
**Testing: Calcium level 0 1 2 3

Total Score _______________

Section 21: Opti Force

Exposed to pesticides, paint or
hair chemicals? N-0 Y-2 S-1
Family History of cancer? N-0 Y-2 S-1
Do you bruise easily? N-0 Y-2 S-1
Are you sensitive to chemicals or
environmental pollution? N-0 Y-2 S-1
Do have vision problems? N-0 Y-2 S-1
**Additional lifestyle question. N-0 Y-2 S-1
**Testing: Oxidata Free Radical 0 1 2 3

Total Score _______________

Section 22: Complete Nutrition +

Do you eat less than 4-6 servings of complex
carbs a day? N-0 Y-2 S-1
Do you consume animal protein? N-0 Y-2 S-1
In your opinion is your diet out of balance? N-0 Y-2 S-1
Are you around toxins or chemicals daily? N-0 Y-2 S-1
Do you skip meals frequently N-0 Y-2 S-1
**Additional lifestyle questions. N-0 Y-2 S-1
**Testing: Adrenal Sufficiency 0 1 2 3

Total Score _______________

Section 23: Fruit and Veggie Plus

Do you eat less than 4-6
servings a day of Fruits? N-0 Y-2 S-1
Do you feel you are aging prematurely? N-0 Y-2 S-1
Is your vision worsening? N-0 Y-2 S-1
Are you around chemicals &
pollutants on a daily basis? N-0 Y-2 S-1
Do you eat less than 4-6
servings a day of Vegetables? N-0 Y-2 S-1
**Additional lifestyle questions. N-0 Y-2 S-1
**Testing: Adrenal Sufficiency 0 1 2 3

Total Score _______________

Section 24: Muscle Rx

Do you eat the same diet but put on weight
easier? N-0 Y-2 S-1
Has your muscle strength gone down as

Section 25 Natural Vitality

Do you have low energy? N-0 Y-2 S-1
Do you have trouble with focus? N-0 Y-2 S-1

you have aged?	N-0	Y-2	S-1
Have you been diagnosed with sarcopenia?	N-0	Y-2	S-1
Do you want to increase muscle strength?	N-0	Y-2	S-1
Do you have scoliosis or a spine weakness?	N-0	Y-2	S-1
**Additional lifestyle questions.	N-0	Y-2	S-1
**Testing: Adrenal Sufficiency	0 1	2	3

Total Score ________________

Section 25: Rem Sleep

Do you have a hard time getting to sleep?	N-0	Y-2	S-1
Are you tired when you wake up?	N-0	Y-2	S-1
Do you get tired in the afternoons?	N-0	Y-2	S-1
Do you get anxiety?	N-0	Y-2	S-1
Is it hard for you to be in large crowds?	N-0	Y-2	S-1
**Additional lifestyle questions.	N-0	Y-2	S-1
**Testing: Adrenal Sufficiency	0 1	2	3

Total Score ________________

Are your energy levels consistent throughout day?	N-0	Y-2	S-1
Do you take caffeine or energy drink/formulas?	N-0	Y-2	S-1
Do you fall asleep in meetings or shows?	N-0	Y-2	S-1
**Additional lifestyle questions.	N-0	Y-2	S-1
**Testing: Adrenal Sufficiency	0 1	2	3

Total Score ________________

Section 26:

LIST ANY SPECIFIC ILLNESSES, COMPLAINTS OR CONDITIONS THAT ARE OF IMPORTANCE THAT WERE NOT ADDRESSED IN THE QUESTIONNAIRE: