Health Assessment & Documentation Sheet

Instructions: Type your information directly into the fields below. To check off symptoms that you have, click on the space next to the symptom. Save the document to your computer when done. You can also print this sheet out blank and fill it in by hand.

Start Date: _____ **Current Weight**: _____lbs
Ideal Weight: _____lbs **Date Ideal Weight Reached:** _____

Check off any of the symptoms you currently have:

CONDITION	NOW	5 DAYS	10 DAYS	30 DAYS
Low Energy/Often Tired				
Skin Problems/Acne/Scarring				
Eczema/Psoriasis/Rosacea/Other Rashes				
Joint Pain/Arthritis				
Muscle Cramps				
Menstrual Cramps/PMS				
Hot Flashes				
Frequent Colds & Infections				
Poor Memory				
Cravings for Sweets/Salts				
Frequent Headaches				
Difficulty Falling Asleep				
Often Bloated				
Heartburn/Indigestion				
Constipation/Diarrhea				
Hemorrhoids				
Hair Loss				
Cellulite				
Allergies/Hay Fever				
Body Odor/Bad Breath				
Low Endurance Level				
Yeast/Fungus/Thrush				
TOTAL CHECKMARKS				

Product(s) Used To Achieve Results:

_____ _____ _____

_____ _____ _____

_____ _____ _____