

EXERCISE

How often do you exercise? _____ What type of exercise? _____

For how long? _____ Hobbies: _____

SLEEP

How long per night? _____ If you wake up frequently, what is the reason? _____

Nightmares: Y N P Wake Refreshed: Y N P Must nap during the day: Y N P

Sleep walk: Y N P Grind Teeth: Y N P Snore: Y N P

TOXIN EXPOSURE

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home? _____

What line of cleaning products do you use? _____

What line of face and body products? _____

SOCIAL LIFE

Enjoy job: Y N P Hours worked per week: _____ Highest Level of Education: _____

Active spiritual practice: Y N P Quality of significant relationship: _____

History of sexual, mental/emotional, physical abuse: Y N P If so, at what age and by whom: _____

What is your greatest health concern? _____

How does it limit you the most? _____

How committed are you towards making valuable changes? Little Moderately Very