PERSONAL ANALYSIS

Name: _____ **Date:** _____

Address: _____ **Postal Code** _____

Home Phone: _____ **Cell:** _____ **Work:** _____ **Ext** _____

How many 8 oz servings of the following do you drink each day?

a) Coffee _____ □ Regular □ Decaf What do you put in your coffee? _____

b) Tea _____ □ Regular □ Herbal c) Pop _____ □ Regular □ Diet

d) Pop _____ □ Regular □ Diet e) Energy/Sports Drinks _____

f) Water _____ □ Tap □ Bottled □ Filtered g) Alcohol _____

h) Juices _____ What kinds? _____

Give a brief description of a typical day of eating for you:

Breakfast	***Morning Snack***	***Lunch***	***Afternoon snack***	***Dinner***	***Evening Snack***

Do you use any artificial sweetener? □ Yes □ No **What kind?** _____

How many times a week do you eat fast food? _____ **Processed foods**? _____

Do you tend to have cravings? _____ **What do you crave?** _____

Do you eat organic foods? □ Yes □ No

Are you on any prescription medications? □ Yes □ No

What medical condition are they for? _____

Do you have any other medical conditions that you are under a doctor's care for? _____

_____

Do you have any allergies?

_____

Have you ever had cancer? □ Yes □ No **What kind?** _____ **When?** _____

Did you have radiation or chemotherapy? □ Yes □ No

With any of your medical conditions, have you ever been told not to eat certain foods or vitamins? □ Yes □ No

Do you work with any chemicals? □ Yes □ No

Do you currently smoke? □ Yes □ No **If yes, how many daily?** _____

Have you ever smoked? □ Yes □ No **When did you quit?** _____

Are you pregnant or nursing? □ Yes □ No

How many bowel movements do you have per day? _____ **per week?** _____**Have you ever had bowel problems?** □ Yes □ No **What was the problem?** _____**Have you ever had stomach problems?** □ Yes □ No **What was the problem?** _____

What other nutritional programs or diets have you tried? _____

Have you tried cleansing before? □ Yes □ No
What nutritional supplements do you take? _____

What is your current training or workout routine? How many times per week, how long, how intense etc.

_____

What is your highest value in life? _____

On a scale of 1-10 (with 10 being the best), how would you rate your over all health? _____
Where would you LIKE it to be? _____
On a scale of 1-10 (with 10 being the best), how would you rate your over all energy? _____
Where would you LIKE it to be? _____
On a scale of 1-10 (with 10 being the worst), how would you rate your level of stress? _____
Where would you LIKE it to be? _____
On a scale of 1-10 (with 10 being the best), how would you rate your financial health? _____
Where would you LIKE it to be? _____

What benefits would you like to experience:

□ Detoxification	□ Less discomfort	□ Improved mobility
□ Increased energy	□ Enhanced mental clarity	□ Better sleep
□ Sugar balance	□ Build lean muscle mass	□ Get rid of a bad habit
□ Better athletic performance	□ Improved digestion	□ Decreased stress levels
□ Improve a relationship	□ Other	

1. **What goals or intentions do you have for yourself in taking part in this program**

30 Day _____
90 Day _____
1 Year _____

On a scale of 1-10, how important is it for you to reach these goals?

If I could wave a MAGIC WAND and time and money was no issue at all and you could do absolutely anything in your life, WHAT WOULD THAT BE? WHAT WOULD MAKE YOU SHINE? What LIGHTS YOU up?

I am 100 percent committed to your success. How can I best support you as your cleanse coach?

_____

_____

How would you describe your willingness to be coached / guided to attain these goals?

□ **High** □ **Medium** □ **Low**

Do you commit to staying in touch with your cleanse coach?

What is the best way to contact you, phone or email? _____
Who are your Support Team? - List the 10 positive people in your life who will want you to succeed.

_____

Who would you like to cleanse with you? _____