

PERSONAL HISTORY AND PROFILE

This form must be completed and submitted in order to receive a telephone consultation and/or an access code to the Company Store. Please allow approximately 5 minutes to complete. Form may be e-mailed, printed and faxed or mailed.

Mail to:
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310-473-8225

RoseNutrition.com and Rose Nutrition Center respects your privacy. We will not disclose your individual identity or personally identifiable information without your prior consent except as required by law, court order, or as requested by other government or law enforcement authority.

PRINTER FRIENDLY VERSION

PART 1 – GENERAL INFORMATION

Last Name: _____

First Name: _____

Email address: _____

Daytime Telephone Number:* _____ *(optional)

Age: _____

Height: _____

Weight: _____

Desired Weight: _____

Occupation: _____

Gender: Male Female

PART 2 – LIFESTYLE INFORMATION

Do you smoke? Yes No

How many years?

When did you quit?

How much exercise do you get?

- 5-7 days per week
- 3-5 days per week
- less than 3 days per week

Type of exercise:

- aerobic
- anaerobic
- combination of aerobic and anaerobic

Duration of exercise:

- less than 30 minutes per session
- between 30 and 60 minutes per session
- more than 60 minutes per session

How many hours of sleep do you get each night?

- Less than 6
- between 6 – 7
- between 7 – 8
- More than 8

How stressful do you perceive your life to be?

- Extremely stressful
- Moderately stressful
- Not stressful

How often do you eat in restaurants?

- More than 7 meals a week
- 3 – 7 meals a week
- Less than 3 meals a week

PART 3 – PHYSICAL HEALTH

Do you currently have, or have you had in the last 5 years, any of the following conditions:

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Surgery (please explain below) |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other (please explain below) |

Surgery (explanation): _____

Other (explanation): _____

Do you think you have ever been “addicted” to any of the following?

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Caffeine |
| <input type="checkbox"/> Sugar | <input type="checkbox"/> Cocaine |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Junk Food | <input type="checkbox"/> Other (please explain below) |

Other (explanation): _____

Do you experience bloating or discomfort after eating?

- No or Rarely** (you have never experienced the symptom, or you have experienced it and perceive it to be insignificant)
- Occasionally** (symptom comes and goes, but is linked to stress or some other identifiable trigger)
- Often** (symptom occurs 2-3 times per week, or enough to bother you)
- Frequently** (symptom occurs 4 or more times per week and/or on a regular basis)

Do you experience reflux or heartburn after eating?

- No or Rarely** (you have never experienced the symptom, or you have experienced it and perceive it to be insignificant)
- Occasionally** (symptom comes and goes, but is linked to stress or some other identifiable trigger)
- Often** (symptom occurs 2-3 times per week, or enough to bother you)
- Frequently** (symptom occurs 4 or more times per week and/or on a regular basis)

Does your energy ebb and flow during the day?

- No or Rarely** (you have never experienced the symptom, or you have experienced it and perceive it to be insignificant)
- Occasionally** (symptom comes and goes, but is linked to stress or some other identifiable trigger)
- Often** (symptom occurs 2-3 times per week, or enough to bother you)
- Frequently** (symptom occurs 4 or more times per week and/or on a regular basis)

Do you get agitated or lightheaded if you miss a meal or go too long without eating?

- No or Rarely** (you have never experienced the symptom, or you have experienced it and perceive it to be insignificant)
- Occasionally** (symptom comes and goes, but is linked to stress or some other identifiable trigger)
- Often** (symptom occurs 2-3 times per week, or enough to bother you)
- Frequently** (symptom occurs 4 or more times per week and/or on a regular basis)

How many bowel movements do you have each day?

- 2 – 3
- 1 – 2
- 1 approximately every other day
- 1 every two or three days or irregular

What is your first health goal? _____

What is your second health goal? _____

Are you currently taking any over-the-counter or prescription medications? (Please list below)

PART 4 – CONSULTATIONS

What type of consult are you interested in?

- Initial Consultation
- Basic Phone Consultation (15 minutes)
- Half-hour Phone Consultation
- Half-hour Phone Consultation with Chemistry

PART 5 – AGREEMENT (agreement to the following is mandatory to receive a consultation and Personal Nutrition Program)

I understand that any suggested program I may receive from Rose Nutrition Center has been prepared, at my request, solely for the purpose of providing nutritional education. Any suggestions made by Rose Nutrition Center relating to nutrition, including herbs, vitamins, minerals, juices, food supplements, teas and food in general, are not to be interpreted or construed as a “diagnosis” in any manner whatsoever. In the event that I use this information without supervision or approval of a medical doctor, I may be “prescribing” for myself, which is my constitutional right, but for which Rose Nutrition Center assumes no responsibility. Therefore, this information is offered without any claims as to what it may or may not do. I further understand that this is a suggested program and is strictly voluntary. If I follow it, I do so according to my own will and at my own risk.

- I agree to the foregoing

SUBMIT