

# BOOST ENERGY

## DO IT, DOING IT, DONE IT!

If your grand total was more than 50 then you should consider doing the Ethical Nutrients Energy and Detox program. It may improve your overall health and energy. Please speak to the Vitamin Consultant within the store.

**Important - Please seek further advice if you answer yes to any of the questions below.**

- Are you pregnant? Y/N
- Do you have any serious medical conditions such as heart disease, epilepsy or cancer? Y/N
- Is your total score over 150? Y/N

If you answered yes to any of these questions then this program may not be suitable for you or may need to be altered. Please discuss this with your Vitamin Consultant or Healthcare Practitioner.

For more information go to [www.ethicalnutrients.com.au](http://www.ethicalnutrients.com.au)



Do you lead an incredibly **busy** life? Would you like to feel full of **vitality**? Would you like to look and feel **younger**? Would you like extra support to **motivate** you and **help you** regain your spark?



Fill out the enclosed **questionnaire** to discover if you would **benefit** from the Ethical Nutrients **Energy** and Detoxification Program.

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**Our Program may be beneficial if you would like to:**

- Increase energy
- Have a better complexion
- Assist concentration
- Eat a better diet
- Improve digestion
- Look and feel healthier

ETH2178 - HEQ - 03/08



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# Ethical Nutrients Health & Energy Questionnaire

Customer's Name:

Commencement Date:

End Date:

Rate each of the following symptoms based upon your typical health profile. Fill in the "Before" column based on how you are feeling now, and after your detox, fill in the "After" column.

**Point Scale:** 0 - Never  
1 - Rarely  
2 - Some of the time  
3 - Often  
4 - Always/Constantly

## SECTION 1

ENERGY/ ACTIVITY		Before	After
Constant fatigue		<input type="checkbox"/>	<input type="checkbox"/>
Poor sleeping pattern		<input type="checkbox"/>	<input type="checkbox"/>
Waking fatigued		<input type="checkbox"/>	<input type="checkbox"/>
Energy slumps during the day		<input type="checkbox"/>	<input type="checkbox"/>
Feeling anxious or upset		<input type="checkbox"/>	<input type="checkbox"/>
Mood swings		<input type="checkbox"/>	<input type="checkbox"/>

MIND		Before	After
Poor memory and concentration		<input type="checkbox"/>	<input type="checkbox"/>
Not thinking clearly		<input type="checkbox"/>	<input type="checkbox"/>
Anger and irritability		<input type="checkbox"/>	<input type="checkbox"/>
Cravings due to fatigue		<input type="checkbox"/>	<input type="checkbox"/>

MUSCLE		Before	After
Pain or aches in joints		<input type="checkbox"/>	<input type="checkbox"/>
Muscle fatigue		<input type="checkbox"/>	<input type="checkbox"/>
Stiffness or limitation of movement		<input type="checkbox"/>	<input type="checkbox"/>
Pain or cramping in muscles		<input type="checkbox"/>	<input type="checkbox"/>
Headaches		<input type="checkbox"/>	<input type="checkbox"/>

BLOOD HEALTH		Before	After
Breathless when exercising		<input type="checkbox"/>	<input type="checkbox"/>
Excessive bleeding or heavy periods		<input type="checkbox"/>	<input type="checkbox"/>
Are you a vegetarian? (if yes add 4 points)		<input type="checkbox"/>	<input type="checkbox"/>

Section 1 total:

## SECTION 2

DIGESTIVE SYSTEM		Before	After
Nausea or vomiting		<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea or loose stools		<input type="checkbox"/>	<input type="checkbox"/>
Constipation		<input type="checkbox"/>	<input type="checkbox"/>
Bloated feeling		<input type="checkbox"/>	<input type="checkbox"/>
Belching, passing gas		<input type="checkbox"/>	<input type="checkbox"/>
Heartburn		<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain		<input type="checkbox"/>	<input type="checkbox"/>
Undigested food particles in stool		<input type="checkbox"/>	<input type="checkbox"/>

HEAD	Headaches	Before	After
		<input type="checkbox"/>	<input type="checkbox"/>

  

EYES, NOSE, MOUTH AND THROAT		Before	After
Watery or itchy		<input type="checkbox"/>	<input type="checkbox"/>
Swollen or red		<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing through nose		<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems		<input type="checkbox"/>	<input type="checkbox"/>
Hay fever		<input type="checkbox"/>	<input type="checkbox"/>
Excess mucous formation		<input type="checkbox"/>	<input type="checkbox"/>
Chronic coughing		<input type="checkbox"/>	<input type="checkbox"/>
Frequent need to clear throat		<input type="checkbox"/>	<input type="checkbox"/>
Swollen or coated tongue		<input type="checkbox"/>	<input type="checkbox"/>
Cracks in the corner of mouth		<input type="checkbox"/>	<input type="checkbox"/>
Frequent illness		<input type="checkbox"/>	<input type="checkbox"/>

SKIN		Before	After
Acne		<input type="checkbox"/>	<input type="checkbox"/>
Hives or rashes		<input type="checkbox"/>	<input type="checkbox"/>
Eczema/ dermatitis/ psoriasis		<input type="checkbox"/>	<input type="checkbox"/>
Fungal infections		<input type="checkbox"/>	<input type="checkbox"/>

CHEST		Before	After
Chest congestion		<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath		<input type="checkbox"/>	<input type="checkbox"/>
Allergies or wheeze		<input type="checkbox"/>	<input type="checkbox"/>
Coughing		<input type="checkbox"/>	<input type="checkbox"/>

WEIGHT		Before	After
Binge eating or drinking		<input type="checkbox"/>	<input type="checkbox"/>
Craving certain foods		<input type="checkbox"/>	<input type="checkbox"/>
Excessive weight		<input type="checkbox"/>	<input type="checkbox"/>

Section 2 total:

## SECTION 3

- Do you eat less than six serves of fruit and vegetables a day? Yes (2 points)
- Do you drink more than one glass of soft drink or cordial a day? Yes (2 points)
- Do you eat takeaway food more than once a week? Yes (2 points)
- Do you eat chocolate, chips or junk food more than once a week? Yes (2 points)
- Do you smoke regularly? Yes (2 points)
- Do you regularly drink more than one standard drink per night or binge drink? Yes (2 points)

Section 3 total:

Add up section 1, 2 and 3 scores. This will be your grand total.

GRAND TOTAL: