

Please check any physical challenges you currently have . . .

	You	Family	Friend		You	Family	Friend
Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Inflammation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Infection/Flu/Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Histamine Levels/Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Insulin Needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo (Dizziness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts/Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Carpal Tunnel Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weak Arteries and Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good Cellular Collagen/Elasticity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor Lower Leg Blood Volume	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Energy/Stamina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor Capillaries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fat Formation/Cellulite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rough Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids/Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brusing/Cracking Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menopause/PMS/Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aging Concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged Artery Lining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Environmental Concerns			
Joint Flexibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wrinkling of the skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis - Inflammation/Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pollution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Hay Fever/ Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				All Free Radical Damage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name: _____

Address: _____

Phone : _____ • E-mail: _____

Do you take vitamins? yes no
 Are you familiar with *ANTIOXIDANTS* and what they do? yes no
 Do you know about *FREE RADICALS* and where they come from? yes no
 Do you know that more than 60 human diseases can be associated with *FREE RADICALS* and their effects on our bodies? yes no

Is there any reason you would not be willing to use a product that would address these concerns? yes no