LIFEWAVE® BRAND PARTNER

HEALTH AWARENESS
RATE YOUR HEALTH

Name _____ Date: _____

Phone # _____ Event: _____

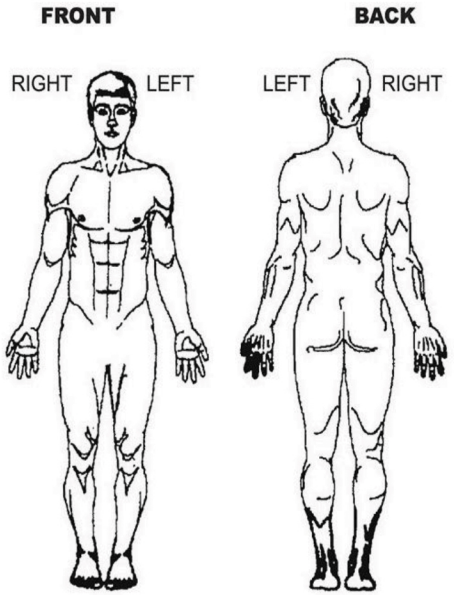
Email Address _____

Referred By: _____

Check Top 5	(1=poor 10=great)	Rate 1 to 10
	Health / Well-being	
	Pain	
	Inflammation	
	Quality of Sleep	
	Energy & Vitality	
	Mental Clarity	
	Headaches	
	Eye Health / Vision	
	Hormone Levels	
	Digestion	
	Skin Appearance	
	Hair & Nails	
	Sports Perf. / Recovery	

PAIN DIAGRAM

Circle the area(s) of most concern describe below



Describe Pain:

Prescriptions / Ailments

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Hormone Levels
Digestion
Skin Appearance
Hair & Nails
Sports Perf. / Recovery

PAIN DIAGRAM

Circle the area(s) of most concern describe below

FRONT
BACK
RIGHT
LEFT
LEFT
RIGHT

Describe Pain:

Prescriptions / Ailments