WELLNESS IMPROVEMENT EXPERTS
Wellness Profile

Dear Wellness Client,

The Wellness Profile form is below. To complete it, type your responses in the yellow background fields. Please read and follow its instructions carefully as your honesty and thoroughness will influence the accuracy and value to you of your Wellness Profile report. Your responses to each statement in the "Points Section" should be about your experiences in the **last 6 to 12 months**, except for those that state "history" which means anytime in your past. Rate each experience according to its severity; **Mild** =1, **Moderate** =2, **Severe** =3; when it occurs. Or the frequency of its occurrence; **Infrequent** (only once in last 6 months) =1, **Occasional** (only about once a month) =2, **Frequent** (more than once a month) =3.

Your wellness is the key to your quality of life. It is our pleasure to make this Wellness Profile (below) available to you as the intake form for your free wellness consultation. A similar assessment and consultation by a physician would cost you a minimum of $50 to $75. The information the Wellness Profile analysis will provide you and your application of it will increase your energy, elevate your mood, reduce your experiences of illness, decrease your medical bills and ultimately increase your enjoyment of daily life. Additionally, the value to your family of your increased wellness is beyond calculation.

The following will help you understand how the Wellness Profile can help you achieve these benefits:

Purpose

People often ask, "What will actually improve my wellness?" The Wellness Profile provides an answer. When you know the answer, you are empowered and at choice to improve your wellness. If you do not know the answer, you are vulnerable to becoming a victim of disease and degenerative illness.

Background

The Wellness Profile is based on statistical studies of people's wellness and what they did to feel better. 7000+ people were used to set a statistical base. Your scores are compared to theirs and suggestions are offered to you with the intention of decreasing and/or eliminating your symptoms. Additionally, certain nutrients and/or herbs have been scientifically show to enhance a person's health and are recommended by the medical profession and government under certain situations. The program asks questions of you to determine if these situations apply. Also your answers to the questionnaire help to determine if you have weaknesses present in your glands, organs and/or other body systems.

Dr. Coyne's, Ph.D., (link to author.htm) work on the science of "Nutritional Symptomatology" was the basis for the questionnaire and the analysis program. This work was used to help determine what a sub clinical deficiency level is, how it affects the human body and what factors determine a high or very high severity level.

Components

1) Questionnaire: You complete a series of questions describing your experiences and your interest in prevention in specific areas. The questions are arranged in groups.
2) The total score from each group is entered into a sophisticated computer analysis program.

3) The program provides a personalized highly detailed multi-page report:
   a) Statistical analysis of where you stand in relation to the norm
   b) Information on those areas where your score is outside the norm
   c) A list of supplements and quantities that have been statistically shown to be of benefit to others with similar scores.

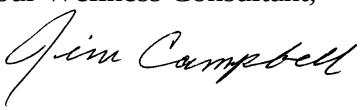
The accuracy of your responses to the questionnaire determines the quality and value of the report. While the analysis program places no significant value on any specific response, the accuracy of a combination of responses is significant.

Please invest the few minutes of time that will complete the questionnaire, **which begins on the next page**, in the interest of improving your future wellness and quality of life. After you have completed the wellness profile:

1. Print this document, and fill it out completely
2. Mail to: **Wellness Improvement Experts**
   3413 Black Hills Road N.E.
   Albuquerque, NM 87111

After your wellness profile is processed, you will be contacted to set your free 1-hour phone wellness consultation.

Your Wellness Consultant,



President

Wellness Improvement Experts

Wellness Profile

Enter data, if known and as appropriate, in each field.

Name					Date						
Address											
City					State		Zip				
Email				Phone				Fax			
Age		Sex(M/F)		Blood Pressure							
Total Cholesterol		HDL		LDL		Height		Weight			
List Medications You Take											

Questionnaire

Yes or No Section

Mark YES or NO questions by checking the appropriate spot.

☐Yes ☐ No — Trying to lose weight
☐Yes ☐ No — Interested in preventing Cancer
☐Yes ☐ No — Exercise frequently
☐Yes ☐ No — Want to strengthen the immune system
☐Yes ☐ No — Eat vegetarian diet
☐Yes ☐ No — Are you overweight
☐Yes ☐ No — Eat less than 3 servings per day of milk, yogurt or cheese
☐Yes ☐ No — Eat fried and processed foods
☐Yes ☐ No — Eat less than 3-5 servings of vegetables daily
☐Yes ☐ No — Eat low fiber, high fat diet
☐Yes ☐ No — Eat less than 6-11 servings of whole grain daily
☐Yes ☐ No — Eat less than 2 servings of fruit daily
☐Yes ☐ No — Are you pregnant
☐Yes ☐ No — Interested in preventing Heart Disease

☐Yes ☐ No — Do you have High Blood Pressure?
☐Yes ☐ No — Do you have Type I Diabetes or medically diagnosed Reactive Hypoglycemia?
☐Yes ☐ No — Do you or does anyone in your immediate household smoke?
☐Yes ☐ No — Do you have high cholesterol?
☐Yes ☐ No — Do you have joint or muscle aches or tenderness, OR abnormal muscle aches from exercise, OR backache?

Points Section Instructions

A) **If a statement does not apply, leave it blank.** Otherwise **place a 1, 2, or 3 in the box** to the left of the statement.
Mild or Infrequent (only once in last 6 months) **= 1**
Moderate or Occasional (only about once a month) **= 2**
Severe or Frequent (more than once a month) **= 3**
B) Do not agonize over each question.
C) Some questions are repeated. It is important that you mark all appropriate statements, even if marked previously.

Section 1

- [ ] — Acne, Blackheads or Warts
- [ ] — Dry, Rough Skin
- [ ] — Poor Appetite
- [ ] — Permanent Goose Bumps on back of arms
- [ ] — Inability to adjust eyes when entering a dark room. Difficulty seeing at night.
- [ ] — Frequent Colds, Respiratory Infections

Group Score 1 0

Section 2

- [ ] — Frequent Fatigue
- [ ] — Irritability
- [ ] — Depression
- [ ] — Craving for Sweets
- [ ] — Can't Concentrate
- [ ] — Fits of Temper
- [ ] — Hurt all over (general)
- [ ] — Heart Palpitations
- [ ] — Graying Hair
- [ ] — Use antibiotics; eat red meat or chicken, drink milk

Group Score 2 0

Section 3

- [ ] — Bleeding Gums
- [ ] — Bruise Easily
- [ ] — Frequent Colds or Flu
- [ ] — Varicose Veins or Broken Capillaries
- [ ] — Slow Healing of Cuts or Scrapes
- [ ] — Nose Bleeds
- [ ] — Cuticles Tear Easily, Hang Nails

Group Score 3 0 **Group Score 4** 0

Section 5

- [ ] — Poor Circulation
- [ ] — Lack of Stamina
- [ ] — Dark Circles under Eyes
- [ ] — History of Anemia
- [ ] — Heavy Menstrual Flow
- [ ] — Thin, Fragile, Brittle Nails
- [ ] — Pale Skin, Palms very pale

Group Score 5 0

Section 6

- [ ] — Menstrual Cramps
- [ ] — Muscle Twitching or Tics
- [ ] — Fingernails won't Grow
- [ ] — Foot or Leg Cramps
- [ ] — Insomnia
- [ ] — Muscle Tension
- [ ] — Joints Pop or Crack
- [ ] — Frequent Backaches
- [ ] — Aching Joints or Muscles
- [ ] — Crave Chocolate

Group Score 6 0

Section 7

- [ ] — Bad Breath
- [ ] — White coated Tongue
- [ ] — White Spots on Fingernails
- [ ] — Diminished Smell or Taste
- [ ] — Slow Healing of Wounds
- [ ] — Stress
- [ ] — ☐Yes ☐ No — Taking Estrogen (The Pill or Premarin)? If so, put a 2 in the box to the left.

Group Score 7 0 **Group Score 8** 0 **Group Score 9** 0

Section 10

- [ ] — Nausea, Headache, Migraine
- [ ] — History of Constipation
- [ ] — Bad Breath, Bad taste in Mouth
- [ ] — History of Hepatitis, Jaundice, Malaria
- [ ] — Occasional Body Odor, Including Feet
- [ ] — Undigested Food in Bowel Movement
- [ ] — Gall Bladder or Stones Removed.
  Year ☐
- [ ] — Frequent Tension in Neck and Shoulders
- [ ] — Occasional Abdominal Pain after big meal
- [ ] — Coated Tongue
- [ ] — Yellow-colored Bowel Movements
- [ ] — Ingest alcohol (more than 1 oz. OR 1 beer per day)

Group Score 10 0

Section 11

- [ ] — History of Colitis, Diverticulitis
- [ ] — Desire to eat often, Especially Starches
- [ ] — History of Hemorrhoids
- [ ] — Alternating Constipation and Diarrhea
- [ ] — Constipation during Menstruation
- [ ] — Thin, Pencil-like Bowel Movements
- [ ] — Painful, Hard Bowel Movements
- [ ] — History of Rectal Fissure
- [ ] — Rarely have daily Bowel Movements

Group Score 11 0

Section 12

- [ ] — Gas after Eating
- [ ] — Stomach Bloating after Eating
- [ ] — Belching, Burping after Meals

Group Score 12 0

Section 12A

- [ ] — Heavy, Tired Feeling after Eating
- [ ] — Drowsy after eating
- [ ] — Very Flabby Tissues
- [ ] — Fingernails Break and Split
- [ ] — Chronic Fluid Retention

Group Score 12A 0 **Group Score 13** 0

Section 14

- [ ] — Stomach Pain 5-6 Hours after Meals, often at Night. Relieved by Drinking Cream or Milk
- [ ] — Above Complaints Aggravated by Worry and tension. Relieved by Vacationing
- [ ] — Taking Pills or Vitamins Causes Stomach Discomfort
- [ ] — History of Ulcers

Group Score 14 0 **Group Score 15** 0

Section 16

- [ ] — Puffy Eyes
- [ ] — Ankles Swell Frequently
- [ ] — History of Kidney or Bladder Infections
- [ ] — Difficult or Painful Urination
- [ ] — Infrequent Urination
- [ ] — Legs often Feel Heavy
- [ ] — Sleep Disturbed by Urge to Urinate 2 or More Times/Night
- [ ] — Severe Pre-Menstrual Bloating

Group Score 16 0

Section 17

- [ ] — Blood Pressure Fluctuates, Sometimes too Low
- [ ] — Craving for Salt
- [ ] — Overly Worried or Concerned about Things Left Undone
- [ ] — Occasional Cold Sweats
- [ ] — Constriction in Throat, Lump that Hurts when Emotionally Disturbed
- [ ] — Perfectionist, Set High Standards
- [ ] — Emotional Upsets cause Exhaustion. Must go and Lie Down
- [ ] — Eyes Sensitive to Headlights, Sun
- [ ] — Easily Startled, Heart Pounds from Unexpected Noise
- [ ] — Allergies, Skin Rash, Hay Fever, Sneezing Attacks

Group Score 17 0

Section 18

(FEMALE — Complete this section then proceed to Section 20)
(MALE — Proceed to Section 19)

- [ ] — Missing Periods
- [ ] — Irregular or Uncomfortable Periods
- [ ] — Menopause, Hot Flashes, night sweats
- [ ] — Feel Nervous, Depressed before Periods
- [ ] — Diminished Sex Drive
- [ ] — Mood changes
- [ ] — Abnormal sleep patterns
- [ ] — ☐Yes ☐ No — Had Ovaries or Uterus Removed (Hysterectomy)? If so, put 2 in the box to the left. Year ____

Group Score 18 0

Section 19

(MALE — Complete this Section then proceed to Section 20)
(FEMALE — Proceed to Section 20)

- ☐ — Prostate Trouble
- ☐ — Difficulty Urinating, Starting, Burning
- ☐ — Diminished Sex drive
- ☐ — Get Up at Night to Urinate
- ☐ — Back or Leg Pains

Group Score 19 0

Section 20

- ☐ — Irritable if Late for a Meal or Missing a Meal
- ☐ — Urinate a Lot
- ☐ — Wake Up at Night Feeling Hungry
- ☐ — Emotional on Empty Stomach
- ☐ — Craving for Sweets, Alcohol or Coffee
- ☐ — Intense, Frequent Thirst
- ☐ — Cold Sweat on Hands even when Warm
- ☐ — Irritable before Breakfast
- ☐ — Nervous, Shaky Feeling, Headaches relieved by eating Sweets or Starches
- ☐ — Weak Spells, Tiredness in Mid-Afternoon
- ☐ — Bouts of Faintness, Dizziness, Lack of Concentration ☐ in Morning ☐ in Mid-Afternoon ☐ in Evening

Group Score 20 0

Section 21

- ☐ — Crave Sweets and Starches, but Eating doesn't Provide Much Relief
- ☐ — Occasional Night Sweats
- ☐ — History of Sores, Especially in Legs, Slow Healing
- ☐ — Diabetes in Family
- ☐ — Chronic Fatigue, Lowered Resistance
- ☐ — Very Thirsty all the Time

Group Score 21 0

Section 22

- ☐ — Feel Better when Resting, Low Exercise Tolerance, Low Endurance
- ☐ — Require Extra Amount of Sleep
- ☐ — Bruise Easily, Black and Blue Spots
- ☐ — Short of Breath when Climbing Stairs
- ☐ — Cold Hands and Feet, Need Extra Covers at Night

Group Score 22 0

Section 22A

- ☐ — Numbness or Heaviness in Arms or Legs
- ☐ — Hands Cramp when Writing
- ☐ — Tingling Sensation in Lips or Fingers
- ☐ — Memory Getting Worse
- ☐ — Short Walks Cause Aches and Pains
- ☐ — Arms and Legs Often go to Sleep

Group Score 22A 0 **Group Score 23** 0

Section 22B

- ☐ — Chest Pains, Sometimes Down Left Arm
- ☐ — Heart Sometimes Flip-Flops
- ☐ — Very Slow Heart Beat (under 50/minute)
- ☐ — Unexplained Headache or Dizziness
- ☐ — Shortness of Breath on Exertion
- ☐ — Diabetes
- ☐ — Very Rapid Heart Beat (over 90/minute)
- ☐ — History of Heart Disease in Family

Group Score 22B 0 **Group Score 24** 0

Section 25

- ☐ — History of Bronchitis, Asthma, Pneumonia, Emphysema, Pleurisy
- ☐ — Chronic Cough
- ☐ — Working in a Factory, or with Chemicals or Fumes
- ☐ — History of Colds, Lung Problems
- ☐ — Chronic Mucus in Throat or Sinus

Group Score 25 0

Section 26

- ☐ — History of Cancer, Multiple Sclerosis, Parkinson's, Rheumatoid Arthritis
- ☐ — Unusual Number of Cavities
- ☐ — Swollen Glands in Groin, Tonsils, Throat, Armpits
- ☐ — Very Susceptible to Infection
- ☐ — Flu-like Symptoms often occur
- ☐ — Feel Puffiness in Throat

Group Score 26 0

Section 27

- ☐ — Frequent Use of Antibiotics
- ☐ — Chronic Diarrhea
- ☐ — Rectal Itching
- ☐ — Bladder Infections
- ☐ — Abnormal Muscle Aches from Exercise
- ☐ — Feel Tired a Lot
- ☐ — Severe Reaction to Tobacco, Perfume, Chemical Odors
- ☐ — Unexpected Weight Gain
- ☐ — Hives, Psoriasis, Acne, Skin Rashes
- ☐ — Endometriosis/Ovary Problems
- ☐ — Recurrent Heartburn/Digestive Upsets
- ☐ — Crave Sugars, Breads, Alcohol
- ☐ — Gas, Abdominal Bloating
- ☐ Yes ☐ No — Are you answering ALL the questions? If so, give yourself a pat on the back.

Group Score 27 0

Section 28

- ☐ — Fluid Retention
- ☐ — Anemia
- ☐ — Low Hormone Levels
- ☐ — Nausea or Dizziness
- ☐ — Weakness in General
- ☐ — Premature Aging
- ☐ — Slow Recovery of Wounds/Illness
- ☐ — Low Resistance to Infection
- ☐ — High Stress Lifestyle
- ☐ Yes ☐ No — Did you put your name on the form and answer all the questions at the beginning? If so, give yourself a pat on the back.

Group Score 28 0

Section 29

(If this section does not apply to you, proceed to Section 30)

DO THE FOLLOWING OCCUR WITHIN 14 DAYS BEFORE MENSTRUAL PERIOD?

- ☐ — Headaches
- ☐ — Weight Gain
- ☐ — Increased Appetite
- ☐ — Frequent Crying
- ☐ — Bloating
- ☐ — Depression
- ☐ — Fatigue
- ☐ — Breast Tenderness
- ☐ — Swelling Hands and Feet
- ☐ — Backache
- ☐ — Nervous Tension, Irritability
- ☐ — Confusion
- ☐ — Crave Sweets
- ☐ — Forgetfulness
- ☐ — Cramps

Group Score 29 0

Section 30

- ☐ — Low energy
- ☐ — Caffeine addiction
- ☐ — Stress
- ☐ — Poor immunity
- ☐ — Chronic illness
- ☐ — Poor endurance

Group Score 30 0

Section 31

- ☐ — Atherosclerosis
- ☐ — Irregular heartbeat
- ☐ — Chronic Heart Failure
- ☐ — High Blood Pressure
- ☐ — Poor mental alertness
- ☐ — Memory loss

Group Score 31 0

Section 32

- ☐ — Joint pain and/or tenderness
- ☐ — Swollen joints
- ☐ — Cartilage degeneration
- ☐ — Decreased mobility
- ☐ — Osteoarthritis

Group Score 32 0

Section 33

- ☐ Yes ☐ No — Are you exposed to chemicals or chemical fumes?
- ☐ — Score 3 for Yes answer in Section 33.

Group Score 33 0

Section 34

- [ ] — Motion sickness: sea, car, plane, etc.
- [ ] — Morning sickness
- [ ] — Gas, indigestion
- [ ] — Abdominal cramps
- [ ] — Diarrhea
- [ ] — Nausea

Group Score 34 0

Section 35

- [ ] — Chronic fatigue or sluggishness
- [ ] — Mood swings
- [ ] — Excessive crying
- [ ] — Suicidal thoughts
- [ ] — Lack of drive or motivation
- [ ] — Persistent sadness or empty feeling

Group Score 35 0

Section 36

- [ ] — Anxiety
- [ ] — Nervousness
- [ ] — Exhaustion
- [ ] — Insomnia
- [ ] — Muscle tension, Fibromyalgia
- [ ] — Headache, Migraines
- [ ] — ADD, Learning disorder, Hyperactivity
- [ ] — Nervous tension

Group Score 36 0

Section 37

- [ ] — Excessive Hair Loss
- [ ] — Thinning Hair
- [ ] — Dandruff
- [ ] — Hair Breaks Easily
- [ ] — Hair Won't Grow

Group Score 37 0

Section 38

- [ ] Yes [ ] No — Are you interested in preventing respiratory diseases?
- [ ] Yes [ ] No — Are you interested in preventing heart disease?
- [ ] Yes [ ] No — Are you interested in preventing cancer?
- [ ] Yes [ ] No — Do you have a mold or similar problem in your home?
- [ ] Yes [ ] No — Do you or does anyone in your immediate household have allergies?
- [ ] Yes [ ] No — Do you or does anyone in your immediate household smoke?
- [ ] Yes [ ] No — Are you interested in the quality of indoor air in your home?
- [ ] — Score 1 for each Yes answer in Section 38

Group Score 38 0

Please double check that you: 1) followed the instructions carefully, 2) answered ALL the relevant questions, and 3) entered all the information, including your name, at the very beginning of the questionnaire.

When finished: Mail to:

Wellness Improvement Experts
3413 Black Hills Road N.E.
Albuquerque, NM 87111

Group Score Summary

Field 1	0
Field 2	0
Field 3	0
Field 4	0
Field 5	0
Field 6	0
Field 7	0
Field 8	0
Field 9	0
Field 10	0
Field 11	0
Field 12	0
Field 12A	0
Field 13	0
Field 14	0
Field 15	0
Field 16	0
Field 17	0
Field 18	0
Field 19	0
Field 20	0
Field 21	0
Field 22	0
Field 22A	0
Field 23	0
Field 22B	0
Field 24	0
Field 25	0
Field 26	0
Field 27	0
Field 28	0
Field 29	0
Field 30	0
Field 31	0
Field 32	0
Field 33	0
Field 34	0
Field 35	0
Field 36	0
Field 37	0
Field 38	0