

Health Evaluation Questionnaire

For more information please contact:

Name:

Fill in this questionnaire before consuming noni juice and every 30 days thereafter.

Rate each of the following symptoms based upon your health profile for the past 30 days. Date:

POINT SCALE	0 = Never or almost never have the symptom		3 = Frequently have it, effect is not severe	
	1 = Occasionally have it, effect is not severe		4 = Frequently have it, effect is severe	
<u>DIGESTIVE TRACT</u>		<u>MIND</u>		
----- Nausea or vomiting		----- Poor memory		
----- Diarrhea		----- Confusion, poor comprehension		
----- Constipation		----- Poor concentration		
----- Bloating feeling		----- Poor physical coordination		
----- Belching or passing gas		----- Difficulty in making decisions		
----- Heartburn		----- Stuttering or stammering		
----- Intestinal/Stomach pain		----- Slurred speech		
TOTAL:		----- Learning disabilities		
-----		TOTAL -----		
<u>EMOTIONS</u>		<u>ENERGY/ ACTIVITY</u>		
----- Mood swings		----- Fatigue, sluggishness		
----- Anxiety, fear or nervousness		----- Apathy, lethargy		
----- Anger, irritability, or aggressiveness		----- Hyperactivity		
----- Depression		----- Restlessness		
TOTAL -----		TOTAL -----		
<u>EARS</u>		<u>HEAD</u>		
----- Itchy ears		----- Headaches		
----- Earaches, ear infections		----- Faintness		
----- Drainage from ear		----- Dizziness		
----- Ringing in ears, hearing loss		----- Insomnia		
TOTAL -----		TOTAL -----		
<u>LUNGS</u>		<u>SKIN</u>		
----- Chest congestion		----- Acne		
----- Asthma, bronchitis		----- Hives, rashes, or dry skin		
----- Shortness of breath		----- Hair loss		
----- Difficulty breathing		----- Flushing or hot flushes		
TOTAL -----		----- Excessive sweating		
-----		TOTAL -----		
<u>JOINTS/ MUSCLES</u>		<u>WEIGHT</u>		
----- Pain or aches in joints		----- Binge eating / drinking		
----- Arthritis		----- Craving certain foods		
----- Stiffness or limitation of movement		----- Excessive weight		
----- Pain or aches in muscles		----- Compulsive eating		
----- Feeling or weakness or tiredness		----- Water retention		
----- Back pain		----- Underweight		
TOTAL -----		TOTAL -----		
<u>MOUTH/ THROAT</u>		<u>EYES</u>		
----- Chronic coughing		----- Watery or itchy eyes		
----- Gagging, frequent need to clear throat		----- Swollen, reddened or sticky eyelids		
----- Sore throat, hoarseness, loss of voice		----- Bags or dark circle under eyes		
----- Swollen or discoloured tongue, gums, lips		----- Blurred or tunnel vision		
----- Mouth ulcers		(does not include near- or far-sightedness)		
----- Cold sores		TOTAL -----		
TOTAL -----		-----		
<u>HEART</u>		<u>OTHER</u>		
----- Irregular or skipped heartbeat		----- Frequent illness		
----- Rapid or pounding heartbeat		----- Frequent or urgent urination (day or night)		
----- Chest pain		----- Genital itch or discharge		
TOTAL -----		TOTAL -----		
-----		TOTAL -----		
COMMENTS:		GRAND TOTAL:		
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