



# Life Style Profile



**"BECAUSE BEING HEALTHY WILL NEVER BE OUT OF STYLE"**

Please answer the following questions so that we can customize your needs.

Name:  Phone number:

E-mail:  Date of Birth:  Height:

Weight:  How often do you work out a week?

Do you know your Blood Type? O A B AB:  Who Ref. you?

Do you regularly consume energy drinks? If yes, what kind? <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you fight fatigue during your day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you eat "on the go" often? If Yes how many times a week? <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you skip meals frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you get "munchies" at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you crave fats?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you crave bread, pasta and other carbohydrates?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you crave sweets/sugars?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have high blood pressure or cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you always feel hungry or unsatisfied?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel "too full" after meals?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you dieted on and off?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you interested in learning how to take your results to the next level?	<input type="checkbox"/> Yes <input type="checkbox"/> NO
Are you interested in learning about our various programs that balance all aspects of a healthy lifestyle?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any health conditions that you feel limit your health or results?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What supplement do you currently take for health or weight loss? <input type="text"/>	
What Sport(s) do you play? <input type="text"/>	
RECREATIONAL / COMPETITIVE / PROFESSIONAL <input type="text"/>	
Do you want to increase any of the following: SPEED / ENDURANCE / STAMINA <input type="text"/>	
Do you want to gain lean muscle?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you want to reduce soreness and recovery time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you want to increase the effectiveness of your workouts?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you are under a doctor's care for any medically related issue, please consult with your doctor before changing diet, exercise, or supplement program. We will be happy to provide your doctor with supplement information. Please adhere to all product labels.

**Your body is your most important asset you have. Without your health you have nothing. Please consider your budget and choose**

**how much per month realistic for you to invest in your health.**

What do you do for work/career at this time?

<b>Do you love what you do?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your career allow you to live life on your own terms?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you see yourself doing this for the rest of your life?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would an additional monthly income on the side interests you	<input type="checkbox"/> Yes <input type="checkbox"/> No

AdvoCare Nutritional products service **1/3 of Olympic Athletes, 32 of 32 NFL locker rooms & 1000's of US households.** We are looking for people with a passion for wellness and motivation to create a strong second income. Would you like to learn about AdvoCare's part time & full time business opportunities?  Yes  No