

# Lifestyle Analysis

Discover the hidden weaknesses that could be keeping you from optimum health.



## 9 BODY SYSTEMS

General weakness or low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you frequently ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body odour or bad breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty digesting some foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent consumption of red meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PMS (female) / Prostate (male)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Used antibiotics in last six months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy alcohol consumption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dark circles under eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor concentration or memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation (less than twice a day)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Belching/burping after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High stress lifestyle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin/complexion problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Craving for sweets/processed foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regularly consume dairy products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you often feel depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Too little sleep/restless sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily broken fingernails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Split ends on hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High fat/cholesterol diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness/anxiety/tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low fibre diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you exposed to air pollution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleepiness when sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy caffeine consumption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel out of control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemical sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent yeast/fungus problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Structural weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you worry excessively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you easily irritated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get too little exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive mucous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>BODY SYSTEM TOTALS</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	1	2	3	4	5	6	7	8	9

### Instructions:

Check off all empty boxes across each of the categories that apply to you. Then total the checks in each of the 9 body system columns. Continue to page 2.



# DETERMINE YOUR STRENGTHS AND WEAKNESSES

Determine your stronger and weaker Body Systems according to the chart below:

		BODY SYSTEMS								
		Digestive System	Intestinal System	Circulatory System	Nervous System	Immune System	Respiratory System	Urinary System	Glandular System	Structural System
		1	2	3	4	5	6	7	8	9
<b>YOUR RATING IS:</b>										
EXCELLENT	IF YOU SCORED:	0-1	0-1	0	0-1	0-1	0	0	0-1	0
GOOD	IF YOU SCORED:	2-3	2-3	1	2-3	2-3	1	1	2-3	1
FAIR	IF YOU SCORED:	4-5	4-5	2-3	4-5	4-5	2-3	2-3	4-6	2-3
POOR	IF YOU SCORED:	6+	6+	4+	6+	6+	4+	4+	7+	4+

- EXCELLENT:** Congratulations! You are leading a lifestyle that will maximize your health and well-being.
- GOOD:** Your lifestyle/diet profile appears to be sound, but you may want to consider certain changes.
- FAIR:** Lifestyle and/or dietary changes are recommended.
- POOR:** Lifestyle and/or dietary changes should be made immediately.

## Identify Body Systems to emphasize

Take note of your "good," "fair," or "poor" ratings and circle the ones on which you plan to focus on improving.

## Choose the products that address your most vulnerable Body Systems

With the help of your NSP Associate and/or the NSP Product Guide review the descriptions of products designed to strengthen your most vulnerable body systems and determine which products best suit your needs.

## Take action today

Begin a supplement program that will help you fill the gaps in your diet/lifestyle. (*Ask your NSP Associate about taking advantage of Nature's Sunshine's wholesale pricing*)

## YOU COULD BE A WINNER

Please complete the adjacent questionnaire and send it to Nature's Sunshine. Each month a prize draw is held and you and the NSP Associate helping you with this questionnaire could win valuable prizes. See the back page for details.

**Jackpot-of-Prizes draw every month. Please complete the adjacent questionnaire to participate** 

This questionnaire will help us to better understand the needs of our customers and to better serve you. Thank you for your participation and good luck in the monthly prize draw. You could be our next winner!

*(Please Print)*

Your Name \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ Province \_\_\_\_\_

Postal Code \_\_\_\_\_ Phone Days ( ) \_\_\_\_\_ Evenings ( ) \_\_\_\_\_

A. Having completed your Lifestyle Analysis, which Body Systems are of most interest/concern for your well-being?  
Please indicate all body systems that are of concern:

- |  |  |
|--|--|
| <input type="checkbox"/> 1. Digestive system   | <input type="checkbox"/> 6. Respiratory system |
| <input type="checkbox"/> 2. Intestinal system  | <input type="checkbox"/> 7. Urinary system     |
| <input type="checkbox"/> 3. Circulatory system | <input type="checkbox"/> 8. Glandular system   |
| <input type="checkbox"/> 4. Nervous system     | <input type="checkbox"/> 9. Structural system  |
| <input type="checkbox"/> 5. Immune system      |  |

B. What are the three most important health issues you would like to change and/or resolve?

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

C. Is nutrition and preventative health care important to you?

- YES  NO

D. The Canada Food Guide, Canadian Cancer Society and Heart and Lung Association all recommend we consume 5-10 servings of fruits and vegetables per day. How many servings of each do you eat per day? \_\_\_\_\_ Fruits \_\_\_\_\_ Vegetables

E. Do you believe that nutritional supplements can help you achieve and maintain a healthier lifestyle?

- YES  NO

F. How much does your household spend monthly on nutritional supplements?

- 0-\$50  \$51-\$99  \$100-\$199  \$200+

G. How many members are in your family/household? \_\_\_\_\_

H. Age range of family members

- 0-6  7-12  13-19  20-29  30-39  40-49  50-59  60+

I. Are you  Male  Female

**IMPORTANT: This section must be completed by your NSP Associate (upline) in order for this questionnaire to be included in the monthly draw.**

ASSOCIATE'S NAME: \_\_\_\_\_

ACCOUNT NUMBER: \_\_\_\_\_

**Detach and mail or Fax this portion to Nature's Sunshine. Fax 1-800-822-4884**

# Jackpot-of-Prizes

*One draw each month*

**Each month we draw one lucky questionnaire.  
The individual who completed and submitted the questionnaire  
plus the signatory Associate are winners.**

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Prizes are:

*To the submitter of the questionnaire:* \$100.00 in retail value of Nature's Sunshine's products to the owner of the lucky questionnaire.

*To the signatory NSP Associate:* A choice of one Jackpot Prize to the signatory Associate whose name must also appear on the questionnaire.  
Jackpot of Associate prizes are listed below.

**Jackpot-of-Prizes Associate winners  
choose one of the following prizes:**

Gas Card • Day at a Spa • Top 20 Nature's Sunshine Products • 2 Zambroza1 Jackets & 2 Zambroza Duffel Bags • Maid Service • Calling Card • Travel Allowance for Conference • Shopping Spree • Weekend Get-A-Way • Case of 20 Zambroza • Limo ride & Dinner for 2

Prizes have a maximum value of \$500.00. Prizes have no cash value.  
Prizes and values are subject to availability and can change without notice.

Your Nature's Sunshine Business Associate is:

**Nature's Sunshine Products of Canada Ltd**  
90 Walker Dr., Unit 1, Brampton, ON L6T 4H6  
1-800-265-9163 Fax 1-800-822-4884