"A NEW BODY LIFESTYLE PROGRAMS

(713) 639-3571 * Web: http://www.acwbinc.org * E-mail: mail@acwbinc.org

COMPREHENSIVE LIFESTYLE ASSESSMENT (CLA) CONSULTATION SERVICE

To schedule your personally customized CLA with ***"A New Body Lifestyle (ANBL)"***, please call or email to set up your appointment, and complete the following Questionnaire prior to your appointment.

The consultations can be conducted through mail, telephone or in person. Whenever possible, the Questionnaire is to be filled out ahead of time. To make the best use of our time, bring your own list of questions and reserve an appropriate amount of time. At the meeting, our staff can help you to understand yourself better, make a recommendation for an upgrade in lifestyle, review your present supplements and diet, identify the areas that need immediate improvement, as well as directions for the future.

During the meeting, we look at each individual's details of the Questionnaire as well as at the traditional eastern vital signs and details of the body: physiology, irises, date of birth, and Acupressure points. The visuals are extremely helpful to give deeper understanding of the whole person's life patterns that brought on dis-ease; furthermore, the date of birth helps to create a clear painting of the individuals past and the anticipated future. **Your investment is $343.00 for 55 minutes (A value of $600.00) with cash, PayPal, certified, personal checks or money order payment.** Clients will receive literature, lifestyle transformation program, and nutritional supplement recommendations.

Consultation via mail: submit the Q/A form, and whenever possible photos with Submit recent photos: 1. a frontal of face with hair removed from ears - no earrings, 2. a side photo with ears showing and (3) a close-up of the eyes. Indicate if you are left-handed. Your CLA investment is $333.00 by certified or personal checks, money order. Make certified or personal checks, money orders payable and mail to ***"A New Body Lifestyle"*** 8544 W. Bellfort St. #208 Houston TX 77071-2208

Consultation is also provided by SKYPE, Email or Phone. Your investment is $333.00 for 55 minutes with a completed questioner submitted ahead of time.

NOTE: If you wish a written report, that details the theory, the research and the program in relationship to your specific conditions, please send in an additional $150. The report is approximately 6 to 20 pages long, depending on space needed to address your situation.

NOTE: If you wish to have a CLA conducted in the comfort of your home or office, there is a minimum $40.00 service charge.

PLEASE ANSWER ALL QUESTIONS AND MAIL OR E-MAIL BACK ***TO "A NEW BODY LIFESTYLE"*** PRIOR TO YOUR CLA.

HEALTH HISTORY REVIEW FORM

IMPORTANT: ALL THE INFORMATION ASKED FOR IN THIS FORM IS VITAL TO OUR FILES AND IS NEEDED TO NOTE THE PROGRESSION OF YOUR PRESENT CONDITION. ALL INFORMATION WILL BE KEPT IN STRICT CONFIDENCE. PLEASE SUBMIT FUNDS VIA MONEY ORDER, CERTIFIED CHECK, OR CASH. **THERE IS A GREAT DEAL OF TIME. CARE AND LOVE INVLOVED IN PREPARING YOUR REPORT.**

Submit recent photos, especially, (1) a frontal of face with hair removed from ears - no earrings (2) a side photo with ears showing, (3) a close-up of the eyes.

BASICS

Name: _____
Address: _____
City: _____ State: _____ Zip + 4: _____ Country _____

Phone (s): _____ Home _____ Work _____ Cell

E-mail: _____ Website: _____

Date of Birth: _____ Age: _____ Sex: _____

Height (ft, in): _____ Weight (lbs) Today: _____ Weight (lbs) 1 yr. Ago: _____

Marital status: _____ No. and ages of children: _____

Highest Education and Major, Minor: _____

Profession: _____

Present Occupation: _____

Hobbies: _____

How did you learn about ***"A NEW BODY LIFESTYLE"*** products and services?

_____

Which health books have you read? _____

Do you have support of family in diet/lifestyle change? _____

FULLY EXPLAIN:

Names and dates of most recent as well as important ailments and operations:

_____

What are your present physical concerns?

When did you last consult a physician about concern(s)?

Doctor's diagnosis: _____

Describe treatment, prescribed medicines, pills or drugs you are taking:

_____

What dietary and herbal supplements you are taking?_____

_____

List all form of mechanical (trauma), chemical (toxins), and mental stress you have been exposed to as pertaining to your employment or lifestyles: _____

_____

Describe fully: accident, falls, fractures, dislocations or chiropractic care:_____

_____

Do you have any type of partial or permanent physical disability? (paralysis, wheelchair, etc.):

_____

Are you following any special diet (vegetarian, vegan, fruitarian, liquidarian, etc.)?_____

What % of your diet is raw (non-cooked foods; sprouted, etc.)? _____

Vitamins: What brand, type; how many/how often? _____

Herbs & supplements: What brand, type; how many/how often? _____

What type of juices: fresh squeezed, bottled, canned; when and how often?

_____

DETAILS ON CLEANSING AND DETOX:

How many times fasted? _____ Do you fast yearly? _____

What type of fast? _____

What health resorts you have visited and your experience? _____

_____

IF RELEVANT, GIVE DETAILS:

Most disliked foods: _____ Favorite foods: _____

Special diet problems, explain: _____

Animal-based Dairy: _____ NON Animal-based Dairy: _____

Fats (mono-, polyunsaturated oils, avocado, nut butters):

Protein (Vegetable or other sources): _____

Complex carbohydrates: sprouted grains, sugar, honey (details, how often and when):_____

_____

Seasoning, spices & salt: _____

EATING PATTERN:

What is your usual breakfast & time? _____

Lunch (What, detail, when)? _____

Dinner (what type & time)? _____

Do you eat only when hungry and stomach is empty? _____

Liquids with meals - describe what type, when, how much? _____

Approximate size of meal in cups (if the whole meal was blended): _____

Number of meals or snacks (small meals) per day: _____

Snack (times/day, are you hungry?): _____

Food/beverage cravings binges (times/week, what): _____

Do you over eat and feel stuffed after meals? _____

Do you feel sleepy few hours after meals? _____

Do you eat close to bedtime & any trouble in falling asleep? _____

Do you feel hungry in the morning? _____

LIQUID INTAKE- GIVE DETAILS:

Juices: fresh, bottled, canned: _____

Coffee: kind, # of cups/day: _____

Tea: kind, # of cups/day: _____

Soda: kind, # of cups/cans/day: _____

Water per day, pattern, kind: spring, distilled, tap, bottled _____

Water temperature: cold, room-temperature? _____

POTENTIAL TOXIC STRESSORS:

Do you use alcoholic beverages (What. How often, with meals)? _____

Do you use tobacco or marijuana (now or recent) kind how often other drugs? _____

How many dental mercury amalgam fillings? _____

How many airplane journey(s) during the last 52 weeks? _____

How many hours of computer work weekly?

How many hours of Cell Phone, hand-held electronic device usage per week? _____

How much Wi-Fi, EMF and RF Radiation exposure per week? _____

What kind of clothing fabric do you wear most often? _____

ACTIVITY DETAILS

Exercise (what kind, how many times / week; length)? _____

Meditate, # of years? _____

Rest or nap during the day? _____ How Long: _____

Hours of sleep at night? _____ Feel refreshed in the morning? _____

How often you have bowel movement? _____ Any trouble?_____

Do you have any sexual problems?_____ Explain: _____

Do you have any mental/emotional, work stress? Explain: _____

Name of health group belong to (natural or otherwise): _____

What are your religious/spiritual beliefs/ Church Affiliation? _____

Additional information that you feel will be helpful to us in understanding you and what you expect to accomplish: _____

My signature that follows certifies that the above information is true to the best of my knowledge and that I fully understand that the program offered through ***"A NEW BODY LIFESTYLE"*** is solely of an educational and nutritional nature, that no diagnosis, treatment or cures of any kind are given or promised, and that I hereby enroll as a student of health of my own free will.

Today's date: _____ Signed: _____