

# NEW CUSTOMER QUESTIONNAIRE



Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

(+Area Code) Telephone Number \_\_\_\_\_

How did you hear about Reliv? \_\_\_\_\_

Are you interested in:  Complete Balanced Nutrition  Energy  Better Sleep  Weight Management  Joint Support  
 Anti-Aging  Others

What do you hope to achieve with Reliv supplementation? \_\_\_\_\_

What else have you tried? \_\_\_\_\_

How long would you reasonably expect to take to achieve your goal? \_\_\_\_\_

## EATING HABITS

	OFTEN	SOMETIMES	SELDOM	NEVER	COMMENTS
1.) Do you eat out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
2.) Do you skip breakfast?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
3.) Do you skip other meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
4.) Do you eat well-balanced meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....

## LIFESTYLE

	OFTEN	SOMETIMES	SELDOM	NEVER	COMMENTS
1.) Do you sleep well?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
2.) Do you wake refreshed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
3.) Do you feel tired or sleepy during daytime?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
4.) Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
5.) What form of exercise or sport do you do? _____					.....
6.) What form of exercise or sport would you like to do? _____					.....
7.) How would you rate your overall wellness? _____					.....

## STRESS LEVELS

On a scale of 1 - 10, (10 being the highest), what is your stress level?  Morning  Afternoon  Evening

On a scale of 1 - 10, (10 being the highest), what are your energy levels?  Morning  Afternoon  Evening

## REFERRALS

Once you have experienced positive results on these products, would you mind if I ask you for referrals to others I could help?  YES  NO

