Pre-Scan Assessment

Name _____ Date _____

Phone _____ Email _____

Lifestyle Assessment

Have you ever had your carotenoid antioxidant levels tested before? Yes No

What is your # 1 Health Concern? _____

How many servings of fresh fruits & vegetables do you eat per day? 1-2 3-5 6-9 10+

Do you consider yourself at your Ideal Weight? _____

How often do you exercise for thirty minutes or more a day? 2/wk 4/wk 6/wk

Do you smoke tobacco or vape? Never Daily Weekly

Supplementation Assessment

Do you take supplements? _____ Why or why not? _____

Monthly Cost? _____ Are your supplements working? Yes No Not Sure

Health Concerns: Please circle any areas you're working on or want to improve.

Overall Health	Bone and Joint Heath	Premature Aging	Stress
Brain Health	Inflammation	Sleep Quality	Weight
Blood Sugar	Bloating	Energy	Mood Swings
Eye health	Heart Disease	Periodontal Health	Immune Function

Motivation:

How motivated are you to improve or maintain your health? Low Medium High Not Sure

Would you like us to recommend supplements to help you meet your health goals? Yes No

What daily investment are you open to making in your health? £2 £6 £10+