# Life Profile Evaluation

**Date:**

## Personal Information

**Name:** ______________________________

**Employment:** ______________________________

**Home Address:** ______________________________

**City:** ____________________ **State:** ____________ **Zip:** ________

**Mailing Address (if different than above):** ______________________________

**Phone:** ____________________ **Fax:** ____________________

**Email:** ____________________ **Pager/Cellular phone:** ____________________

## Questionnaire

**How do you feel now?** ___ **Great** ___ **Very Good** ___ **Good** ___ **OK** ___ **Poor** ___ **Very poor**

**When did you last feel great?** ______________________________

**When did you last see your doctor?** ______________________________

**What did your doctor say?** ______________________________

______________________________

______________________________

______________________________

**What problems are you experiencing?** ______________________________

______________________________

______________________________

______________________________

Note: This service, or any products recommended, are not intended to constitute medical advice or treatment. This service is designed to accompany, not constitute, your total healthcare program. Please consult your physician for medical attention regarding specific ailments.

# Life Profile Evaluation

## Questionnaire cont.

**How many times a week do you consume raw food?**_______________________________

**How many times a week do you drink fresh juice?** _______________________________

**Describe a typical breakfast:** _______________________________

**Describe a typical lunch:** _______________________________

**Describe a typical dinner:** _______________________________

**Describe typical snacks:** _______________________________

**How many times per week do you drink alcohol?** _______________________________

**How many cups of coffee do you drink in a week?** _______________________________

**Do you smoke cigarettes? ___Yes ___ No How many per day?**____________________

**Put a check next to any of these known EMF emitters that you spend more than two hours near:**

**___ Computer monitor ___ Television ___ Cellular phone**

**___ Pager ___ High RPM motor ___Known EMF problem area ___ Portable phone**

**What alternative healing methods have you tried?** _______________________________

_______________________________________________________________

_______________________________________________________________

**What would you most like to change in your life?** _______________________________

_______________________________________________________________

**Are you truly willing to evolve into a higher state of health?** ____________________

_______________________________________________________________

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## Questionnaire cont.

**Do you have allergies? ___ Yes ___ No**

**What allergies do you have?** ______________________________

**What medications are you currently taking?**______________________________

______________________________

**What supplements do you currently take?** ______________________________

______________________________

______________________________

**What Tachyon tools have you used?** ______________________________

______________________________

**What best describes your physical activity? ___ 4+ hours per day ___ 2+ hours per day**

**___1-2 hours per day ___ 0-1 hours per day**

**Would you consider your energy level as : ___ High ___ Medium ___Low**

**How many hours a night do you sleep? ___ 5 or less ___ 6 ___7 ___ 8 ___ more than 8**

**Do you feel you get enough sleep? ___Yes ___ No**

**How would you rate your stress level? ___ Stress is named after me ___ High**

**___ Medium-high ___Medium ___Medium-low ___Low ___ What's stress?**

**What best describes your diet?: ___Vegan ___ Vegetarian ___Vegetarian plus fish**

**___ Vegetarian plus chicken and fish ___Everything!**

**How many times a week do you eat red meat?** ______________________________

**What foods do you avoid?** ______________________________

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