

Community Health Survey

(Door-to-Door)

*****Please circle or check off all that apply below*****

#1: Do you or anyone in your home have HEART DISEASE, HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, ARTHRITIS, DIABETES, or CANCER? YES or NO

#2: Do you or anyone in your home currently have a COUGH, COLD, FLU, EARACHE, HEADACHE, TOOTHACHE or any OPEN WOUND? YES or NO

#3: Do you eat BREAKFAST every day? YES or NO

#4: How many cups of water have you had today?(please give your answer in cups) ___ cups

#5: Do you drink Coffee, Tea(Lipton, green, black, chai), Diet Soda, Regular Soda or any type of Energy drink? YES or NO

#6: How Often do you Exercise a minimum of 30 minutes each day? ___Rarely ___1-2 times per week ___3-4 times per week ___5 or more per week

#7: How often do you get 7-8 HOURS OF SLEEP? ___Rarely ___1-2 times per week ___3-4 times per week ___5 or more per week

#8: When is the last time you had your Blood Pressure Checked? _____ What was it? _____

#9: Have you seen the documentary 'Forks Over Knives'? YES or NO

#10: *BONUS QUESTIONS: ***Please answer YES or NO to the following questions:**

___ Are you interested in losing any weight?

___ Do you want to feel better?

___ Do you want to improve, stabilize, or even reverse a chronic condition such as heart disease, high cholesterol, diabetes, high blood pressure or any other condition not mentioned?

___ Would you like to take fewer medications?

___ Are you open to changing your diet if it could really improve your health?

___ Are you interested in learning how to quit SMOKING or DRINKING

NAME: _____

ADDRESS: _____

CONTACT #: _____

EMAIL ADDRESS: _____