Stress Survey

Do you feel that stress in your life has in anyway affected you adversely?_____

Concerns	You	Family	Friend
Bleeding Gums	☐	☐	☐
Sensitive Teeth	☐	☐	☐
Anxiety	☐	☐	☐
Crying	☐	☐	☐
Anger	☐	☐	☐
Low Energy	☐	☐	☐
Pale Skin	☐	☐	☐
Overwhelm	☐	☐	☐
Anemia	☐	☐	☐
Depression	☐	☐	☐
Manic Behavior	☐	☐	☐
Emotional	☐	☐	☐
Irrational	☐	☐	☐
Loss of Sleep	☐	☐	☐
Perspiring when cool	☐	☐	☐

History	You	Family	Friend
Heart Rhythm	☐	☐	☐
Loss of Bone	☐	☐	☐
Clotting issues	☐	☐	☐
Restless Leg	☐	☐	☐
Neurological Dx.	☐	☐	☐
Decayed Teeth	☐	☐	☐
Weak Limbs	☐	☐	☐
Photosensitivity	☐	☐	☐
Sore Throat	☐	☐	☐
Swollen Tongue	☐	☐	☐
Mental Confusion	☐	☐	☐
Diarrhea	☐	☐	☐
Water Retention	☐	☐	☐
Numbness	☐	☐	☐
Depression	☐	☐	☐
Anxiety	☐	☐	☐

Name_____

Address_____

_____

City_____

State_____ **ZIP**_____

Phone_____

Email_____

Do you know that Calcium is for the nervous system? YES NO (circle)

Are you taking anything for stress? YES NO (circle)

Have you experienced a family history of stress disorders? YES NO (circle)?

Is there any reason you would not be willing to use a product that would address these concerns **? YES NO (circle)**

Notes and Questions

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I would like to have a private consultation with a representative. YES NO (circle)