Before you start the **Micronutrient Miracle 28-Day Program** here are a few questions for you to answer, as well as some followup:

NAME ____

ADDRESS ____

____

PHONE (__________)_______________________________________

EMAIL ______________________ **DOB** _______________________

AGE _______________________ **GENDER** ____________________

HEIGHT _____________________ **WEIGHT** ____________________

CURRENT SIZE: _______________ **HIGHEST ADULT WEIGHT:** __________

HIGHEST SIZE _______________ **LOWEST ADULT WEIGHT:** __________

LOWEST SIZE _______________

WHAT IS YOUR GOAL WEIGHT? _______________

STARTING MEASUREMENTS

NECK: __________________(in)

CHEST: _________________(in)

WAIST:__________________(in)

HIPS:___________________(in)

UPPER ARM/
BICEP:__________________(in)

MID THIGH:______________(in)

CALF: __________________(in)

BODY FAT: ______________(%)**

LEAN MUSCLE: ___________(lbs)**

AFTER 28-DAY MEASUREMENTS

NECK: __________________(in)

CHEST: _________________(in)

WAIST:__________________(in)

HIPS:___________________(in)

UPPER ARM/
BICEP:__________________(in)

MID THIGH:______________(in)

CALF: __________________(in)

BODY FAT: ______________(%)**

LEAN MUSCLE: ___________(lbs)**

*** If applicable*

SLEEP

HOW MANY HOURS A NIGHT DO YOU SLEEP ON AVERAGE? ____________

ARE YOU A RESTLESS SLEEPER, OR DO YOU ONLY WAKE TO GO TO THE BATHROOM? ____

HOW MANY TIMES DO YOU WAKE UP EACH NIGHT? ___________________

HOW LONG DOES IT TAKE YOU TO FALL ASLEEP? _____________________

WRITE A SENTENCE DESCRIBING YOUR SLEEP PATTERN: ______________

____

Rate the following on a scale of (0 – 10)

0 being nonexistent - 10 being the greatest

- Your daily anxiety level _______________
- Your energy level _______________
- Depression level _______________
- Ability to concentrate _______________
- Your willpower _______________
- PMS _______________
- Appetite _______________
- Knowledge of nutrition _______________
- Organizational Skills _______________
- Desire to succeed _______________
- Cravings for sweets _______________
- Cravings for salty _______________
- Strength & Stamina during exercise _______________

CALTON NUTRITION
DISCOVER HEALTH

HEADACHES

HOW OFTEN DO YOU GET HEADACHES? ___________________________

RATE THE SEVERITY OF THEM FROM 1 BEING MILD TO 10 BEING A MIGRAINE?____

HOW OFTEN DO YOU USE MEDICATION TO COUNTERACT THESE HEADACHES?____

WHICH OF THESE CONDITIONS DO YOU HAVE/HAD: MARK WITH AN **(X)**

__LOW BONE DENSITY	__HIGH CHOLESTEROL	__ARTHRITIS
__HORMONE IMBALANCE	__HIGH BLOOD PRESSURE	__CANCER
__INTESTINAL DISORDER	__HEART DISEASE	__STROKE
__LUNG DISEASE	__ANXIETY	__GOUT
__EATING DISORDER	__ALLERGIES	__HIV/AIDS
__HEARTBURN	__SKIN/HAIR CONDITION	__ALZHEIMER'S
__AUTOIMMUNE DISEASE	__DEPRESSION	__DIABETES

PLEASE LIST ANY OTHERS MEDICAL CONDITIONS OR ALLERGIES YOU MAY HAVE: ____

PLEASE EXPAND ON ANY CONDITIONS YOU HAVE INDICATED HAVING ABOVE: ____

____

____

____

PLEASE LIST ANY MEDICATION AND/OR SUPPLEMENTS YOU ARE CURRENTLY TAKING, AND AT WHAT QUANTITY YOU ARE TAKING IT. PLEASE ALSO SPECIFY THE REASON OR CONDITION FOR EACH MEDICATION OR SUPPLEMENT:

____

____

____

PLEASE BRIEFLY DESCRIBE YOUR TOP THREE GOALS YOU WISH TO ACHIEVE WHILE ON THIS PROGRAM

GOAL 1:

____

____

____

GOAL 2:

____

____

____

GOAL 3:

____

____

____

Plan:

- ☐ Signature
- ☐ Fat Loss
- ☐ Autoimmune-Chronic Inflammation
- ☐ Digestive Health
- ☐ Blood Sugar Regulation
- ☐ Ketogenic
- ☐ Cardiovascular Health
- ☐ Bone Building
- ☐ Hormone Regulation