



**10-DAY PROGRAM
BLOOD SUGAR**

Pre & Post Survey

This information will be used to provide a clearer picture of your health. There are no correct answers, so honestly rate each question. Please read and mark the score for each question on the scale.

Print your Name: _____

Date: _____

Circle One: **Pre-Program** or **Post-Program**

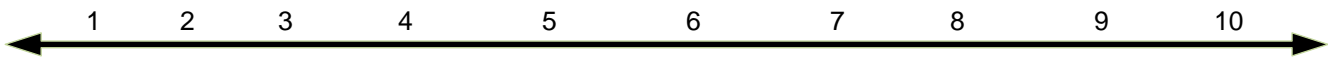
Energy Level



I don't have enough energy to do simple everyday activities.

I am living an active life.

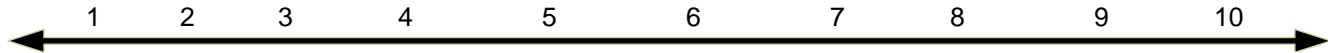
Restful Sleep



I am exhausted as soon as I wake up.

I wake up refreshed.

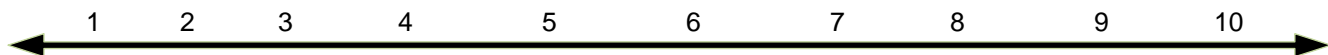
Irritable/Moodiness



I emotionally react to situations.

I considerably respond to situations.

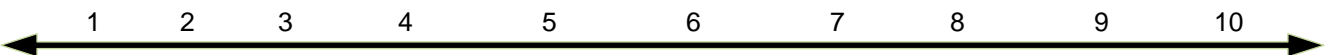
Craving for sweets/snacks



I need sugar to get through the day.

I make healthy food choices.

Afternoon Headache



I often experience painful headaches.

I rarely get headaches.

Any Other Comments: _____

For Clinical Use Only:

Weight: _____ Height: _____ Frame: _____ Age: _____

Res: _____ Reac: _____ % BF: _____ PA: _____ BMI: _____