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

1 2 3 4 5 6 7 8 9 10

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

I am living an active life.

Restful Sleep

1 2 3 4 5 6 7 8 9 10

I am exhausted as soon as I wake up.

I wake up refreshed.

Irritable/Moodiness

1 2 3 4 5 6 7 8 9 10

I emotionally react to situations.

I considerately respond to situations.

Craving for sweets/snacks

1 2 3 4 5 6 7 8 9 10

I need sugar to get through the day.

I make healthy food choices.

Afternoon Headache

1 2 3 4 5 6 7 8 9 10

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: _____