

# Andolina Distributors

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[www.YouFoundYourFuture.com](http://www.YouFoundYourFuture.com)

[www.shaklee.net/FYI](http://www.shaklee.net/FYI)

Thank you for allowing us to provide you with the enclosed *Personal Wellness Profile Questionnaire*.

You are taking the first step in improving your health by finding out what quality food supplements can do for improving your diet and health. So many people today are coming to the realization that a balanced nutritional diet is the first step in preventing health problems. Many symptoms people live with can be avoided by simply making sure their diet is up to standards, which is so hard to do with today's many food choices. Your personal wellness profile will give you the answers to what you can do today to start on the road to better health and you will feel the difference in as little as 30 days.

The enclosed symptom questionnaire will ask many questions, some of which are repeated. It is very important to answer all questions to the best of your knowledge. If you don't know your cholesterol, HDL, LDL or blood pressure, that is ok and will not affect your profile. These answers are only for comparison of your health before starting a nutrition program and then afterwards to see your improvements. Again, they will not affect your personal profile.

After you answer all the questions, be sure to go over them again to make sure you did not miss any questions. Then, simply return the questionnaire to us at the above address along with a **check for \$20 made out to Robert Andolina**. Once we receive your questionnaire, we will run your profile and return your printout to you ASAP.

If you decide to act on the information and recommendations contained in your report and start on a Shaklee nutritional program, check with the Shaklee distributor who introduced you to the Wellness Profile for any discounts they may be offering on your profile as well as on any Shaklee products. Also, we want you to know that we offer you a full money back guarantee on any Shaklee products you purchase if you are not 100% satisfied with your results after using them for 30-60 days.

We have been helping people to feel their best for over 85 years so we know you will be pleased with your health improvements. Our goal is to provide you with the products and the services that you expect and deserve. Now it is up to you to take the next step.

You have nothing to lose and everything to gain, so why not get started in building your better health today? You will feel the difference and others will notice as well!

I look forward to hearing from you soon.

To your future health,  
*Robert Andolina*  
Wellness Profile Director  
Andolina Distributors

# Wellness Profile

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: (M/F) \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Total Cholesterol: \_\_\_\_\_ HDL: \_\_\_\_\_ LDL: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

List medications you take: \_\_\_\_\_

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## Instructions

- 1) If a statement does not apply, leave it blank. Otherwise place a 1, 2 or 3 on the line to the left of the question.  
**1- for mild or infrequent 2- for Moderate or Occasional 3- for Severe or Frequent.**
- 2) Underline the particular part of the statement that applies. Do not agonize over each statement.
- 3) Some statements are repeated. It is important that you mark all appropriate statements, even if marked previously.
- 4) Mark Yes or No statements by checking the appropriate spot.

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## Supplemental Information

Please check Yes or No to the following.

- |  |  |  |                              |
|--|--|--|------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Interested in preventing Heart Disease                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Trying to lose weight        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Interested in preventing Cancer                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Exercise frequently          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Want to strengthen immune system                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eat vegetarian diet          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Eat fried and processed foods                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eat low fiber, high fat diet |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have high blood pressure                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you pregnant             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Eat less than 3-5 servings of vegetables daily             |  |                              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Eat less than 6-11 servings of whole grain daily           |  |                              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Eat less than 2 servings of fruit daily                    |  |                              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Eat less than 3 servings per day of milk, yogurt or cheese |  |                              |

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## Questionnaire

Mark each question with

**1- for mild or infrequent 2- for Moderate or Occasional 3- for Severe or Frequent.**

If the statement does not apply to you, leave it blank.

- 
- (1)  Acne, Blackheads or Warts  Dry, Rough Skin  
 Permanent Goose Bumps on back of arms  Poor Appetite  
 Frequent Colds, Respiratory Infections  
 Inability to adjust eyes when entering a dark room. Difficulty seeing.

Total (1) \_\_\_\_\_







- (26)  Flu-like Symptoms often Occur  Unusual Number of Cavities  
 Very Susceptible to Infection  Feel Puffiness in Throat  
 Swollen Glands in Groin, Tonsils, Throat, Armpits  
 History of Cancer, Multiple Sclerosis, Parkinson's, Rheumatoid Arthritis **Total (26)** \_\_\_\_\_
- 

- (27)  Frequent Use of Antibiotics  Chronic Diarrhea  
 Bladder Infections  Feel Tired a Lot  
 Gas, Abdominal Bloating  Crave Sugars, Breads, Alcohol  
 Recurrent Heartburn/Digestive Upsets  Rectal Itching  
 Endometriosis/Ovary Problems  Unexpected Weight Gain  
 Hives, Psoriasis, Acne, Skin Rashes  Abnormal Muscle Aches from Exercise  
 Severe Reaction to Tobacco, Perfume, Chemical Odors **Total (27)** \_\_\_\_\_
- 

- (28)  Fluid Retention  Anemia  Low Hormone Levels  
 Nausea or Dizziness  Weakness in General  Premature Aging  
 High Stress lifestyle  Low Resistance to Infection  Slow recovery of Wounds/Illness  
**Total (28)** \_\_\_\_\_

**Move on to the next section if this section does not apply to you.**

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**Do the Following Occur Within 14 days Before Menstrual Period?**

- (29)  Headaches  Weight Gain  Increased Appetite  
 Frequent Crying  Bloating  Depression  
 Fatigue  Breast Tenderness  Backache  
 Confusion  Crave Sweets  Forgetfulness  
 Cramps  Swelling Hands and Feet  Nervous Tension, Irritability  
 Yes  No Did you put your name on the form? If yes, you deserve another pat on the back.  
**Total (29)** \_\_\_\_\_
- 

- (30)  Low Energy  Caffeine Addiction  Stress  
 Chronic Illness  Poor Endurance  Poor Immunity  
**Total (30)** \_\_\_\_\_
- 

- (31)  Artherosclerosis  Irregular Heartbeat  Chronic Heart Failure  
 High Blood Pressure  Poor Mental Alertness  Memory Loss  
**Total (31)** \_\_\_\_\_
- 

- (32)  Joint pain and/or Tenderness  Swollen Joints  Osteoarthritis  
 Cartilage Degeneration  Decreased Mobility **Total (32)** \_\_\_\_\_
- 

- (33)  Yes  No Are you exposed to chemicals or chemical fumes?  
 Yes  No Do you smoke, or live/work with a smoker? Score 3 for each Yes answer.  
**Total (33)** \_\_\_\_\_
-

