The Diennet Institute

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Questionnaire B

The questions that are mandatory are marked with a * symbol

Basic Information

Last Name		Phone Number	
First Name		Mobile Number	
e-mail Address		Marital Status	
Gender	○ Male ○ Female	Kids	
Date of Birth		Profession	
		Height	

Current Address

Street		State/Province	
		ZIP	
City		Country	

1. Nervousness

A. Are you nervous on the program?	○ Yes ○ No
B. Are you tired on the program?	○ Yes ○ No
C. Are you energetic on the program?	○ Yes ○ No
D. Do you repress your feelings on the program?	○ Yes ○ No
E. Are you anxious on the program?	○ Yes ○ No
F. Are you depressed on the program?	○ Yes ○ No

G. Do you cry often on the program? ○ Yes ○ No

H. Are you claustrophobic on the program? ○ Yes ○ No

I. Do you sleep better on the program? ○ Yes ○ No

J. Do you have nightmares on the program? ○ Yes ○ No

K. Do you take sleeping pills on the program? ○ Yes ○ No

L. Do you sleep too much on the program? ○ Yes ○ No

M. Do you sleep less on the program? ○ Yes ○ No

N. Do you have sexual problems while on the program? ○ Yes ○ No

Comments

2. Other

A. Has your hearing improved on the program? ○ Yes ○ No

B. Has your vision improved on the program? ○ Yes ○ No

C. Do you suffer from headaches while on the program? ○ Yes ○ No

D. Do you suffer from any additional allergies on the program? ○ Yes ○ No

E. Do you still have a monthly period? ○ Yes ○ No

Comments

3. Digestion

A. Has your digestion improved on the program? ○ Yes ○ No

B. Do you feel bloated after meals on the program? ○ Yes ○ No

C. Do you have stomach aches while on the program? ○ Yes ○ No

D. Is your stomach ever distended with gas on the program?	○ Yes ○ No	
E. Do you have intestinal gas on the program?	○ Yes ○ No	
F. Do you feel sick after eating or drinking on the program?	○ Yes ○ No	
G. Are you constipated while on the program?	○ Yes ○ No	

4. Weight

A. What is your current weight? *	lbs	**B.** How many pounds did you lose?	lbs
C. Have you reached your ideal weight?	○ Yes ○ No	**D.** How many more pounds do you want to lose?	lbs
E. Do you want to maintain your current weight?	○ Yes ○ No	**F.** Do you have a difficult time following the guidelines of the program?	○ Yes ○ No

Comments

Would you like any changes made to your next formula?

List changes

5. Medical Treatment

A. List any current medical conditions

B. List all allergies, including food and medications

C. Are you taking any of the following medications?

a. Antibiotics	Yes	No
b. Diuretics	Yes	No
c. Appetite suppressant	Yes	No
d. Cardiac medication	Yes	No
e. Cortisone medication	Yes	No
f. Thyroid medication	Yes	No
g. Hormone: Progesterone	Yes	No
h. Hormone: Estrogen	Yes	No

If you answered 'yes' to any of the above, list name, strength, and dosage

Name, strength, and dosage

Are you taking any additional medications, including over the counter and/or herbal products. List name, strength, and frequency.

Additional medications

FDA

By requirements of the FDA, please answer the following question

Is there any medication you refuse to be in your prescription? *	Yes	No

If "yes", which one

By submitting this questionnaire, I hereby certify that:

The above information is accurate and that I take full responsibility for following the guidelines of the program.

I understand that my medical and prescription information will not be disclosed to any other party, except upon my authorization.

I have read and agree with the Waiver and Consent Agreement.

Referred by

Print your name	
Signature	
Date	