NEW CUSTOMER QUESTIONNAIRE

Name: _____ Date: _____

Contact No.: _____ Email: _____

Address: _____

_____

How did you hear about Reliv? _____

Are you interested in:

- ☐ Complete Balanced Nutrition _____
- ☐ Energy _____
- ☐ Better Sleep _____
- ☐ Weight Management (Weight Loss) _____
- ☐ Joint Support _____
- ☐ Children's Wellness _____
- ☐ Athletic Performance Enhancement (Sports Nutrition) _____
- ☐ Anti-Aging _____
- ☐ Others _____

What do you hope to achieve with Reliv supplementation? _____

What else have you tried? _____

Why didn't it work? _____

How long would you reasonably expect to take achieve your goal? _____

LIFESTYLE

	YES	NO	COMMENTS
1.) Do you sleep well?	☐	☐	
2.) Do you wake refreshed?	☐	☐	
3.) Do you fall asleep before going to bed?	☐	☐	
4.) Do you exercise regularly?	☐	☐	
5.) Do you feel stressed?	☐	☐	
6.) Do you eat out often?	☐	☐	
7.) Do you skip meals?	☐	☐	
8.) Do you eat well-balanced meals?	☐	☐	

9.) What form of exercise or sport do you do? _____

10.) What form of exercise or sport would you like to do? _____

11.) How would you rate your overall wellness? _____

REFERRALS

	YES	NO
Once you have experienced positive results on these products, would you mind if I ask you for referrals to others I could help?	☐	☐