

Shaklee 180 HEALTH CHECK LIST

Would you like to feel better while you are shedding weight?

Many times we forget the little things that are bothering us.

One day we suddenly realize they bother us no more.

When you start Cinch make a check to the left of each item that applies to you.

Check your progress as the weeks go by!

Start Date: _____	Week 1	Week 3	Week 6	Week 10
_____ low energy	_____	_____	_____	_____
_____ difficult to get going in the A.M.	_____	_____	_____	_____
_____ overweight by _____ pounds	_____	_____	_____	_____
_____ difficulty losing weight	_____	_____	_____	_____
_____ desire for sweets or chocolate	_____	_____	_____	_____
_____ clothes too tight-too many bulges	_____	_____	_____	_____
_____ need caffeine to function in a.m.	_____	_____	_____	_____
_____ under stress(note level 1-10)	_____	_____	_____	_____
_____ blood pressure problems	_____	_____	_____	_____
_____ hi cholesterol or triglycerides	_____	_____	_____	_____
_____ lose weight just to gain it back	_____	_____	_____	_____
_____ eat out of boredom/loneliness/stress	_____	_____	_____	_____
_____ headaches/migraines (how often: _____)	_____	_____	_____	_____
_____ water retention	_____	_____	_____	_____
_____ constipation	_____	_____	_____	_____
_____ shortness of breath on walking or climbing stairs	_____	_____	_____	_____
_____ drink 1 or more diet sodas daily	_____	_____	_____	_____
_____ poor digestion	_____	_____	_____	_____
_____ don't eat breakfast	_____	_____	_____	_____
_____ start diets and fall off quickly	_____	_____	_____	_____
_____ suffer with GERD or acid reflux	_____	_____	_____	_____
_____ take aspirin or Tylenol often	_____	_____	_____	_____
_____ difficulty falling asleep/sleep apnea	_____	_____	_____	_____
_____ subject to colds, flu or infections	_____	_____	_____	_____
_____ sinus/allergy/breathing problems	_____	_____	_____	_____
_____ frequently skip meals	_____	_____	_____	_____
_____ nervous, tense or depressed	_____	_____	_____	_____
_____ poor circulation or cold hands or feet	_____	_____	_____	_____
_____ feelings of self loathing	_____	_____	_____	_____
_____ back aches or achey painful joints	_____	_____	_____	_____
_____ self esteem not as high as want	_____	_____	_____	_____
_____ don't know how to maintain ideal weight	_____	_____	_____	_____
_____ other	_____	_____	_____	_____

Name _____ Phone No. _____

NOTES: