



## Female Symptom Assessment

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Gender: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

### General Health Assessment (Part 1)

Please indicate how frequently you experience the following symptoms according to these guidelines:

**Never** = 0% of the time

**Rarely** = Less than 30% of the time

**Sometimes** = About 50% of the time

**Often** = More than 70% of the time

Do you feel tired most of the time?	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Lifestyle-altering fatigue	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Intestinal gas	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Abdominal bloating	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Sugar cravings	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Bread or beer cravings	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Constipation and/or diarrhea	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Irritability and/or moodiness	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Brain fog and/or poor memory	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Feeling faint, dizzy, or lightheaded	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Muscle or body aches	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Itching or burning sensation in rectum or vagina	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Loss of sexual desire	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
White thrush or yellow fuzzy tongue	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Athlete's foot, ringworm, or jock itch	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Fingernail or toenail fungus	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Sensitivity to perfumes, insecticides, or other Chemical smells	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Weight gain and/or struggling to maintain a healthy weight	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Think your weight is out of control	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often

## General Health Assessment (Part 2)

Please indicate how frequently you've taken the following medications throughout your life.

Antibiotics	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Birth Control	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Steroids drugs (possibly for allergies, asthma, or injuries)	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Synthetic hormones (such as HRT or bioidentical)	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often

## Thyroid Function Assessment

Please indicate to how frequently you experience the following symptoms and conditions according to these guidelines:

**Never** = 0% of the time

**Rarely** = Less than 30% of the time

**Sometimes** = About 50% of the time

**Often** = More than 70% of the time

Difficulty getting out of bed in the morning	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Need caffeine or other stimulants to get going	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Gain Weight easily	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Difficulty losing weight	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Dry skin	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Irregular menstrual cycles	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Mood swings	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Thinning hair	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Outer third of eyebrows missing or nothing	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Dry or brittle hair	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
High cholesterol	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Low blood pressure	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Depression	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Yellow skin	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Do you have a family history of thyroid disease?	<input type="radio"/> Yes		<input type="radio"/> No	

## Stress Assessment

Please indicate how frequently you experience the following situations according to these guidelines:

**Never** = 0% of the time

**Rarely** = Less than 30% of the time

**Sometimes** = About 50% of the time

**Often** = More than 70% of the time

Close support network of family and friends	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Happy with your current job/profession	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Exercise regularly	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Eat 3 meals and 0-2 snacks per day	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Consume caffeine, sugar, and/or refined carbohydrates	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Take time off work to recharge your batteries	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Take a multivitamin/mineral	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Worry about money and finances	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Satisfaction with your life and its direction	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
8 hours of uninterrupted sleep at night	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Anxiety and/or panic attacks	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Think you're too stressed	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Suffer from allergies, arthritis, fibromyalgia, and/ or asthma	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Trouble falling asleep	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Feel exhausted after exercising	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Major life stressors such as death, divorce, etc.	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Catch colds and flu easily	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often

## Hormone Assessment

Please indicate how frequently you experience the following situations according to these guidelines:

**Never** = 0% of the time

**Rarely** = Less than 30% of the time

**Sometimes** = about 50% of the time

**Often** = More than 70% of the time

Vaginal dryness	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Mood swings	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Sagging skin	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Poor sleep quality	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Memory problems	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Night sweats	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Hot flashes	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Painful intercourse	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Bladder infections	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Low blood sugar	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Migraine/tension headaches	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Heavy blood flow	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Puffiness/bloating	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Anxiety	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Insomnia	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Infertility	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Miscarriages	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
PMS symptoms	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Painful or lumpy breast	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Endometriosis	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Osteoporosis	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Water retention	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Unusual facial/arm/leg hair	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Acne breakouts	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Painful ovaries	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Brown age spots	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Inability to exercise	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often

## Toxic Burden Assessment (Part 1 - Consumption)

Please indicate how frequently you consume the following foods on a daily and/or weekly basis according to these guidelines:

**Never** = 0% of the time

**Rarely** = Less than 30% of the time

**Sometimes** = About 50% of the time

**Often** = More than 70% of the time

Organic, pesticide-free produce	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
A wide variety of different colored fruits and vegetables	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Salads with dark leafy greens	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Flaxseeds and/or flaxseed oil	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Green juices or smoothies	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Organic, extra-virgin oils	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Fresh green herbs	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Coffee (including specialty)	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Tobacco and nicotine (including e-cigarettes)	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Alcohol (beer, wine, hard liquor, etc.)	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Soda (regular and or diet)	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
"Diet foods" sweetened with aspartame, Splenda, or saccharin	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Vegetables oil, canola oil, and/ or margarine	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Foods flavored with MSG (monosodium glutamate)	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Foods that are artificially colored	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Foods microwaved in plastic containers	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Fast foods	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Processed foods( from a box, bag, or can)	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often

## Toxic Burden Assessment (Part 2 - Supplementation)

Please mark how frequently you use the following supplements or medications on a daily and/or weekly basis:

Hormone and antibiotic-free whey protein	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Probiotic and/ or prebiotic supplements	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Digestive enzymes	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Prescription or over the counter (OTC) drugs	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Healthy oil supplements ( like salmon, flaxseed, or evening primrose oil)	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Clean and 100% pure supplements (like the Solutions4 products that are sold in our office)	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often

## Toxic Burden Assessment (Part 3-Lifestyle and Habits)

Please mark how frequently you do the following:

Overeat	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Chew your food completely	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Experience lower bowel issues	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Exercise to induce a hard sweat	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Sit in a sauna	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Use a cell phone with a headset or hands free	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Live or work in an environment that recirculates the indoor air	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Use pesticides on your property	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Travel by plane	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Use a computer	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Live by someone who smokes	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Use household cleaners (such as bleach, etc.)	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Keep green plants in your house	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Filter your water	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Use air purifiers in your home	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often
Drink half your body weight in ounces of water each day	<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Sometimes	<input type="radio"/> Often

## Frequency of Consumption

Please mark how many of each item(s) you consume on a daily and weekly basis.

	Daily	Weekly
Soda	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9
Brewed Coffee	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9
Specialty Coffee	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9
Chips	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9
Candy	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9
Gum	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9
Alcoholic Beverage	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9
Cigarettes	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9
Energy Drinks	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9
Protein Bars	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9
Bagels / Muffins / Donuts / Twinkies	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9
Fast Food	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9