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| 1 | CDA GRADE | D |
| 2 | Submission Date | 2019-01-24 20:06:11 |
| 3 | First Name | |
| 4 | Last Name | |
| 5 | Gender | Female |
| 6 | Please enter your email | |
| 7 | Organization 1 | |
| 8 | Organization 2 | Heritage Fellowship |
| 9 | Specify | |
| 10 | What is your date of birth? | 1978-11-25 |
| 11 | What is your current age? | 40 - 49 |
| 12 | What jobs have you had? | Executive, Manager, Admin.<br>Retail, Restaurant<br>Student, Homemaker |
| 13 | Do you take supplements? | Sometimes - Not Regularly |
| 14 | What States have you called "home?" | Louisiana<br>Tennessee |
| 15 | Where have you traveled overseas? | Not Applicable |
| 16 | What is your ancestral heritage? | West European |
| 17 | What level of schooling have you completed? | Some College |
| 18 | I'm HIGHLY motivated to get off medications | Strongly Agree - Very Motivated |
| 19 | I'm willing to work with a health coach to improve my health. | Strongly Agree - Very Motivated |
| 20 | Do you take a vitamin D supplement? | Sometimes - Not Regularly |
| 21 | How motivated are you to become more healthy? | Very Motivated |
| 22 | CDA Score 1 - Personal Information | 3 |
| 23 | How well do you feel normally? | Lack of Energy<br>Memory Issues |
| 24 | How frequently do you have HIGH stress or anxiety? | Daily |
| 25 | Select what is contributing to your stress or anxiety | Finances<br>Work, Job or School<br>Personal Relationships<br>Lack of Time (Frustration) |
| 26 | What is your level of exercise weekly? | Once / Week |
| 27 | What activities do you do at least weekly? | Walk or Hike<br>Garden<br>Other - Mini Trampoline |
| 28 | Do you have pets or animals? | Yes Cats Only |
| 29 | Where are your pets allowed? | Indoors Only |
| 30 | How much sun exposure do you get? | Limited - Don't Tan |
| 31 | What allergens affect you? | Mold<br>Pollen |
| 32 | How much sleep do you get - on average? | 7 - 9 Hours |

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| 33 | What disturbs your sleep? | Interruptions (Environment)<br>Need for Bathroom |
| 34 | What is bedtime usually - during the week? | 9 - 10pm |
| 35 | Do you take a nap during the day? | Never |
| 36 | How long does it take you to fall asleep? | < 5 Minutes |
| 37 | Select the sleep aids you use. | None |
| 38 | Select any supplement you take a least once each week. | Magnesium<br>Vitamin C<br>Other supplement(s) not listed |
| 39 | Do you wear a seatbelt? | Yes - Always |
| 40 | Do you or have you always practiced safe sex? | Yes - Always |
| 41 | Do you smoke - cigars, cigarettes, chew or vape? | NO |
| 42 | Please answer these smoking related questions. | |
| 43 | Do you drink alcohol - beer, wine or hard liquor? | NO |
| 44 | Please answer these alcohol related questions. | |
| 45 | Indicate recreational substances you have used. | Never Used / Not Applicable |
| 46 | CDA Score 2 - Lifestyle Information | 13 |
| 47 | How often do you BRUSH your teeth? | Twice Daily |
| 48 | How often do you FLOSS your teeth? | Daily |
| 49 | Do your gums bleed? | Never |
| 50 | What toothpaste / oral products do you use? | Conventional Toothpaste<br>Baking Soda |
| 51 | How often do you see a dentist? | 2 Times / Year or More |
| 52 | Is your home water fluoridated? | No |
| 53 | Do you have dental implants, root canals, or dentures? | NO |
| 54 | Implants, root canals or dentures - Select all that apply | |
| 55 | Have you been diagnosed with Periodontal disease? | No / Never |
| 56 | How many cavities (fillings) do you have? | 1 - 5 |
| 57 | How many teeth have you lost or had extracted? | 1 - 5<br>4 wisdom teeth extracted |
| 58 | CDA Score 3 - Oral Health | 3 |
| 59 | What diet style best describes your normal eating habits? | American (Meat, Potato, Veggie)<br>Protein is a Priority |
| 60 | What's for Breakfast? | Eggs<br>Hot beverage<br>Often / always skip breakfast |
| 61 | What's for Lunch? | Fast Food |
| 62 | What's Snacking? | Seldom / Never Snack |
| 63 | Are you enjoying the Survey? | 7 |

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| 64 | How often do you eat dinner at home? | 3 - 4 Times |
| 65 | How often is food prepared FRESH at home? | 3 - 4 Times |
| 66 | How many times each week do you obtain food or a snack from a gas station or convenience store? | 1 - 2 Times |
| 67 | List your TOP 3 restaurant choices | Chipotle, Panera, Applebees |
| 68 | How frequently do you consume foods with healthy fats? | Rarely |
| 69 | Describe your relationship with sugar & sweets | Relieved when eating them<br>Guilt after "enjoying" them |
| 70 | What foods cause an allergic reaction? | Not Sure / Not Tested |
| 71 | What foods do you avoid? | Fried Food |
| 72 | Select the beverages you drink every day or regularly. | Water<br>Sweet Tea or Coffee |
| 73 | Do you consume fermented foods? | A Few Times Each Week |
| 74 | What cooking oils do you use at home? | Butter<br>Coconut oil<br>Olive oil |
| 75 | How do you use sugar in cooking? | Follow the Recipe |
| 76 | How do you use salt? | Use Sea Salt |
| 77 | CDA Score 4 - Food & Beverage | 18 |
| 78 | How often do you catch a cold? | Once a Year |
| 79 | How often do you get the Flu? | Never / Almost Never |
| 80 | Do you get migraines or severe headaches? | Sometimes |
| 81 | Do you take a Fish, Krill, Cod Liver Oil or Omega-3 Supplement? | NO |
| 82 | How much Omega-3 supplement do you take daily? | |
| 83 | Do you get dizzy or lightheaded? | When Hungry, Thirsty or Tired<br>Occasionally - < Weekly |
| 84 | Do you get night sweats? | Never / Not Applicable |
| 85 | Do you take an antioxidant supplement | No Never |
| 86 | Do you have depression or a history of depression? | I was diagnosed and treated for postpartum depression after the birth of my first child |
| 87 | Do you have Anxiety? | Almost Never |
| 88 | How is your memory? Are you forgetful? | Sometimes Forgetful |
| 89 | Can you answer in 5 seconds - What did you have for dinner last night? | NO |

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| 90 | Please describe your normal mood. | Confident<br>Joyful<br>Thankful |
| 91 | Toxins you have been exposed to. | Mold<br>Pesticides<br>Mercury<br>Fertilizers<br>Frequent X-Ray (Cat Scan, Chest or Teeth X-Rays)<br>Cleaning Agents<br>Air Pollution<br>Water Contamination (E-Coli, Metals, Fluoride, Industrial Chemicals) |
| 92 | What medications are you currently taking? | None / Not Applicable |
| 93 | What bugs have bitten you? | Tick<br>Mosquitoes - Lots of Bites<br>Spider |
| 94 | Reproductive History | Had two children in 20's |
| 95 | Birth control used | Condoms |
| 96 | Are you pregnant or planning to become pregnant? | |
| 97 | CDA Score 5 - Health Information | 15 |
| 98 | How old is your father? | 50 - 69 |
| 99 | How old is your mother? | 50 - 69 |
| 100 | How old was your father when he passed? | |
| 101 | How old was your mother when she passed? | |
| 102 | Select all chronic diseases either of your parents had. | Cancer<br>Cardiovascular / Heart<br>Respiratory<br>Mental Health |
| 103 | If siblings have died, please select the age ranges that apply. | Not Applicable |
| 104 | Select all chronic diseases your siblings have or had. | Not sure |
| 105 | Almost Done! How are you doing? | 7 |
| 106 | CDA Score 6 - Family & History | 4 |
| 107 | Select any surgeries you have had - or are planning | Appendectomy |
| 108 | Metabolic / Endocrine: Select any disease / problem you CURRENTLY have. | Hypothyroidism<br>Endocrine Problems<br>Infertility<br>Sudden Weight Changes<br>Bulimia<br>Pituitary tumor / Prolactinoma |
| 109 | Endocrine / Diabetes: Are you taking any of these drugs? | None / Not Applicable |
| 110 | Respiratory: Select any disease / problem you CURRENTLY have. | Wheezing or Shortness of Breath |
| 111 | Cancer: Select any disease / problem you CURRENTLY have. | None/ Not Applicable |
| 112 | Cancer: Are you taking any of these drugs / treatments? | |
| 113 | Gastrointestinal: Select any disease / problem you CURRENTLY have. | Bloating / Abdominal Pain |
| 114 | Gut: Are you taking any of these drugs? | None / Not Applicable |

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| 115 | Eyes: Select any disease / problem you CURRENTLY have. | Ocular migraine 1-2x/year |
| 116 | Eyes: Are you taking any of these drugs? | None / Not Applicable |
| 117 | Skin: Select any disease / problem you CURRENTLY have. | Numbness<br>Changing Mole<br>Easy Bruising |
| 118 | Skin: Are you taking any of these drugs? | None / Not Applicable |
| 119 | Musculoskeletal: Select any disease / problem you CURRENTLY have. | Neck Pain |
| 120 | Musculoskeletal: Do you use any of these remedies? | Ice or Heat<br>Manipulation / Chiropathic<br>Massage<br>Aspirin |
| 121 | Heart: Select any disease / problem you CURRENTLY have. | High Blood Pressure<br>Irregular Heart Beat<br>Abnormal Cholesterol<br>Chest Pain/Tightness (Angina)<br>Low Blood Pressure<br>Fainting<br>Cold Hands/Feet |
| 122 | Heart: Are you taking any of these drugs? | Aspirin |
| 123 | Brain: Select any disease / problem you CURRENTLY have. | Depression, Anxiety ...<br>Headaches, Migraines ...<br>Memory Loss...<br>Tumors, Masses |
| 124 | Brain: Are you taking any of these drugs? | None / Not Applicable |
| 125 | Autoimmune & Inflammation: Select any disease / problem you CURRENTLY have. | Thyroid / Energy Issues |
| 126 | Inflammation: Are you taking any of these "Biologic" drugs? | None / Not Applicable |
| 127 | And lastly - Yes - Please describe your bowel movements. | Frequency: ≥1 time per day<br>Color: Brown |
| 128 | The #1 reason your doctor is unable to reverse disease and give you alternatives to medications is TIME. Our program works when, together, we take the time to know all of your unique circumstances. We are committed to helping you achieve your goals of disease reversal and better health. Are you willing to spend 1-2 hours per month working with your coach to improve your health? | YES |
| 129 | Most, if not ALL, chronic disease develops from eating and lifestyle habits. Our program meets you where you are by making small and impactful 'swap outs' based on your current eating and lifestyle routine. To create an individualized plan that will set you up for success, we need to understand what and when you are eating. Are you willing to keep a food journal for 4-7 days every 3 months? | YES |
| 130 | Please explain why you would like to participate in this program | I am at the most unhealthy place I've ever been in my life and I want to regain control but need help / direction. Many people depend on me and if I can't get my health back on track, I feel that I am shortening my time and ability to help those who need me most. |
| 131 | CDA Score 7 - Body Systems | 79 |
| 132 | CDA TOTAL Score: | 135 |

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CDA GRADE

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