EXPERIENCE WITH THE QI DEVICE (NO. 2)

Dear Customer,

Your first weeks with the Qi Device are over now. Today you'll fill out the second questionnaire. You are likely very curious about how your information and results have changed. So that you can evaluate the questionnaire without bias or influence, we recommend that you do not read the first questionnaire again before answering the second questionnaire. Please note that you should complete the questionnaires at the same time each day, preferably in the morning on an empty stomach.

Thank you!

Sex: ☐ Female ☐ Male Date: _____ Time: _____

Age: _____ Height: _____ Weight: _____

Daily water consumption: _____ Liter(s) Do you smoke? ☐ No ☐ Yes

Do you have allergies? ☐ No ☐ Yes, the following:

_____

Please circle your answer in questions 1-16:

1. How would you rate your overall health? (1 = very unhealthy, 10 = very healthy)

1	2	3	4	5	6	7	8	9	10

2. How would you rate your ability to complete daily tasks? (1 = very hard, 10 = very easy)

1	2	3	4	5	6	7	8	9	10

3. How would you rate your daily energy level? (1 = very low, 10 = very high)

1	2	3	4	5	6	7	8	9	10

4. Are you often tired or exhausted? (1 = never, 10 = always)

1	2	3	4	5	6	7	8	9	10

5. How do you feel about your sleep quality? (1 = very bad, 10 = very good)

1	2	3	4	5	6	7	8	9	10

6. How often do you have a headache or migraine? (1 = never, 10 = very often)

1	2	3	4	5	6	7	8	9	10

7. How often do you feel the need to consume caffeine? (1 = never, 10 = very often)

1	2	3	4	5	6	7	8	9	10

8. How often do you take painkillers? (1 = never, 10 = very often)

1	2	3	4	5	6	7	8	9	10

9. How often do you consume alcohol? (1 = never, 10 = more than 3 times a week)

1	2	3	4	5	6	7	8	9	10

10. How would you rate the water quality in your house? (1 = very bad, 10 = very good)

1	2	3	4	5	6	7	8	9	10

11. How would you rate your sensitivity to EMFs? (1 = not sensitive, 10 = highly sensitive) (symptoms include: headache, restlessness, anxiety, poor sleep quality, etc.)

1	2	3	4	5	6	7	8	9	10

12. How stressful do you perceive phone calls with a mobile phone?
(1 = not stressful, 10 = very stressful)

1	2	3	4	5	6	7	8	9	10

13. How would you assess the health of your pets? (1 = very bad, 10 = very good)

1	2	3	4	5	6	7	8	9	10

14. How would you rate your overall disposition? (1 = very sad, 10 = very happy)

1	2	3	4	5	6	7	8	9	10

15. How would you rate the quality of your Qi device? (1 = very low, 10 = very high)

1	2	3	4	5	6	7	8	9	10

Have you experienced one or more of the following diseases, conditions, or treatments?

☐ Heart disease	☐ Circulatory diseases	☐ High blood pressure
☐ Heart attack	☐ Bypass/Stent	☐ Pacemaker
☐ Jaundice	☐ Hepatitis A, B, C	☐ Chronic lung disease
☐ Tuberculosis	☐ Renal impairment	☐ Alzheimer's disease
☐ Eye diseases	☐ Diabetes type 1 or 2	☐ Gastrointestinal diseases
☐ Thyroid disease	☐ Osteoporosis	☐ Epilepsy
☐ Tumor	☐ Blood clotting disorder	☐ Immunodeficiency (HIV/AIDS)

Are there any other diseases, conditions, or treatments you are experiencing?

Personal assessment and experience (optional):