



GrassrootsHealth
Moving Research into Practice



myData
myAnswers

myQuestionnaire

Thank you for taking the time to complete the following questionnaire. It should take about 10-20 minutes of your time. Have all supplement bottles on hand to reference when necessary to help speed the process.



Health Info

Done



Nutrition

Done



Lifestyle

Done



Authorization

Done

Biometrics

Enter your information below or update pre-filled information as needed.

*All fields are mandatory unless specified as Optional.

What is your current weight without clothing, measured in

- Pounds (lbs)
- Killograms (kg)

reset

186

Whole number only

(Your previous answer was _____)

What is your current height without shoes, measured in

- feet and inches
- centimeters

reset

Enter values below

6

ft - Whole number only

(Your previous answer was _____)

3

in - Whole number only

(Your previous answer was _____)

Do you know your average blood pressure over the last 6 months?

- Yes
 No

reset

What was your average **systolic** blood pressure for the past 6 months?

(the top number of your blood pressure reading)

What was your average **diastolic** blood pressure for the past 6 months?

(the bottom number of your blood pressure reading)

Have you had your blood cholesterol measured?

- Yes (I have blood cholesterol results to enter that I have not entered previously)
 No (I do not have blood cholesterol results, or I have no new results since my last entry)
 I don't know

reset

Submit

Save & Return Later



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Health History- Diagnoses

Please enter any diagnoses below. Entries will be saved and displayed for future questionnaires.

*All fields are mandatory unless specified Optional.

Cancer Diagnoses

Have you been diagnosed with any of the following?

(Check for Yes, if Yes, enter Date of Diagnosis & Recurrence Date if applicable)

Breast Cancer

Yes

reset

Colon Cancer

Yes

reset

Melanoma

Yes

reset

Ovarian Cancer

Yes

reset

Prostate Cancer

Yes

reset

Other Cancer (1)

Yes

reset

Autoimmune Diagnoses

Celiac Disease

Yes

reset

Chronic Fatigue

Yes

reset

Eczema or Serious Rash

Yes

reset

Fibromyalgia

Yes

reset

Myasthenia Gravis

Yes

reset

Type 1 Diabetes

Yes

reset

Type 2 Diabetes

Yes

reset

Cardiovascular Diagnoses

Angina Pectoris

Yes

reset

Heart Attack

Yes

reset

Hypertension

Yes

reset

Stroke

Yes

reset

Digestive Diagnoses

Gluten Intolerance

Yes

reset

Lactose Intolerance

Yes

reset

Hepatic Diagnoses

Non-alcoholic Fatty Liver Disease

Yes

reset

Neurological Diagnoses

Alzheimer's (and other dementias)

Yes

reset

Multiple Sclerosis

Yes

reset

Parkinsons

Yes

reset

Pulmonary Diagnoses

Pneumonia

Yes

reset

Renal Diagnoses

Kidney Failure

Yes

reset

Kidney Stones

Yes

reset

Kidney Stones: Year of Diagnosis
(or best estimate)

Year as YYYY

Kidney Stones: Month of Diagnosis
(or best estimate)

Month as MM

Kidney Stones: Year of Recurrence
(or best estimate)

Year as YYYY

Kidney Stones: Month of Recurrence
(or best estimate)

Month as MM

Other Diagnoses

Other Disease

Yes

[reset](#)

[Submit](#)

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Recent Health History

*All fields are mandatory unless specified Optional.

In the last 6 months have you fallen?

Yes No

reset

In the last 6 months have you broken a bone?

Yes No

reset

In the last 6 months have you had a cold lasting at least 3 days?

Yes No

reset

In the last 6 months have you had the flu with fever?

Yes No

reset

In the last 6 months, on a regular basis (ie. more than once per week), have you experienced any joint discomfort or stiffness?

Yes No

reset

In the last 6 months have you had any regular, chronic pain (lasting at least 12 weeks)?

Yes No

reset

Body part affected

Pain Rating (back) on a scale from 1-10 (1=minor, 10=major)

1 2 3 4 5 6 7 8 9 10

reset

Reason if known (back pain)

In the last 6 months have you experienced any other regular, chronic pain?

Yes No

reset

In the last 6 months have you experienced any acute, non-chronic pain?

Yes No

reset

If you have regularly monitored your blood pressure, have you noticed a change over the last 6 months?

- Clear improvement
- Some improvement
- Unchanged
- Some worsening
- Clear worsening
- Don't know
- I do not regularly monitor my blood pressure

reset

In the last 6 months, have you noticed a change in your cognitive function or memory?

- Clear improvement
- Some improvement
- Unchanged
- Some worsening
- Clear worsening
- Don't know

reset

In the last 6 months, have you noticed a change in your overall mood (depression, anxiety, etc.)?

- Clear improvement
- Some improvement
- Unchanged
- Some worsening
- Clear worsening
- Don't know

reset



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Medications

*All fields are mandatory unless specified Optional.

Do you currently take, or have you taken within the last month, any of the following medications?

- Statins** (such as atorvastatin (Lipitor), fluvastatin (Lescol, Lescol XL), lovastatin (Mevacor, Altoprev), pravastatin (Pravachol), rosuvastatin (Crestor), simvastatin (Zocor), or pitavastatin (Livalo))
- Fibrates** (such as gemfibrozil (Lopid), or fenofibrate (Tricor))
- Nicotinic acid**
- I have not taken any of the above medications in the last month

Do you regularly use (ie. more than once per week) any of the following over the counter NSAIDS (NOT including acetaminophen or Tylenol products)?
Check all that apply.

- Advil
- Aleve
- Anaprox
- Aspirin
- Ibuprofen
- Motrin
- Naprosyn
- Other
- I do not regularly use over the counter NSAIDS

Do you regularly use (ie. more than once per week) any of the following prescription-only NSAID medications? *Check all that apply.*

- Catafla
- Celebrex
- Clinoril
- Daypro
- Diflunisal
- Etodolac
- Feldene
- Fenoprofen
- Flurbiprofen
- Indomethacin
- Ketoprofen
- Meclofenamate
- Mobic
- Nabumetone
- Piroxicam
- Ponstel
- Suldinac
- Tolmetin
- Voltaren
- Zipsor
- Other
- I do not regularly use prescription NSAIDS

Over the last 3 months, have you started or stopped taking any type of hormone therapy or birth control pills?

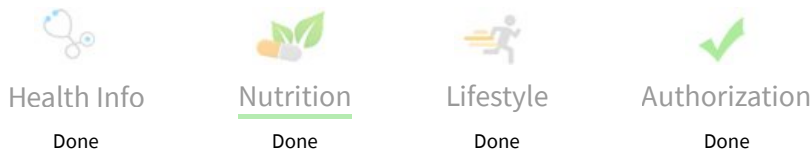
- Yes No

reset



myQuestionnaire

Thank you for taking the time to complete the following questionnaire. It should take about 10-20 minutes of your time. Have all supplement bottles on hand to reference when necessary to help speed the process.



Diet & Supplements

Vitamin D Supplementation

*All fields are mandatory unless specified Optional.

During the past 6 months, did you take any vitamin D supplements?

Yes No

reset

During the past 6 months on average, how much vitamin D from supplements did you take per day?

25000

Whole numbers only - no commas or decimals; Enter '0' for None and '9999' for Don't Know

Your previous answer was _____ IU/day

IU mcg

reset

Please answer the following questions for any vitamin D supplement(s) taken within the last 6 months. If you took more than one, complete each set of questions for your 3 most recent vitamin D supplements, entering information for one supplement at a time.

Supplement Name (Vitamin D Supplement #1)

Begin typing brand or product name to find your supplement

Bio-Tech Pharmacal D3-50 50,000 IU

Type of Vitamin D supplement

(Vitamin D Supplement #1)

- Liquid (including drops or sprays)
- Liquid-filled capsule(s) or softgel(s)
- Powder or powder-filled capsule(s)
- Pill(s)/tablet(s)
- Gummie(s)
- Sublingual(s) or lozenge(s)
- Packet(s) or squeezie(s)
- Topical patch or cream
- Other (specify)

reset

What was the typical amount taken or used per day? (for example, enter "2" if you usually took 2 softgels, gummies, or teaspoons each day)

(Vitamin D Supplement #1)

0

Please enter a number value only

How often did you generally take this supplement, in this amount?

(*Vitamin D Supplement #1*)

- Every day
- Most days (4-6 days/week)
- Some days (2-3 days/week)
- Once a week
- Once every 2 weeks
- Once a month
- Inconsistently (or infrequently)
- Other (specify)

reset

Have you taken this vitamin D supplement

(*Vitamin D Supplement #1*)

- For the entire past 6 months
- More than 4 months, but less than 6
- More than 2 months, but less than 4
- More than 1 month, but less than 2
- Started taking it within the past month
- Stopped taking it within the past month
- Stopped taking more than 1 month, but less than 2 months ago
- Stopped taking more than 2 months but less than 4 months ago
- Stopped taking more than 4 months but less than 6 months ago

reset

Have you taken any other vitamin D supplements during the past 6 months?

- Yes
- No

reset

Have you taken any *other* supplements that included vitamin D during the past 6 months, such as a multivitamin?

- Yes
- No

reset

In the past 2 months, have you taken an extra-large dose of vitamin D?

- Yes
- No

reset

What was the dose? (per day)

10000

Whole numbers only - no commas or decimals; Enter '0' for None and '9999' for Don't Know

IU mcg

reset

How many days did you take that dose?

2

days

How long ago did you take it?

- Within the past week
- 1-2 weeks ago
- 2-4 weeks ago
- 4-6 weeks ago
- More than 6 weeks ago

reset

(Optional) Additional comments about your vitamin D supplements:

Take vitamin D once every 4 days

Expand

Next Page >>

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Health Info

Done



Nutrition

Incomplete...



Lifestyle

Done



Authorization

Done

Magnesium Supplementation

*All fields are mandatory unless specified Optional.

Did you complete/will you be completing a magnesium (Mg+ELEMENTS) blood spot test within 2 months of answering this questionnaire?

- Yes No

reset

During the past 6 months, did you take any supplements containing magnesium that were not entered in a previous supplement section? (Please include any supplements containing any form of magnesium.)

- Yes
 No
 I reported all of my magnesium supplements in the previous supplement sections
(My vitamin D and/or omega-3 supplements also contained magnesium)

reset

Please answer the following questions for any magnesium supplements taken within the last 6 months. If you took more than one magnesium supplement, complete each set of questions for your 3 most recent magnesium products, entering information for one supplement at a time.

(Magnesium Supplement #1) Supplement Name
Begin typing brand or product name to find your supplement

Don't know

Enter "Don't Know" if Unsure

Type of supplement
(*Magnesium Supplement #1*)

- Liquid
- Softgel(s) or liquid-filled capsule(s)
- Powder-filled capsule(s)
- Powder (loose)
- Pill(s)/tablet(s)
- Gummie(s)
- Sublingual(s) or lozenge(s)
- Packet(s) or squeezie(s)
- Topical patch or cream
- Other (specify)

reset

How do you usually measure your powder supplement when taken?
(*Magnesium Supplement #1*)

- Packet(s)
- Scoop(s)
- Teaspoon(s)
- Tablespoon(s)
- Other (specify)

reset

What was the typical amount taken or used per day? (for example, enter "2" if you usually took 2 softgels, gummies, or teaspoons each day)
(*Magnesium Supplement #1*)

Please enter a number value only

How often did you generally take this supplement, in this amount?
(*Magnesium Supplement #1*)

- Every day
- Most days (4-6 days/week)
- Some days (2-3 days/week)
- Once a week
- Once every 2 weeks
- Once a month
- Inconsistently (or infrequently)
- Other (specify)

reset

Have you taken this supplement
(*Magnesium Supplement #1*)

- For the entire past 6 months
- More than 4 months, but less than 6
- More than 2 months, but less than 4
- More than 1 month, but less than 2
- Started taking it within the past month
- Stopped taking it within the past month
- Stopped taking more than 1 month, but less than 2 months ago
- Stopped taking more than 2 months but less than 4 months ago
- Stopped taking more than 4 months but less than 6 months ago

reset

For the following section, please refer to the label on this magnesium supplement bottle for information (see picture below for example).

EXAMPLE LABEL:

Supplement Facts			
Serving size: 1 Tablespoon (15 ml)			
Servings Per Container: 32			
	Amount Per Serving	% DV* Under 4 yrs	% DV* 4 yrs+
Calories	15		
Total Carbohydrate	4 g	†	1%
Sugars	2 g	†	†
Vitamin D (as Cholecalciferol)	100 IU	25%	25%
Calcium (as Calcium Citrate)	252 mg	32%	25%
Magnesium (as Magnesium Citrate)	115 mg	57%	29%
Zinc (as Zinc Citrate)	2 mg	25%	13%

* Percent Daily Values are based upon a 2,000 calorie diet.
† Daily Value not established.

(Magnesium Supplement #1) What is the serving size or amount referenced on the supplement's nutrition label? (Please provide exactly what is on the label, regardless of how much or how often you take this supplement. For example, enter "1" if the serving size on the label is 1 softgel, capsule or other.)

Please enter a number value only; Enter "9999" for don't know

(Magnesium Supplement #1) What is the serving size unit of measure shown on the label for this powder supplement?

- Packets
- Scoops
- Teaspoons
- Tablespoons
- Other (specify)

reset

(*Magnesium Supplement #1*) For this magnesium supplement, which of the following are listed on the label? (Choose all that apply)

- Magnesium Amino Acid Chelate
- Magnesium Malate
- Magnesium Aspartate
- Magnesium Carbonate
- Magnesium Chloride
- Magnesium Citrate
- Magnesium Glycinate
- Magnesium Hydroxide
- Magnesium Lactate
- Magnesium Orotate
- Magnesium Oxide
- Magnesium Sulfate
- Magnesium Taurate
- Magnesium Threonate
- I don't know
- Other (specify)

Magnesium amount listed on the label (all forms combined)

mg

Have you taken any other supplements that included magnesium during the past 6 months?

Yes No

reset

In the last 3 months, on average, how often did you take an Epsom salt bath?

- Once per week or more
- About once every 2 weeks
- About once per month
- Less than once per month
- I have not taken an Epsom salt bath in the last 3 months

reset

(Optional) Additional comments about your magnesium supplements:

Magnesium Chloride bath, not Epsom salt

Expand

<< Previous Page

Next Page >>

Save & Return Later



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Health Info

Done



Nutrition

Done



Lifestyle

Done



Authorization

Done

Diet & Supplements (Cont.)

*All fields are mandatory unless specified Optional.

During the past 6 months, on average, please indicate your daily intake of the following nutrients from supplements:

Vitamin A (as retinol or retinyl palmitate)

IU - no commas or decimals; Enter '0' for None and '9999' for Don't Know (**Your previous answer was _____ IU/day**)

Calcium

mg - no commas or decimals; Enter '0' for None and '9999' for Don't Know (**Your previous answer was _____ mg/day**)

Vitamin K2 (Menaquinone) Total

m μ g - no commas or decimals; Enter '0' for None and '9999' for Don't Know (**Your previous answer was _____ m μ g/day**)

(Optional) Vitamin K2 (as MK-4)

m μ g - no commas or decimals; Enter '0' for None and '9999' for Don't Know (**Your previous answer was _____ m μ g/day**)

(Optional) Vitamin K2 (as MK-7)

m μ g - no commas or decimals; Enter '0' for None and '9999' for Don't Know (**Your previous answer was _____ m μ g/day**)

(Optional) Vitamin B6

mg - no commas or decimals; Enter '0' for None and '9999' for Don't Know (**Your previous answer was _____**)

(Optional) Vitamin B12

No commas or decimals; Enter '0' for None and '9999' for Don't Know (**Your previous answer was _____**)

mcg mg mcg/mL I don't know how much

reset

(Optional) Vitamin C

No commas or decimals; Enter '0' for None and '9999' for Don't Know (**Your previous answer was _____**)

During the last 6 months, which of the following additional nutrients did you take on a regular basis? (check all that apply)

- Iron
- Probiotics
- Vitamin A (as beta carotene)
- Vitamin B1/Thiamin
- Vitamin B2/Riboflavin
- Vitamin B3/Niacin
- Vitamin B5/Pantothenic Acid
- Vitamin B9/Folic Acid
- Vitamin E
- Vitamin K1
- Zinc
- All of the Above
- None of the Above
- I don't know

Do you consider yourself to be a

- Strict vegetarian (does not eat meat or some other animal products)
- Lacto/ovo vegetarian (a person who eats vegetables, eggs, and dairy products but who does not eat meat)
- Vegan (a person who does not eat or use any animal products)
- None of the above

reset

How many meals containing **fatty/oily fish** do you normally have per week, such as salmon, mackerel, herring, sardines or tuna?

- 0
- 1
- 2
- 3
- 4
- More than 4
- I don't know

reset

Which fish do you normally eat? (Such as salmon, anchovies, tuna, trout, mahi mahi, etc.)

How many meals containing **plant-based omega-3s** do you normally have per week, such as flaxseed, flaxseed oil, chia seeds or walnuts?

0 1 2 3 4 More than 4 I don't know

reset

(Optional) Additional comments about your diet and other supplements taken:

Expand

<< Previous Page

Submit

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Nutrition

Done



Lifestyle

Done



Authorization

Done

Sun Exposure

*All fields are mandatory unless specified Optional.

On average, during the past 12 months, approximately how many minutes per day have you spent outdoors in the sun between 10:00 am and 2:00 pm?

				30			
	None	1-14	15-29	minutes -	1 hour	1-2 hours	2-4 hours
April - June	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
							reset
July - September	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
							reset
October - December	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
							reset
January - March	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
							reset

Describe your usual clothing when outdoors in the sun between 10:00 am and 2:00 pm during each season during the past 12 months.

	Shorts and no or very brief top with shoulders exposed	Shorts and T-shirt or similar top	Shorts and long sleeves	Long pants and T-shirt or similar top	Long pants and long sleeves
April - June	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
					reset
July - September	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
					reset
October - December	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
					reset
January - March	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
					reset

Excluding your face and neck, describe your usual use of sunscreen when outdoors in the sun between 10:00 am and 2:00 pm during each season during the past 12 months.

	I never or almost never used sunscreen	I used it occasionally (5-20% of the time)	I used it regularly (20-50% of the time)	I used it most of the time (50-80% of the time)	I used it almost all of the time (80-95% of the time)	I used it all the time (95-100%)
April - June	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
						reset
July - September	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
						reset
October - December	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
						reset
January - March	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
						reset

Excluding your face and neck, what SPF sunscreen did you usually use during the past 12 months?

4
 8
 10
 15
 20
 30
 40
 50
 60+
 None
 Don't Know

reset

SPF sunscreen level

During the past 6 months

- I have not used indoor tanning equipment
- I have received UV exposure from indoor tanning just a few times (1-5 times in six months)
- I have received UV exposure from indoor tanning regularly (1-3 tanning visits a week on average)

reset

Enter your occupation during the past 6 months below. If you are retired, specify the occupation you were in for most of your life.

I am currently retired.

During the past 2 months, have you been to a place other than where you live today, such as on a vacation or a work assignment, for 7 days or longer?

- Yes, vacation
- Yes, work assignment
- Yes, both
- Yes, other reason
- No

reset

Physical Activity

During the past 6 months, which forms of exercise did you typically engage in for at least 20 minutes per day, 3 or more times per week? (Choose all that apply)

- Mild physical activity such as gardening, walking or biking
- Moderate physical activity to the point where you usually break a sweat
- Strenuous physical activity to the point where you always break a sweat
- Less than or none of the above
- Other (specify)
- Don't know

Smoking

Have you ever smoked a total of 100 or more cigarettes in your whole lifetime?

- Yes No Don't Know

reset

Do you currently smoke cigarettes?

Yes No Don't Know

reset

Do you currently use an electronic cigarette?

Yes No

reset

Does anyone currently smoke cigarettes in your presence for at least 30 minutes per day on average?

Yes No

reset

Alcohol

Have you had any drinks containing alcohol during the past 6 months?

Yes No Don't Know

reset

If yes, mark the average number of drinks during a typical week (Monday through Sunday); 1 drink is equal to a 5 oz glass of wine, 12 oz bottle of beer, or 1.5 oz shot of liquor:

- Less than 1
- 1-5
- 6-10
- 11-15
- 16-20
- 21 or more
- Don't know

reset

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Done



Lifestyle

Done



Authorization

Done

Authorization for Study Participation

Yes indicates I have read the details in the "Research Subject Information Sheet" and choose to enroll in this project. This authorization is equivalent to my signature.

Yes

Click to view study participation details and use of data authorization

View "Research Subject Information Sheet"

Sponsor: GrassrootsHealth

Protocol Title: 25-hydroxyvitamin D [25(OH)D] serum levels and associated health outcomes in the population resulting from a program of education and testing

Investigator: Dr. Cedric Garland

The purpose of this population study is to offer testing and/or feedback about results and education to make necessary lifestyle changes to effect serum level concentrations. In this study you will create an account with GrassrootsHealth (GRH), fill out a health questionnaire and receive vitamin D test results either from a home blood spot test provided by GRH or from a participating GRH Certified physician and lab (available only to participants of qualifying GRH projects). You may also choose to include additional nutrient tests by enrolling in a sub-project. For the home blood spot test(s), you will provide drops of blood on the blood spot card and return it to GRH. The results of the test(s) will be made available to you through the account created on the GRH website along with information about target levels. The test results are strictly informational. The review of your test results by the study investigator does not represent diagnosis and treatment. The health questionnaire will be filled out and testing will occur at regular intervals. It is an international study which is expected to involve over 100,000 participants. You may not receive a direct benefit if you agree to participate. However, people in the future may benefit from the information obtained from this research.

There is minimal risk to obtaining blood drops for testing 25(OH)D and other nutrient tests available by home blood spot test kits. The test generally will be done in your home, using a sterile self-loaded lancet to puncture the fingertip. This will be done after a thorough washing of hands with soap and warm water and the use of an alcohol swab where the blood drops will be obtained. We are aware of no reports of harm other than short term pain with using the test. You are advised that if any complications develop you should consult your healthcare provider. You will be advised if there is any new information that would influence your decision about participation.

Your alternative to participating in this study includes requesting your own physician to order the 25(OH)D or other test(s). Results from physician ordered tests can only be used by participants of a qualifying GRH project and if the physician and lab are contracted with GRH. You can use the free educational pieces on the website without participating in the study. Contact Jen Aliano at (760) 710-9305 for questions about the research or if you think you have been harmed as a result of joining this research. Contact the Western Institutional Review Board (WIRB) if you have questions about your rights as a research subject: 1-800-562-4789. WIRB is a group of people who perform independent review of research.

If you use certain electronic health applications (apps), you may opt to have data from that application securely shared with GrassrootsHealth. Third-party data, such as that from the health application, is de-identified and transmitted with a unique identification code that will link health data from each application with information in your GrassrootsHealth account, and will allow for expanded analysis.

Your individual health data will be kept confidential except for where required by law. The accumulated data will be stored in a secured, encrypted database operating behind a firewall, and password protected. The only person that will have access to the identified data will be our primary data biostatistician. This will be for purposes of accessing hospital records as indicated and released by participants, or for clarification of entries in the health questionnaire. The de-identified health information is shared so the research can be conducted, properly monitored and published. The Principal Investigator and other researchers will access the data in a de-identified form. For all analyses only an arbitrary number will identify the participant.

If you are under 18 years of age, parental consent must be provided to participate in this study. This permission will not end unless you cancel it. You may cancel it by sending written notice to the study leader at:
GrassrootsHealth, 315 S Coast Hwy 101, Suite U-87, Encinitas, CA 92024.

Your decision to be in this study is voluntary. You will not be penalized or lose benefits if you decide not to participate or if you decide to stop participating. There may be a sponsorship fee associated with participation in this study. Sponsorship supports the efforts of documenting serum levels and health outcomes, feedback of the information, as well as the tests and laboratory fees.

END OF DOCUMENT

Hospital Information

Any hospital or urgent care for your medical care in the last 6 months?

Yes No

reset

Authorization for Nutrient Testing and Release of Test Results

"Yes" indicates my request, authorization and/or consent for laboratory testing. I understand that test results are strictly informational. The review of my test results by the study investigator does not represent diagnosis or treatment. I am responsible for contacting my personal health care provider for follow-up and interpretation of my test results. This authorization is equivalent to my signature.

Yes

reset

Authorization for Use of Health Data

"Yes" indicates my authorization for the research use of my de-identified health data by GrassrootsHealth or its designated researchers. This authorization is equivalent to my signature.

Yes

reset

Authorization to Receive Text Messages

"Yes" indicates my authorization for GrassrootsHealth to send text messages to the phone number listed above regarding important study reminders. I am responsible for any text or data fees that may apply based on my carrier and plan. I can opt out of receiving text messages at any time by texting STOP in reply. This authorization is equivalent to my signature.

Yes No

reset



(Optional) QUESTIONS, COMMENTS OR FEEDBACK?

Enter it here.

Expand

Thank you!

PLEASE NOTE: All participants in this project will be subscribed to GrassrootsHealth news and updates emails. You may unsubscribe at any time by clicking the "SafeUnsubscribe" link at the bottom of each email.

Submit

Save & Return Later