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Return, fax or mail this completed form to us OR
 register online at www.aocresearch.com

Respondent Profile Form (All Adults in Household Must Register Separately)

First Name: _____ Last Name: _____ **Circle Gender: M / F**

Date of Birth: ____/____/____ Email Address: _____

Home Phone #: _____-_____-____ Mobile Phone #: _____-_____-____

Work Phone #: _____-_____-____ ext. _____ Fax #: _____-_____-____

Home Address: _____ City: _____

State: NC / SC Zip Code: _____ County: _____

Employment Status: Full Time Part Time Unemployed Homemaker Student Retired

Primary Occupation/Industry: _____ Title: _____

Company: _____

Education Completed: Less than High School High School Some College College Grad Post Grad

Race: Caucasian African American Hispanic Asian Other **Party Affiliation:** Democrat Republican Independent Other

Marital Status: Married Living with Significant Other Divorced Separated Single Widowed

Spouse's Employment Status: Full Time Part Time Unemployed Homemaker Student Retired

Spouse's Primary Occupation/Industry: _____

Annual Household Income: less than 15K 15-20K 20-29K 30-39K 40-49K 50-59K 60-75K 75-99K 100-124K
 125-149K 150-174K 175-199K 200-250K 250K+

Please list the dates of birth and ____/____/____ Gender: M / F ____/____/____ Gender: M / F

circle the genders of all **children** under ____/____/____ Gender: M / F ____/____/____ Gender: M / F

age 18 **living in your household:** ____/____/____ Gender: M / F ____/____/____ Gender: M / F

What type of music/radio programming do you listen to **on a regular basis**? ("X" all that apply)

- Alternative Bluegrass Blues R&B Classic Rock Classical Country Disco Easy Listening Electronica/Trance Folk
- Hard Rock Heavy Metal Hip Hop Rap Jazz Latin New Age News Talk Oldies Punk/Hardcore/Ska Reggae
- Religious/Gospel Sports Talk Talk Radio (Morning, Afternoon or Evening) Top 40/Pop Other

What is your housing type? Single Family Home Apartment Condominium or Town Home Dormitory or Student Housing

Do you own a dog? Yes No Do you own a cat? Yes No Are you a vegetarian or vegan? Yes No

Are you a sports fan? Yes No If so, which sports? NASCAR Baseball Basketball Football Hockey Golf Other

What kind of electronics are used in your household? ("X" all that apply)

- Bluetooth Cable Phone Service Cell Phone Digital Camera Video Camera Desktop Computer Notebook or Laptop Computer
- Webcam Wireless Network Flat Panel Computer Monitor Digital Photo Frame DVD Player DVD Recorder or Burner
- Portable Game System Stationary Game System Global Positioning System (GPS) Handheld, PDA or Blackberry
- Home Theatre System Portable Music Player-MP3 or IPOD Satellite Radio Service Liquid Crystal Display (LCD) TV
- Digital Light Processing (DLP) TV Plasma Screen TV TiVo DVR

Do you drink beer? Yes No Do you drink liquor or mixed drinks? Yes No Do you subscribe to cable television? Yes No

Do you drink wine? Yes No Do you own an ATV or four wheeler? Yes No Do you subscribe to satellite television? Yes No

Do you smoke cigarettes? Yes No If so, list brand you use **most often:** _____

Type: Non-Menthol Menthol Strength: Full Flavor Medium Milds Lights Ultra Lights

Do you smoke cigars? Yes No If so, what type? Plain Flavored Both

Do you use chewing tobacco? Yes No If so, list the brand you use most often: _____

Do you use moist snuff tobacco or dip? Yes No If so, list brand you use **most often:** _____

Type: Fine Cut Long Cut Pouches Other Flavor: _____

"X" one: I do not exercise I exercise on avg. 3 or more times per week most weeks I exercise on avg. LESS than 3 times per week most weeks

Do you do your own vehicle maintenance? Yes No Sometimes Do you purchase organic foods? Yes No

Do you take vitamins or supplements? Yes No Do you consider yourself a "Do it Yourselfer"? Yes No

List the stores where you regularly purchase groceries for your household: _____

Do you or anyone in your household wear corrective lenses? Yes No Select: Glasses Contacts Both

If you would like to participate in confidential medical-related studies, "X" all that apply for you or anyone in your household:

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Diabetes (Type I) | <input type="checkbox"/> Multiple Sclerosis (MS) |
| <input type="checkbox"/> Attention Deficit Disorder (ADD) | <input type="checkbox"/> Diabetes (Type II) | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> PMS/PDD |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Restless Leg Syndrome (RLS) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Baldness | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> IBS/Colitis /Crohn's | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Incontinence | |

Do you or does anyone in your household suffer with allergies? Yes No If so, which types? Food Drug Seasonal/Environmental Other

How did you hear about us? **SEE BACK OF SHEET FOR MORE INFORMATION**