**HEALTH AND NUTRITION EVALUATION**

Providing the following information will allow a better understanding of your condition, and enable us to help you more. Explain fully where necessary. Use separate sheets for additional information.

**PLEASE PRINT**

**NAME:**       **DOB:**

**ADDRESS**: **Street****:**       **City:**

 **State:**       **Zip:**       **Phone:**    -   -

 **Age:**       S**ex:**       **Height:**        **Weight:**       **Weight one year ago:**

**Nationality:** **Religious preference:** **Marital Status:**

**PLEASE ADD A FIELD FOR EMAIL**

**MEDICAL HISTORY**

**Give medical history - names and dates of past ailments, operations (anything you feel significant, including past complaints).**

**When did you last consult a physician?**

**For what reason?**

**What are you currently being treated for?**

**What specific conditions would you like this consultation to address**?

**List all medicine, pills, or drugs you are taking now:**

**List mineral and/or vitamin supplements you are taking/how many and how often:**

**Do you have indigestion?** [ ] Yes [ ] No Gas? [ ] Yes [ ] No Bloating? [ ] Yes [ ] No **How Often?**

**What foods tend to cause indigestion, bloating or gas?**

**How often do you have bowel evacuations?** [ ] Yes [ ] No Color **& texture:**

**Do you have Diarrhea?** [ ] Yes [ ] No **Constipation?** [ ] Yes [ ] No

**What color is your urine usually?**

**Do you wear eyeglasses?** [ ] Yes [ ] No **contact lenses?** [ ] Yes [ ] No **How many years?**

**Do you have or have you had any of the following? Check the appropriate box and explain fully in the space which follows.**

|  |
| --- |
| **Blank = Never 1 = Rarely 2 = Occasionally 3 = Sometimes 4 = Most of the time 5 = Always** |
| ***Past*** | ***Present*** |  | ***Past*** | ***Present*** |  | ***Past*** | ***Present*** |  |
|   |   | Absent Minded |   |   | Excessive Hunger |   |   | Lumbago |
|   |   | Acne |   |   | Excessive Worry |   |   | Mental Disorder |
|   |   | Alcoholism |   |   | Faint When Hungry |   |   | Motion Sickness |
|   |   | Allergies |   |   | Fatigue |   |   | Nausea |
|   |   | Anemia |   |   | Feels Shaky if Hungry |   |   | Nervous Disorder |
|   |   | Appendicitis |   |   | Foul Smelling BM |   |   | Night Blindness |
|   |   | Arthritis |   |   | Foul Smelling Urine |   |   | Pain w/bowel movement |
|   |   | Asthma |   |   | Frequent Colds |   |   | Poliomyelitis |
|   |   | Bad Breath |   |   | Frequent Kidney Infections |   |   | Prostate Trouble |
|   |   | Cancer |   |   | Frequent Lower Bowel Gas |   |   | Respiratory Problems |
|   |   | Chest Pains |   |   | Frequent Urination |   |   | Rheumatic Fever |
|   |   | Chills/Cold Skin |   |   | Gallstones |   |   | Sexual Disorders |
|   |   | Cold Hands/Feet |   |   | Hay fever |   |   | Sinusitis |
|   |   | Constipation |   |   | Headaches |   |   | Skin Problems |
|   |   | Crave sweets/coffee |   |   | Heart Disease |   |   | Sluggish in the A.M. |
|   |   | Depression |   |   | Heart Pounds Hard |   |   | Swollen Glands |
|   |   | Diabetes |   |   | Hemorrhoids |   |   | Too Fast Digestion |
|   |   | Diarrhea |   |   | High Blood Pressure |   |   | Tuberculosis |
|   |   | Difficulty Breathing |   |   | Hot Most of the Time |   |   | Ulcers/Colitis |
|   |   | Digestive Disorders |   |   | Indigestion/Heartburn |   |   | Venereal Infection |
|   |   | Dizziness |   |   | Insomnia |   |   | Wake Up Tired |
|   |   | Eat When Depressed |   |   | Irritable before Meals |   |   | Weight Problem |
|   |   | Eat When Nervous |   |   | Itching of the Nose |   |   |  |
|   |   | Eating relieves fatigue |   |   | Itching of the Rectum |   |   |  |
|   |   | Eczema |   |   | Kidney Stones |   |   |  |
|   |   | Emphysema |   |   | Light-headedness |   |   |  |
|   |   | Excessive Fear |   |   | Low Blood Pressure |   |   |  |

**Explain fully the past or present ailments checked above on a separate piece of paper if needed:**

 **GODLY TRUST**

**Occupations:**

**What hours do you work?**

**Health of spouse (if applicable):**

**How many children do you have?**       **Ages:**

**Health of children:**

**Recreational activities enjoyed:**

**Hours per week viewing TV****:**      **Do you often feel guilty about past mistakes?** [ ] Yes [ ] No

**Do you worry about the future?** [ ] Yes [ ] No **Do you have stress?** [ ] Yes [ ] No **Depression?** [ ] Yes [ ] No

**Check the following categories which cause stress:**  [ ] financial

  [ ] job related

 [ ] getting along with people

 [ ] family

 [ ] not happy with myself

**On a scale of 1 to 10 rate your stress level (1= very little stress and 10=an extreme amt. of stress)****:**

Do you enjoy the work that you do? [ ] Yes [ ] No **If not, explain****:**

**Are you developing your mental and spiritual capabilities by daily study, meditation and prayer?**

[ ] Yes [ ] No

**Are you involved in some type of activity in which you are helping others?** [ ] Yes [ ] No

**The following space is provided for those who would like to elaborate more on the causes of their stress, depression and other negative emotions.**

 **OPEN AIR**

**How many hours daily do you spend out of doors?**

**Do you sleep with your windows closed?** [ ] Yes [ ] No

**Are you able to breathe fresh air while you are working?** [ ] Yes [ ] No

**Is the building where you work a none-smoking facility:** [ ] Yes [ ] No

**DAILY EXERCISE**

**How often do you exercise?**       **Describe the exercise:**

**How do you feel after you exercise?**

**SUNSHINE**

**How much time daily do you spend out of doors in the sunlight?**

**Do you often get sunburned?** [ ] Yes [ ] No **Do you visit tanning beds?** [ ] Yes [ ] No

**Are you afraid of getting skin cancer?** [ ] Yes [ ] No

**PROPER REST**

**What time do you go to bed?**       **What time do you awaken?**

**What time is your last meal before retiring?**       **Do you snack just before bedtime?** [ ] Yes [ ] No

**Do you wake up during the night and snack?** [ ] Yes [ ] No **If so, what do you eat?**

**Do you have trouble sleeping?** [ ] Yes [ ] No **Explain:**

**LOTS OF WATER**

**How much water do you drink daily?**

**What type? (spring, filtered, distilled, tap):**

**Check below the beverages you drink and indicate how much of each:**

 **BEVERAGE NAME BRAND # OF glasses, cans or bottles daily**

 [ ] Soda

 [ ] Coffee

 [ ] Tea

 [ ] Fruit Juice ­­­­­­­­­

 [ ] Punch

 [ ] Milk

 [ ] Other

**What is the usual color of your urine?**

**Explain your understanding of the principles of hygiene:**

**ALWAYS TEMPERATE**

**Do you ingest caffeine in any form? Yes No If so, for how many years?**

**Have you ingested caffeine in the past?** [ ] Yes [ ] No **For how many years?**

**If so, when did you stop?**       **Do you smoke or chew tobacco?** [ ] Yes [ ] No **indicate which:**

**If so, for how many years?** **Have you used tobacco in the past?** [ ] Yes [ ] No

**For how many years?**

**If so, when did you stop?**       **Do you drink alcohol?** [ ] Yes [ ] No **If so, what kind?**

**For how many years?**       **Have you drank alcohol in the past?** [ ] Yes [ ] No **For** **how many years?**

**NUTRITION**

**Do you overeat?** [ ] Yes [ ] No **Do you feel stuffed after your meals?** [ ] Yes [ ] No

**Do you eat between meals?** [ ] Yes [ ] No **Explain:**

**Do you drink with your meals?** [ ] Yes [ ] No **If so, what liquids?**

**Do you wear removable dentures or plates?** [ ] Yes [ ] No **Do you eat fast?** [ ] Yes [ ] No

**How long does it take you to eat?**       **Do you have a peaceful environment at meal**

**times?**

**Do you have set meal times?** [ ] Yes [ ] No **Are you following any special diet?** [ ] Yes [ ] No

**Explain what type:**

**Do you eat animal products?** [ ] Yes [ ] No **If so, what kind?**

**How Often?**

**Do you eat dairy products?** [ ] Yes [ ] No: [ ] Milk? [ ] Cheese? [ ] Egg?

**Do you eat desserts, candy or other sweets regularly?** [ ] Yes [ ] No **Explain how often and what**

**Type:**

**What time do you eat breakfast?**       **What foods do you usually eat?**

**How often do you eat a tossed green leafy salad?**

**How often do you eat steamed or cooked vegetables?**

**How often do you eat fruits?**

**How often do you eat soup or stew?**

**What time do you eat lunch (dinner)?** **What foods do you eat?**

**What time do you eat supper?**       **What foods do you eat?**

**PLEASE REMEMBER TO SIGN AND DATE THIS QUESTIONNAIRE! WE CANNOT RESPOND WITHOUT YOUR SIGNATURE AND DATE: BY SIGNING YOU ARE SHOWING THAT YOU UNDERSTAND THAT THIS QUESTIONNAIRE AND THE EDUCATIONAL INFORMATION GIVEN IN THIS CONSULTATION IS BIBLICAL LIFE-STYLE EDUCATION AND IS NOT INTENDED TO DIAGNOSE OR TREAT ANY DISEASE, AILMENT OR ABNORMALITY.**

Sign: Date: