

Natural Healing Through the Laws of Health Lifestyle Assessment

“Knowing that if you have the faith of a mustard seed, your faith can move mountains”

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CONFIDENTIAL

IMPORTANT

Please Note: The health information received during this consultation is for general education and is not intended to be specific medical advice. No medical care, diagnosis, or treatment is provided during this consultation. It is advisable to consult with ones personal health care provider before implementing any lifestyle changes.

I release Home Health Education Services Online Inc., Lifestyle counselors or associated organizations from any and all liability. Participation in this consultation indicates acceptance of these terms.

Signature: _____ Date: _____

General Information

Name: _____

Address: _____

Telephone: Home (____) _____ Work: (____) _____

Cell: (____) _____ Email Address: _____

Church Affiliation: _____ how long have you been a member? _____

List any health concerns you have: (physical, mental, social or spiritual):

When did you last consult a physician? _____

Are you currently being treated for any ailments? Yes / No

If yes, which ones?

Please list any surgery that you have had (along with the date):

What diseases have you been diagnosed with? (please list all)

Are you presently experiencing any of the following: (please circle)

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|----------------------|---------------------------|--------------------|
| Dizziness | Numbness | Bad body odor |
| Fainting | Clammy skin | Excessive sweating |
| Nausea | Cold hands or feet | Hair loss |
| Pain | Constipation | Fever |
| Heart palpitations | Diarrhea | Infections |
| Fatigue | Indigestion / Acid Reflux | Bleeding |
| Headaches | Cold / Flu | Weight loss |
| Memory loss | Blurred vision | Weight gain |
| Insomnia | Swelling anywhere | Sexual dysfunction |
| Difficulty breathing | Parasites / Worms | Anemia |

Do you suffer from any of the following emotional / mental disorders: (please circle)

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|---------------|-------------------------------|---------------|
| Depression | Chronic anxiety | Bipolar |
| Co-dependency | Manias | Schizophrenia |
| Phobias | Obsessive compulsive disorder | Neurosis |

What specific condition(s) would you like this consultation to address?

Age: ____ yrs.

Sex: (Circle one) Male Female

Marital Status – (circle) Single, Married (1st / 2nd / 3rd or more), Divorced (1st / 2nd or more), Widowed

How long have you been married or divorced _____

Weight: _____ lbs. Height: _____ Sedimentation Rate: _____

Blood Pressure: ____/____ Pulse _____

Glucose: _____ Postprandial (2 hours after meal): _____

Cholesterol: _____ HDL: ____ LDL: ____ Triglycerides _____

Please list all medicines or pills you are currently taking:

Please list all supplements and / or herbs that you are taking (vitamins, minerals, nutritional drinks etc...)

Nutrition

Circle One where needed

1. Do you eat any meat or flesh items (chicken, turkey, pork, fish, shrimp etc...)? Yes / No
2. Do you eat any dairy items or eggs (i.e. milk, cheese, yogurt, chocolate etc...)? Yes / No
3. Which ones?

4. Do you eat refined white products (i.e. white bread, white rice, white flour products, etc...)?
Yes / No
5. How many servings of fruit per day? ____ How many servings of vegetables? ____
6. Do you use condiments (i.e. ketchup, mustard, mayonnaise, barbeque sauces, veggienaise, nayonaise, salad dressings, pickles, vinegar, etc...)? Yes / No
7. Do you add any of the following spices to your foods: cinnamon, nutmeg, cloves, curry, hot sauces, and cayenne peppers, black and white peppers and etc? Yes / No
8. Do you eat fried foods? Yes / No If so, how often? _____
9. Do you use margarine or butter? Yes / No If so, how often? _____
10. Do you use baking powder or baking soda? Yes / No
11. Do you eat fresh bread? (bread eaten less than 48 hours after baking) Yes / No / Sometimes
12. Do you eat or drink any cocoa, chocolate or ice cream? Yes / No How often? _____
13. Which oils do you cook with? _____
14. Do you read the labels of food items that you buy from the store? Yes / No

15. List any sweeteners you consume (i.e. sugar, honey, splenda, sweet & low, equal or additional artificial sweeteners, etc...) _____
16. How much & often do you eat nuts? _____ which ones? _____
17. Do you eat any canned items (beans, veggies, fruits, veggie meats etc...)? Yes / No
18. Which ones? _____
19. Are you on any special diet? Yes / No
20. If so, please list: _____
21. Do you eat out? Yes / No If so how often: _____
22. Do you use salt? Yes / No Does the salt contain iodine? Yes / No

Exercise

1. Do you exercise? Yes / No
2. How many times per week? _____ How many minutes per day? _____
3. How would you rate your exercise? (circle one) Mild Moderate Vigorous
4. What are your favorite exercise sessions?

5. How do you feel after you exercise?

6. Do you experience any pain while you are exercising? Yes? No

Water

1. How many glasses of water do you usually drink per day? _____
2. What kind of water do you commonly drink? _____
3. Is your water filtered? Yes / No
4. At what temperature do you drink your water? (circle one) Hot Cold Room temp.
5. Do you eat ice? Yes / No
6. How many glasses of juice do you drink per day? _____

7. How many cans / bottles of soda per day? _____
8. What other liquid do you drink (i.e. tea, wine, alcohol, beer, soda, milk, vitamin water, etc...)?

9. Do you drink with your meals? Yes / No / Sometimes
10. What color is your urine normally? (clear, pale, slight yellow, yellow and dark yellow)

Sunlight

1. How much sun exposure do you get per day? _____
2. Do you sunbathe? Yes / No If so how long? _____
3. Do you wear short sleeves? Yes / No
4. Do you use sun block? Yes / No / Sometimes
5. Do you have any abnormal sensitivity to the sun naturally or due to any medications? Yes / No
6. Do you take vitamin D supplements? Yes / No
7. Do you have any family history of skin cancer? Yes / No

Temperance

1. Do you smoke / use tobacco products in any form (i.e. chewing tobacco)? Yes / No
2. Did you use tobacco in the past? Yes / No If so how much and for how long? _____
3. Do you use alcohol in any form? Yes / No If so, how much and for how long? _____
4. Do you ingest caffeine in any form? Yes / No (e.g. coffee, teas, mate, colas, energy drinks, etc.)
5. If so, please list _____.
6. Do you overeat? Yes / No / Sometimes
7. Do you eat too fast? Yes / No / Sometimes
8. Do you chew your food thoroughly? Yes / No
9. Do you snack between meals? (this includes any food items and juice) Yes / No / Sometimes

10. List any desserts you eat? (include candies, cakes, or pies) _____
11. Do you eat at set meal times? Yes / No
12. Please list times for all meals: Breakfast _____ Lunch _____ Supper _____
13. Would you say that your dress is healthful and modest? Yes / No
14. Please list your leisure activities (i.e. watching TV, reading, sports, dancing, board games etc...)

15. How much time do you spend on leisure activities? _____
16. Do you overwork? Yes / No / Sometimes
17. Please list any addictions

18. Have you been involved with substance abuse? Yes / No If so please list: _____
19. Do you read novels, science fiction, pornography, fashion magazines, computer games? Yes / No
20. If so, which ones? _____
21. Do you attend cinemas, dances, night clubs, house parties and amusement parks? Yes / No
22. If so, which ones? _____
23. Do you play any competitive sports? Yes / No
24. If so, what sports are they? _____
25. Please list all types of music that you listen to? _____

| |
|------------|
| Air |
|------------|

1. Where do you live? (Circle one) City Suburbs Country
2. Do you sleep with your windows open? Yes / No
3. Do you open your windows / doors daily to air out the home? Yes / No
4. Do you live or work in a smoke-filled environment? Yes / No
5. Do you have any smokers living in your home? Yes / No

6. Do you have live plants throughout your home? Yes / No
7. Are there any environments that you are in that do not have a good supply of fresh air? Yes / No
8. If so what are they? _____
9. Do you wear tight fitted clothing that restricts your lung expansion? Yes / No

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|-------------|
| Rest |
|-------------|

1. What is your usual bedtime? _____
2. Do you wake up during the night? Yes / No / Sometimes
3. Do you snack before you go to bed? Yes / No / Sometimes
4. Do you sleep with the lights on? Yes / No / Sometimes
5. Do you work the night shift or swing shift? Yes / No / Sometimes
6. Do you wake up early in the morning and find it difficult to get back to sleep? Yes / No / Sometimes
7. Do you take sleeping pills? Yes / No
8. Do you make it a practice to get to bed at a certain time? Yes / No
9. Do you rest from labor at least one day per week? Yes / No

| |
|--------------|
| Trust |
|--------------|

1. Do you have a daily devotional time? Yes / No
2. If no, would you like to have one? Yes / No
3. Do you spend time reading the Bible daily? _____
4. Do you return a faithful systematic tithe, plus offerings? Yes / No
5. Do you have difficulty in trusting the Lord with your problems? Yes / No / Sometimes
6. Do you suffer any remorse, guilt, worry or fear at present? Yes / No
7. Do you believe that you have experienced the forgiveness of God in your life? Yes / No
8. Do you struggle with knowing God's will for your life? Yes / No

9. Would you consider your family to have good relations with each other? Yes / No
10. Do you have a spiritually strong immediate family? Yes / No?
11. Do you have peace with God and your fellow men? Yes / No
12. Have you broken any vows or promises to God that is within your power to fulfill? Yes / No
13. How has the Lord been treating you? _____
14. How have you been treating the Lord? _____
15. If the Lord were to come today, knowing the life that you are currently living, would you be saved? Yes / No **“Please answer this question within yourself.”**

LIFESTYLE RECCOMENDATION

MORNING DEVOTION

Start with prayer

Sing a few hymns

Read a devotional book

Read the conflict of the ages

1. Patriarchs and Prophets

2. Prophets and Kings

3. Desire of Ages

4. Acts of Apostles

5. Great Controversy

God Cares series

1. Daniel

2. Revelation

Close with a word of prayer

Ps: please read the scriptures when studying the conflict of the ages.

EVENING DEVOTION

Start with prayer

Sing a few hymns

Do your lesson study

Study health message

Close with prayer

Daily Schedule

Time to get up: _____

Time for worship: _____

Time for exercise: _____

Time for breakfast: _____

Time for digestion walk: _____

Time for lunch: _____

Time for digestive walk: _____

Time for Supper: _____

Time for digestive walk: _____

Time for evening worship: _____

Time for rest: _____

Special notes:

Sample Meal 1

I. Fruit: 3-5 servings

**II. Whole Grain
Cereal sweetened w/
Fruit** 1 cup servings

- 2 Tablespoon of flax seed freshly grounded can be sprinkled over cereal at breakfast.
- ¼ cup of pumpkin seed can be eaten with the breakfast cereal.

III. 1-2 slice of whole grain bread with natural almond.

- Other natural healthy spreads/butter is acceptable as well. (i.e. Tahini, cashew)

Sample Meal 2

**I. Salad and/ or
Vegetables** ½ of the plate

II. Grains ¼ of the plate

- Grains consist of starches (i.e. brown rice, baked potatoes, whole wheat pasta.)

III. Nut or Bean Loaf ¼ of the plate

Recipes for nut, grain and bean loaves can be found in the following cookbooks: Tasty Vegan Delight, Seven Secrets, the Optimal Diet, and Foods with their Healing Power vol. 3.

Dinner

PASS ON DINNER.

If third meal is required, a few fruits or a slice or two of toasted whole grain bread with 100% fruit spread can be eaten. No nut butters should be used.

HERBAL REMEDIES AND RECCOMENDATIONS