HEALTH QUESTIONNAIRE

This information is for educational purposes only. It will enable you to see the need to adopt an altered diet and lifestyle program to better preserve your health. This evaluation is not intent to be used to diagnose, prescribe, treat or cure any disease.

Name: _____Date: _____

Address: _____ City: _____ State: _____ Zip: ____

Phone: _____ Referred by: _____

Biographical data:

Marital status: S M D W Date of birth:_____/____/_____ Screening Time: _____

Occupation: _____ Religion: _____

Sex: M F Age: _____ Height: _____ weight: _____ Race: _____

SUGAR: URINE pH: _____ SALT: ALB: UREA: ----------
SALIVA Ph:

Section 1: Past Health Problems

In this section, please try to respond accurately to the questions. Circle either No or Yes as they apply to you and fill in the blanks provided with the appropriate response.

Have you ever had a broken bone? No Yes Which? _____
Have you had any operations No Yes What kind? _____
Have you had any recent weight loss? No Yes How many pounds? _____
Have you had any recent weight gain? No Yes How many pounds? _____

Give the names and dates of any medical condition that you have had or currently have. _____
_____
_____

What are you currently being treated for? _____
_____

List all medications that you are currently taking and how long you have been taking each one. _____
_____
_____
_____

List all minerals, vitamins and herbal supplements that you are currently taking. _____
_____

What is your greatest health concerned at the present time for which you are seeking nutritional and lifestyle counseling? _____
_____

How willing are you to make changes in your diet and lifestyle? (1) maybe (2) average (3) willing (4) very willing
Other: _____

NATURAL LAWS OF HEALTH

Fill in the space provided or put an "X" in the blank next to the appropriate answer.

NUTRITION

How often do you drink a glass of milk? _____ times/week. What kind of milk do you use?_____
How often do you eat a tossed green leafy salad? _____ times/week.
How often do you eat steamed or cooked vegetables? *(e.g. kale, collards, broccoli, carrots, etc.)*____times/week..
How often do you eat fruits? _____ times/week. Which fruits do you eat most often?_____
How often do you eat soup or stew? _____ times/week.
Which soups do you eat most often? (not brand names) _____
How often do you eat meat (fish, seafood, chicken, turkey, beef, pork)? _____times/week.
What kind of meats do you eat most often? _____
How often do you eat nuts or nut butter? _____times/day-week My favorite nut/butter is _____
How often do you eat hot spicy foods? _____ times/week.
List the foods that you use most often as between meal snacks. _____
What time do you eat your largest meal of the day? _____ am/pm.
How often do you eat breakfast? Daily____ Seldom____ Never____
What time do you have your last meal of the day? _____ pm. Are you exhausted at mealtime Yes ____ No____
How often do you use salt? ____ times/day-week

Godly Trust

Are there lots of negative stresses in you life? No Yes; If yes circle one: least 1 2 3 4 5 6 7 8 9 10 greatest stress
How often do you have bible reading/devotion? ____ x/day/week OR ___ hours ____ x/day/week
Are you stressed, tensed, or angry at mealtime? Yes___ No___ How often? Sometimes__ always___ Never____
Which one cause the greatest stress in your life? Family___, Health___, Work___, Church___, Finance___

Open Air

How much time do you spend indoor each day? _____ hours; almost all day____
Does fresh air to circulate inside your home daily? Yes____ No____

Daily Exercise

Do you exercise regularly? Yes___ No___ What type? _____
What time of the day do you exercise? _____ How often? _____ x/day/week/month.
Do you perspire (sweat) during your exercise routine? Yes____ No____ Most of the time___ Always___ Sometimes_____
How much time do you spend sitting each day? _____ hours; most of the time___; always sitting____

Plenty of Water

How many glasses of water do you drink daily? _____ How many ounces per day?_____
How much liquid do you drink with meals? _____ ounces; Which liquid? _____ Hot___ /cold____?
What is the color of your urine most times? Pale ____; Yellow ____; Orange ___; Other _____
Which beverage do you drink most often? _____ How many ounces? _____

Lots of Rest

What time do you go to bed at nights? _____pm. Do you rest during the day? Yes_____ No___
How many hours of sleep do you get each night? _____ hours *Note*_____
Are you unable to sleep at some point during the night? Yes___ No___. What time of the night? _____

Always Temperate

Do you use any alcoholic beverages? No___ Yes___ which? _____ how often? _____
How often do you eat chocolate? _____times/week.
How often do you drink brewed or iced tea, Lipton's tea, Nestea? _____times/week.
Did you ever take any drugs? No___ Yes____ Which?_____
When did you quit? _____
Do you smoke? No___ Yes___ if so, how many packs per day? ___ How long?__ _
if No, did you ever smoke? No___ Yes___ How long ago did you quit? _____
Do you drink coffee? No___ Yes____ if so, how many cups?_____
How many bowel movements do you have per day/week? _____ Do you use laxatives? Yes___ or No____

Sunshine

How much sunshine do you get each day? _____ min/hour or Lots____ None____
Do you allow sunshine in your home? Yes__ No___ Sometimes, Never___, Always___ Most of the time__
Do you avoid exposing yourself to sunlight? Yes ___ No_____

Food Diary

Make a list of the foods and beverages that you drank for the past five days or that best represent your dietary intake. Be sure to list the approximate time that the foods and beverages are consumed. Use the categories below.

TIME	DESCRIPTION	FOODS	BEVERAGE
	SNACK		
	BREAKFAST		
	SNACK		
	LUNCH		
	SNACK		
	DINNER		
	SNACK		