

Application and Authorization
for
Health Consultation Service

Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Phone: _____ E-mail _____ Occupation _____ Age: _____

How did you learn about this program? _____

Best time to Contact: _____

Getting Started

Download the Health Questionnaire ([here](#)) and fill it out as best as you can. Unless you have the necessary method to check the pH of the urine and the saliva, skip that section or you may buy pH paper at your local health food store. The pH would be helpful if available, but not required.

What we need from you:

1. Health Questionnaire filled out.
2. Consultation Application, completed
3. Service Fee

What you receive from us:

1. Call you for some clarification
2. Send the program to you
3. Consultation: we call and explain the program

Follow-up:

- On the 14th day, then 21st day later, then 21 days later, from the beginning of the program.

Timing:

- Once we receive your information, you will receive your program within 7 to 10 business days.

Method of Payment:

- Check one. Checks _____ Credit Cards _____ Paypal _____

This service is for educational purposes only. It is not intended for treatment, cure, diagnosis, or as prescription for any disease. For any of the above intent, you should contact your Medical Doctor. The education that you receive will enable you to make better choices in areas of nutrition and other lifestyles factors. Claim this promise for healing: Exodus 15:26.

Signed _____ Date _____

Mail Check or Money Order Payable to: *C.H.E.M. P.O Box 853, Camden, Tennessee 38320*

HEALTH QUESTIONNAIRE

This information is being gathered for research purposes and statistical analysis. No attempt will be made to diagnose, treat, cure, or alleviate your illness. Thank you for responding to and answering all questions. As much as possible this information will be treated as confidential material.

Name: _____ Date: _____

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

Phone: _____ E-Mail: _____

Biographical Data:

Marital Status: S M D W Date of birth: ____/____/____ Referred by: _____

Occupation: _____ Religion: _____

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

Record the pH of your Urine and saliva; check them at 6:00 – 7:00 a.m., 11: 00 a. m. 2:00 p.m. & 7:00 –8:00 p.m.

Time:	6:00 –7:00 a.m.	11:00 a.m.	2:00 p.m.	7:00-8:00 p.m.	Date
Urine					
Saliva					

Section 1: “What’s wrong?”

In this section, please try to identify what’s wrong with you at the present time. Put the number in the blank that most accurately represents how often you have the indicated trouble (or the severity of the problem). Use the following numbers:

Blank = never 1 = rarely 2 = occasional 3 = sometimes 4 = most of the time 5 = always

Head & Neck

- ___ headaches
- ___ light-headedness
- ___ motion sickness
- ___ dizziness
- ___ absent-mindedness
- ___ forgetfulness
- ___ black-outs
- ___ seizures
- ___ neck pain
- ___ neck stiffness
- ___ cracking noises in neck
- ___ head pain
- ___ facial pain
- ___ eye pains
- ___ eye strain
- ___ night blindness
- ___ blurring of the eyes
- ___ blurred vision
- ___ double vision
- ___ red lines in eyes
- ___ yellow (jaundice) eyes
- ___ puffiness under the eyes
- ___ eyes feel gritty
- ___ excessive eye itching
- ___ can’t focus distant to close
- ___ wear glasses to read
- ___ wear glasses to drive
- ___ wear contacts
- ___ dark circles under the eyes
- ___ glare bothers eyes
- ___ excessive tearing in eyes
- ___ eyes bulge or protrude
- ___ have cataracts
- ___ enlarged (dilated) pupils
- ___ constricted pupils
- ___ pupils are of unequal size
- ___ crossed eyes (muscle weakness)
- ___ “lazy” eye – drifts outward

- ___ ringing or noises in the ears
- ___ deafness R ___ L ___
- ___ excessive wax build-up in the ears
- ___ recurrent ear infection
- ___ wear a hearing aid
- ___ discharge from ear
- ___ itching of the nose
- ___ sinus trouble
- ___ postnasal drip
- ___ spontaneous nosebleeds
- ___ hay fever
- ___ allergies
- ___ excessive sneezing
- ___ frequent colds
- ___ difficulty breathing through nose
- ___ change in sense of smell
- ___ receding gums
- ___ bleeding gums
- ___ teeth glassy on ends
- ___ coated tongue
- ___ black tongue
- ___ burning tongue
- ___ dryness of mouth
- ___ mouth ulcers (canker sores)
- ___ cold sores on lips
- ___ cracked lips
- ___ change in sense of taste
- ___ lost sense of taste
- ___ salty taste in mouth
- ___ excessive thirst
- ___ bad breath
- ___ frequent sore throats
- ___ swollen glands
- ___ severe toothaches
- ___ increased saliva
- ___ decreased saliva
- ___ acne
- ___ hair is dull, no sheen

- ___ hair falling out
- ___ baldness
- ___ premature gray

Arms & Legs

- ___ shoulder pain R ___ L ___
- ___ arm pain R ___ L ___
- ___ leg pain R ___ L ___
- ___ left arm aches
- ___ numbness/tingling of arms R ___ L ___
- ___ numbness/tingling of hands R ___ L ___
- ___ numbness/tingling of feet R ___ L ___
- ___ numbness/tingling of legs R ___ L ___
- ___ numbness/tingling other _____
- ___ stiffness of joints
- ___ cold hands/feet
- ___ feet/ankles swollen in evening
- ___ hands/fingers swollen in morning
- ___ athletes foot
- ___ burning feet
- ___ painful feet
- ___ fingernails (circle any problems: split, brittle, rough, soft, ridges)
- ___ shakiness/tremors
- ___ muscle weakness in limbs
- ___ difficulty in walking
- ___ leg cramps (charley horse)
- ___ cramps in feet or toes
- ___ frequent soreness in muscles
- ___ cracking joints
- ___ excessive perspiration in feet
- ___ plantar warts

Section 1: “What’s wrong?” (continued)

In this section, please try to identify what’s wrong with you at the present time. Put the number in the blank that most accurately represents how often you have the indicated trouble (or the severity of the problem). Use the following numbers:

Blank = never 1 = rarely 2 = occasional 3 = sometimes 4 = most of the time 5 = always

Torso (vital organs)

- ___ nausea
- ___ vomiting
- ___ difficulty swallowing
- ___ excessive hunger
- ___ feel shaky if hungry
- ___ irritable before meals
- ___ eat when nervous
- ___ eat when depressed
- ___ faint feeling when hungry
- ___ eating relieves fatigue
- ___ crave sweets or coffee
- ___ crave other foods
- ___ poor appetite
- ___ loss of appetite
- ___ excessive hiccups
- ___ cold most of the time
- ___ hot flashes
- ___ hot most of the time
- ___ alternate between hot and cold
- ___ night sweats
- ___ slow (poor) digestion
- ___ too fast digestion
- ___ constipation
- ___ diarrhea
- ___ pain with BM
- ___ burning with BM
- ___ hemorrhoids
- ___ bleeding from rectum
- ___ BM has unusual consistency
- ___ irregularity of BM
- ___ itching of rectum
- ___ jock itch
- ___ burning with urination
- ___ dribbling urine
- ___ urine has lost its force
- ___ urine is hard to stop
- ___ urine is hard to start
- ___ bladder pain
- ___ bed-wetting
- ___ frequency of urination
- ___ urgent urination
- ___ blood in urine
- ___ pus in urine
- ___ frequent kidney infections
- ___ frequent bladder infections
- ___ awoken at night to urinate
- ___ kidney stones
- ___ can’t find comfortable position in bed
- ___ foul-smelling urine
- ___ foul-smelling BM
- ___ foul-smelling lower bowel gas
- ___ bloated feeling
- ___ abdominal swelling
- ___ abdominal pain or cramps
- ___ gall bladder pain

- ___ frequent belching
- ___ frequent lower bowel gas
- ___ indigestion/heartburn
- ___ chest pains
- ___ shortness of breath
- ___ rapid heartbeat
- ___ slow heartbeat
- ___ heart pounds hard
- ___ irregular heartbeat
- ___ high blood pressure
- ___ low blood pressure
- ___ varicose veins
- ___ chronic coughing
- ___ spitting up phlegm
- ___ spitting up blood
- ___ difficulty breathing
- ___ wheezing
- ___ low back pain
- ___ low back ache – especially after sitting or riding
- ___ pain in tailbone
- ___ pain between shoulder blades

Female only

- ___ painful periods
- ___ irregular cycles
- ___ excessive flow
- ___ clots in flow
- ___ will miss a period
- ___ backache with period
- ___ cramps
- ___ moody with period
- ___ hot flashes
- ___ vaginal discharge
- ___ lumps in breast
- ___ soreness in breast
- ___ cyst in breast
- ___ cyst on ovary
- ___ depressed before period
- ___ acne worse at menstruation
- ___ hair growth on face/body
- ___ painful intercourse
- ___ other female problem _____

Male only

- ___ prostrate trouble
- ___ lumps in testicle
- ___ diminished sexual activity
- ___ swollen testicles
- ___ difficulty urinating

- ___ swelling external genitalia
- ___ painful external genitalia
- ___ pain after intercourse
- ___ impotency
- ___ other male problem _____

General

- ___ weight problem
- ___ fatigue
- ___ weakness
- ___ hives
- ___ anemic
- ___ chronic fever
- ___ skin too oily
- ___ skin too dry
- ___ skin abnormal color
- ___ red, scaly patches on skin
- ___ muscular pains
- ___ muscular soreness
- ___ sharp, shooting knife-like pains where? _____
- ___ spinal curvature
- ___ faulty posture
- ___ sluggish in the morning
- ___ wake up tired
- ___ lack stamina
- ___ unusually nervous or jumpy
- ___ restlessness
- ___ insomnia
- ___ nightmares
- ___ recurrent dreams
- ___ cry easily
- ___ lose temper easily
- ___ excessive worry
- ___ depression
- ___ excessive fear
- ___ stuttering or stammering
- ___ feel “keyed up”
- ___ bite fingernails

Do any of these foods upset you?

- ___ onions
- ___ cucumber
- ___ radish
- ___ garlic
- ___ cabbage
- ___ tomato
- ___ green pepper
- ___ rich foods
- ___ greasy foods
- ___ spicy foods
- ___ other _____

Section 2: What' right

In this section, please try to identify what's right with you at the present time. Put the number in the blank which most accurately represents how often you have the indicated quality, trait or habit. Use the following numbers:

Blank = never 1 =rarely 2 = occasional 3 = sometimes 4 = most of the time 5 = always

Character quality & traits

- ___good attitudes
- ___self-control
- ___faithfulness
- ___beneficial service to others
- ___enthusiasm
- ___peaceful
- ___patient
- ___kindness
- ___gentleness
- ___joy
- ___mercy and compassion
- ___loving of God
- ___loving of others
- ___loving of self
- ___happiness
- ___honesty
- ___accepting of others
- ___flexibility
- ___good motivation
- ___perseverance
- ___vitality

health & lifestyle habits

- ___clarity of thought
- ___good memory
- ___strength
- ___endurance/stamina
- ___freedom of motion
- ___resistance to illness
- ___pain-free
- ___healthful appearance to others
- ___restful sleep
- ___feels great
- ___normal weight
- ___good eyesight
- ___good hearing
- ___good skin tone
- ___good skin color
- ___good muscle tone
- ___regular exercise
- ___wide variety in diet
- ___eat breakfast daily
- ___overeats
- ___feel stressed at meal

- ___exhausted at mealtime
- ___feel stuffed after meal
- ___avoids junk food
- ___non-smoker
- ___non abuser of alcohol
- ___proper fluid intake
- ___drinks fluids with meals
- ___regularity in meals
- ___temperate in food and drink
- ___temperate in behavior
- ___exhausted at the end of day
- ___normal body temperature
- ___willing to make changes in diet & lifestyle
- ___work indoors
- ___watch TV ___hrs./week
- ___devotional reading ___hrs./week
- ___angry at others
- ___feel hurt by others
- ___have enemies
- ___others _____

Section 3: Past Health Problems and Lifestyle Habits

In this section, please try to respond accurately to the questions. Indicate or fill in the blanks provided with the appropriate response.

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

Section 3: Past Health Problems & Lifestyle Habits (continued)

In this section, please try to respond accurately to the questions. Circle either Yes or No as they apply to you. Fill in the blanks if you response affirmatively to any question.

Past Health History:

Have you ever had a broken bone?	No	Yes	which? _____
Have you had any operations?	No	Yes	what? _____
Have you had any recent weight loss?	No	Yes	how many pounds? ____ reason?
Have you had any recent weight gain?	No	Yes	how many pounds? ____ reason?
Do you have any missing limbs?	No	Yes	which? _____
Do you have any paralysis in any limb?	No	Yes	which? _____
Does your head tilt to one side?	No	Yes	
Have you ever passed out?	No	Yes	please describe: _____
Have you ever been knocked unconscious?	No	Yes	please describe: _____
Do you have any cavities/fillings in your teeth?	No	Yes	approximately how many? ____
Do you have any teeth missing?	No	Yes	

FEMALE ONLY:

Are you pregnant now?	No	Yes	for how many years? _____
Do you currently take birth control pills?	No	Yes	for how long? _____ when did you quit?
Have you done so in the past?	_____		
Have you ever had a previous miscarriage?	No	Yes	
Have you ever had a previous abortion?	No	Yes	
How many successful pregnancies have you had?	_____		
Are you still menstruating regularly?	No	Yes	if no, age when stopped: _____ why?
No Yes Maybe if yes, how many months? _____	_____		

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?
How often do you have bible reading/devotion?
Are you stressed, tensed, or angry at mealtime?
Which one cause the greatest stress in your life?

No Yes; If yes circle one: least 1 2 3 4 5 6 7 8 9 10 greatest stress
____ x/day/week OR ____ hours ____ x/day/week
Yes__ No__ How often? Sometimes__ always__ Never__
Family__, Health__, Work__, Church__, Finance__

Open Air

How much time do you spend indoor each day?
Does fresh air to circulate inside your home daily?

____ hours; almost all day ____
Yes__ No__

Daily Exercise

Do you exercise regularly?
What time of the day do you exercise?
Do you perspire (sweat) during your exercise routine?
How much time do you spend sitting each day?

Yes__ No__ What type? _____
_____ How often? _____ x/day/week/month.
Yes__ No__ Most of the time__ Always__ Sometimes__
____ hours; most of the time__; always sitting__

Plenty of Water

How many glasses of water do you drink daily?
How much liquid do you drink with meals?
What is the color of your urine most times?
Which beverage do you drink most often?

_____ How many ounces per day? _____
_____ ounces; Which liquid? _____ Hot__ /cold__?
Pale __; Yellow __; Orange __; Other _____
_____ How many ounces? _____

Lots of Rest

What time do you go to bed at nights?
How many hours of sleep do you get each night?
Are you unable to sleep at some point during the night?

_____ pm. Do you rest during the day? Yes__ No__
_____ hours Note _____
Yes__ No__. What time of the night? _____

Always Temperate

Do you use any alcoholic beverages?
How often do you eat chocolate?
How often do you drink brewed or iced tea, Lipton's tea, Nestea?
Did you ever take any drugs?
When did you quit?
Do you smoke?
if No, did you ever smoke?
Do you drink coffee?
How many bowel movements do you have per day/week?

No__ Yes__ which? _____ how often? _____
_____ times/week.
_____ times/week.
No__ Yes__ Which? _____
No__ Yes__ if so, how many packs per day? ____ How long?__ _
No__ Yes__ How long ago did you quit? _____
No__ Yes__ if so, how many cups? _____
_____ Do you use laxatives? Yes__ or No__

Sunshine

How much sunshine do you get each day?
Do you allow sunshine in your home?
Do you avoid exposing yourself to sunlight?

_____ min/hour or Lots__ None__
Yes__ No__ Sometimes, Never__, Always__ Most of the time__
Yes__ No__

Additional comments that may be helpful

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		