**Lifestyle Assessment Questionnaire**

**\*\*\*Please circle all that apply when there is a multiple choice question\*\*\* CONFIDENTIAL – DONATIONS ACCEPTED**

**I do not charge for this assessment, but donations are accepted as this takes time and work to do this for you. If you cannot afford to donate that is not a problem, but if you can please ask me how.**

**Please Note:** Due to the laws of the land, we are required to tell you that 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 all 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_ yrs. **Sex**: Male Female

**Marital Status:** – (circle all that apply)

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:** Left side \_\_\_\_/\_\_\_\_ Right side \_\_\_\_/\_\_\_\_ **Pulse** \_\_\_\_\_\_\_

**Blood Glucose:** \_\_\_\_\_ **Cholesterol:** \_\_\_\_\_ HDL: \_\_\_ LDL: \_\_\_\_ Triglycerides \_\_\_\_\_\_

**Last BM you had?** \_\_\_\_\_\_\_\_\_\_\_ **Color**: Orng Blk Brn Other **Size:** S M L **Hard** or **Soft**

**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 or NO

\*\*\*If yes, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any surgery(ies) that you have had** (include the date)**:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What diseases/health condition(s) have you been diagnosed with?** (please list all)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you presently experiencing any of the following?** (Please circle all that apply)

Anemia

Bad body odor

Bad Breath

Bleeding

Bloated Stomach

Blood in stool

Blood in Urine

Blurred vision

Chest Pain or Tightness

Chills

Clammy skin

Cold / Flu

Cold hands or feet

Confusion

Constipation

Cough

Diarrhea

Difficulty breathing

Difficulty Hearing

Dizziness

Earache

Excessive sweating

Fainting

Fatigue

Fever

Hair loss

Headaches

Heart palpitations

Hemorrhoids

Hives

Increased Hunger

Indigestion / Heartburn

Infections

Insomnia

Itching in Rectal area

Joint Pain

Loss of Appetite

Low Energy

Memory loss

Nausea/Vomiting

Neurosis

Numbness/Tingling

Pain

Pain in the Eyes

Painful Urination

Parasites / Worms

Rash

Ringing in the Ears

Seizures

Sensitivity to sunlight

Sexual dysfunction

Sores on Your body

Stuffy Nose

Swelling anywhere

Taste Problems

Vision Problems

Watery Eyes

Weight gain

Weight loss

Yellowing of Eyes

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

Bipolar

Chronic anxiety

Co-dependency

Depression

Manias

Obsessive compulsive disorder (OCD)

Panic Attacks

Phobias

Schizophrenia

Worry

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all medication** (prescribed or OTC) **you have taken in the last two months**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list all herbs or supplements(**including vitamins) **you have taken in the last two** **months:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**On a Scale of 0-10, How serious are you about getting to the root of your problem/s? \_\_\_\_\_**

**On a Scale of 0-10, how willing are you to do whatever it takes to improve your condition/s? \_\_\_\_\_**

(Within realistic limits)

**HEALTH QUESTIONS:**

1. Do you currently use tobacco in any form (smoke or chew)? YES or NO

How many cigs or cigars per day?

If No, have you ever smoked or chewed tobacco in the past? YES or NO

If so, how long ago did you quit?

1. Do you currently drink alcohol in any form (wine, beer, liquor)?

**Please list how often:**

If No, have you ever drunk in the past? YES or NO If so, how long ago did you quit?

1. Do you drink coffee, tea, or any caffeinated beverages (soda, diet soda, energy drinks, etc.)? YES or NO

How many cups OR cans each day?

**4.** Do you eat flesh in any form? (beef, pork, lamb, chicken, turkey, deer, fish, seafood, etc.) YES or NO

How many times a day? How many ounces each meal?

1. Do you eat any animal products such as eggs, milk, butter, cheese, yogurt, cream, etc.? YES or NO

When was the last time you ate any of these? How often?

**6.** How many times do you eat a day on average?

What time do you eat Breakfast: Lunch: Dinner:

Do you snack in between meals? YES or NO

**7.** How many pieces of fruit have you eaten today? Yesterday?

**8.** How many cooked green vegetables (peas and corn are not vegetables) did you eat yesterday?

Are you eating them raw or cooked?

**9.** How many days a week do you exercise at least 30 minutes INDOORS?\_\_\_\_days

How many days a week do you exercise at least 30 minutes OUTDOORS?\_\_\_days

What type of exercise (walking, running, jogging, weights, other equipment)

On average, what time of day do you exercise?\_\_\_\_\_\_am/pm

**10.** How much water did you drink in ounces yesterday? Today?

Do you SIP or GULP? Do you drink SOFT or HARD water?

**11.** How much direct sunlight did you get yesterday? Today?

What time of day did you get it? am or pm

**12.** Do you do deep breathing exercises every day? YES or NO

Do you sleep with your windows opened every night? YES or NO

**13**. What time do you wake up on average? am or pm

What time do you go to bed on average? am or pm

**14.** Do you use CRYSTAL LIGHT, SOY SAUCE, or any SUGAR SUBSTITUTE? YES or NO

**15.** How much do you weigh? \_\_\_\_lbs. How tall? \_\_\_\_\_\_\_\_

How much water did you drink in ounces yesterday \_\_\_\_ today \_\_\_\_?

Do you SIP or GULP? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you drink SOFT or HARD water? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**16.** What kind of salt to you use/cook with? Table Salt, White Sea Salt, Himalayan Sea Salt

**NAME:**

**EMAIL ADDRESS:**

**CONTACT NUMBER:**

**TODAY’S DATE:**

**MEDICAL CONDITION(s):**

**MEDICATIONS and/or SUPPLEMENTS/HERBS:**

**WHAT DID YOU EAT YESTERDAY FOR THE FOLLOWING MEALS? PLEASE INCLUDE EVERYTHING YOU ATE AS WELL AS HOW MUCH.**

**BREAKFAST:**

**1. FRUIT**

(This can include tomatoes, avocados, olives, bell peppers, squash, and anything else that has a seed in it)

**A. How many? \_\_\_\_**

**B. Which kinds?**

**1. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**3. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**4. List any other fruit you had here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. GRAIN:** (this includes corn, any type of rice, oats, oatmeal, cereal, pancakes, granola, rye, barley, millet, quinoa, wheat, bread, muffins, toast, etc.)

**A. How many? \_\_\_\_**

**B. Which kinds?**

**1. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**3. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**3. NUTS & SEEDS** (including nut butters like tahini and peanut butter or any other nut butter)

**A. How many? \_\_\_\_**

**B. Which kinds**

**1. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**3. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**c. Raw, Cooked or Roasted?**

**d. Salted or Unsalted?**

**4. Please list anything else you may have eaten for breakfast that is not included above. Include how much as well:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**LUNCH** (aka the 2nd meal…this might not have been your lunch but you call it your supper or dinner):

**1. DARK GREEN VEGETABLE** (this includes spinach, mustard greens, beet greens, collard greens, dandelion greens, cabbage, broccoli, asparagus, bock choy, kale (any type), and the list goes on)(you may include your salad greens here as well)

**A. How many? \_\_\_\_**

**B. Which kinds?**

**1. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**3. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**4. List any other vegetable** (that is not green) **that you had here**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(This can include beets, radishes, turnips, sweet potatoes, yams, red potatoes, purple potatoes, white potatoes, Jicama, carrots, etc.)

**2. GRAIN:** (this includes corn, any type of rice, oats, oatmeal, cereal, pancakes, granola, rye, barley, millet, quinoa, wheat, bread, muffins, toast, etc.)

**A. How many?\_\_\_\_**

**B. Which kinds**

**1. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**3. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**3. LEGUMES** (including any type of bean, peas, green beans, and tofu, you may include any nuts or seeds you had as well)

**A. How many? \_\_\_\_**

**B. Which kinds**

**1. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**3. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**4. \_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_**

**4. Please list anything else you may have eaten for breakfast that is not included above as well as how much:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**DINNER:** (aka the 3rd Meal)

**Please list anything you ate for this meal. Be sure to include how much of each item you ate as well.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SNACKS:**

**Please list any and every thing you snacked on that you didn’t eat with your meals. This can include 1 peanut or carob morsel between meals. Anything you ate that was not a part of your meals.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**EXERCISE:**

**1.** How many minutes do you exercise each day? \_\_\_\_minutes

**2.** What type of exercise/s do you do? (Please list all including gardening if you do any)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3.** Would you rate your exercise MILD MODERATE or VIGOROUS?

**4.** How many days a week do you exercise **OUTDOORS?** \_\_\_\_\_\_\_

**5.** Do you exercise in a GYM? YES or NO

If yes, how many days a week? 1 2 3 4 5 6 7

If yes, is it aired out daily? YES or NO or DON’T KNOW

**6.** Do you lift weights? YES or NO

If yes, HOW MANY POUNDS?\_\_\_\_\_

**7.** Do you feel any pain when you exercise? YES or NO

\*\*\*If yes, please rate on a scale from 1-10 (10 being the highest for pain) / Pain Score:\_\_\_\_

**8.** Does your chest tighten when you exercise or do you experience chest pain? YES or NO

**9.** What type of shoes do you wear while exercising? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10.** Do you take any **Protein Powder** or **Supplements** to build strong muscles? YES or NO

\*\*\*If yes, please list the brands/types: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**11.** Have you ever had a magnesium test done? YES NO NOT SURE

\*\*\*If yes, what were your results? \_\_\_\_\_\_ Was this done by a blood test? YES NO

**WATER:**

**1.** How much water did you drink in ounces yesterday\_\_\_\_ today\_\_\_\_?

Do you SIP or GULP? Do you drink SOFT or HARD water?

**2.** How much water do you drink upon arising in the morning?\_\_\_\_\_\_\_(How many oz.)

**3.** Do you drink with your meals? YES or NO / Do you get thirsty right before or after eating? YES or NO

**4.** Do you drink cold water? YES or NO

**5.** Do you eat ice or put ice in your water/drinks? YES or NO

**6.** What type of water do you drink? TAP FILTERED SPRING DISTILLED WELL BOTTLED (which brand)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Some have baking soda and other bad ingredients in them.)

**7.** What type of water do you bathe in? TAP FILTERED SPRING DISTILLED WELL

**8.** Do you have filtered water throughout your home(bathtub too)? YES or NO

**9.** Do your **lips ever feel dry**? YES or NO

**10.** Does your **skin ever feel dry**? YES or NO

**11.** What color is your URINE usually?

CLEAR LIGHT YELLOW ORANGISH DARK YELLOW TEA COLOR BROWN

**12.** Do you drink Vitamin Water? YES or NO

**13.** Do you drink Flavored Water? YES or NO

**14.** Do you drink **Kool-Aid, Punch**, or **Fruit Juice**? YES or NO

**18.** Do you add sugar or anything else to your water?

**19.** Do you drink fresh raw vegetable juice? YES NO SOMETIMES

\*\*\*If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which vegetables? Carrots Broccoli Beets Cabbage Potatoes Greens Etc.

**20.** Do you drink **coffee**? YES or NO

\*\*\*If yes, how many cups a day? \_\_\_cups

**21.** Do you drink TEA (Black, Lipton, Arizona, White, Chai, or Green) YES or NO?

\*\*\*If yes, how many cups per day? \_\_\_cups

**22.** Do you drink **Soda** or **Diet Soda?** YES or NO

\*\*\*If yes, how many cans per day? \_\_\_cans

**23.** Do you drink mineral water? YES or NO

**SUNSHINE:**

**1.** How many minutes of direct sunlight did you get yesterday? \_\_\_\_\_\_ today? \_\_\_\_\_\_\_?

(sitting in front of a window does not count)

**2.** Do you go out into the sunshine in the winter months? YES or NO

**3.** How many minutes do you get direct sunlight each day (list average amount)? \_\_\_\_minutes

**4.** What time of the day do you mostly get your sunlight?

6:00 AM to 12:00 PM **OR**  12:00 PM to 6:00 PM

**5.** Are you FAIR-SKINNED LIGHT SKINNED OLIVE COMPLEXION BROWN or DARK-SKINNED?

**6.** Do you wear prescription glasses OR sunglasses when out in the sun? YES or NO

**7.** Do you wear sunscreen? YES or NO

\*\*\*If yes, which parts of your body? FACE ARMS LEGS CHEST BACK

**8.** Do you wear a hat when you go out into the sun? YES or NO

**9.** Do you feel faint when you are out in the sun? YES NO SOMETIMES

**10.** Have you ever had a Vitamin D (25 hydroxy ) test done? YES NO NOT SURE

\*\*\*If yes, what was your results in number? \_\_\_ng/ml

You cannot go by what doctors say is good because their recommended results are too

low according to The Vitamin D Council

**11.** Do you take a Vitamin D supplement? YES or NO

\*\*\*If yes, how many IU's each day ?\_\_\_IU's per day What Brand?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12.** Are you ALLERGIC TO or BREAK OUT from the sun? YES or NO

**13.** Are you on any medication that prevents you from being able to go out into the sun? YES or NO

**TEMPERANCE:**

**1.** Do you use ANY TYPE OF RECREATIONAL DRUGS? YES or NO

\*\*\*If yes to drugs, which ones?

**2.** Do you watch COMPETITIVE SPORTS, MOVIES, T.V. SHOWS, or NEWS? YES or NO

\*\*\*If yes to movies, what type? ACTION, DRAMA, SUSPENSE, COMEDY, LOVE STORIES

**3.** Do you listen to music? YES or NO What types? ROCK N ROLL, COUNTRY, SOUL, HIP HOP, POP, R&B, LOVE

SONGS, JAZZ, TECHNO, HYMNS, CHRISTIAN ROCK, CHRISTIAN CONTEMPORARY, or CLASSICAL

**4.** Do you GAMBLE? YES or NO (this can include lotteries, bingo, slots, cards, horse races, sports bets, etc.)

**5.** Do you get quick to ANGER? YES or NO

**6.** Do you have VIOLENT OUTBURSTS? YES or NO

**7.** Do you talk excessively at work or on the phone(whether you are required to or not)? YES or NO

**8.** Are you having physical relations with your spouse more than 2-3 x week? YES or NO

I know this is a personal question and you can answer “I choose not to answer”

But this one topic has a lot to do with many health issues

**9.** Are you involved in any type of “secret vice”? YES or NO

**10.** Do you have any addictions that are not listed? YES or NO

\*\*\*Just answer yes or no...please don't list addiction

**AIR:**

**1.** Do you have a hard time breathing? YES or NO

**2.** Do you do deep breathing exercises outdoors upon arising in the morning? YES or NO

\*\*\*If yes, how many sets?\_\_\_\_

**3.** Right now, put your hand on your stomach and inhale!!! Did your stomach go IN or OUT?

**4.** Do you inhale through your NOSE or MOUTH?

**5.** Do you use your THROAT or STOMACH MUSCLES when you sing?

**6.** Do you slouch over when you STAND or SIT? YES or NO

**7.** Do you get fresh air every day? YES or NO (going out in the air)

\*\*\*If yes, how many minutes each day?\_\_\_\_minutes

**8.** Do you air out every room in your home every day? YES or NO

**9.** Do you sleep with your windows in your room cracked in the winter, wide in the summer? YES or NO

**10.** Approximately How many square feet is your home? \_\_\_\_\_\_sq. ft.

**11.** Do you have any plants in your home? YES or NO

\*\*\*If yes, how many?\_\_\_\_ Which Kinds?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12.** Do you live IN or NEAR an environment where the air is polluted? YES or NO

**REST:**

**1.** Do you take a nap every day? YES or NO \*\*\*If yes, how often a week?\_\_\_days \_\_\_minutes

**2.** What time do you go to bed on average? \_\_\_\_p.m.

**3.** What time do you wake up in the morning?\_\_\_\_a.m.

**4.** Do you have a hard time getting to sleep? YES or NO

**5.** Do you have a hard time staying asleep? YES or NO

**6.** Do you wake up in the middle of the night to use the restroom? \*\*\*If yes, how many times?\_\_\_\_\_\_\_\_\_\_

**7.** Do you sleep with the LIGHTS, TELEVISION, RADIO, or COMPUTER on? YES or NO

**8.** Do you watch TELEVISION, or USE THE COMPUTER right before bedtime? YES or NO

**9.** Do you have nightmares? YES or NO

**10.** What times to you eat Breakfast:\_\_\_\_\_ Lunch:\_\_\_\_\_\_ Dinner: \_\_\_\_\_

**11.** Do you snack between meals? YES or NO

**12.** Do you do late-night snacking? YES or NO

**13.** Do you work the SWING or GRAVEYARD SHIFT? YES or NO

**14.** Do you drink ENERGY DRINKS, COFFEE, or ANYTHING WITH CAFFEINE IN IT? YES or NO

**15.** Do you take anything to sleep? YES or NO \*\*\*If yes, what is it?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**16.** Do you take one 24 hour period off every week where you don't cook, clean, run errands, do business, pay

bills, shop, do laundry, etc.? YES or NO

**NUTRITION:**

**1.** Are you on any special diet? YES NO

\*\*\*If yes, what type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2.** Do you use any Condiments such as **Mustard, Ketchup, Mayonnaise, Vegenaise, Worcestershire,**

**Soy Sauce, Braggs Aminos, Vinegar, Bottled Salad Dressings, A-1 Steak Sauce, BBQ Sauce, or**

**any not mentioned?** YES or NO

\*\*\*Please list any condiment not mentioned that you use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3.** Do you eat CHOCOLATE of any kind? YES or NO

**4.** Do you use SUGAR, AGAVE, HONEY, MAPLE SYRUP, MOLASSES, SWEET N LOW, ASPARTAME, SPLENDA,

EQUAL, STEVIA, CORN SYRUP, or ANY OTHER SWEETENER? YES or NO

\*\*\*If yes to sugar, what kind? WHITE BROWN RAW TURBINADO SUCINAT?

**5.** Do you eat or use WHITE FLOUR, WHITE BREAD, WHITE RICE, WHITE PASTRIES? YES or NO

**6.** How many times a day do you eat BREAD \_\_\_\_\_x a day or PASTA \_\_\_\_x a day

Is this white bread and pasta you are referring to? YES or NO

**7.** Do you eat “store bought” COOKIES, CAKE, CUPCAKES, BROWNIES, FUDGE, MUFFINS, BAGELS, CANDIES?

YES or NO \*\*\*If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8.** Do you eat RAW VEGETABLES? YES or NO

\*\*\*If yes, which ones? **Spinach, Kale, Greens, Broccoli, Cauliflower, Beets, Carrots, Cabbage,**

**Greens Of Any Kind, Potatoes, Turnips,** **etc.**

**9.** Do you eat fruit and veggies at the same meal (including fruit based dressings)? YES or NO

**10.** Do you use SALT? YES or NO

\*\*\*If yes, what kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**11.** Do you cook with any type of OIL? YES or NO

\*\*\*If yes, which ones? **Vegetable, Olive, Peanut, Safflower, Sunflower, Canola, Coconut, Sesame, Palm,**

or **any other**?

**12.** Do you eat fried food (includes french fries, chips, Fritos, Doritos, Corn chips, donuts etc.)? YES or NO

\*\*\*If yes, how often? ONCE A DAY, ONCE A WEEK, COUPLE TIMES A WEEK, COUPLE TIMES A MONTH?

**13.** Do you cook with or eat anything with FOOD COLORING? YES or NO

(this includes Kool-Aid, cakes, frosting, lollipops, candy, etc.)

**14.** Do you use or eat **Nutmeg, Cinnamon, All Spice, White Pepper, Black Pepper, Red Pepper, Hot Chilis,**

**Hot Sauce** or **Jalapenos**? YES or NO

**15.** Do you **chew gum** or eat **any type of breath mint**? YES or NO

**16.** Do you read labels? YES or NO

**17.** Do you know the 25 Hidden names for **MSG**? YES or NO

**18.** Do you know what Aspartame is? YES or NO

**19.** Which of the following cookware do you use? **Aluminum, Glass, Stainless Steel, Cast Iron, Ceramic,**

**Teflon, Porcelain, New Flimsy Bakeware**

**20.** Do you **pile too much food onto your plate**? YES or NO

**21.** Do you go back for **seconds** or **thirds** of food? YES or NO

**DRESS:**

**1.** Do you wear PANTS, SKIRTS, or BOTH?

(this is not referring to pants underneath skirts, but pants worn by themselves)

How long are your skirts? RIGHT BELOW THE CALF, CLOSER TO THE GROUND, or NEAR THE KNEE AREA?

**2.** Do you wear a belt around the waist? YES or NO

**3.** If you wear skirts, do they suspend from your HIPS or SHOULDERS?

**4.** Do you wear SHORT, LONG, or 3/4 SLEEVES?

**5.** Do you wear shorts? YES or NO

**6.** How many layers of clothing over your legs do you wear in the winter time? \_\_\_\_layers

**7.** How many layers of clothing do you wear over your arms in the winter time? \_\_\_\_ layers

**8.** How many layers of clothing do you wear over your chest in the winter time? \_\_\_\_ layers

**9.** What material do you wear in the winter time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10.** What material do you wear in the summer time?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**11.** Do you wear extra socks when your feet are cold? YES or NO

**12.** Do you wear any type of jewelry? YES or NO

(this includes wedding rings, rings, earrings, bracelets, anklets, necklaces, broches, pins, etc.)

**13.** Do you wear any make-up? YES or NO

If yes, which kind? LIPSTICK, EYE SHADOW, BLUSH, EYE LINER, LIP STICK OR GLOSS, FOUNDATION, MASCARA, ETC.)

**14.** Do you polish your finger nails or toe nails?

**15.** Are your LEGS, CHEST, or BACK ever exposed? YES or NO

**16.** Do you wear leggings in the summer time? YES or NO

**17.** Do you wear a hat of any type in the house when it’s cold? YES or NO

**18.** Do you wear any type of scarf around your neck when it’s cold? YES or NO

**19.** Do you wear any heels that are higher than 1 inch? YES or NO

**20.** If yes to the above question, do you wear spiked heels? YES or NO

**21.** Do you wear any flip flops or sandals that expose your feet? YES or NO

**HYGIENE/CLEANLINESS:**

1. Do you take a shower or bath every day? YES or NO

If no, how often do you do so in a week?\_\_\_\_\_\_ x week

1. Do you brush your teeth every day? YES or NO

If no, how often do you do so in a week?\_\_\_\_\_ x week

1. Do you brush your teeth after every meal? YES or NO

What brand toothpaste do you use?\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you floss every day? YES or NO
2. Do you change your clothes every day? YES or NO
3. Do you use deodorant? YES or NO What is the brand?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Do you use lotion? YES or NO If yes, what kind? What is the brand name ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. What kind of soap do you use? What is the Brand name?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. What brand of shampoo do you use?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. What brand of conditioner do you use?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Do you use any perfume or body spray?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Do you have animals living inside your home? YES or NO
10. Do you have animal feces lying near your home? YES or NO
11. Do you have dead leaves lying near your home? YES or NO
12. Do you have a compost bin near your home? YES or NO

If yes, how many feet away from the house is it? \_\_\_\_ feet

1. Do you have carpet in your home? YES or NO
2. Do you vacuum every day? YES or NO

If no, how often in a week do you vacuum? \_\_\_\_\_\_\_\_\_\_\_\_\_x per week

1. Do you clean your kitchen every day? YES or NO

If no, how often in a week do you clean it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_x per week

Do you mop every day? YES or NO

1. If no, how often in a week do you mop? \_\_\_\_\_\_\_\_\_\_\_\_\_x per week
2. Do you wash your dishes every day OR do you leave them in the sink some days?

(Circle that which applies)

1. How often in a week do you wash your clothes?\_\_\_\_\_\_\_\_\_\_\_x per week

**\*\*\*These next two portions are in no way designed to judge or condemn; just simply to get an idea about each person.\*\*\***

**SPIRITUAL COMPONENT:**

**1.** Do you believe in God? YES or NO

**2.** Do you pray to God? YES or NO \*\*\*If yes, how often a day?\_\_\_\_ x day

**3.** Do you believe the Bible is true? YES NO SOME OF IT

**4.** Do you read the Bible? YES or NO \*\*\*If yes, Which Version?\_\_\_\_\_\_\_\_

How Many Times? **EVERY DAY ONCE A WEEK ONCE A MONTH ONCE A YEAR NEVER**

**5.** Do you feel like God has been GOOD, BAD, or OKAY to you?

**6.** Do you feel you have been GOOD or NOT GOOD to God?

**7.** Do you trust God 100% implicitly? YES or NO

**8.** Do you believe God loves you? YES or NO

**9.** Do you believe God is LOVING and CARING or a MERCILESS TYRANT?

**10.** Do you take EVERYTHING to God when you have a problem or want some type of direction? YES or NO

**11.** Do you tend to worry? NOT AT ALL SOMETIMES FREQUENTLY

What do you do when you worry (that’s if you worry)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL:** (Please answer as truthfully as possible)

**1.** Do you have a good family unit? YES or NO

**2.** Are you close to your parents? YES or NO

**3.** Are you close to your children? YES or NO

**4.** Were you raised by your Biological parents? MOTHER or FATHER or BOTH? YES or NO

**5.** Were you raised with SIBLINGS, COUSINS, AUNTS, UNCLES? YES or NO

**6.** Do you get along well with others? YES or NO

**7.** Do you feel you have been cheated in life? YES or NO

**8.** Do you feel people misunderstand you? YES or NO \*\*\*If yes...MOST OF THE TIME or SOME OF THE TIME?

**9.** Are you a SENSITIVE PERSON or THINGS DON'T BOTHER YOU EASILY?

**10.** Do you have a social circle that you are a member of? (Church, Senior Center, Club, etc.) YES or NO

**11.** Do you feel that you make good choices in picking friends and partners? YES or NO

**12.** Is there any unfulfilled promise you made that you wish you could fix? YES or NO

**13.** Is it easy for you to forgive others when they have wronged you? YES or NO

**14.** Are you willing to admit when you are wrong? YES NO SOMETIMES

**15.** Are you more SHY and TO YOURSELF or OUTGOING?

**16.** Are you an EMOTIONAL or SENSITIVE person, BOTH or NEITHER?

**17.** Do you feel your personality is ABRASIVE and HARSH or GENTLE and KIND?

**18.** Do you feel you are more of a LISTENER or TALKER?

**19.** Are you an OUTSPOKEN person or QUIET?

**20.** Would you consider yourself to be one who EXPRESSES YOURSELF & COMPLAIN when things don’t go your

way, or one who KEEPS IT IN TO YOURSELF?

**21.** Are you the type to tell all your personal business? YES or NO

**22.** Do you talk about others'? YES NO SOMETIMES

**23.** Are you more OPTIMISTIC or PESSIMISTIC?

**24.** On a scale of 0-100, what do you believe you are worth?\_\_\_\_\_

**LIFESTYLE RECOMMENDATIONS:**

**Daily Schedule**

Time to get up: \_\_\_\_\_\_\_\_ Time for digestive walk: \_\_\_\_\_\_

Time for worship: \_\_\_\_\_\_\_\_ Time for Supper: \_\_\_\_\_\_\_

Time for exercise: \_\_\_\_\_\_\_\_ Time for digestive walk: \_\_\_\_\_\_

Time for breakfast: \_\_\_\_\_\_\_\_ Time for evening worship: \_\_\_\_\_\_

Time for digestion walk: \_\_\_\_\_\_\_ Time for rest: \_\_\_\_\_\_\_

Time for lunch: \_\_\_\_\_\_\_

**RECOMMENDED MEAL SERVINGS:**

**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. 1-2 green cooked green Vegetable** (or 1 green, 1 orange like carrot or sweet potato)

OR salad (½ of the plate)

**II. Grains**

¼ of the plate

These are to be fully cooked, not sprouted

\*\*\*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.(to order these, call 661-940-4788)

**Take notes of lifestyle changes that need to be made:**

(do not fill in this portion)

**NUTRITION:**

**EXERCISE:**

**WATER:**

**SUNSHINE:**

**TEMPERANCE:**

**AIR:**

**REST:**

**TRUST IN GOD:**

**HERBAL REMEDIES AND LIFESTYLE RECOMMENDATIONS**

**MORNING DEVOTION: EVENING DEVOTION:**

Start with prayer Start with prayer

Sing a few hymns Sing a few hymns

Read a devotional book Do your lesson study

**Read the Conflict Of The Ages Study Health Message**

1. Patriarchs and Prophets 1. Ministry of Healing

2. Prophets and Kings 2. Counsels on Diet and Foods

3. Desire of Ages 3. Counsels on Health

4. Acts of Apostles 4. Healthful Living

5. Great Controversy 5. Christian Temperance & Bible Hygiene

6. Daniel & the Revelation by Uriah Smith

**Close with a word of prayer**

**Note: Please read the scriptures when studying the conflict of the ages.**

**NOTES:**

**HERBAL REMEDIES AND LIFESTYLE RECOMMENDATIONS**

**MORE NOTES:**