

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	Earache	Neurosis
Bad body odor	Excessive sweating	Numbness/Tingling
Bad Breath	Fainting	Pain
Bleeding	Fatigue	Pain in the Eyes
Bloated Stomach	Fever	Painful Urination
Blood in stool	Hair loss	Parasites / Worms
Blood in Urine	Headaches	Rash
Blurred vision	Heart palpitations	Ringing in the Ears
Chest Pain or Tightness	Hemorrhoids	Seizures
Chills	Hives	Sensitivity to sunlight
Clammy skin	Increased Hunger	Sexual dysfunction
Cold / Flu	Indigestion / Heartburn	Sores on Your body
Cold hands or feet	Infections	Stuffy Nose
Confusion	Insomnia	Swelling anywhere
Constipation	Itching in Rectal area	Taste Problems
Cough	Joint Pain	Vision Problems
Diarrhea	Loss of Appetite	Watery Eyes
Difficulty breathing	Low Energy	Weight gain
Difficulty Hearing	Memory loss	Weight loss
Dizziness	Nausea/Vomiting	Yellowing of Eyes

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

Bipolar	Manias	Phobias
Chronic anxiety	Obsessive compulsive disorder	Schizophrenia
Co-dependency	(OCD)	Worry
Depression	Panic Attacks	

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?
2. 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?
3. 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?
5. 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:

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, bok 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:

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.

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.

THE LAWS OF HEALTH

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)?

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, 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

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 doctor's 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?

8. Do you eat or use WHITE FLOUR, WHITE BREAD, WHITE RICE, WHITE PASTRIES? YES or NO
9. 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
10. Do you eat “store bought” COOKIES, CAKE, CUPCAKES, BROWNIES, FUDGE, MUFFINS, BAGELS, CANDIES?
YES or NO ***If yes, how often? _____
11. 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.
12. Do you eat fruit and veggies at the same meal(including fruit based dressings)? YES or NO
13. Do you use SALT? YES or NO ***If yes, what kind? _____
14. 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?
15. Do you eat fried food (this 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?
16. Do you cook with or eat anything with FOOD COLORING? YES or NO
(this includes Kool-Aid, cakes, frosting, lollipops, candy, etc.)
17. Do you use or eat NUTMEG, CINNAMON, ALL SPICE, WHITE PEPPER, BLACK PEPPER, RED PEPPER, HOT
CHILIS, HOT SAUCE or JALAPENOS? YES or NO
18. Do you CHEW GUM or eat ANY TYPE OF BREATH MINT? YES or NO
19. Do you read labels? YES or NO
20. Do you know the 25 Hidden names for MSG? YES or NO
21. Do you know what Aspartame is? YES or NO
22. Which of the following cookware do you use? ALUMINUM, GLASS, STAINLESS STEEL, CAST IRON,
CERAMIC, TEFLON, PORCELAIN, NEW FLIMSY BAKEWARE
23. Do you PILE TOO MUCH FOOD ONTO YOUR PLATE? YES or NO
24. 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

2. If no, how often do you do so in a week? _____ x week
3. Do you brush your teeth every day? YES or NO
4. If no, how often do you do so in a week? _____ x week
5. Do you brush your teeth after every meal? YES or NO What brand toothpaste do you use? _____
6. Do you change your clothes every day? YES or NO
7. Do you use deodorant? YES or NO What is the brand? _____
8. Do you use lotion? YES or NO If yes, what kind? What is the Brand? _____
9. What kind of soap do you use? What is the Brand name? _____
10. What Brand of Shampoo do you use? _____
11. What Brand of Conditioner do you use? _____
12. Do you use any perfume or body spray? _____
13. Do you have animals living inside your home? YES or NO
14. Do you have animal feces lying near your home? YES or NO
15. Do you have dead leaves lying near your home? YES or NO
16. Do you have a compost bin near your home? YES or NO
17. If yes, how many feet away from the house is it? _____
18. Do you have carpet in your home? YES or NO
19. Do you vacuum every day? YES or NO
20. If no, how often in a week do you vacuum? _____ x per week
21. Do you clean your kitchen every day? YES or NO
22. If no, how often in a week do you clean it? _____ x per week
23. Do you mop every day? YES or NO
24. If no, how often in a week do you mop? _____ x per week
25. Do you wash your dishes every day OR do you leave them in the sink some days?

(Circle that which applies)

26. 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

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:

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
6. Daniel & the Revelation by Uriah Smith

Close with a word of prayer

EVENING DEVOTION:

Start with prayer

Sing a few hymns

Do your lesson study

Study Health Message

1. Ministry of Healing
2. Counsels on Diet and Foods
3. Counsels on Health
4. Healthful Living
5. Christian Temperance & Bible Hygiene

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

NOTES:

HERBAL REMEDIES AND LIFESTYLE RECOMMENDATIONS

MORE NOTES: