LIFESTYLE ASSESSMENT QUESTIONNAIRE

(Complete Form)

Please circle all that apply when there is a multiple choice question

CONFIDENTIAL

Website: Healthy Christian Living - Living by the Blueprint

IMPORTANT

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 one's 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 OR 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*** _____ ***Pain Level:***_____

Blood Glucose: _____

Cholesterol: _____ *HDL: ___ LDL: ____* *Triglycerides* _____

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

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)

continue on next page

Are you allergic to anything? YES or NO

****If yes, please list all that apply?*

_____

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)

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

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

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

******continue on next page******

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)

continue on next page

HEALTH QUESTIONS:

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

How many cigs or cigars a day?____ 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?_____times
How many ounces each meal?____oz.

5. Do you eat any animal products such as eggs, milk, butter, cheese, yogurt, cream, etc.? YES or NO
How often?_____ When was the last time you ate any of these?_____

6. How many times do you eat a day on average? ___times
What time do you eat Breafkast:_____ 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?_____

9. How many days a week do you exercise at least 30 minutes?____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_____min. today ____min.
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 day? 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

******continue on next page******
What did you eat today 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, 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? _____

continue on next page*

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.

_____
_____

continue on next page
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, 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? _____

continue on next page*

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.

_____
_____

continue on next page

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 EXTREME?*

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

******continue on next page******

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 (soft or hard)*
*BOTTLED(which brand)?*_____

7. What type of water do you bathe in? TAP FILTERED SPRING DISTILLED WELL (soft or hard)

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 Mineral Water? YES or NO

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

15. Do you drink *KOOL-AID, PUNCH, or FRUIT JUICE? YES or NO*

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

17. Do you drink fresh *raw vegetable juice? YES NO SOMETIMES*
****If yes, how often?* _____
Which vegetables? Carrots Broccoli Beets Cabbage Potatoes Greens Etc.

18. Do you drink COFFEE? *YES or NO*
****If yes, how many cups a day? ___cups*

19. Do you drink TEA*(Black, Lipton, Arizona, White, Chai, Green) YES or NO?*
****If yes, how many cups per day? ___cups*

20. Do you drink SODA or DIET SODA? *YES or NO*
****If yes, how many cans per day? ___cans*

******continue on next page******

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 wear a wet cool towel around your neck or head when out in the hot sun? YES or NOW

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

11. 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

12. Do you take a Vitamin D supplement? *YES or NO*
****If yes, how many IU's each day ?___IU's per day*
*What Brand?*_____

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

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

******continue on next page******

TEMPERANCE:

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

****If yes to drugs, which ones? MARIJUANA, ECSTASY, METH, HEROIN, COCAINE, CRACK, PCP, ACID, PILLS*
Or ANY NOT LISTED _____

2. Do you watch COMPETITIVE SPORTS, MOVIES, T.V. SHOWS, 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, CLASSICAL or ANY NOT MENTIONED?

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

5. Do you play any of the following? CHESS, CHECKERS, VIDEO GAMES, CARDS, BOARD GAMES? YES or NO
(please circle all that apply)

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

7. Do you have VIOLENT OUTBURSTS? *YES or NO or SOMETIMES*

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

9. 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

10. Are you involved in any type of "secret vice"? YES or NO

11. Do you have any addictions that are not listed? *YES or NO*
****Just answer yes or no...please don't list addiction*

12. How many hours a day do you work? ____
How many days per week? ____

13. Do you eat between meals? YES or NO
(even if it's just a morsel like a raisin or nut)

******continue on next page******

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*

13. Do you live in the country where there are many different trees? YES or NO

******continue on next page******

REST:

1. Do you take a nap every day*? YES 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 do late-night snacking? *YES or NO*

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

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

14. Do you take anything to get to sleep? *YES or NO*
    ****If yes, what is it?*_____

15. 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, school, etc.? *YES or NO*

    If so, which day? _____

******continue on next page******

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, WORCESTIRE, SOY SAUCE, BRAGGS AMINOS(any type of 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 OF ANY KIND, BROCCOLI, CAULIFLOWER, BEETS, CARROTS, CABBAGE, POTATOES, TURNIPS, ETC.*
9. Do you eat fruit and veggies at the same meal*(including fruit based dressings)? YES or NO*
   (NOTE: anything with a seed in it, like a tomato, bell pepper, or avocado, is a fruit)
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, GRAPESEED or ANY OTHER?*
12. Do you eat fried food*(this includes french fries, onion rings, 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 ALWAYS read labels? *YES or NO*

******continue on next page******

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

continue on next page

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, GLOSS, FOUNDATION, MASCARA, ETC.)

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

15. Are your ANKLES, 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

continue on next page

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

2. Do you brush your teeth every day? YES or NO
If no, how often do you do so in a week?_____ x week

3. Do you brush your teeth after every meal? YES or NO
What brand toothpaste do you use?_____

4. Do you floss every day? YES or NO

5. Do you change your clothes every day? YES or NO

6. Do you use deodorant? YES or NO
What is the brand?_____

7. Do you use lotion? YES or NO
If yes, what kind? What is the Brand Name?_____

8. What kind of soap do you use?
What is the Brand name?_____

9. What Brand of Shampoo do you use?_____

10. What Brand of Conditioner do you use?_____

11. Do you use any perfume or body spray?_____

12. Do you have animals living inside your home? YES or NO

13. Do you have animal feces lying near your home? YES or NO

14. Do you have dead leaves lying near your home? YES or NO

15. Do you have a compost bin near your home? YES or NO
If yes, how many feet away from the house is it? ____ feet

16. Do you have carpet in your home? YES or NO

17. Do you vacuum every day? YES or NO
If no, how often in a week do you vacuum?_____x per week

18. Do you clean your kitchen every day? YES or NO
If no, how often in a week do you clean it?_____x per week

19. Do you wash your dishes every day OR do you leave them in the sink some days? YES or NO
(circle that which applies)

continue on next page

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 COMPONENT:
(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 SOMETIMES*

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?*

******continue on next page******

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*? Or BOTH

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?_____

******continue on next page******

LIFESTYLE RECOMMENDATIONS: *(do not fill this section out)*

Daily Schedule

Time to get up: _____

Time for worship: _____

Time for exercise (before breakfast): _____

Time for breakfast: _____

Time for digestion walk: _____

Time for Exercise (before lunch): _____

Time for lunch(2nd meal): _____

Time for digestive walk: _____

Time for Supper(3rd meal): _____

Time for digestive walk: _____

Time for evening worship: _____

Time for nap/bedtime: _____/_____

RECOMMENDED MEAL SERVINGS:

SAMPLE MEAL #1:

I. Fruit:
3 servings

II. Whole Grain
Cereal sweetened w/ Fruit OR pancakes (2) OR waffles (1 large) etc.
½ to 1 cup servings of some type of hot cereal

- 2 Tablespoon of some type of seed freshly grounded or whole can be sprinkled over cereal at breakfast.
  OR
- ¼ cup of nuts can be eaten with the breakfast cereal.

III. 1 slice of whole grain bread with natural almond butter (omit if having waffles, pancakes, crepes, or French toast)

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

SAMPLE MEAL #2:

I. 1 dark, leafy green cooked green Vegetable AND 1 other colored vegetable(cooked), like an orange carrot or sweet potato, beet, white potato, (1/2 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, whole wheat pasta.)

III. Nut or Bean Loaf or some other type of protein like tofu or beans (tofu not to be eaten more than 1 x every other week); 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, Encyclopedia of Foods & Their Healing Power vol. 3. OR contact Renee Bushor)* ***continue***

Take notes of lifestyle changes that need to be made:
(do not fill in this portion)

NUTRITION:

EXERCISE:

WATER:

SUNSHINE:

TEMPERANCE:

AIR:

continue on next page

REST:

TRUST IN GOD:

DRESS:

HYGIENE/CLEANLINESS:

SOCIAL:

continue on next page

MORNING DEVOTION:

Start with prayer

EVENING DEVOTION:

Start with prayer

Sing a few hymns

Read a SOP book or Pioneer book of some kind

Sing a few hymns

Do your lesson study

<u>Read the conflict of the ages</u>

1. Patriarchs and Prophets

2. Prophets and Kings

3. Desire of Ages

4. Acts of Apostles

5. Great Controversy

<u>Study health message</u>

1. Ministry of Healing

2. Counsels on Diet and Foods

3. Counsels on Health

4. Healthful Living

5. Christian Temperance & Bible Hygiene

6. And the list goes on

Read a Pioneer Book (see 9T 73.1-.2; 1MR 60.6-63.4; 10MR 49.1-50.1; CW 145.2)

1. Story of Daniel the Prophet by: Stephen Haskell
2. Story of the Seer of Patmos by: Stephen Haskell
3. Daniel & the Revelation by Uriah Smith (correct 1897 Edition)
4. Great Second Advent Movement by: Loughborough
5. Autobiography of Joseph Bates
6. Second Advent Waymarks by: Joseph Bates
7. Second Advent Manual by: Apollos Hale
8. Millers Works #2: Views of the Prophecies and Prophetic Chronology
9. Memoirs of William Miller by: Sylvester Bliss

NOTE: Don't read "devotionals" but our complete books

Close with a word of prayer

<u>NOTE: Please read the scriptures when studying the conflict of the ages.</u>

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