**HEALTH AND NUTRITION EVALUATION**

Providing the following information will allow a better understanding of your condition, and enable us to help you more. Explain fully where necessary. Use separate sheets for additional information.

**PLEASE PRINT**

**NAME:**       **DOB:**

**ADDRESS**: **Street****:**       **City:**

**State:**       **Zip:**       **Phone:**    -   -

**Age:**       S**ex:**       **Height:**        **Weight:**       **Weight one year ago:**

**Nationality:** **Religious preference:** **Marital Status:**

**PLEASE ADD A FIELD FOR EMAIL**

**MEDICAL HISTORY**

**Give medical history - names and dates of past ailments, operations (anything you feel significant, including past complaints).**

**When did you last consult a physician?**

**For what reason?**

**What are you currently being treated for?**

**What specific conditions would you like this consultation to address**?      

**List all medicine, pills, or drugs you are taking now:**

**List mineral and/or vitamin supplements you are taking/how many and how often:**

**Do you have indigestion?** Yes No Gas? Yes No Bloating? Yes No **How Often?**

**What foods tend to cause indigestion, bloating or gas?**

**How often do you have bowel evacuations?** Yes No Color **& texture:**

**Do you have Diarrhea?** Yes No **Constipation?** Yes No

**What color is your urine usually?**

**Do you wear eyeglasses?** Yes No **contact lenses?** Yes No **How many years?**

**Do you have or have you had any of the following? Check the appropriate box and explain fully in the space which follows.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Blank = Never 1 = Rarely 2 = Occasionally 3 = Sometimes 4 = Most of the time 5 = Always** | | | | | | | | |
| ***Past*** | ***Present*** |  | ***Past*** | ***Present*** |  | ***Past*** | ***Present*** |  |
|  |  | Absent Minded |  |  | Excessive Hunger |  |  | Lumbago |
|  |  | Acne |  |  | Excessive Worry |  |  | Mental Disorder |
|  |  | Alcoholism |  |  | Faint When Hungry |  |  | Motion Sickness |
|  |  | Allergies |  |  | Fatigue |  |  | Nausea |
|  |  | Anemia |  |  | Feels Shaky if Hungry |  |  | Nervous Disorder |
|  |  | Appendicitis |  |  | Foul Smelling BM |  |  | Night Blindness |
|  |  | Arthritis |  |  | Foul Smelling Urine |  |  | Pain w/bowel movement |
|  |  | Asthma |  |  | Frequent Colds |  |  | Poliomyelitis |
|  |  | Bad Breath |  |  | Frequent Kidney Infections |  |  | Prostate Trouble |
|  |  | Cancer |  |  | Frequent Lower Bowel Gas |  |  | Respiratory Problems |
|  |  | Chest Pains |  |  | Frequent Urination |  |  | Rheumatic Fever |
|  |  | Chills/Cold Skin |  |  | Gallstones |  |  | Sexual Disorders |
|  |  | Cold Hands/Feet |  |  | Hay fever |  |  | Sinusitis |
|  |  | Constipation |  |  | Headaches |  |  | Skin Problems |
|  |  | Crave sweets/coffee |  |  | Heart Disease |  |  | Sluggish in the A.M. |
|  |  | Depression |  |  | Heart Pounds Hard |  |  | Swollen Glands |
|  |  | Diabetes |  |  | Hemorrhoids |  |  | Too Fast Digestion |
|  |  | Diarrhea |  |  | High Blood Pressure |  |  | Tuberculosis |
|  |  | Difficulty Breathing |  |  | Hot Most of the Time |  |  | Ulcers/Colitis |
|  |  | Digestive Disorders |  |  | Indigestion/Heartburn |  |  | Venereal Infection |
|  |  | Dizziness |  |  | Insomnia |  |  | Wake Up Tired |
|  |  | Eat When Depressed |  |  | Irritable before Meals |  |  | Weight Problem |
|  |  | Eat When Nervous |  |  | Itching of the Nose |  |  |  |
|  |  | Eating relieves fatigue |  |  | Itching of the Rectum |  |  |  |
|  |  | Eczema |  |  | Kidney Stones |  |  |  |
|  |  | Emphysema |  |  | Light-headedness |  |  |  |
|  |  | Excessive Fear |  |  | Low Blood Pressure |  |  |  |

**Explain fully the past or present ailments checked above on a separate piece of paper if needed:**

**GODLY TRUST**

**Occupations:**      

**What hours do you work?**

**Health of spouse (if applicable):**

**How many children do you have?**       **Ages:**

**Health of children:**

**Recreational activities enjoyed:**

**Hours per week viewing TV****:**      **Do you often feel guilty about past mistakes?** Yes No

**Do you worry about the future?** Yes No **Do you have stress?** Yes No **Depression?** Yes No

**Check the following categories which cause stress:**  financial

job related

getting along with people

family

not happy with myself

**On a scale of 1 to 10 rate your stress level (1= very little stress and 10=an extreme amt. of stress)****:**

Do you enjoy the work that you do? Yes No **If not, explain****:**

**Are you developing your mental and spiritual capabilities by daily study, meditation and prayer?**

Yes No

**Are you involved in some type of activity in which you are helping others?** Yes No

**The following space is provided for those who would like to elaborate more on the causes of their stress, depression and other negative emotions.**

**OPEN AIR**

**How many hours daily do you spend out of doors?**

**Do you sleep with your windows closed?** Yes No

**Are you able to breathe fresh air while you are working?** Yes No

**Is the building where you work a none-smoking facility:** Yes No

**DAILY EXERCISE**

**How often do you exercise?**       **Describe the exercise:**

**How do you feel after you exercise?**

**SUNSHINE**

**How much time daily do you spend out of doors in the sunlight?**

**Do you often get sunburned?** Yes No **Do you visit tanning beds?** Yes No

**Are you afraid of getting skin cancer?** Yes No

**PROPER REST**

**What time do you go to bed?**       **What time do you awaken?**

**What time is your last meal before retiring?**       **Do you snack just before bedtime?** Yes No

**Do you wake up during the night and snack?** Yes No **If so, what do you eat?**      

**Do you have trouble sleeping?** Yes No **Explain:**

**LOTS OF WATER**

**How much water do you drink daily?**

**What type? (spring, filtered, distilled, tap):**

**Check below the beverages you drink and indicate how much of each:**

**BEVERAGE NAME BRAND # OF glasses, cans or bottles daily**

Soda      

Coffee      

Tea      

Fruit Juice ­­­­­­­­­      

Punch      

Milk      

Other      

**What is the usual color of your urine?**

**Explain your understanding of the principles of hygiene:**

**ALWAYS TEMPERATE**

**Do you ingest caffeine in any form? Yes No If so, for how many years?**

**Have you ingested caffeine in the past?** Yes No **For how many years?**

**If so, when did you stop?**       **Do you smoke or chew tobacco?** Yes No **indicate which:**

**If so, for how many years?** **Have you used tobacco in the past?** Yes No

**For how many years?**

**If so, when did you stop?**       **Do you drink alcohol?** Yes No **If so, what kind?**

**For how many years?**       **Have you drank alcohol in the past?** Yes No **For** **how many years?**

**NUTRITION**

**Do you overeat?** Yes No **Do you feel stuffed after your meals?** Yes No

**Do you eat between meals?** Yes No **Explain:**

**Do you drink with your meals?** Yes No **If so, what liquids?**

**Do you wear removable dentures or plates?** Yes No **Do you eat fast?** Yes No

**How long does it take you to eat?**       **Do you have a peaceful environment at meal**

**times?**

**Do you have set meal times?** Yes No **Are you following any special diet?** Yes No

**Explain what type:**

**Do you eat animal products?** Yes No **If so, what kind?**

**How Often?**

**Do you eat dairy products?** Yes No: Milk? Cheese? Egg?

**Do you eat desserts, candy or other sweets regularly?** Yes No **Explain how often and what**

**Type:**

**What time do you eat breakfast?**       **What foods do you usually eat?**

**How often do you eat a tossed green leafy salad?**

**How often do you eat steamed or cooked vegetables?**

**How often do you eat fruits?**

**How often do you eat soup or stew?**

**What time do you eat lunch (dinner)?** **What foods do you eat?**

**What time do you eat supper?**       **What foods do you eat?**

**PLEASE REMEMBER TO SIGN AND DATE THIS QUESTIONNAIRE! WE CANNOT RESPOND WITHOUT YOUR SIGNATURE AND DATE: BY SIGNING YOU ARE SHOWING THAT YOU UNDERSTAND THAT THIS QUESTIONNAIRE AND THE EDUCATIONAL INFORMATION GIVEN IN THIS CONSULTATION IS BIBLICAL LIFE-STYLE EDUCATION AND IS NOT INTENDED TO DIAGNOSE OR TREAT ANY DISEASE, AILMENT OR ABNORMALITY.**

Sign: Date: