NATURAL HEALTH RETREAT

480 Neely Lane, Huntingdon, TN 38344 • 731.244.2140 • fax 731.244.2241 • godsplan@meetministry.org • www.meetministry.org

FOR YOUR INFORMATION

CONDITIONS OF ACCEPTANCE

Our Home Natural Health Retreat is a learning facility where health guests are admitted as students to learn to recover and to preserve their health and medically take charge of their own lives. We are not a medical facility or treatment center, nor do we give medical advice.

Our guest must be:

1. Be of legal age of accountability
2. Be physically mobile and able to perform one's own personal hygiene
3. Be mentally competent and capable of making their own decisions
4. Be emotionally stable and self-responsible
5. Be able to follow clearly written instructions

To reserve a space and to be confirmed as a health guest, he/she must submit:

1. A completed health questionnaire for review
2. A deposit of $500

The above must be received no later than 2 weeks prior to the beginning of the health session. Please note, as we do operate a small facility with limited space, it is prudent to send in your application as soon as possible to guarantee your desired date of attendance.

Health guests are also required to submit recent medical records (lab reports, CAT scans, x-ray reports, summaries, or other pertinent information) 2 weeks before the session begins.

We give no guarantee of healing; we cooperate with God who is the true source of healing. An individualized plan will be shared with you, placing you on the road to recovery. This plan will be based on the submitted health questionnaire, medical records and other provided information.

If, during the implementation of the program, circumstances or problems arise as a result of purposeful withholding of important medical information or a lack transparency, for your sake as well as the sake of the ministry and other guests, you may be informed that we are no longer able to assist you. No refunds will be given for health guests choosing to leave before the session ends or asked to leave due to undisclosed information.

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FINANCIAL INFORMATION

Suggested Donations

18-day Program		**10-day Program**	
1 person (full participant)	$4,995	1 person (full participant)	$2,700
2 persons (2 participating)	$9,450	2 persons (only one participating)	$5,150
2 persons (only one participating)	$7,695	2 persons (husband and wife)	$4,200

A nonrefundable $500 deposit is requested with application prior to the beginning of session. The balance is due 2 weeks before session begins. All checks or money orders should be made payable to: M.E.E.T. Ministry. Credit and debit cards are also accepted.

The balance, which is due 2 weeks before session, is also nonrefundable, except for uncontrollably dire circumstances, such as death or other unforeseen emergency. In cases which are not necessarily emergencies, but are important nevertheless, the applicant has 3 sessions to make up the time. After that time, the submitted funds become nonrefundable.

If other situations exist where a person chooses to cancel their plans to come after submitting the nonrefundable deposit and/or balance, there is yet another option. Someone else can be referred to M.E.E.T. Ministry, and the funds can be used in your place and adjusted between the two parties involved.

Billing Information

Name: _____

Address: _____ City: _____

State/Province: _____ Zip Code: _____ Country: _____

Home Phone: _____ Work Phone: _____

Person responsible for payment if other than guest: _____

Address: _____ City: _____

State/Province: _____ Zip Code: _____ Country: _____

Home Phone: _____ Work Phone: _____

Method of Payment

Attending: ☐ 10-day session ☐ 18-day session Session Dates: _____

Check

If paying by check, please mail to:

M.E.E.T. Ministry
480 Neely Lane
Huntingdon, TN, 38344

Credit Card

If paying by Credit Card, please call the office during regular business hours at 731-244-2140 from 9 am to 5 p.m., Monday through Thursday.

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HEALTH GUEST QUESTIONNAIRE FORM

Name: _____ Age: _____

Address: _____ City: _____

State/Province: _____ Zip Code: _____ Country: _____

Phone: _____ Email: _____

Birth date: ___ /___ /___ Nationality: _____ Religion: _____

Marital Status: _____ Referred by: _____

Highest Education Completed: _____ Occupation: _____

Emergency Contact (Relationship): _____ (_____) Phone: _____

You want to have help dealing with:

- ☐ Arthritis
- ☐ Cancer
  Type: _____
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Overweight
- ☐ Stress, Anxiety, Depression
- ☐ Other: _____

Would you like to be added to our email list? ☐ Yes ☐ No

I hereby state that I do not represent any food, drug, medical, or government organization.

Date: ___ /___ /___ Health Guest Signature: _____

PERSONAL INFORMATION

Weight: _____ Height: _____ Any weight loss in the past year? ☐ No ☐ Yes If yes, How much loss? _____
Do you have any indoor pets? ☐ No ☐ Yes How many and what kind? _____
List any past or present environmental hazards at work place or at home.

_____

_____

Are you a smoker? ☐ No ☐ Yes If yes, what kind? _____ How much? _____
Do you drink alcoholic beverages? ☐ No ☐ Yes If yes, what kind? _____ How much? _____
Do you drink caffeinated drinks? ☐ No ☐ Yes If yes, what kind? _____ How much? _____
On a scale 1-10, what is your energy level? _____ Do you take a nap during the day? ☐ No ☐ Yes
Do you stay active throughout the day? ☐ No ☐ Yes Do you exercise regularly? ☐ No ☐ Yes
How many hours a day do you spend on: ☐ TV _____ ☐ Computer _____ ☐ Other devices: _____
How many hours do you sleep each night? _____
If you have difficulty sleeping, check the following that applies to you.

☐ Inability to fall asleep ☐ Inability to get back to sleep ☐ Hard to awaken
☐ Inability to stay asleep ☐ Awaken after few hours of sleep ☐ Other: _____

NUTRITION

Is your diet primarily:

- ☐ Regular American diet
  - Do you regularly partake of:
    - ☐ Chicken ☐ Beef ☐ Turkey
    - ☐ Catfish ☐ Pork ☐ Shrimp
    - ☐ Lobster ☐ Shellfish ☐ Other: _____
- ☐ Vegetarian
  - ☐ Milk, eggs, dairy
  - ☐ Fish
- ☐ Wheat free
- ☐ Gluten free
- ☐ Other: _____

Do you regularly partake of:

- ☐ Whole grains, i.e. brown rice, millet, quinoa, oats, etc.
- ☐ Processed refined foods: white rice, white pasta, white bread, etc.
- ☐ Junk food/fast food
- ☐ Sugar
- ☐ Other: _____

PERSONAL HEALTH HISTORY

ALLERGIES

Are you allergic or sensitive to any of the following?

Medication ☐ No ☐ Yes List: _____

Food ☐ No ☐ Yes List: _____

Other ☐ No ☐ Yes List: _____

MEDICATIONS & SUPPLEMENTS

List the names and dosage of any medications and supplements you are currently taking.

Medications

_____

_____

_____

Supplements

_____

_____

_____

Have you ever taken any of the following? If yes, describe what type, when, and for how long.

Antibiotics ☐ No ☐ Yes _____

Blood Pressure Meds ☐ No ☐ Yes _____

Birth Control Pills ☐ No ☐ Yes _____

Hormones ☐ No ☐ Yes _____

Insulin ☐ No ☐ Yes _____

Pain Meds ☐ No ☐ Yes _____

Steroids ☐ No ☐ Yes _____

Thyroid Meds ☐ No ☐ Yes _____

Tranquilizers/Sedatives ☐ No ☐ Yes _____

DEVICES

Do you use any of the following?

Artificial Limb	☐ No ☐ Yes	Contact Lenses	☐ No ☐ Yes	Hearing Aid	☐ No ☐ Yes
Back Braces	☐ No ☐ Yes	Dentures	☐ No ☐ Yes	IUD	☐ No ☐ Yes
Braces	☐ No ☐ Yes	Eyeglasses	☐ No ☐ Yes	Pacemaker	☐ No ☐ Yes
Neck Brace	☐ No ☐ Yes	Other: _____			

Do you require assistance with:

☐ Walking ☐ Sitting ☐ Getting in & out of bed ☐ Other: _____

PERSONAL HEALTH HISTORY Continues:

SURGERIES

Have you ever had surgeries on the following?

Appendix	☐ No ☐ Yes When? _____	Kidney	☐ No ☐ Yes When? _____
Colon	☐ No ☐ Yes When? _____	Small Intestine	☐ No ☐ Yes When? _____
Gallbladder	☐ No ☐ Yes When? _____	Stomach	☐ No ☐ Yes When? _____
Heart	☐ No ☐ Yes When? _____	Varicose Veins	☐ No ☐ Yes When? _____
Hernia	☐ No ☐ Yes When? _____	Other: _____	

Women

Breast	☐ No ☐ Yes When? _____	Uterus	☐ No ☐ Yes When? _____
Ovaries	☐ No ☐ Yes When? _____		

Men

Prostate ☐ No ☐ Yes When? _____

RADIATION PROCEDURES

List any x-rays, CT scans, MRI, and/or radiation treatment that you have ever had and indicate when.

_____

_____

_____

INJURIES

List and describe any past or present injuries that you have experienced.

Past

_____

_____

Present

_____

_____

IMMUNIZATION

List any immunization, especially tetanus, which you have ever received and indicate when the last shot was.

_____

_____

_____

MEDICAL DOCTOR DIAGNOSES

Check all medical doctor diagnoses which you have ever had, and indicate when it was in the past.

Anemia—What kind? _____	☐ Present	☐ Past	When? _____
Angina	☐ Present	☐ Past	When? _____
Arthritis	☐ Present	☐ Past	When? _____
Asthma	☐ Present	☐ Past	When? _____
Blindness (either eye)	☐ Present	☐ Past	When? _____
Boils, recurrent	☐ Present	☐ Past	When? _____
Cancer—What kind? _____	☐ Present	☐ Past	When? _____
Cataracts	☐ Present	☐ Past	When? _____
Chronic Bronchitis	☐ Present	☐ Past	When? _____
Cirrhosis of the Liver	☐ Present	☐ Past	When? _____
Colitis	☐ Present	☐ Past	When? _____
Crohn's Disease	☐ Present	☐ Past	When? _____
Deafness	☐ Present	☐ Past	When? _____
Depression	☐ Present	☐ Past	When? _____
Diabetes	☐ Present	☐ Past	When? _____
Dysentery or Serious Diarrhea	☐ Present	☐ Past	When? _____
Emotional Problems	☐ Present	☐ Past	When? _____
Emphysema	☐ Present	☐ Past	When? _____
Epilepsy or Seizures	☐ Present	☐ Past	When? _____
Fibromyalgia	☐ Present	☐ Past	When? _____
Gall Stones	☐ Present	☐ Past	When? _____
Glaucoma	☐ Present	☐ Past	When? _____
Goiter	☐ Present	☐ Past	When? _____
Gout	☐ Present	☐ Past	When? _____
Hay fever	☐ Present	☐ Past	When? _____
Heart Attack	☐ Present	☐ Past	When? _____
Heart Murmur as an adult	☐ Present	☐ Past	When? _____
Heart, enlarged	☐ Present	☐ Past	When? _____
Hemorrhoids or Piles	☐ Present	☐ Past	When? _____
Hepatitis	☐ Present	☐ Past	When? _____
High Blood Pressure	☐ Present	☐ Past	When? _____
Kidney Stones	☐ Present	☐ Past	When? _____
Kidney/Bladder Infection	☐ Present	☐ Past	When? _____
Lupus – Autoimmune Disease	☐ Present	☐ Past	When? _____
Migraine Headaches	☐ Present	☐ Past	When? _____
Multiple Sclerosis	☐ Present	☐ Past	When? _____
Nervous Breakdown	☐ Present	☐ Past	When? _____
Parkinson's	☐ Present	☐ Past	When? _____
Phlebitis	☐ Present	☐ Past	When? _____

Polio	☐ Present	☐ Past	When? _____
Poor Blood Clotting	☐ Present	☐ Past	When? _____
Rheumatic Fever	☐ Present	☐ Past	When? _____
Stomach or Duodenal Ulcer	☐ Present	☐ Past	When? _____
Stroke	☐ Present	☐ Past	When? _____
Thyroid, overactive	☐ Present	☐ Past	When? _____
Thyroid, underactive	☐ Present	☐ Past	When? _____
Tuberculosis	☐ Present	☐ Past	When? _____
Varicose Veins	☐ Present	☐ Past	When? _____
Venereal Disease	☐ Present	☐ Past	When? _____
Abnormal Chest X-ray	☐ Present	☐ Past	When? _____
Abnormal Electrocardiogram	☐ Present	☐ Past	When? _____
Abnormal Stomach X-ray	☐ Present	☐ Past	When? _____
Colon or Bowel Trouble	☐ Present	☐ Past	When? _____
Rectal Trouble	☐ Present	☐ Past	When? _____

Female

Breast Cancer	☐ Present	☐ Past	When? _____
Cystitis	☐ Present	☐ Past	When? _____
Mastitis	☐ Present	☐ Past	When? _____
Ovarian Cyst	☐ Present	☐ Past	When? _____
Uterine Fibroid	☐ Present	☐ Past	When? _____
Other: _____	☐ Present	☐ Past	When? _____

Male

Enlarged Prostate	☐ Present	☐ Past	When? _____
Prostate Cancer	☐ Present	☐ Past	When? _____

FAMILY HEALTH INFORMATION

Family Member	Present Age or Age at Death	If living, health: good, fair, poor If deceased, cause of death
Spouse		
Father		
Mother		
Sibling #1		
Sibling #2		
Sibling #3		
Child #1		
Child #2		
Child #3		
Other:		

FAMILY HEALTH HISTORY

Check any condition a blood relative has ever had.

Alcoholism ☐ Yes ☐ Relationship: _____
Arthritis ☐ Yes ☐ Relationship: _____
Cancer, including Leukemia ☐ Yes ☐ Relationship: _____
Diabetes ☐ Yes ☐ Relationship: _____
Heart Attack ☐ Yes ☐ Relationship: _____
Heart Trouble ☐ Yes ☐ Relationship: _____
High Blood Pressure ☐ Yes ☐ Relationship: _____
Mental Illness ☐ Yes ☐ Relationship: _____
Stroke ☐ Yes ☐ Relationship: _____
Suicide ☐ Yes ☐ Relationship: _____
Thyroid Trouble ☐ Yes ☐ Relationship: _____
Tuberculosis ☐ Yes ☐ Relationship: _____
Other: _____ ☐ Yes ☐ Relationship: _____

SYSTEM REVIEW

Review the following symptoms and check all that apply to you.

EYES

Dry eyes	☐ Past ☐ Present
Blurred vision not corrected by glasses	☐ Past ☐ Present
Double vision	☐ Past ☐ Present
Light flashes	☐ Past ☐ Present
Halos around lights	☐ Past ☐ Present
Eye pain	☐ Past ☐ Present

EARS

Ear pain	☐ Past ☐ Present
Drainage from ear	☐ Past ☐ Present
Hearing difficulty or deafness	☐ Past ☐ Present
Ringing in ears	☐ Past ☐ Present

NOSE/SINUS

Dry nose	☐ Past ☐ Present
Sinus trouble	☐ Past ☐ Present
Post nasal drip	☐ Past ☐ Present
Nasal congestion	☐ Past ☐ Present
Recurrent nose bleeds	☐ Past ☐ Present

THROAT/MOUTH

Dry mouth	☐ Past ☐ Present
Difficulty swallowing	☐ Past ☐ Present
Coated tongue	☐ Past ☐ Present
Bad breath	☐ Past ☐ Present
Bleeding gums	☐ Past ☐ Present
Pyorrhea	☐ Past ☐ Present
Dental caries	☐ Past ☐ Present
Persistent hoarseness	☐ Past ☐ Present

SKIN

Dry or scaly skin	☐ Past ☐ Present
Changing mole	☐ Past ☐ Present
Rash	☐ Past ☐ Present
Yellow skin	☐ Past ☐ Present
Acne	☐ Past ☐ Present
Foul body odor	☐ Past ☐ Present
Brittle fingernails	☐ Past ☐ Present
Itching skin and feet	☐ Past ☐ Present
Bruise easily	☐ Past ☐ Present
Wounds heal slowly	☐ Past ☐ Present

NECK

Swelling/Lumps	☐ Past ☐ Present
Stiffness	☐ Past ☐ Present

RESPIRATORY SYSTEM

Frequent cough	☐ Past ☐ Present
Coughing up blood	☐ Past ☐ Present
Shortness of breath	☐ Past ☐ Present
Difficulty breathing	☐ Past ☐ Present
Wheezing	☐ Past ☐ Present
Allergies/asthma tendency	☐ Past ☐ Present

CIRCULATORY SYSTEM

Fatigue	☐ Past ☐ Present
Sluggishness	☐ Past ☐ Present
Chest pain or pressure	☐ Past ☐ Present
Poor exercise tolerance	☐ Past ☐ Present
Unusual heartbeat	☐ Past ☐ Present
Pulse slow/irregular	☐ Past ☐ Present
Heart palpitations/flutters	☐ Past ☐ Present
Low blood pressure	☐ Past ☐ Present
Ankles swell in evening	☐ Past ☐ Present
Ankles swell in morning	☐ Past ☐ Present
Cold hands & feet	☐ Past ☐ Present
Cold/heat intolerance	☐ Past ☐ Present
Fluid retention	☐ Past ☐ Present

NERVOUS SYSTEM

Poor memory/concentration	☐ Past ☐ Present
Headaches	☐ Past ☐ Present
Migraine	☐ Past ☐ Present
Weakness in arm or leg	☐ Past ☐ Present
Nerve pains	☐ Past ☐ Present
Tremor	☐ Past ☐ Present
Nervousness	☐ Past ☐ Present
Numbness	☐ Past ☐ Present
Hands & feet go to sleep easily	☐ Past ☐ Present
Difficulty with balance	☐ Past ☐ Present
Dizzy spells	☐ Past ☐ Present
Fainting spells	☐ Past ☐ Present
Speech difficulty	☐ Past ☐ Present

MUSCULOSKELETAL SYSTEM

Painful joints ☐ Past ☐ Present
Swollen joints ☐ Past ☐ Present
Joint stiffness in evening ☐ Past ☐ Present
Joint stiffness in morning ☐ Past ☐ Present
Loss of muscle strength ☐ Past ☐ Present
Muscle cramps, worse during exercise/"Charley Horses" ☐ Past ☐ Present
Muscle twitching ☐ Past ☐ Present
Muscle-leg-toe cramps at night ☐ Past ☐ Present
Lump or swelling in muscle ☐ Past ☐ Present
Lump on bone ☐ Past ☐ Present
Back pain ☐ Past ☐ Present

URINARY SYSTEM

Increased urine ☐ Past ☐ Present
Frequent urination ☐ Past ☐ Present
Blood in urine ☐ Past ☐ Present
Cloudy urine ☐ Past ☐ Present
Urine bubbles ☐ Past ☐ Present
Difficulty passing urine ☐ Past ☐ Present
Difficulty passing urine ☐ Past ☐ Present
Difficulty controlling urination ☐ Past ☐ Present
Pain or burning with urination ☐ Past ☐ Present
Getting up at night to urinate ☐ Past ☐ Present

GASTROINTESTINAL SYSTEM

Cannot gain weight ☐ Past ☐ Present
Poor appetite ☐ Past ☐ Present
Increased appetite ☐ Past ☐ Present
Indigestion or heartburn ☐ Past ☐ Present
Bloating ☐ Past ☐ Present
Gas ☐ Past ☐ Present
Greasy food intolerance ☐ Past ☐ Present
Nausea or vomiting ☐ Past ☐ Present
Vomiting blood ☐ Past ☐ Present
Abdominal pain or cramps ☐ Past ☐ Present
Abdominal swelling ☐ Past ☐ Present
Constipation ☐ Past ☐ Present
Diarrhea ☐ Past ☐ Present
Constipation & diarrhea, alternating ☐ Past ☐ Present
Black or bloody stools ☐ Past ☐ Present
Light-colored stools ☐ Past ☐ Present
Painful bowel movements ☐ Past ☐ Present
Burning or itching anus ☐ Past ☐ Present

REPRODUCTIVE SYSTEM

Female

Breast lump ☐ Past ☐ Present
Nipple discharge ☐ Past ☐ Present
Vaginal bleeding or spotting not with periods ☐ Past ☐ Present
Decreased sex drive ☐ Past ☐ Present
Sterility ☐ Past ☐ Present
Pain not related with periods ☐ Past ☐ Present
Possibly pregnant ☐ Past ☐ Present

Age menses started: _____

# of days of flow _____
# of days of cycle _____
Date of last period _____

Change in periods ☐ Past ☐ Present
Irregular periods ☐ Past ☐ Present
Heavy menses ☐ Past ☐ Present
Scanty menses ☐ Past ☐ Present
PMS ☐ Past ☐ Present
Severe menstrual cramps ☐ Past ☐ Present
Painful period ☐ Past ☐ Present
Acne worse during period ☐ Past ☐ Present
Surgical menopause ☐ Past ☐ Present
Hot flashes ☐ Past ☐ Present
Pain with intercourse ☐ Past ☐ Present
Vaginal dryness ☐ Past ☐ Present

Male

Breast lump ☐ Past ☐ Present
Decreased sex drive ☐ Past ☐ Present
Impotence/sterility ☐ Past ☐ Present
Difficulty having erections ☐ Past ☐ Present
Penile discharge ☐ Past ☐ Present
Penile soreness ☐ Past ☐ Present
Lump in testicles ☐ Past ☐ Present

ENDOCRINE SYSTEM

Increased thirst ☐ Past ☐ Present
Night sweats, cold ☐ Past ☐ Present
Night sweats, hot ☐ Past ☐ Present
Perspiration, decreased ☐ Past ☐ Present
Perspiration, increased ☐ Past ☐ Present
Hair loss ☐ Past ☐ Present

LIFE SCRIPT WORKSHEET

PERSONALITY TRAITS

Check everything on the following list that describes you.

☐ Assertive	☐ Disorganized	☐ Idealistic	☐ Practical	☐ Withdrawn
☐ Aggressive	☐ Easily excitable	☐ Melancholic	☐ Quiet	☐ Worrier
☐ Approachable	☐ Easily irritable	☐ Moody	☐ Reserved	
☐ Animated	☐ Enthusiastic	☐ Optimistic	☐ Self-confident	
☐ Calm	☐ Fearful	☐ Organized	☐ Self-conscious	
☐ Compassionate	☐ Feel anxious	☐ Outgoing	☐ Sensitive	
☐ Decisive	☐ Feel inferior	☐ Perfectionist	☐ Shy	
☐ Dependable	☐ Friendly	☐ Pessimistic	☐ Spontaneous	
☐ Depressed	☐ Highly emotional	☐ Poised	☐ Undependable	

Which of your personality weakness would you like to be strengthened? _____

What are your main interests or hobbies? _____

_____

Describe your childhood.

_____

_____

_____

Have you ever seriously considered suicide or attempted suicide? Explain.

_____

_____

How do you describe your life in general—satisfactory, unsatisfactory, fulfilling, boring, too demanding?

_____

_____

Have you experienced any recent traumatic, life-changing events? If so, describe how it has impacted you.

_____

_____

On a scale of 1-10 (1=very little stress, &10=an extreme amount of stress), what is your stress level?

_____

List 3 major sources of your stress. Describe.

_____

_____

_____

What do you believe about God and His healing power?

_____

_____

FOOD JOURNAL

Keep a record of your food intake for three consecutive days, including one weekend day. If you do not work Monday through Friday, then include two workdays, and one off day.

Example:	Days	1	2	3	4
		Wed	Thurs	Fri	Sat
	OR				
		Sun	Mon	Tues	Wed

- Record all foods and beverages consumed immediately after eating, as accurately as possible including the amount.
- Consider the ingredients in sandwiches or mixed dishes as separate items.
- List all fats used, including those in cooking and frying, and on bread, potatoes, and vegetables.
- Indicate if food or beverage is fresh, frozen, or canned and whether it was eaten raw or cooked.
- Be honest and do not change your regular eating pattern while you are keeping this diary.

SUMMARY OF HOW TO RECORD PORTION SIZES

All Beverages: Record in ounces (1 cup=8 ounces):

Meat: Record meat in ounces (1 ounce of meat is about the size of a matchbox)

Potatoes, rice, fruits, and vegetables: Record in cups:

Jam, gravies, salad dressing, margarine, butter: Record in teaspoons or tablespoons (3 tsp. = 1 Tbs.):

Bread, raw fruits and vegetables, cookies, nuts: Record by number and size:

Desserts: Record by servings (large or small):

Mixed dishes (such as stews, casseroles, etc.) record the total amount eaten, e.g.: 1 cup chicken soup or 1 cup of a casserole

Sandwiches: List ingredients separately, e.g. a vege-sandwich: 2 slices whole wheat bread, 1 tsp. Mayonnaise, 1 slice vege-meat, etc.

DAY ONE

Time of Day	Food & Amount	Feelings	Time Spent Eating	Activity While Eating	Specific Location

DAY TWO

Time of Day	Food & Amount	Feelings	Time Spent Eating	Activity While Eating	Specific Location

DAY THREE

Time of Day	Food & Amount	Feelings	Time Spent Eating	Activity While Eating	Specific Location