

Lifestyle Assessment Questionnaire

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

CONFIDENTIAL – DONATIONS ACCEPTED

540-297-3593

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**

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 (within realistic limits) to improve your condition/s?

Are you allergic to anything? YES or NO

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

List any health concerns you have: (physical or mental)

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 or mental disorders: (please circle all that apply)

Depression Chronic anxiety Bipolar Panic Attacks

Co-dependency
Phobias

Manias
Obsessive compulsive

Schizophrenia
Neurosis

Worry
Disorder (OCD)

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)

EXERCISE:

1. How many days a week do you exercise? 0 1 2 3 4 5 6 7

2. How many minutes do you exercise each day? _____minutes

3. What type of exercise/s do you do? (Please list all)

1. _____
2. _____
3. _____

4. Would you rate your exercise MILD MODERATE or VIGOROUS?

5. Do you exercise INDOORS, OUTDOORS, or BOTH?

***If indoors or both, DO YOU EXERCISE IN A GYM? YES or NO

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? 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 do you weigh? _____lbs.

2. How many cups (8 oz.) of water do you drink each day? _____cups

How many cups have you drunk so far today? _____cups

3. How much water do you drink upon arising in the morning? _____(How many cups)

Is it SOFT or HARD water?

4. Do you SIP or GULP?

5. Do you drink with your meals? YES or NO

6. Do you drink cold water? YES or NO

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

8. What type of water do you drink? TAP FILTERED SPRING DISTILLED BOTTLED

Which brand? _____

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

10. Do your LIPS EVER FEEL DRY? YES or NO

11. Does your SKIN EVER FEEL DRY? YES or NO

12. Do you suffer from MIGRAINES or HEADACHES? YES or NO

13. What color is your URINE usually? CLEAR LIGHT YELLOW ORANGISH DARK YELLOW
TEA COLOR BROWN

14. Do you drink Vitamin Water? YES or NO

15. Do you drink Flavored Water? YES or NO

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

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

SUNSHINE:

1. How many days each week do you go out into the direct sunlight? ____days

2. How many minutes do you get direct sunlight each day(list average amount)? ____minutes
(sitting in front of a window does not count)

3. 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

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

5. Do you wear sunglasses when out in the sun? YES or NO

6. Do you wear sunscreen? YES or NO

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

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

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

9. Have you ever had a Vitamin D (Hydroxy 25) test done? YES NO NOT SURE

***If yes, what was your results in number? ____ng/ml

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

***If yes, how many IU's each day? ____IU's per day What Brand? _____

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

TEMPERANCE:

1. Do you SMOKE, CHEW TOBACCO, DRINK ALCOHOL, or 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 OVEREAT? YES or NO

8. 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
***If yes, how many minutes each day?_____minutes
8. Do you air out your home every day? YES or NO
9. Do you sleep with your windows in your room cracked? 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 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 eat any RED MEAT, PORK, FISH, CHICKEN, TURKEY, SEAFOOD, or ANY OTHER MEAT NOT MENTIONED? YES or NO
***If yes, how many times a day?____ How many times per week?____
3. Do you eat EGGS, CHEESE, BUTTER, MARGARINE, or ANY DAIRY PRODUCTS? YES or NO
4. Do you drink MILK? YES or NO
5. Do you use any Condiments such as MUSTARD, KETCHUP, MAYONNAISE, VEGGIENAISE, WORCESTERSHIRE SAUCE 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: _____
6. Do you eat CHOCOLATE? YES NO
7. 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, and WHITE PASTRIES? YES or NO
9. How many times a day do you eat BREAD_____x a day or PASTA_____x a day
10. Do you eat “store bought” COOKIES, CAKE, CUPCAKES, BROWNIES, FUDGE, MUFFINS, BAGELS, CANDIES? YES or NO

***If yes, how often?

11. How many COOKED GREEN VEGGIES do you eat each day (peas and green beans are not veggies)?
_____ per day
12. How many COOKED ORANGE VEGGIES do you eat each day? _____
13. How many RAW____ or DRIED FRUIT____ do you eat each day?
14. Do you eat RAW VEGETABLES? YES or NO
***If yes, which ones? SPINACH, KALE, GREENS, BROCCOLI, CAULIFLOWER, BEETS, CARROTS,
CABBAGE, GREENS, POTATOES, TURNIPS, ETC.
15. Do you eat fruit and veggies at the same meal(including fruit based dressings)?
YES or NO
16. How many servings of GRAIN(rice, corn, millet, rye, wheat, barley, oats, quinoa, etc.)
do you eat each day? _____
17. How many servings of RAW NUTS do you eat each day?_____
18. How many servings of RAW SEEDS do you eat each day?_____
19. Do you use SALT? YES or NO
***If yes, what kind?_____
20. Do you cook with OIL? YES or NO
***If yes, which ones? VEGETABLE, OLIVE, PEANUT, SAFFLOWER, SUNFLOWER, CANOLA, COCONUT,
SESAME, PALM, or ANY OTHER?
21. Do you eat fried food(this includes French fries, chips, Fritos etc.)? YES or NO
***If yes, how often? ONCE A DAY, ONCE A WEEK, COUPLE TIMES A WEEK, COUPLE TIMES A MONTH?
22. Do you cook with or eat anything with FOOD COLORING? YES or NO
23. Do you use or eat NUTMEG, CINNAMON, ALL SPICE, WHITE PEPPER, BLACK PEPPER, RED PEPPER,
HOT CHILIS, HOT SAUCE? YES or NO
24. Do you eat between meals? YES or NO
25. Do you CHEW GUM or eat ANY TYPE OF BREATH MINT? YES or NO
26. Do you read labels? YES or NO
27. Do you know the 25 Hidden names for MSG? YES or NO
28. Do you know what Aspartame is? YES or NO
29. Which of the following cookware do you use?: ALUMINUM, GLASS, STAINLESS STEEL, CAST IRON,
CERAMIC, TEFLON, PORCELAIN, NEW FLIMSY BAKEWARE

*****These next three 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?_____

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

NOTES:

DRESS:

1. Do you wear SKIRTS, PANTS, or BOTH?
2. Do you wear leggings (not pantyhose) or thermals underneath your skirts at all times? YES or NO
3. Approximately how many inches from the ground are your skirts? _____
(also list if it's floor length/ankle length/calf length/knee length/ or shorter)
4. Do you wear SHORT, LONG, or 3/4 SLEEVES?
5. Are your tops/blouses low neck (below the clavicle bone)? YES or NO or SOMETIMES
6. What material do you wear? Spandex/Cotton/Rayon/Acrylic/Nylon/Silk/Wool/Linen (include undergarments as well)
List any other material not mentioned _____
7. Do you wear WIGS, HAIR EXTENSTIONS, WEAVES, ADDED? YES or NO
8. Do you wear any make-up (including finger or toe nail polish)? YES or NO
9. Do you wear high heels? YES or NO or SOMETIMES ***If yes, are they spiked? YES or NO
10. How many layers of clothing do you wear in the winter time? ____layers
11. What material do you wear in the winter time? _____
12. What material do you wear in the summer time?

13. Do you wear extra socks when your feet are cold?

14. Do you wear any type of jewelry (including pendants)? YES or NO
15. What undergarments do you wear? (Panty hose, bra, slip, girdle, corset, camisole, underwear)
What material are they? (Nylon, silk, satin, polyester, cotton)

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:](#)

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

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

Close with a word of prayer

[Ps: please read the scriptures when studying the conflict of the ages.](#)

NOTES: