GEMS LIFESTYLE ASSESSMENT

CONFIDENTIAL

******A DONATION IS REQUIRED FOR THE EVALUATION OF THIS FORM******

IMPORTANT

I release GEMS NATURAL HEALTH CENTER 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: _____

Church Affiliation: _____ How long have you been a member? _____

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 / No

If yes, which ones?
_____
_____
_____

Please list any surgery that you have had (along with the date):
_____
_____
_____

What diseases have you been diagnosed with? (please list all)
_____
_____
_____

Are you presently experiencing any of the following: (please circle)

Dizziness	Numbness	Bad body odor
Fainting	Clammy skin	Excessive sweating
Nausea	Cold hands or feet	Hair loss
Pain	Constipation	Fever
Heart palpitations	Diarrhea	Infections
Fatigue	Indigestion / Acid Reflux	Bleeding
Headaches	Cold / Flu	Weight loss
Memory loss	Blurred vision	Weight gain
Insomnia	Swelling anywhere	Sexual dysfunction
Difficulty breathing	Parasites / Worms	Anemia

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

Depression	Chronic anxiety	Bipolar
Co-dependency	Manias	Schizophrenia
Phobias	Obsessive compulsive disorder	Neurosis

What specific condition(s) would you like this consultation to address?_____
_____
_
_____

Age:_____ yrs.

Sex: (Circle one) Male Female

Marital Status – (circle) Single, Married (1^{st} / 2^{nd} /3^{rd}or more), Divorced (1^{st} /2^{nd} or more), Widowed

How long have you been married or divorced _____

Weight: _____ lbs. Height: _____ Sedimentation Rate: _____

Blood Pressure: ____/____ Pulse _____

Glucose: _____ Postprandial (2 hours after meal): _____

Cholesterol: _____HDL: ___ LDL: ____ Triglycerides _____

Please list all medicines or pills you are currently taking:
_____
_____
_____

Please list all supplements and/or herbs that you are taking (vitamins, minerals, nutritional drinks etc…)
_____
_____
_____

Nutrition

Circle <u>one</u> where needed

1. Do you eat any meat or flesh items (chicken, turkey, pork, fish, shrimp etc…)? Yes / No
2. Do you eat any dairy items or eggs (i.e. milk, cheese, yogurt, chocolate etc…)? Yes / No
3. Which ones?
   _____
4. Do you eat refined white products (i.e. white bread, white rice, white flour products, etc…)?
   Yes / No
5. How many servings of fruit per day? ____ How many servings of vegetables? ____
6. Do you use condiments (i.e. ketchup, mustard, mayonnaise, barbeque sauces, veggienaise, nayonaise, salad dressings, pickles, vinegar, etc…)? Yes / No
7. Do you add any of the following spices to your foods: cinnamon, nutmeg, cloves, curry, hot sauces, and cayenne peppers, black and white peppers and etc? Yes / No

8. Do you eat fried foods? Yes / No If so, how often? _____
9. Do you use margarine or butter? Yes / No If so, how often? _____

10. Do you use baking powder or baking soda? Yes / No

11. Do you eat fresh bread? (bread eaten less than48 hours after baking) Yes / No / Sometimes

12. Do you eat or drink any cocoa, chocolate or ice cream? Yes / No How often? _____

13. Which oils do you cook with? _____

14. Do you read the labels of food items that you buy from the store? Yes / No

15. List any sweeteners you consume (i.e. sugar, honey, splenda, sweet & low, equal or additional artificial sweeteners, etc…)_____

16. How much & often do you eat nuts? _____ Which ones? _____

17. Do you eat any canned items (beans, veggies, fruits, veggie meats etc…)? Yes / No

18. Which ones?_____

19. Are you on any special diet? Yes / No

20. If so, please list: _____

21. Do you eat out? Yes / No If so how often: _____

22. Do you use salt? Yes / No Does the salt contain iodine? Yes / No

Exercise

1. Do you exercise? Yes / No

2. How many times per week? _____ How many minutes per day? _____

3. How would you rate your exercise? (circle one) Mild Moderate Vigorous

4. What are your favorite exercise sessions?
_____

5. How do you feel after you exercise?
_____

6. Do you experience any pain while you are exercising? Yes? No

Water

1. How many glasses of water do you usually drink per day? _____
2. What kind of water do you commonly drink? _____
3. Is your water filtered? Yes / No
4. At what temperature do you drink your water? (circle one) Hot Cold Room temp.
5. Do you eat ice? Yes / No
6. How many glasses of juice do you drink per day? _____
7. How many cans / bottles of soda per day? _____
8. What other liquid do you drink (i.e. tea, wine, alcohol, beer, soda, milk,vitamin water, etc…)? _____
9. Do you drink with your meals? Yes / No / Sometimes
10. What color is your urine normally? (clear, pale, slight yellow, yellow and dark yellow)

Sunlight

1. How much sun exposure do you get per day? _____
2. Do you sunbathe? Yes / No If so how long? _____
3. Do you wear short sleeves? Yes / No
4. Do you use sun block? Yes / No / Sometimes
5. Do you have any abnormal sensitivity to the sun naturally or due to any medications? Yes / No
6. Do you take vitamin D supplements? Yes / No
7. Do you have any family history of skin cancer? Yes / No

Temperance

1. What is your current occupation? _____
2. Please list your last five jobs and the years of service: _____

_____
_____
_____

3. Do you smoke / use tobacco products in any form (i.e. chewing tobacco)? Yes / No
4. Did you use tobacco in the past? Yes / No If so how much and for how long? _____
5. Do you use alcohol in any form? Yes / No If so, how much and for how long? _____
6. Do you ingest caffeine in any form? Yes / No (e.g. coffee, teas, mate, colas, energy drinks, etc.)
7. If so, please list _____.
8. Do you overeat? Yes / No / Sometimes
9. Do you eat too fast? Yes / No / Sometimes
10. Do you chew your food thoroughly? Yes / No
11. Do you snack between meals? (this includes any food items and juice)Yes / No / Sometimes
12. List any desserts you eat? (include candies, cakes, or pies) _____
13. Do you eat at set meal times? Yes / No
14. Please list times for all meals: Breakfast _____ Lunch _____ Supper _____
15. Would you say that your dress is healthful and modest? Yes / No
16. Please list your leisure activities (i.e. watching TV, reading, sports, dancing, board games etc…)
    _____
17. How much time do you spend on leisure activities? _____
18. Do you overwork? Yes / No / Sometimes
19. Please list any addictions _____
20. Have you been involved with substance abuse? Yes / No If so please list: _____
21. Do you read novels, science fiction, pornography, fashion magazines, computer games? Yes / No
22. If so, which ones? _____
23. Do you attend cinemas, dances, night clubs, house parties and amusement parks? Yes / No
24. If so, which ones? _____
25. Do you play any competitive sports? Yes / No

26. If so, what sports are they? _____

27. Please list all types of music that you listen to? _____

Air

1. Where do you live? (Circle one) City Suburbs Country
2. Do you sleep with your windows open? Yes / No
3. Do you open your windows / doors daily to air out the home? Yes / No
4. Do you live or work in a smoke-filled environment? Yes / No
5. Do you have any smokers living in your home? Yes / No
6. Do you have live plants throughout your home? Yes / No
7. Are there any environments that you are in that do not have a good supply of fresh air? Yes / No
8. If so what are they? _____
9. Do you wear tight fitted clothing that restricts your lung expansion? Yes / No

Rest

1. What is your usual bedtime? _____
2. Do you wake up during the night? Yes / No / Sometimes
3. Do you snack before you go to bed? Yes / No / Sometimes
4. Do you sleep with the lights on? Yes / No / Sometimes
5. Do you work the night shift or swing shift? Yes / No / Sometimes
6. Do you wake up early in the morning and find it difficult to get back to sleep? Yes / No / Sometimes
7. Do you take sleeping pills? Yes / No
8. Do you make it a practice to get to bed at a certain time? Yes / No
9. Do you rest from labor at least one day per week? Yes / No

Trust

1. Do you have a daily devotional time? Yes / No
2. If no, would you like to have one? Yes / No
3. Do you spend time reading the Bible daily? _____
4. Do you return a faithful systematic tithe, plus offerings? Yes / No
5. Do you have difficulty in trusting the Lord with your problems? Yes / No / Sometimes
6. Do you suffer any remorse, guilt, worry or fear at present? Yes / No
7. Do you believe that you have experienced the forgiveness of God in your life? Yes / No
8. Do you struggle with knowing God's will for your life? Yes / No
9. Would you consider your family to have good relations with each other? Yes / No
10. Do you have a spiritually strong immediate family? Yes / No?
11. Do you have peace with God and your fellow men? Yes / No
12. Have you broken any vows or promises to God that is within your power to fulfill? Yes / No
13. How has the Lord been treating you? _____
14. How have you been treating the Lord? _____
15. If the Lord were too come today, knowing the life that you are currently living, would you be saved? Yes / No ***"Please answer this question within yourself."***

LIFESTYLE RECOMMENDATIONS

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MORNING DEVOTIONEVENING DEVOTION

Start with prayer

Sing a few hymns

Read a devotional book / Bible Do your lesson study

Read the conflict of the ages series Study health message

1. Patriarchs and Prophets1. Pathways / Ministry of Healing

2. Prophets and Kings ***2. Counsels on Diet and Foods***

3. Desire of Ages ***3. Counsels on Health***

4. Acts of Apostles ***4. Temperance***

5. Great Controversy ***5. Health books***

God Cares series Close with a word of prayer

1. Daniel
2. Revelation

Close with a word of prayer

PS: please read the scriptures when studying the conflict of the ages.

DAILY SCHEDULE

Time to get up: _____

Time for worship: _____

Time for exercise: _____

Time for breakfast: _____

Time for digestion walk: _____

Time for lunch: _____

Time for digestive walk: _____

Time for Supper: _____

Time for digestive walk: _____

Time for evening worship: _____

Time for rest: _____

Special notes:

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