SWIFT INTERNATIONAL Majuba Hill Lifestyle Center
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LIFESTYLE ASSESSMENT

CONFIDENTIAL

IMPORTANT

Please Note: 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 Swift International Majuba Hill Lifestyle Center Foundation through the Laws of Health, 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 select)

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 select)

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 (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: _______/________ 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…)

____

____

____

Pure Air

1. Where do you live? 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

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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

Abstemiousness

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? ____

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

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

Proper Diet

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 than 48 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? __________________

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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

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)

Trust in Divine Power

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."***

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