OUR HOME
NATURAL HEALTH RETREAT

Rosend District, Annotto Bay P.O., St. Mary, Jamaica, West Indies
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CONSULTATION FORM

IMPORTANT: This health and nutrition evaluation is intended for educational purposes only, to assist the individual in learning how to preserve their own health. It is not the intention of this evaluation to diagnose or to prescribe any medication, treatment or modality for any physical or mental disorder, disease, ailment, complaint or anomaly. Therefore any use of the information obtained from this health and nutritional evaluation, is at the sole discretion of, and in response to the direct request made by the individual whose name is signed on this form.

Signature Date / / mm/dd/yr

Please complete the entire consultation form and return it to MEET Ministry Jamaica to be reviewed by one of our health educators. After careful review, specific suggestions will be outlined for you in your search for better health using GOD'S PLAN. Please submit a $3,000 Jamaican dollars donation with the consultation form to help us cover expenses involved. Forward the form to MEET Ministry in Jamaica by regular mail or email. If sending by mail, you may use cheques as a form of payment. Please call us for other payment options and banking details.

Payment Information

Name:_

Address: City: District/Town: Parish/Province/State:

Postal/ZIP Code: Country:

Home Phone: ( ) - Work Phone: ( ) - Cell Phone ( ) -

Method of Payment

☐ Cheque
☐ Bank deposit

CONSULTATION FORM

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.

Name:

Address: City: District/Town:

Parish/Province/State: Postal/ZIP Code: Country:

Home Phone: ( ) - Work Phone: ( ) - Cell Phone ( ) -

Email: Age: Sex: ☐ Male ☐ Female

Marital Status: Nationality: Religion:

MEDICAL HISTORY

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

What was the date of your most recent physician consult? / /
mm dd yr

For what reason?

What are you currently being treated for?

What specific conditions would you like this consultation to address?

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

Medications

Supplements

Weight: **Height**: **Weight loss in the past year?** ☐☐ **Yes** ☐ **No How much?**

Do you experience any of the following?

Indigestion? ☐**Yes** ☐**No How Often?**

Gas? ☐**Yes** ☐**No How Often?**

Bloating? ☐**Yes** ☐**No How Often?**

What foods tend to cause indigestion, bloating or gas?

How often do you have bowel movements? **If daily, how many time in a day?**

Color & texture:

Review the following symptoms, and rate all that apply to you on a scale 1-5.

Blank = Never 1 = Rarely 2 = Occasionally 3 = Sometimes 4 = Most of the time 5 = Always

Past	*Present*		*Past*	*Present*		*Past*	*Present*	
		Absent			Feels Shaky if Hungry			Nausea
		Acne			Foul Smelling BM			Nervous Disorder
		Alcoholism			Foul Smelling Urine			Night Blindness
		Allergies			Frequent Colds			Pain w/bowel
		Bad Breath			Frequent Kidney Infections			Prostate Trouble
		Chest Pains			Frequent Lower Bowel			Respiratory Problems
		Chills/Cold Skin			Frequent Urination			Sexual Disorders
		Cold Hands/Feet			Headaches			Sinusitis
		Crave sweets/coffe			Heart Disease			Skin Problems
		Difficulty Breathing			Heart Pounds Hard			Sluggish in the
		Digestive Disorders			Hemorrhoids			Swollen Glands
		Dizziness			Hot Most of the Time			Too Fast Digestion
		Eat When Depressed			Indigestion/Heartburn			Venereal Infection
		Eat When Nervous			Irritable before Meals			Wake Up Tired
		Eating relieves			Itching of the Nose			Weight Problem
		Excessive Fear			Itching of the Rectum			
		Excessive Hunger			Light-headedness			
		Excessive Worry			Low Back Pain			
		Faint When Hungry			Mental Disorder			
		Fatigue			Motion Sickness			

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

GODLY TRUST

Current occupation(s):

What are the hours of your occupation?

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

Health of spouse (if applicable):

How many children do you have? Ages:

Health of children:

Recreational activities enjoyed:

Hours per week on use of digital devices (i.e. TV, computer, tablets, cell phones, etc.):

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

Have you ever thought or attempted committing suicide? Explain.

On a scale of 1 to 10, rate your stress level (1 = very little stress and 10=an extreme amt. of stress): List 3 major sources of your stress, and describe.

What do you believe about God and His healing power?

Do you have spiritual practices that are meaningful to you? ☐ Yes ☐ No
If yes, describe what they are and how they are meaningful to you.

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

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 long do you spend time outdoor daily?

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

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

Do you work in a non-smoking facility? ☐**Yes** ☐**No**

DAILY EXERCISE

How often and how long do you exercise?

Describe the exercise.

How do you feel after you exercise?

SUNSHINE

How long do you spend time outdoors daily 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 wake up?**

Do you have trouble sleeping? ☐**Yes** ☐**No** **If yes, explain.**

Do you keep any lights on during sleep? ☐**Yes** ☐**No** **If yes, indicate the type of lights.**

Do you leave electronics on in the bedroom when you sleep? ☐**Yes** ☐**No**
If yes, list the electronics.

LOTS OF WATER

How much water, in fluid ounces, do you drink daily?

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

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

BEVERAGE	BRAND	# OF GLASSES, CANS, OR BOTTLES
Soda		
Coffee		
Tea		
Fruit Juice		
Punch		
Milk		
Other:		

What is the usual color of your urine?

ALWAYS TEMPERATE

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

Have you ingested caffeine in the past? ☐Yes ☐No

If yes, when did you stop and for how many years?

Do you currently smoke or chew tobacco? ☐Yes ☐No Indicate type:

If yes, when did you stop and for how many years?

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

Do you drink alcohol? ☐Yes ☐No If yes, what kind? For how many years?

Have you drunk alcohol in the past? ☐Yes ☐No If yes, for how many years?

NUTRITION

EQUIPMENT/AIDS

Do you wear removable dentures or plates? ☐Yes ☐No

HABIT PATTERNS

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

Do you eat between meals? ☐Yes ☐No Do you snack before bedtime? ☐Yes ☐No

Do you wake up to snack during the night? ☐Yes ☐No

Do you drink with your meals? ☐Yes ☐No

How long does it take you to eat?

Do you have a peaceful environment at meal times? ☐Yes ☐No

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

Explain about the type of special diet eaten.

MEAL PATTERN

What time do you eat: breakfast? lunch (dinner)? supper?

What do you usually eat for:

breakfast?

lunch/Dinner?

Supper?

How often do you eat:

Tossed green leafy salads? Steamed or cooked vegetables?

Fruits? Soup or stew?

MISCELLANEOUS

Do you eat animal products? ☐Yes ☐No How Often?

If yes, what kind?

Do you eat dairy products? ☐Yes ☐No

If yes, indicate: ☐Milk ☐Cheese ☐Egg ☐Other:

Do you eat desserts, candy or other sweets regularly? ☐Yes ☐No How Often?

What kind?

Do you consume vinegar and its products? ☐Yes ☐No

PLEASE REMEMBER TO SIGN AND DATE THE FRONT OF 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.

FOR OFFICE USE ONLY

Consultant _____ Date of response _____

Written material given _____

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Life-style suggestions: _____

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