



Application to Attend Wellness Secrets Live-In Program

Name: _____ Age: _____ Date: _____

Address _____ Phone _____ Email _____

Blood Pressure: _____ Weight: _____ Height: _____ Blood Sugar: _____

What health problems do you have? _____

What medications and supplements are you taking? _____

Allergies _____

What is your main concern and goal for this program? _____

Do you have any handicaps, or restrictions in normal activities of daily living? _____

Method of Payment _____

NUTRITION

What time do you eat: Breakfast? _____ Dinner? _____ Supper? _____

What do you eat for breakfast? _____

What do you eat for dinner? _____

What do you eat for supper? _____

Which of these do you eat: (Circle) Pork, beef, chicken, fish, lobster, shrimp?

What fried foods do you eat, and how often? _____

What animal products do you use and how often? (milk, cheese, eggs...) _____

Do you eat fresh fruit every day? _____ List: _____

Do you eat raw and cooked vegetables every day? _____ List: _____

What whole grains do you use? _____

Do you eat between your meals? _____

Do you eat in restaurants? _____ How frequently? _____

What are your favorite foods? _____

EXERCISE

What do you do for exercise? _____

How many times a week do you exercise? _____

WATER

How many glasses of water do you drink each day? _____

Do you drink any beverage with your meals? _____

Do you bathe everyday? _____

SUNSHINE-How much time do you spend in the sun each day? _____

TEMPERANCE

Do you drink alcohol? _____ How often do you drink it? _____

Do you smoke? _____ How much? _____ For how long? _____

Do you use recreational drugs? _____ What do you use? _____

Which of these do you drink: (Circle) Coffee, Tea, Herbal Tea, Coke, Pepsi (other soda pop), chocolate, 100% Juice, Tang, Juice drink, Koolaid, Lemonade, Other

How much each day? _____

Do you have a Asweet tooth≅? _____

How often do you eat desserts? _____

Do you eat spicy food? _____ How often? _____
Vinegar? _____ Black pepper? _____

How much time each day do you spend watching TV, videos, Internet, games, etc? _____

Do you have a daily bowel movement? _____

Do you think you are constipated? _____

Ladies, do you have menstrual or menopause problems? _____

AIR

Do you do deep breathing exercise every day? _____

Do you spend time in the outside air? _____

Do you let fresh air into your home everyday and sleep with the window open? _____

REST

What time do you go to sleep at night? _____

What time do you get up in the morning? _____

How many hours do you sleep? _____

Do you have trouble sleeping? _____

Do you take naps during the day? _____

TRUST IN GOD

Do you attend church regularly? _____ Which one? _____

Do you have family worship? _____

Do you pray and read your Bible every day? _____

What things in your life take your attention and time away from God? _____

Are you holding a grudge against anyone? _____

Is guilt weighing you down? _____

Are you under stress? _____

Do you consider yourself to be a happy person? _____

Is there anything else you would like for me to know? _____