Mountain View Conference
Valley Vista Wellness Camp Health Information Form

Name _____ Date _____ Male / Female

Mailing Address_____

City _____ State _____ Zip Code _____

Phone_____ Cell_____ Email _____

Emergency Phone _____ Name_____

Relationship _____ email address _____

Height _____ Weight _____ Date of Birth _____ Age _____

My health concerns include _____

_____

_____

Any other disease, illness or disorder we should know about? _____

_____

Do you have mobility, sight, or food restrictions? Please list _____

_____

What would you like to see accomplished during your stay at Valley Vista Wellness Camp? _____

_____

_____

Please have your physician sign that you are able to exercise moderately at this Wellness Camp

I, Dr. _____, agree to have my patient _____,

participate in your moderate exercise program which includes walking and stretching exercises.

Signature of Physician _____ Date_____

Medical History

(Check appropriate boxes.)

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

Past	*Present*		*Past*	*Present*		*Past*	*Present*	
		Absent-minded			Excessive Hunger			Low Blood Pressure
		Acne			Excessive Worry			Lumbago
		Allergies			Faint When Hungry			Mental Disorder
		Anemia			Fatigue			Motion Sickness
		Appendicitis			Feel Shaky if Hungry			Nausea
		Arthritis			Foul –smelling BM			Nervous Disorder
		Asthma			Foul-smelling urine			Night Blindness
		Bad Breath			Frequent Colds			Pain with BM
		Cancer			Freq. Kidney Infection			Poliomyelitis
		Chest Pains			Freq. Lower Bowel Gas			Prostate Trouble
		Chills/Cold Skin			Frequent Urination			Respiratory Problems
		Cold Hands/Feet			Gallstones			Rheumatic Fever
		Constipation			Hay Fever			Sexual Disorders
		Crave Sweets/Coffee			Headaches			Sinusitis
		Depression			Heart Disease			Skin Problems
		Diabetes			Heart Pounds Hard			Sluggish in morning
		Diarrhea			Hemorrhoids			Swollen Glands
		Difficulty Breathing			High Blood Pressure			Too Fast Digestion
		Digestive Disorders			Hot Most of the Time			Tuberculosis
		Dizziness			Indigestion/Heartburn			Ulcers/Colitis
		Eat When Depressed			Insomnia			Venereal Infection
		Eat When Nervous			Irritable Before Meal			Wake Up Tired
		Eating Relieves Fatigue			Itching of the Nose			Weight Problem
		Eczema			Itching of the Rectum			
		Emphysema			Kidney Stones			
		Excessive Fear			Light-headedness			

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

_____

_____

_____

_____

_____

_____

_____

List names and dates of past ailments, operations, and anything you feel significant, including past complaints._____

_____

_____

_____

When did you last consult a physician? _____For what reason? _____

What are you currently being treated for? _____

List all medicines, pills, or drugs you are currently taking: _____

_____

_____

List mineral/vitamin/herbal supplements you are taking – how many and how often:_____

_____

_____

Do you have indigestion? _____ Gas? _____ Bloating? _____How often?_____

Foods that cause you indigestion, bloating, or gas? _____

How often do you have bowel movements?_____ Do you have diarrhea? ___ Constipation? ___

TRUST IN GOD

Occupation(s):_____ What hours do you work?_____

Health of spouse (if applicable)?_____

How many children do you have?____ Health of children_____

Recreational activities enjoyed:_____

Hours per week viewing TV_____ Do you often feel guilty about past mistakes?_____

Stress factors: __financial __job-related __getting along with people __family __not happy with myself

On a scale of 1 – 10, rate your stress level (1= very little stress; 10= an extreme amount of stress)_____

Do you enjoy the work you do? _____If not, explain: _____

_____

Are you developing your mental and spiritual capabilities by daily study, meditation and prayer?_____

Explain further, if possible or necessary_____

_____

The following space is provided for those who would like to elaborate more on the causes of their stress, depression, and/or other negative emotions_____

_____

_____

_____

_____

OPEN AIR

How many hours daily do you spend out-of-doors? _____ Do you sleep with your windows closed?____

Are you able to breathe fresh air while you are working? _____ Is the building where you work well ventilated or have windows that you can open? _____

List any known pollutants in your home atmosphere?_____

DAILY EXERCISE

How often do you exercise? _____ Describe the exercise _____

_____

_____

How do you feel after you exercise? _____

SUNSHINE

How much time daily do you spend out-of-doors in the sunlight? _____

Often get sunburned? ____ Do you visit tanning beds? ____ Are you afraid of getting skin cancer? ____

PROPER REST

What time do you get to bed? _____ What time do you awaken? _____

What time is your last meal before retiring? _____ Do you snack just before bedtime? _____

Do you wake up during the night and snack? _____ If so, what do you eat? _____

Do you have trouble sleeping? _____If so, explain _____

_____

_____

_____

WATER (internal and external)

Amount of water you drink daily: ____glasses ____ounces (spring, filtered, distilled, tap, chlorinated)

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

Beverage	**Name Brand**	**# of Glasses, Cans, or Bottles daily**
Soda	_____	_____
Coffee	_____	_____
Tea	_____	_____
Fruit Juice	_____	_____
Punch	_____	_____
Milk	_____	_____
Other	_____	_____

What is the usual color of your urine? _____

TEMPERANCE

Do you smoke or chew tobacco (Indicate which)?_____ If so, how many years?_____

Have you used tobacco in the past?____ How many years?____ If so, when did you stop?____

Do you drink alcohol?_____ If so, what kind?_____

For how many years?_____ Have you drank alcohol in the past?_____ For how many years?_____

Do you overeat?_____ How long have you been overeating? ____

Do you feel stuffed after your meals?_____ Do you eat between meals? _____

Have you ever been, or now currently are, addicted to any food, beverage, substance or habit?

If Yes, please explain?_____

NUTRITION

Do you drink with your meals? _____ If so, what liquids? ____ Do you thoroughly your food?____

Do you wear removable dentures or plates?_____ How long does it take you to eat? _____

Do you have a peaceful environment at meal times? _____ Do you have set meal times? _____

Do you eat a table designed for eating? ____ Do you eat when worried, anxious, angry? ____Yes ___No

Are you following any special diet? _____ Explain what type _____

Do you eat animal products? _____ If so, what kind?_____

How often? _____ Do you eat fish? _____

Do you eat dessert, candy or other sweets regularly?_____ Explain how often and what type_____

_____

How often do you eat a green leafy salad? _____ Fresh Fruit? _____

Steamed or cooked vegetables? _____ Soups/stews? _____ Whole Grains? _____

What time do you eat breakfast? _____ What breakfast foods do you usually eat? _____

What time do you eat lunch (dinner) _____ What foods do you eat?_____

What time do you eat supper? _____ What foods do you eat?_____

_____

_____

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 BIBLICALLY-BASED LIFESTYLE 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: _____

_____

_____

Lifestyle Suggestions: _____

_____

_____

_____