HEALTH-EVALUATION
144000teachers.org

1. Do you enjoy physical activity such as a brisk, one mile walk?
2. Do you ever feel chilly or have cold skin on any body part?
3. Do you have a set mealtime? Do you think you eat too much?
4. Do you frequently have colds?
5. Do you use tobacco? alcohol? caffeine? medication?
6. Do you fall asleep when sitting still? How many hours of sleep do you get per night? What time to you go to bed at night?
7. Do you have pain or discomfort in head? trunk? or extremities?
8. Do you have one or more bowel evacuations daily? how many?
9. Do you have pale urine? how many glasses of water do you drink daily?
10. Do you have allergies? Hay fever? Skin problems? Sinusitis?
11. Do you have frequent infections? or accidents?
12. Do you ever feel depressed or gloomy?
13. Do you frequently have gas? indigestion?
14. Are you developing your mental and spiritual capabilities by daily study, meditation and prayer?

- Would you like to be personally instructed in how to restore your health and prevent sicknesses and diseases naturally?
- Or participate in a health seminar series when we present one?

Name of interested person: _____
Phone Number: _____

144000teachers School of Health and Natural Remedies
Lifestyle Educator Name: _____

Date: _____