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?

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| riione Number. | |
| | 144000teachers School of Health and Natural Remedies |
| | Lifestyle Educator Name: |
| | Date: |