LIFESTYLE ASSESSMENT QUESTIONNAIRE

CONFIDENTIAL

Important:

Please Note: Due to the laws of the land, we are required to tell you that the health information received during this consultation is for general education and is not intended to be specific medical advice. No medical care, diagnosis, or treatment is provided during this consultation. It is advisable to consult with one's personal healthcare provider before implementing any lifestyle changes.

I release all Lifestyle counselors or associated organizations from any and all liability. Participation in this consultation indicates acceptance of these terms.

➢ *Need help filling this out? CALL* or TEXT: +1 (520) 221-7846

Signature:	Date:

On a Scale of 0-10, How serious are you about getting to the root of your problem(s)?

On a Scale of 0-10, how willing are you to do whatever it takes to improve your condition(s)?
(Within realistic limits)

General Information:

Name:	Age:	Gender: ◯ Male ◯ Female
Address:		
Email Address:	Contact Mobile: / Home:	

Marital Status *(please indicate the number of times you got married, divorced, or widowed):*

☐ Single	☐ Married	☐ Divorced	☐ Widowed
	◯ 1st Marriage ◯ 2nd Marriage ◯ 3rd or More	◯ 1st Divorced ◯ 2nd or More	◯ 1st Death Experienced ◯ 2nd Death or More

Basic Biometrics

Weight: lbs.	Height: ft. in.	Sedimentation:	Pain Level:
Blood Sugar: *NR: 70 – 100 mg/dL*	Cholesterol: *NR: < 200 mg/dL*	HDL: LDL: *NR > 40 mg/dL, < 100 mg/dL*	Triglycerides: *NR: < 150 mg/dL*
Magnesium: *NR: 1.7 – 2.2 mg/dL*	Sodium: *NR: 134 – 144 mmol/L*	Calcium: *NR: 8.7 – 10.3 mg/dL*	Potassium: *NR: 3.5 – 5.2 mmol/L*
Creatinine: *NR: 0.76-1.27 mg/dL*	BUN: *NR: 5-26 mg/dL*	Vitamin D: *NR: 20-40 ng/mL*	Blood Pressure Rt.: Lt.:
Last BM:	Color:	Size:	Consistency:

HEALTH HISTORY

1. Are you allergic to anything? ○ YES ○ NO If "YES," please list all that apply.

2. List any health concerns you have (physical, mental, social or spiritual):

3. When did you last consult a physician?

4. Are you currently being treated for any ailments? ○ YES ○ NO If "YES," which ones?

5. Please list any surgery(ies) that you have had *(include the date):*

6. What diseases/health condition(s) have you been diagnosed with? *(Please list all)*

7. Are you presently experiencing any of the following? (please check all that apply)

☐ Dizziness	☐ Numbness/Tingling	☐ Bad body odor
☐ Fainting	☐ Clammy skin	☐ Excessive sweating
☐ Nausea/Vomiting	☐ Cold hands or feet	☐ Hair loss
☐ Pain	☐ Constipation	☐ Fever
☐ Heart palpitations	☐ Diarrhea	☐ Infections
☐ Fatigue	☐ Indigestion / Heartburn	☐ Bleeding
☐ Headaches	☐ Cold / Flu	☐ Weight loss
☐ Memory loss	☐ Blurred vision	☐ Weight gain
☐ Insomnia	☐ Swelling anywhere	☐ Sexual dysfunction
☐ Difficulty breathing	☐ Parasites / Worms	☐ Anemia
☐ Bad Breath	☐ Chest Pain or Tightness	☐ Ringing in the Ears
☐ Difficulty Hearing	☐ Vision Problems	☐ Bloated Stomach
☐ Itching in Rectal area	☐ Watery Eyes	☐ Stomach Pain
☐ Sensitivity to sunlight	☐ Sores on Your body	☐ Joint Pain
☐ Rash	☐ Pain in the Eyes	☐ Stuffy Nose
☐ Low Energy	☐ Taste Problems	☐ Chills
☐ Hives	☐ Yellowing of Eyes	☐ Cough
☐ Earache	☐ Hemorrhoids	☐ Seizures

☐ Increased Hunger ☐ Loss of Appetite ☐ Painful Urination

☐ Blood in Urine ☐ Blood in stool ☐ Confusion

☐ Others:

8. Do you suffer from any of the following emotional/mental disorders *(please check all that apply)*:

☐ Depression ☐ Chronic anxiety ☐ Bipolar

☐ Co-dependency ☐ Manias ☐ Schizophrenia

☐ Panic Attacks ☐ Phobias ☐ Worry

☐ Obsessive-compulsive disorder (OCD) ☐ Others:

9. What specific condition(s) would you like this consultation to address?

10. Please list all medication *(prescribed or OTC)* you have taken in the last two months:

11. Please list all herbs or supplements *(including vitamins)* you have taken in the last two months:

On a Scale of 0-10, How serious are you about getting to the root of your problem(s)?

On a Scale of 0-10, how willing are you to do whatever it takes to improve your condition(s)?

(Within realistic limits)

LAWS OF HEALTH: GOD'S PLAN

Godly Trust

1. Do you believe in God? ◯ YES ◯ NO
2. Do you pray to God? ◯ YES ◯ NO If "YES," how many times a day?
3. Do you believe the Bible is true and the actual word of God? ◯ YES ◯ NO
4. Do you have a routine for reading the Bible? ◯ YES ◯ NO

   If "YES," how many often? ◯ Daily ◯ 3x weekly ◯ 1x weekly
5. Do you feel like God has been GOOD, BAD, or Neutral to you? ◯ GOOD ◯ BAD ◯ Neutral
6. Do you feel you have been GOOD or BAD to God? ◯ GOOD ◯ BAD ◯ Neutral
7. Do you trust 100% that God can fulfill His promises in the Bible? ◯ YES ◯ NO

8. Do you believe that God loves you no matter who or what you are? ◯ YES ◯ NO
9. Do you believe God is LOVING and CARING or a MERCILESS TYRANT? ◯ Loving ◯ Tyrant
10. Do you take EVERYTHING to God when you have a problem or want some type of direction? ◯ YES ◯ NO
11. Do you tend to worry? ◯ Never ◯ Sometimes ◯ Frequently
12. What do you do when you are sad or worried? *(List some activities)*

Open Air

1. Do you have a hard time breathing? ◯ YES ◯ NO
2. Do you do deep breathing exercises outdoors upon arising in the morning? ◯ YES ◯ NO
   If "YES," how many cycles and how often?
3. Right now, put your hand on your stomach and inhale… Did your stomach go IN or OUT? ◯ IN ◯ OUT
4. Do you inhale through your NOSE or MOUTH? ◯ Nose ◯ Mouth
5. Do you use your THROAT or STOMACH MUSCLES when you sing? ◯ Throat ◯ Stomach
6. Do you slouch over when you STAND or SIT? ◯ YES ◯ NO
7. Do you spend time outdoors for fresh air every day? ◯ YES ◯ NO
   If "YES," how many minutes each day? mins.
8. Do you air out every room in your home every day? ◯ YES ◯ NO
9. Do you sleep with your windows in your room cracked in the winter, & wide in the summer? ◯ YES ◯ NO
10. Approximately how many square feet is your home? sq.ft.
11. Do you have any plants in your home? ◯ YES ◯ NO If "YES," how many?
    Which kind of plants?
12. Do you live IN or NEAR an environment where the air is polluted? ◯ YES ◯ NO
13. Do you live in a country where there are many different trees? ◯ YES ◯ NO

Daily Exercise

1. Do you have regular exercise? ◯ YES ◯ NO

   If "YES," what exercise, frequency, how often, rate, and location?

Type	Mins.	Days/ Week	Rate	Location

2. Do you exercise in a GYM? ◯ YES ◯ NO If "YES," how many days a week? _____

   If "YES," is it aired out daily? ◯ YES ◯ NO

3. Do you lift weights? ◯ YES ◯ NO If "YES," HOW MANY POUNDS? _____ lbs.

4. Do you feel any pain when you exercise? ◯ YES ◯ NO

   If "YES," please rate on a scale from 1 to 10 (10 being the highest for pain) **Pain Score:** _____

5. Does your chest tighten or experience chest pain when you exercise? ◯ YES ◯ NO

6. What type of shoes do you wear while exercising? _____

7. Do you take any protein powder or supplements to build strong muscles? ◯ YES ◯ NO

   If "YES," please list the brands and how often.

Sunshine

1. How many minutes of direct sunlight did you get yesterday and today? Yesterday: _____

   Note: Sitting in front of a window does not count. Today: _____

2. On average, how many minutes do you get direct sunlight each day? _____ mins.

3. Do you go out into the sunshine in the winter months? ◯ YES ◯ NO

4. What time of the day do you mostly get your sunlight? ◯ 6:00 AM to 12:00 PM ◯ 12:00 PM to 6:00 PM

5. What is your skin complexion? ◯ Light ◯ Medium ◯ Brown ◯ Dark

6. Do you wear prescription glasses or sunglasses when out in the sun? ◯ YES ◯ NO

7. Do you wear sunscreen? ◯ YES ◯ NO If "YES," which parts of your body? *(Select all that apply)*

   ☐ FACE ☐ ARMS ☐ LEGS ☐ CHEST ☐ BACK

8. Do you wear a hat when you go out into the sun? ◯ YES ◯ NO

9. Do you feel faint when you are out in the sun? ◯ Never ◯ Sometimes ◯ Frequently

11. Do you take a Vitamin D supplement? ◯ YES ◯ NO

    If "YES," what brand and how many IUs each day? _____

12. Are you ALLERGIC TO or BREAK OUT from the sun? ◯ YES ◯ NO

13. Are you on any medication that prevents you from being able to go out into the sun? ◯ YES ◯ NO

If "YES," Medication	Frequency	Dosage

Proper Rest

1. Do you take a nap every day? ◯ YES ◯ NO

   If "YES," how often a week? _____ days and _____ minutes.

2. What time do you go to bed on average? _____ PM
3. What time do you wake up in the morning? _____ AM
4. Do you have a hard time getting to sleep? ◯ YES ◯ NO
5. Do you have a hard time staying asleep? ◯ YES ◯ NO
6. Do you wake up in the middle of the night to use the restroom? ◯ YES ◯ NO

   If "YES," how many times? _____

7. Do you sleep with the LIGHTS, TELEVISION, RADIO, or COMPUTER on? ◯ YES ◯ NO
8. Do you watch TELEVISION, USE THE COMPUTER, or mobile phone right before bedtime? ◯ YES ◯ NO
9. Do you have nightmares? ◯ YES ◯ NO
11. Do you do late-night snacking? ◯ YES ◯ NO
12. Do you work the SWING or GRAVEYARD SHIFT? ◯ YES ◯ NO
13. Do you drink ENERGY DRINKS, COFFEE, TEA, or ANYTHING WITH CAFFEINE? ◯ YES ◯ NO
14. Do you take anything to help you go to sleep? ◯ YES ◯ NO

    If "YES," what is it? _____

15. Do you take one 24-hour period off every week where you don't cook, clean, run errands, do business, pay bills, shop, do laundry, do school, etc.? ◯ YES ◯ NO If "YES," what day? _____

Lots of Water

1. How much water did you drink in ounces yesterday and today? **Yesterday:** _____ **Today:** _____

   Do you SIP or GULP? ◯ Sip ◯ Gulp Do you drink SOFT or HARD water? ◯ Soft ◯ Hard

2. How much ounce of water do you drink upon arising in the morning? _____ oz.
3. Do you drink with your meals? ◯ YES ◯ NO

   Do you get thirsty right before or after eating? ◯ YES ◯ NO

4. At what temperature you usually drink your water? ◯ Cold ◯ Tap ◯ Warm
5. Do you eat ice or put ice in your water/drinks? ◯ YES ◯ NO
6. What type of water do you drink? *(Select all that apply)*

   ☐ TAP water ☐ FILTERED water ☐ SPRING water ☐ DISTILLED water

   ☐ WELL water ☐ BOTTLED water (which brand)? _____

7. What type of water do you bathe in? *(Select all that apply)*

☐ TAP water ☐ FILTERED water ☐ SPRING water

☐ DISTILLED water ☐ WELL water

8. Do you have filtered water throughout your home *(bathtub too)*? ○ YES ○ NO

9. Do you feel these symptoms? *(Select all that apply)*

☐ Lips cracking & dry ☐ Skin feel rough & dry ☐ Dark-colored urine

☐ Dry sticky tongue ☐ Dry eyes ☐ Feeling thirsty

19. Do you drink fresh raw vegetable juice like carrots, spinach, broccoli, beets, etc.? ○ YES ○ NO

If "YES," what vegetables and how often?

Type of Vegetables	How Often

10. Do you drink Flavored or Vitamin Water? ○ YES ○ NO

11. Do you drink KOOL AID, PUNCH, or FRUIT JUICE? ○ YES ○ NO

18. Do you add sugar or anything else to your water? ○ YES ○ NO

20. Do you drink COFFEE? ○ YES ○ NO If "YES," how many cups a day?

21. Do you drink TEA (Black, Lipton, Arizona, Chai, Green)? ○ YES ○ NO

If "YES," what and how many cups a day?

22. Do you drink SODA or DIET SODA? ○ YES ○ NO If "YES," how many cans per day?

Always Temperate

1. Do you use any type of recreational drugs? ○ YES ○ NO If "YES," what drugs and how often?

2. Do you watch Movies and TV shows? ○ YES ○ NO If "YES," what type of movies? *(Mark all that apply)*

☐ Action ☐ Drama ☐ Suspense ☐ Sports

☐ Comedy ☐ Documentary ☐ SCI-FI ☐ Horror

☐ Others:

3. Do you listen to music? ○ YES ○ NO If "YES," what type of music? *(Select all that apply)*

☐ ROCK N ROLL ☐ COUNTRY ☐ CLASSICAL ☐ HIP HOP

☐ POP ☐ R&B ☐ LOVE SONGS ☐ JAZZ

☐ TECHNO ☐ CHRISTIAN ROCK ☐ CHRISTIAN CONTEMPORARY

☐ Others: _____

4. Do you GAMBLE? ○ YES ○ NO

Note: this can include lotteries, bingo, slots, cards, horse races, sports bets, etc.

5. Do you play any of the games listed below? ○ YES ○ NO If "YES," please select all that apply.

☐ CHESS ☐ CHECKERS ☐ VIDEO GAMES ☐ CARDS

☐ BOARD GAMES ☐ Mobile phone games ☐ Others: _____

6. Do you get quick to ANGER? ○ YES ○ NO

7. Do you have VIOLENT OUTBURSTS? ○ Never ○ Sometimes ○ Frequently

8. Do you talk excessively at work or on the phone (whether you are required to or not)? ○ YES ○ NO

9. Are you having physical relations with your spouse more than 2 to 3 x week? ○ YES ○ NO

Note: We understand if you can choose not to answer, but this topic link to many health issues.

10. Are you involved in any type of "secret vice?" ○ YES ○ NO

11. Do you have any addictions *(not necessarily drugs, but may include hobbies or food)*? ○ YES ○ NO

12. How many hours a day do you work? _____ How many days per week? _____

13. Do you eat between meals? ○ YES ○ NO If "YES," how many times? _____

(Note even if it's just a morsel like a raisin or a nut)

14. Do you currently use tobacco in any form (smoke or chew)? ○ YES ○ NO

If "YES," how many cigs or cigars a day? _____

If "NO," have you ever smoked or chewed tobacco in the past? ○ YES ○ NO

If "YES," how long ago did you quit? _____

15. Do you currently drink alcohol in any form (wine, beer, liquor)? ○ YES ○ NO

If "YES," please list how often: _____

If "NO", have you ever drunk in the past? ○ YES ○ NO

If "YES," how long ago did you quit? _____

Nutrition

1. How many times do you eat a day on average? _____

What time do you eat on **Breakfast:** _____ **Lunch:** _____ **Dinner:** _____

2. Do you snack in between meals? ○ YES ○ NO If "YES," how many times per day? _____

3. Are you on any special diet? ○ YES ○ NO If "YES," what type of diet? _____

4. Do you use any condiments such as mustard, ketchup, mayonnaise, Vegenaise, Worcestire, soy sauce, Braggs aminos, vinegar, salad dressing, BBQ sauce or any condiments not mentioned? ◯ YES ◯ NO
   If "YES," please list any condiment that you use:
5. Do you eat CHOCOLATE of any kind? ◯ YES ◯ NO
6. Do you use any sweeteners such as sugar, agave, honey, maple syrup, molasses, Sweet n Low, Aspartame, Splenda, Equal, Stevia, Corn syrup, etc.? ◯ YES ◯ NO
   If "YES" to sugar, what kind? ◯ White ◯ Brown ◯ Raw Turbinado
7. Do you eat or use white flour, white bread, white rice, and pastries? ◯ YES ◯ NO
   Do you eat "store bought" cookies, cake, brownies, fudge, muffins, bagels, and candies? ◯ YES ◯ NO
   If "YES" to any, please list what kind and how often?

White Flour Products per day		Store Bought Sweets per day	
Food Items	**How Often**	**Food Items**	**How Often**

8. Do you eat raw vegetable greens of any kind like spinach, kale, broccoli, cauliflower, beets, cabbage, and other vegetables like potatoes, turnips, carrots, etc.? ◯ YES ◯ NO If "YES," which ones?
9. Do you eat fruit and veggies at the same meal? ◯ YES ◯ NO
   Note: This includes fruit-based dressing, and anything with seeds, like a tomato, bell pepper, or avocado
10. Do you use SALT? ◯ YES ◯ NO If "YES," what kind?
11. Do you cook with any type of OIL from vegetable, olive, peanut, safflower, sunflower, coconut, sesame, palm, grapeseed, or any other? ◯ YES ◯ NO If "YES," which ones?
12. Do you eat fried food such as French fries, chips, Doritos, Corn chips, donuts, etc.)? ◯ YES ◯ NO
    If "YES," how often? ◯ Daily ◯ 3x week ◯ 1x week ◯ 1x month
13. Do you eat items with food coloring like Juice, cakes, frosting, lollipops, candy, etc.? ◯ YES ◯ NO

14. Do you use or eat nutmeg, cinnamon, all spice, white pepper, black petter, red pepper, hot chilis, hot sauce, jalapenos, etc.? ◯ YES ◯ NO

15. Do you chew gum or eat any type of breath mint? ◯ YES ◯ NO

16. Do you ALWAYS read food labels? ◯ YES ◯ NO

17. Do you know the 25 Hidden names for MSG? ◯ YES ◯ NO

18. Do you know what Aspartame is? ◯ YES ◯ NO

19. Which of the following cookware do you use? *(Select all that apply)*

☐ ALUMINUM ☐ GLASS ☐ STAINLESS STEEL ☐ CAST IRON

☐ CERAMIC ☐ TEFLON ☐ PORCELAIN ☐ FLIMSY BAKEWARE

20. Do you pile too much food on your plate? ◯ YES ◯ NO

21. Do you go back for SECONDS or THIRDS for your food? ◯ YES ◯ NO

22. Do you eat flesh in any form (beef, pork, lamb, chicken, turkey, deer, fish, seafood, etc.) ◯ YES ◯ NO

If "YES," how many times a day? _____ If "YES," how many ounces each meal? _____

23. Do you eat any animal products such as eggs, milk, butter, cheese, yogurt, cream, etc.? ◯ YES ◯ NO

If "YES," how often? _____

If "YES," when was the last time you ate any of these? _____

DAILY DIETARY INTAKE:

Please list the meals you ate for the past 2 days. Please include everything you ate as well as how much.

Breakfast or 1st Meal for the day

1. Fruit, this can include tomatoes, avocados, olives, bell squash, and anything else that has a seed in it)

DAY 1		DAY 2	
Green Vegetables	**How much**	**Green Vegetables**	**How much**

2. Grain, this includes corn, rice, oats, cereal, granola, rye, barley, millet, quinoa, wheat, bread, & muffins.

DAY 1		DAY 2	
Kinds of Grain	**How much**	**Kinds of Grain**	**How much**

3. Nuts & Seeds, including nut butter like tahini and peanut butter or any other nut (indicate salted or raw).

DAY 1				DAY 2			
Nuts & Seeds	How much	Salted	Raw	Nuts & Seeds	How much	Salted	Raw
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐

4. Please list anything else you may have eaten that is not included above, including meat products:

DAY 1		DAY 2	
Food Items	How much	Food Items	How much

Lunch or 2nd Meal for the day

1. Dark Green Vegetable: includes spinach, mustard greens, broccoli, asparagus, salad greens, etc. Also list other vegetables including beets, radishes, turnips, sweet potatoes, yams, potatoes, carrots, etc.)

DAY 1		DAY 2	
Vegetables	How much	Vegetables	How much

2. Grain, this includes corn, rice, oats, cereal, granola, rye, barley, millet, quinoa, wheat, bread, & muffins.

DAY 1		DAY 2	
Kinds of Grain	How much	Kinds of Grain	How much

3. Legumes, including any type of bean, peas, and tofu. You may include any nuts or seeds you had as well.

DAY 1		DAY 2	
Legumes	How much	Legumes	How much

4. Please list anything else you may have eaten that is not included above, including meat products.

DAY 1		DAY 2	
Food Items	**How much**	**Food Items**	**How much**

Dinner or 3rd Meal for the day

1. Dark Green Vegetable: includes spinach, mustard greens, broccoli, asparagus, salad greens, etc. Also list other vegetables including beets, radishes, turnips, sweet potatoes, yams, potatoes, carrots, etc.)

DAY 1		DAY 2	
Vegetables	**How much**	**Vegetables**	**How much**

2. Grain, this includes corn, rice, oats, cereal, granola, rye, barley, millet, quinoa, wheat, bread, & muffins.

DAY 1		DAY 2	
Kinds of Grain	**How much**	**Kinds of Grain**	**How much**

3. Legumes, including any type of bean, peas, and tofu. You may include any nuts or seeds you had as well.

DAY 1		DAY 2	
Legumes	**How much**	**Legumes**	**How much**

4. Please list anything else you may have eaten that is not included above, including meat products.

DAY 1		DAY 2	
Food Items	**How much**	**Food Items**	**How much**

Snacks:

Please list any and everything you ate that was **not a part of your meals**.

DAY 1		DAY 2	
Food Items	**How much**	**Food Items**	**How much**

On a Scale of 0-10, How serious are you about getting to the root of your problem(s)? ☐

On a Scale of 0-10, how willing are you to do whatever it takes to improve your condition(s)? ☐
(Within realistic limits)

GOD'S PLAN PLUS

Social Component

1. Do you have a good family relationship? ◯ YES ◯ NO
2. Are you close to your parents? ◯ YES ◯ NO
3. Are you close to your children? ◯ YES ◯ NO
4. Were you raised by your biological parents (mother, father, or both)? ◯ YES ◯ NO
5. Were you raised with SIBLINGS, COUSINS, AUNTS, and UNCLES? ◯ YES ◯ NO
6. Do you get along well with other people? ◯ YES ◯ NO
7. Do you feel you have been cheated in life? ◯ YES ◯ NO
8. Do you feel people misunderstand you? ◯ YES ◯ NO
   If "YES," how frequent? ◯ Daily ◯ Sometimes ◯ Rarely
9. Are you a SENSITIVE PERSON or THINGS DON'T BOTHER YOU EASILY? ◯ Sensitive ◯ Not Sensitive
10. Do you have a social circle that you are a member of (church, senior center, club, etc.)? ◯ YES ◯ NO
11. Do you feel that you make good choices in picking friends and partners? ◯ YES ◯ NO
12. Is there any unfulfilled promise you made that you wish you could fix? ◯ YES ◯ NO
13. Is it easy for you to forgive others when they have wronged you? ◯ YES ◯ NO
14. Are you willing to admit when you are wrong? ◯ YES ◯ Sometimes ◯ NO
15. Are you more of a SHY and TO YOURSELF or OUTGOING person? ◯ Shy ◯ Outgoing
16. Do you feel you are an emotional and sensitive type of person? ◯ YES ◯ NO
17. Do you feel your personality is more abrasive & harsh or gentle & kind. ◯ Harsh ◯ Gentle
18. Do you feel you are more of a LISTENER or TALKER? ◯ Listener ◯ Talker
19. Are you more of an OUTSPOKEN person or QUIET type of person? ◯ Quiet ◯ Outspoken

20. Would you consider yourself to be one who EXPRESSES YOURSELF & COMPLAIN when things don't go your way, or one who KEEPS IT TO YOURSELF? ○ Complains ○ Keeps to self
21. Are you the type of person who loves to share your personal business? ○ YES ○ NO
22. Do you talk about others? ○ YES ○ NO ○ Sometimes
23. Are you more OPTIMISTIC or PESSIMISTIC? ○ Optimistic ○ Pessimistic
24. On a scale of 0 - 100, what do you believe you are worth? _____

Dress

1. What do you wear for lower clothing? Select all that apply. (Not referring to underneath skirts, but pants worn by themselves). ☐ PANTS ☐ SHORTS ☐ SKIRTS
2. How long are your skirts? ○ Below the Calf ○ Knee level ○ Above knee
3. Do you wear a belt around the waist? ○ YES ○ NO
3. If you wear skirts, do they suspend from your HIPS or SHOULDERS? ○ Hips ○ Shoulder
4. What upper clothing sleeves do you usually wear? ○ Sleeveless ○ Short sleeve ○ Long sleeve
5. How many layers of clothing over your legs do you wear in the wintertime? _____ layers
7. How many layers of clothing do you wear over your arms in the wintertime? _____ layers
8. How many layers of clothing do you wear over your chest in the wintertime? _____ layers
9. What material do you wear in the wintertime? _____
10. What material do you wear in the summertime? _____
11. Do you wear extra socks when your feet are cold? ○ YES ○ NO
12. Do you wear any type of jewelry? ○ YES ○ NO

Note: This includes wedding rings, rings, earrings, bracelets, anklets, necklaces, broaches, and pins.

13. Do you wear any makeup? ○ YES ○ NO If "YES," what kind? *(Select all that apply)*

☐ LIPSTICK ☐ EYE SHADOW ☐ BLUSH ☐ EYELINER
☐ LIP GLOSS ☐ FOUNDATION ☐ MASCARA
☐ Others: _____

14. Do you polish your fingernails or toenails? ○ YES ○ NO
15. Are your ANKLES, LEGS, CHEST, or BACK ever exposed? ○ YES ○ NO
16. Do you wear leggings in the summertime? ○ YES ○ NO
17. Do you wear a hat of any type in the house when it's cold? ○ YES ○ NO
18. Do you wear any type of scarf around your neck when it's cold? ○ YES ○ NO
19. Do you wear any heels that are higher than 1 inch? ○ YES ○ NO
20. If you wear any heels, do you wear spiked heels? ○ YES ○ NO

21. Do you wear any flip-flops or sandals that expose your feet? ○ YES ○ NO

Hygiene and Cleanliness

1. How many days a week do you bathe or shower? _____
2. How many times a day do you brush your teeth? _____
3. What kind or brand of toothpaste do you use? _____
4. Do you brush your teeth after every meal? ○ YES ○ NO
5. Do you floss every day? ○ YES ○ NO
6. Do you change your clothes every day? ○ YES ○ NO
7. What kind or brand of deodorant do you use? _____
8. What kind or brand of lotion do you use? _____
9. What brand/kind of soap do you use? _____
10. What brand of shampoo do you use? _____
11. What brand of conditioner do you use? _____
12. What kind or brand of perfume/body spray do you use if any? _____
13. Do you have animals living inside your home? ○ YES ○ NO
14. Do you have animal feces lying near your home? ○ YES ○ NO
15. Do you have dead leaves lying near your home? ○ YES ○ NO
16. Do you have a compost bin near your home? ○ YES ○ NO If "YES," how far from the house? _____ ft.
17. Do you have carpet in your home? ○ YES ○ NO

    If "YES," how many days a week do you vacuum? _____
18. How many days a week do you clean your kitchen? _____
19. Do you wash your dishes every day or leave them in the sink some days? ○ Every day ○ Leave in sink