Faith in Action

Personal Information

Faith in Action

Personal Data

Date:							
Name:				Age:		 -	
Address: Street				Height:			
#							
City, State, Zip							
E-mail address:							
Home phone:			Work:				
Cell phone:			Referred	l by:			
Date of Birth:	/	/					
Occupation:							
Medications:							
Injuries:						······································	
Emergency Contact:	1						
	Phone:			·			
	2						
	Phone:			·			
Family Physician:							
Doctor's Address: Stree	t						
Ste:							
City. State. Zip.				Phone #:	_		_

Present History

Check the space in front of those questions to which your answer is yes. _____ Has a doctor ever said that your blood pressure was too high or too low? _____ Do you ever have pain in your heart or chest? _____ Does your heart ever race like mad? _____ Do you ever notice extra heart beats or skipped beats? _____ Are your ankles often badly swollen? Do cold hands or feet trouble you even in hot weather? Has a doctor ever said that you had or have heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack or coronary? _____ Do you suffer from frequent cramps in your legs? _____ Do you often have difficulty breathing? Has a doctor ever told you your cholesterol level was high? Comments: Do you have now or have you recently had: _____ A chronic, recurrent or morning cough? _____ Increased anxiety or depression? _____ Problems with recurrent fatigue, trouble sleeping or increased irritability? _____ Migraine or recurrent headaches? _____ Swollen or painful knees or ankles? _____Pain in your legs after walking short distances? _____ Back pain? _____ Kidney problems, such as passing stones, burning, increased frequency decreased force of stream or difficulty in starting or stopping your stream? Any stomach or intestinal problems such as recurrent heartburn, ulcers, constipation or diarrhea? ____ Any significant vision or hearing problems? Women Only answer the following: ______ Do you have any menstrual period problems? _____ Did you or do you have any significant childbirth problems? Pregnancies_____ Living children_____ Please give number of:

N	Ien	and	Women	answer	the fo	llowing:
---	-----	-----	-------	--------	--------	----------

List any prescription medications you are now taking:

List any self-prescribed medications or dietary supplements you are now taking:

Date of last phys	ical examination:			
	Can't remember	Normal	Abnormal	
Date of last chest	t x-ray:			
	Can't remember	Normal	Abnormal	
Date of last elect	rocardiogram:			
	Can't remember	Normal	Abnormal	
		1 11 1		
List any other me	edical or diagnostic test you have	ve had in the past two y	ears:	
List any hospital	izations including dates of and r	caseons for hospitalizat	ion:	
List any nospitan	izations including dates of and i	easons for nospitalizat	JOII.	
List any drug alle	ergies:			
, ,				
				عالد
والمالوالمالوالوالوالوالم			والمالمالمالمالمالمالمالمالمالم	العاال
	Stres	SS		
	hat you believe your current lev	vel of stress in your pe	rsonal life to be l	Эy
placing an "X" o	on the line below:			
Totally fund from	a atmosa	Extran	nalv high strassa	
Totally free from	istress	Extre	nely high stresse	J
Please indicate w	vhat you believe your current lev	vel of stress to be in the	e work place by	
	on the line below:	, or or our object to be in the	e work place by	
p				
Totally free from	ı stress	Extren	nely high stresse	 d

Past History

Have you ever had	:		
Diseases o	of the arteries		
	of legs or arms		
	o back, legs, arms or j	oints	
•	or abnormal blood sug		
	or fainting spells	9	
Strokes	9.1		
Any nervo	ous or emotional prob	lems	
Thyroid p			
Pneumoni			
Bronchitis	S		
Asthma			
Abnormal	l chest x-ray		
Other lun			
Broken bo			
Epilepsy of	or fits		
Anemia			
Poor intal	ke due to:		
Nausea			
Vomiting/	Diarrhea		
	Swallowing Difficulty		
_	food choices/options		
	_		
00000000000	1000000000000	1000000000000	0000000000000
	Family Me	edical History	7
T .1			
Father:	Alive	Current Age	
General health now:	Cood	Poor	Don't Imov
Excellent Deceased	Good Age of death	P00I	Don't know
Cause of death or reason	1 for poor health now:		
Mother:	Alive	Current Age	
	111110	Current rigo	
General health now:			
Excellent	Good	Poor	Don't know
Deceased	Age of death		

Cause of death or reason for poor health now:	
Siblings: Number of brothers Age range	Number of sisters
Health problems:	
Family Diseases: Have any of your blood relagrandparents, aunts and uncles, but exclude cousins, relatives by	
	Congenital heart disease Heart operations
Obesity (20 or more pounds overweight)	Diabetes Asthma or hay fever
Other heart diseases	risk factors
Have you ever smoked cigarettes, cigars or a pipe? If no, skip to diet section.	Yes No
Do you smoke presently?	Yes No
If you did or do smoke cigarettes, how many per day? Age you started	
If you did or do smoke cigars, how many per day? Age you started	
If you did or do smoke a pipe, how many pipefuls per Age you started	
If you now are a non-smoker, when was it you quit? ((month, year)

\mathbf{Diet}

	ever had any previous i ou consider a good wei				Lbs.
What is the	e most you have ever we?				Lbs.
	Now	One year a	ngo	At age 21	l
	meals you usually eat e of meals (circle):			Large	
	umber of whole eggs you do baking):	ou usually eat	per week (do no	t count eggs	used in
Bi	times you eat the following read, Rice, Pasta egetables eef Fhips/Crackers	ish F	Desserts Fruit Pork Fried foods		
Number of H SI	of fat or oil do you use servings (cups/ glasse omogenized (whole) n kim or non-fat milk we any food allergies or	s) per week yo nilk7	u usually consur Buttermilk Fea	me of:	Coffee
•	er drink alcoholic beve t is your approximate i	-		Yes	No
	None drinks per week?		ccasional	Often	
	None drinks per week?		occasional	Often	
Hard Liquo How many	or N drinks per week?		Occasiona	1	Often
•	e in the past were you ee? Yes	•	r (consumption o	of 6oz. Of ha	ard liquor per

${\bf Exercise}$

Are you currently involve	ed in a regular ex	ercise program?	
Y	es	No	
Do you regularly walk or	run one or more	miles continuously?	
Lo you regularly walk of Y			Don't know
			_
What is your average time	e per mile?	Minutes / seconds	Don't know
Do you practice resistance	e or weight train	ing or home calisthenics?	
	es		
Are you involved in an ae	robics program?	,	
Y			
If yes, the average time ye	ou spend each we	eek doing aerobics is:	
Have you taken in the last	t 6 months:		
12 minut		1.5 mile run	Neither
If yes, your mile in minut	es:		
Your 1.5 mile run (minute	es / seconds):		
Do you currently participartic	-	-	
If yes, which one or ones	?		
None	Soccer	Gymnastics	Motor-Cross
			Mountain biking
		Hockey	
		Diving	
Track	Golf	Sky diving	Roller Blading
Are there other sports or i	ecreational activ	vities you participate in that	at we have not
mentioned?			
Have you ever trained wit	th a professional	personal trainer before?	
•	es	No	

Have you ever been introduced weights?	to fun-ctional personal trai	ning using Swiss balls and free
Yes	No	
On a scale from one to ten how being very low – 10 being very	much value do you place o	on exercise in your life? (1
Explain any other significant m know:	nedical problems that you co	onsider important for us to
	Spirituality	
Which Religious or Spiritual at	ffiliation were you born in to	o if any?
Christian	Atheist	Jewish
	Muslim	Other
	Widshiii	
Which Religious or Spiritual at	ffiliation do you belong to n	now if any?
Christian	Atheist	Jewish
Buddhist	Atheist Muslim	Other
Buddinst		
Which church / synagogue or p	place of worship do you atte	nd?
How often do you attend per m	onth?	
How often do you pray or med	itate during the course of yo	our average day?
When you do pray or meditate finished?	•	you are usually
Would you be interested in lear Action offers? Yes	rning about the Christian ba No	sed program that Faith in

How excited are you right this very moment?

Measuring your intention by the "End Result"

Measurements	Start	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7
Date								
Body weight								
Shoulder								
Chest								
Waist								
Hips								
Thighs								
Calves								
Upper arm								
Forearm								
Percent Body Fat								
Resting Heart Rate								
Cholesterol								
Blood Pressure								
Measurements	Wk 8	Wk 9	Wk 10	Wk 11	Wk 12	Wk 13	Wk 14	Wk 15
Date								
Body weight								
Shoulder								
Chest								
Waist								
Waist Hips								
Hips								
Hips Thighs								
Hips Thighs Calves								
Hips Thighs Calves Upper arm								
Hips Thighs Calves Upper arm Forearm								
Hips Thighs Calves Upper arm Forearm Percent Body Fat								