10-DAY RESET

Bringing preventive, restorative, and sustainable health solutions to the whole person.
Guest Information Form

CONFIDENTIAL

IMPORTANT

Please Note: The information received during this program and/or any services, or any future programs or interactions, and/or any services, are for general education and community service, and are not intended to supply specific medical care or advice. No medical care, treatment, or diagnosis is provided during this program, and/or services. It is advisable to consult with one's personal health care provider before implementing any lifestyle changes.

I release Beehive International, Healthy Self, Pulse Café, Path of Life Healing Center, or associated persons, facilities, and/or organizations from any and all liability. Participation in this program indicates acceptance of all these and additional terms found in our Liability Release Waiver.

Signature: _____ Date: _____

General Information:

Name: _____

Address: _____

Phone: Main (____) _____

Email Address: _____

Optional:

Religious Affiliation (if any): _____ Length of affiliation? _____

Marital Status – (circle): Single, Married, Divorced, Separated, Widowed

Do you have any children? If so, what ages? _____

Emergency Contact Name: _____

Cell and Email: _____

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

_____

_____

_____

When did you last consult a physician? _____

Are you currently being treated for any ailments? Yes /No If yes, which ones? _____

_____

Please list any surgery that you have had (include date(s)): _____

_____

What diseases have you been diagnosed with? (please list all): _____

_____

_____

Do you have any family history of disease? If so, please list all. _____

_____

_____

Are you presently experiencing any of the following: (please circle)		
Dizziness	Numbness	Bad body odor
Fainting	Clammy skin	Excessive sweating
Nausea	Cold hands or feet	Hair loss
Pain	Constipation	Fever
Heart palpitations	Diarrhea	Infections
Fatigue	Indigestion / Acid Reflux	Bleeding
Headaches	Cold / Flu	Weight loss
Memory loss	Blurred vision	Weight gain
Insomnia	Swelling anywhere	Sexual dysfunction
Difficulty breathing	Parasites / Worms	Anemia

Please list any food allergies, and/or allergies of any kind (please be specific). _____

_____

_____

_____

Do you suffer from any of the following emotional / mental disorders? (please circle)

Depression	Chronic Anxiety	Bipolar
Codependency	Mania	Schizophrenia
Phobias	OCD	Neurosis
Other: _____		

Are you experiencing any addictions or substance abuse? Yes / No (If yes, please list below):

_____

Are you currently suffering from any eating disorders? (please circle all that apply):
Anorexia Bulimia Binge Eating Other: _____

What specific condition(s) would you like this program to address? _____

_____

_____

_____

Age: _____ Date of Birth: _____

Gender: _____ Male: _____ Female_____ Prefer not to say: _____

Weight: _____lbs. Height: _____

Blood Pressure: _____ / _____

Glucose: _____ Postprandial (2 hours after meal): _____

Cholesterol: _____ HDL: _____ LDL: _____ Triglycerides: _____

Sedimentation Rate: _____ C-Reactive Protein: _____

Please list all medications and / or pills, prescription or otherwise, you are currently taking (or have taken in the past 60 days): List usage, dosage and what they were/are prescribed for:

Please list all supplements and / or herbs that you are taking or have taken in the past 60 days (vitamins, minerals, nutritional drinks, etc.).

FAITH CARE INFORMATION

To Help Yourself And Staff Understand These Pertinent Lifestyle Habits That Are Foundational To Your Health, Please Fill Out This Information Below. You Can Bring This Part With You. However, The First Four Pages Should Be Sent At Least One Week Prior To Your Arrival.
Check Yes Or No, When Applicable, As You Answer Questions In Sections Below:

TRUST MORE, STRESS LESS

Do you have a daily time for mindfulness? Yes ___ / No ___ If no, would you like to have one? Yes ___ / No ___

Do you spend time reading the Bible daily? Yes ___ / No ___

Do you pray routinely? Yes ___ / No ___

Do you participate/share in a fellowship, support group, or any group of "like-minded" individuals with whom you share a strong sense of community and accountability? Yes ___ / No ___ / Sometimes ____

Do you donate to charity? Yes ___ / No ___

Have you experienced any extreme stress in the past 5 years (loss of loved one, job, marriage, health, etc.)? Yes ___ / No ___

Do you experience chronic stress? Yes ___ / No ___

Do you have a therapist? Yes ___ / No ___

What things do you actively do to help mitigate stress in your life? _____

Do you have difficulty in sharing your problems? Yes ___ / No ___

Do you suffer any remorse, guilt, worry or fear at present? Yes ___ / No ___

Do you believe that you have experienced forgiveness in your life? Yes ___ / No ___

Do you struggle with knowing your purpose? Yes ___ / No ___

Would you consider your immediate family to have healthy relationships with each other? Yes ___ / No ___

Do you have a mentally/emotionally strong immediate family? Yes ___ / No ___?

Do you have peace with yourself and others? Yes ___ / No ___

Have you broken any vows or promises to yourself or loved ones that are within your power to fulfill? Yes ___ / No ___

How has life been treating you? _____

How have you been treating life? _____

HAVE REFRESHING REST

What is your usual bedtime? _____

Do you wake up during the night? Yes ___ / No ___ / Sometimes ____

Do you snack before you go to bed? Yes ___ / No ___ / Sometimes ____

Do you sleep with the lights on? Yes ___ / No ___ / Sometimes ____

Do you work the night shift or swing shift? Yes ___ / No ___ / Sometimes ____

When you wake up do you find it difficult to get back to sleep? Yes ___ / No ___ / Sometimes ____

Do you take any sleep aids? Yes ___ / No ___ (If yes, please list) _____

Do you make it a practice to get to bed at a certain time? Yes ___ / No ___

Do you have at least one day off per week? Yes ___ / No ___

Do you have a bedtime routine/ritual with which you are consistent? Yes ___ / No ___

ENJOY SUNSHINE

How much sun exposure do you get per day? _____

Do you sunbathe? Yes ___ / No ___ If so how long? _____

Do you use sun block? Yes ___ / No ___ / Sometimes ____

Do you have any abnormal sensitivity to the sun naturally or due to any medications? Yes ___ / No ___

Do you take vitamin D supplements? Yes ___ / No ___

Do you have any family history of skin cancer? Yes ___ / No ___

NUTRITION

Do you eat any meat (chicken, turkey, pork, fish, shrimp etc.)? Yes ___ / No ___

Do you eat any dairy products or eggs (i.e., milk, cheese, yogurt, ice cream, etc.)? Yes ___ / No ___

Which ones? _____

Do you eat heavily refined products (i.e., white bread, white rice, white flour, etc.)? Yes ___ / No ___

How many servings of fruit per day do you eat? _____ How many servings of vegetables? _____

Do you use condiments (i.e., ketchup, mustard, mayonnaise, barbeque sauces, salad dressings, siracha, hot sauce, pickles, vinegar, etc.)? Yes ___ / No ___

Do you add any of the following spices to your foods: cinnamon, nutmeg, cloves, curry, hot peppers, cayenne pepper, black and white pepper, etc.? Yes ___ / No ___

Do you eat fried foods? Yes ___ / No ___ If so, how often? _____

Do you use margarine or butter? Yes ___ / No ___ If so, how often? _____

Do you use baking powder or baking soda? Yes ___ / No ___

Do you eat fresh bread? (bread eaten less than 24-48 hours after baking) Yes ___ / No ___ / Sometimes _____

Do you eat or drink any caffeine products? Yes ___ / No ___ How often? _____

Which oils do you cook with? _____

Do you read the labels of food items that you buy from the store? Yes ___ / No ___

List any sweeteners you consume (i.e., sugar, honey, Splenda, Sweet & Low, Equal, or additional artificial sweeteners, etc.) _____

How much and often do you eat nuts? _____

Which ones? _____

Do you eat any canned items (beans, veggies, fruits, veggie meats etc.)? Yes ___ / No ___

Which ones? _____

Are you on any special diet? Yes ___ / No ___

If so, please list: _____

Do you eat out? Yes ___ / No ___ If so how often: _____

Do you use salt? Yes ___ / No ___ Does the salt contain iodine? Yes ___ / No ___

EXERCISE

Do you exercise? Yes ___ / No ___

How many times per week? _____ How many minutes per day? _____

How would you rate your exercise? (circle one) _____ Mild _____ Moderate _____ Vigorous

What is your healthy/Goal weight? _____

What are your favorite exercises/routines? _____

How do you feel after you exercise? _____

Do you experience any pain while you are exercising? Yes ___ / No ___ (If yes, please briefly explain below):

_____

_____

WATER

How many glasses of water do you usually drink per day (or how many ounces)? _____

What kind of water do you commonly drink? _____

Is your water filtered? Yes ___ / No ___

At what temperature do you drink your water? (circle one) _____ Hot _____ Cold _____ Room temperature

Do you eat ice? Yes ___ / No ___

How many glasses of juice do you drink per day? _____

How many cans / bottles of soda per day? _____

What other liquids do you drink (i.e., tea, wine, alcohol, beer, soda, milk, flavored water, etc.)?

_____

Do you drink with your meals? Yes ___ / No ___ / Sometimes

What color is your urine normally? (clear, pale, slight yellow, yellow, or dark yellow, other)

LIVE TEMPERATELY

What is your current occupation? _____

Please list your last five jobs and the years of service:

_____

_____

_____

Do you smoke/use tobacco or nicotine products in any form (i.e., chew, patch, etc.)? Yes ___ / No ___

Did you use tobacco in the past? Yes ___ / No ___ If so how much and for how long? _____

Do you use alcohol in any form? Yes ___ / No ___ If so, how much and for how long? _____

Do you consume marijuana in any form (i.e., vaping, smoking, edibles, etc.)? Yes ___ / No ___

Do you ingest caffeine in any form? Yes ___ / No ___ (e.g., coffee, teas, mate, colas, energy drinks, etc.) If so, please list:

_____

_____

_____

How many devices do you own? _____ How much screen time do you have p/day? _____

Do you overeat? Yes ___ / No ___ / Sometimes ____

Do you eat fast? Yes ___ / No ___ / Sometimes ____

Do you chew your food thoroughly? Yes ___ / No ___

Do you snack between meals? (including any food items, gum, juice, etc.) Yes ___ / No ___ / Sometimes ____

List any desserts you eat? (include candies, cakes, or pies) _____

_____

_____

Do you eat at set mealtimes? Yes ___ / No ___

Please list times for all meals: Breakfast: _____ Lunch: _____ Supper: _____

Snacks: _____

How much time do you spend on leisure activities per/day? _____

What are your favorite leisure activities? _____
_____

_____

Do you overwork? Yes ___ / No ___ / Sometimes _____

Please list any addictions: _____

Have you ever experienced substance abuse? Yes ____ / No _____

If so please list: _____

INVEST TIME IN OTHERS

Do you have anyone you care for directly? _____

Do you volunteer for any charitable service or organization? _____

If so which ones? _____

How often? _____

What is your personal mission? _____

What worthy cause are you most passionate about? _____

FRESH AIR

Where do you live? (Circle one): City Suburb Rural

Do you sleep with your windows open? Yes ___ / No ___

Do you open your windows / doors daily to air out the home? Yes ___ / No ___

Do you live or work in a smoke or vape-filled environment? Yes ___ / No ___

Do you have any smokers or vapers living in your home? Yes ___ / No ___

Do you have live plants throughout your home? Yes ___ / No ___

Are there any environments that you are in that do not have a good supply of fresh air? Yes ___ / No ___

If so, what are they? _____

Do you wear tight fitting clothing that restricts your lung expansion? Yes ___ / No ___

EDUCATE YOURSELF

Do you read regularly? Yes ___ / No ___

If so what topics do you enjoy? _____

Do you listen to podcasts regularly? Yes ___ / No ___

If so, what topics do you enjoy? _____

Do you have any degrees or certifications? Yes ___ / No ___

If so, which ones? _____

Do you have any hobbies? Yes ___ / No ___

If so, what are they? _____

What games or challenges do you enjoy? _____

Do you express yourself in any form(s) of creative art (writing, music, media, visual)? Yes ___ / No ___

If so, what type(s) _____

Do you like to share things you've learned with others? Yes ___ / No ___

Beloved, I pray that all may go well with you and that you may be in good health, as it goes well with your soul. 3 John 1:2