OUR HOME
NATURAL HEALTH RETREAT

Rosend District, Annotto Bay P.O., St. Mary, Jamaica, West Indies • (876) 351-1779
E-mail: meetministryja@gmail.com • www.meetministryja.org

FOR YOUR INFORMATION

CONDITIONS OF ACCEPTANCE

Our Home Natural Health Retreat is a learning facility where health guests are admitted as students to learn to recover and preserve their health. We are not a medical facility or treatment center, nor do we give medical advice.

Our guest must be:

1. Of legal age of accountability
2. Physically mobile and able to perform one's own personal hygiene
3. Mentally competent and capable of making their own decisions
4. Emotionally stable and self-responsible
5. Able to follow clearly written instructions

To reserve a space and to be confirmed as a health guest, he/she must submit:

1. A completed health questionnaire for review
2. A deposit of $500 USD or equivalent $JA

The above must be received no later than 2 weeks prior to the beginning of the health session. Please note, as we do operate a small facility with limited space, it is best to send in your application as soon as possible to guarantee your desired date of attendance.

Health guests are also required to submit recent medical records (lab reports, CAT scans, x-ray reports, summaries, or other pertinent information) 2 weeks before the session begins.

We give no guarantee of healing; we cooperate with God who is the true source of healing. An individualized plan will be shared with you, placing you on the road to recovery. This plan will be based on the submitted health questionnaire, medical records and other provided information.

If, during the implementation of the program, circumstances or problems arise as a result of purposeful withholding of important medical information or a lack transparency, for your sake as well as the sake of the ministry and other guests, you may be informed that we are no longer able to assist you. No refunds will be given for health guests choosing to leave before the session ends or asked to leave due to undisclosed information.

FINANCIAL INFORMATION

Suggested Donations

Where do you reside?	18-Day Session	10-Day Session	5-Day Detox.
Jamaican Resident	JMD $135,000	JMD $90,000	JMD $45,000
Caribbean Resident	USD $1,550	USD $1,050	USD $525
International Resident	USD $2,500	USD $1,650	USD $825

Please call us for rates for a non-participating support person.

A non-refundable $500 USD deposit is required to reserve a place in the desired health session once the application has been accepted. The balance is due 2 weeks before session begins. All cheques or money orders should be made payable to M.E.E.T. Ministry and mailed to the address in Jamaica.

Except for uncontrollable, dire circumstances, such as death, all submitted monies are nonrefundable. In cases which are not necessarily emergencies, but are important nonetheless, the applicant has the next three sessions to reschedule their attendance, according to space availability.

If other situations exist where a person chooses to cancel their plans to come after submitting the designated funds, there is yet another option. The canceling guest may request a potential substitute to be considered as a health guest. If they are accepted as a guest, the ministry will apply any previously paid monies toward the stay of the substitute guest. Any reimbursement or adjustment expected to the original payer will occur between the two individuals.

Billing Information

Name:

Address: **City:**

District/Town: **Parish**: **Postal Code:** **Country:**

Home Phone: **Work Phone:**

Person responsible for payment if other than guest:

Address: **City:**

District/Town: **Parish**: **Postal Code:** **Country:**

Home Phone: **Work Phone:**

Method of Payment

Attending: ☐ **5-day session** ☐ **10-day session** ☐ **18-day session** **Session Dates:**

☐ **Cheque** ☐ **Wire transfer** ☐ **Local bank deposit:**

I have read and understand this statement and financial agreement and agree to comply with the arrangements as stated in this form.

Date: / / Health Guest Signature: _____

Date: / / Business Office: _____

mm dd yr

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HEALTH GUEST QUESTIONNAIRE FORM

Name: **Age:**

Address: **City:**

District/Town: **Parish**: **Postal Code:** **Country:**

Home Phone: **Work Phone:** **Email:**

Nationality: **Religion:**

Marital Status: **Referred by:**

Highest Level of Education Completed: **Occupation:**

Emergency Contact: **Relationship:** **Phone:** ( ) -

You want to have help dealing with:

- ☐ **Arthritis**
- ☐ **Cancer, Type:**
- ☐ **Diabetes**
- ☐ **High Blood Pressure**
- ☐ **Heart Disease**
- ☐ **Other:**
- ☐ **Overweight**
- ☐ **Stress**

Would you like to be added to our email list? ☐ **Yes** ☐ **No**

Email address:

I hereby state that I do not represent any food, drug, medical, or government organization.

Date: / / Health Guest Signature: _____
mm dd yr

PERSONAL INFORMATION

Weight: **Height:** **Weight loss in the past year?** ☐Yes ☐No **How much?**

Do you have any indoor pets? ☐**Yes** ☐**No** **How many and what kind?**

List any past or present environmental hazards at work place or at home.

Are you a smoker? ☐**Yes** ☐**No** **If yes, what kind?** **How much?**

Do you drink alcoholic beverages? ☐**Yes** ☐**No** **If yes, what kind?** **How much?**

Do you drink caffeinated drinks? ☐**Yes** ☐**No** **If yes, what kind?** **How much?**

On a scale 1-10, what is your energy level? **Do you take a nap during the day?** ☐**Yes** ☐**No**

Do you stay active throughout the day? ☐**Yes** ☐**No** **Do you exercise regularly?** ☐**Yes** ☐**No**

How many hours a day do you spend on: TV **Computer** **Other electronic devices**:

How many hours do you sleep each night?

If you have difficulty sleeping, check the following that applies to you.

☐**Inability to fall asleep** ☐**Inability to get back to sleep** ☐**Hard to awaken**

☐**Inability to stay asleep** ☐**Awaken after few hours of sleep** ☐**Other:**

NUTRITION

Is your diet primarily:

☐**Regular American diet**

Do you regularly partake of:

☐ **Chicken** ☐ **Beef** ☐ **Turkey**

☐ **Catfish** ☐ **Pork** ☐ **Shrimp**

☐ **Lobster** ☐**Shellfish** ☐ **Other:**

☐**Vegetarian**

☐**Milk, eggs, dairy** ☐**Fish**

☐**Wheat free** ☐**Gluten free** ☐**Other:**

Do you regularly partake of:

☐**Whole grains, i.e. brown rice, millet, quinoa, oats, etc**.

☐**Processed refined foods: white rice, white pasta, white bread, etc.**

☐**Junk food/fast food**

☐**Sugar**

☐**Other:**

PERSONAL HEALTH HISTORY

ALLERGIES

Are you allergic or sensitive to any of the following?

Medication ☐ **Yes** ☐ **No** **List:**

Food ☐ **Yes** ☐ **No** **List:**

Other ☐ **Yes** ☐ **No** **List:**

MEDICATIONS & SUPPLEMENTS

List the names and dosage of any medications and supplements you are currently taking.

Medications

Supplements

Have you ever taken any of the following? If yes, describe what type, when, and for how long.

Antibiotics ☐ **Yes** ☐ **No**

Blood Pressure Meds ☐ **Yes** ☐ **No**

Birth Control Pills ☐ **Yes** ☐ **No**

Hormones ☐ **Yes** ☐ **No**

Insulin ☐ **Yes** ☐ **No**

Pain Meds ☐ **Yes** ☐ **No**

Steroids ☐ **Yes** ☐ **No**

Thyroid Meds ☐ **Yes** ☐ **No**

Tranquilizers/ Sedatives ☐ **Yes** ☐ **No**

DEVICES

Do you use any of the following?

Artificial Limb ☐ **Yes** ☐ **No**

Back Brace ☐ **Yes** ☐ **No**

Braces ☐ **Yes** ☐ **No**

Neck Brace ☐ **Yes** ☐ **No**

Contact Lenses ☐ **Yes** ☐ **No**

Dentures ☐ **Yes** ☐ **No**

Eyeglasses ☐ **Yes** ☐ **No**

Other:

Hearing Aid ☐ **Yes** ☐ **No**

IUD ☐ **Yes** ☐ **No**

Pacemaker ☐ **Yes** ☐ **No**

Do you require assistance with:

☐ **Walking** ☐ **Sitting** ☐ **Getting in & out of bed** ☐ **Other:**

SURGERIES

Have you ever had surgeries on the following?

Appendix	☐ Yes ☐ No When?	**Kidney**	☐ Yes ☐ No When?
Colon	☐ Yes ☐ No When?	**Small Intestine**	☐ Yes ☐ No When?
Gallbladder	☐ Yes ☐ No When?	**Stomach**	☐ Yes ☐ No When?
Heart	☐ Yes ☐ No When?	**Varicose Veins**	☐ Yes ☐ No When?
Hernia	☐ Yes ☐ No When?	**Other:**	

Women

Breast	☐ Yes ☐ No When?	**Uterus**	☐ Yes ☐ No When?
Ovaries	☐ Yes ☐ No When?		

Men

Prostate ☐ Yes ☐ No When?

RADIATION PROCEDURES

List any x-rays, CT scans, MRI, and/or radiation treatment that you have ever had and indicate when.

INJURIES

List and describe any past or present injures that you have experienced.

Past

Present

IMMUNIZATION

List any immunization, especially tetanus, which you have ever received and indicate when the last shot was.

MEDICAL DOCTOR DIAGNOSES

Check all medical doctor diagnoses which you have ever had, and indicate when if it was in the past.

Diagnosis	Past	Present	When
Cardiovascular			
Angina	☐	☐	
Heart Attack	☐	☐	
Heart Murmur as an adult	☐	☐	
Heart, enlarged	☐	☐	
High Blood Pressure	☐	☐	
Phlebitis	☐	☐	
Poor Blood Clotting	☐	☐	
Stroke	☐	☐	
Varicose Veins	☐	☐	
Musculoskeletal			
Arthritis	☐	☐	
Gout	☐	☐	
Respiratory			
Asthma	☐	☐	
Chronic Bronchitis	☐	☐	
Emphysema	☐	☐	
Tuberculosis	☐	☐	
Vision			
Blindness (either eye)	☐	☐	
Cataracts	☐	☐	
Glaucoma	☐	☐	
Miscellaneous			
Cancer and type			
Anemia and type			
Deafness	☐	☐	
Boils, recurrent	☐	☐	
Abnormal X-rays, ultrasound, etc. Please specify:			
Endocrine			
Diabetes	☐	☐	
Goiter	☐	☐	
Thyroid, overactive	☐	☐	
Thyroid, underactive	☐	☐	
Neurological			
Epilepsy or Seizures	☐	☐	
Migraine Headaches	☐	☐	
Multiple Sclerosis	☐	☐	
Parkinson’s	☐	☐	
Polio	☐	☐	
Allergy/ Immunology			
Hay fever	☐	☐	
Rheumatic Fever	☐	☐	

Diagnosis	Past	Present	When
Genito-Urinary/Kidney			
Kidney Stones	☐	☐	
Kidney/Bladder Infection	☐	☐	
Venereal Disease	☐	☐	
Psychological			
Depression	☐	☐	
Emotional Problems	☐	☐	
Nervous Breakdown	☐	☐	
Digestive Disorder			
Cirrhosis of the Liver	☐	☐	
Colitis	☐	☐	
Colon or Bowel Trouble	☐	☐	
Dysentery or Serious Diarrhea	☐	☐	
Gall Stones	☐	☐	
Hemorrhoids or Piles	☐	☐	
Hepatitis	☐	☐	
Rectal Trouble	☐	☐	
Stomach or Duodenal Ulcer	☐	☐	
Female			
Breast Cancer	☐	☐	
Cystitis	☐	☐	
Mastitis	☐	☐	
Ovarian Cyst	☐	☐	
Uterine Fibroid	☐	☐	
Other:			
Male			
Enlarged Prostate	☐	☐	
Prostate Cancer	☐	☐	

FAMILY HEALTH INFORMATION

Family Member	Present Age or Age at Death	If living, health: good, fair, poor If deceased, cause of death
Spouse		
Father		
Mother		
Sibling #1		
Sibling #2		
Sibling #3		
Child #1		
Child #2		
Child #3		
Other:		

FAMILY HEALTH HISTORY

Check any condition a blood relative has ever had.

Alcoholism	☐**Yes**	Relationship:
Arthritis	☐**Yes**	Relationship:
Cancer, including Leukemia	☐**Yes**	Relationship:
Diabetes	☐**Yes**	Relationship:
Heart Attack	☐**Yes**	Relationship:
Heart Trouble	☐**Yes**	Relationship:
High Blood Pressure	☐**Yes**	Relationship:
Mental Illness	☐**Yes**	Relationship:
Stroke	☐**Yes**	Relationship:
Suicide	☐**Yes**	Relationship:
Thyroid Trouble	☐**Yes**	Relationship:
Tuberculosis	☐**Yes**	Relationship:
Other:	☐**Yes**	Relationship:

SYSTEM REVIEW

Review the following symptoms, and rate all that apply to you on a scale 1-5 (1=mild, 3=moderate, 5=severe).

Symptoms	Past	Present
SKIN		
Dry or scaly skin		
Changing mole		
Rash		
Yellow skin		
Acne		
Foul body odor		
Brittle fingernails		
Itching skin and feet		
Bruise easily		
Wounds heal slowly		
RESPIRATORY SYSTEM		
Frequent cough		
Coughing up blood		
Shortness of breath		
Difficulty breathing		
Wheezing		
Allergies/asthma tendency		
CIRCULATORY SYSTEM		
Fatigue		
Sluggishness		
Chest pain or pressure		
Poor exercise tolerance		
Unusual heartbeat		
Pulse slow/irregular		
Heart palpitations/ flutters		
Low blood pressure		
Ankles swell in evening		
Ankles swell in morning		
Cold hands & feet		
Cold/heat intolerance		
Fluid retention		

Symptoms	Past	Present
EYES		
Dry eyes		
Blurred vision not corrected by glasses		
Double vision		
Light flashes		
Halos around lights		
Eye pain		
EARS		
Ear pain		
Drainage from ear		
Hearing difficulty or deafness		
Ringing in ears		
NOSE/SINUS		
Dry nose		
Sinus trouble		
Post nasal drip		
Nasal congestion		
Recurrent nose bleeds		
THROAT/MOUTH		
Dry mouth		
Difficulty swallowing		
Coated tongue		
Bad breath		
Bleeding gums		
Pyorrhea		
Dental caries		
Persistent hoarseness		
NECK		
Swelling/Lumps		
Stiffness		

Symptoms	Past	Present
URINARY SYSTEM		
Increased urine		
Frequent urination		
Blood in urine		
Cloudy urine		
Urine bubbles		
Difficulty passing urine		
Difficulty controlling urination		
Pain or burning with urination		
Getting up at night to urinate		
GASTROINTESTINAL SYSTEM		
Cannot gain weight		
Poor appetite		
Increased appetite		
Indigestion or heartburn		
Bloating		
Gas		
Greasy food intolerance		
Nausea or vomiting		
Vomiting blood		
Abdominal pain or cramps		
Abdominal swelling		
Constipation		
Diarrhea		
Constipation & diarrhea, alternating		
Black or bloody stools		
Light-colored stools		
Painful bowel movements		
Burning or itching anus		

Symptoms	Past	Present
NERVOUS SYSTEM		
Poor memory/ concentration		
Headaches		
Migraine		
Weakness in arm or leg		
Nerve pains		
Tremor		
Nervousness		
Numbness		
Hands & feet go to sleep easily		
Difficulty with balance		
Dizzy spells		
Fainting spells		
Speech difficulty		
MUSCULOSKELETAL SYSTEM		
Painful joints		
Swollen joints		
Joint stiffness in evening		
Joint stiffness in morning		
Loss of muscle strength		
Muscle cramps, worse during exercise/”Charley Horses”		
Muscle twitching		
Muscle-leg-toe cramps at night		
Lump or swelling in muscle		
Lump on bone		
Back pain		

Symptoms	Past	Present
REPRODUCTIVE SYSTEM		
Female		
Breast lump		
Nipple discharge		
Vaginal bleeding or spotting not with periods		
Decreased sex drive		
Sterility		
Pain not related with periods		
Possibly pregnant		
Age menses started:		
# of days of flow:		
# of days of cycle:		
Date of last period:		
Change in periods		
Irregular periods		
Heavy menses		
Scanty menses		
PMS		
Severe menstrual cramps		
Painful period		
Acne worse during period		
Surgical menopause		
Hot flashes		
Pain with intercourse		
Vaginal dryness		
Male		
Breast lump		
Decreased sex drive		
Impotence/sterility		
Difficulty having erections		
Penile discharge		
Penile soreness		
Lump in testicles		

Symptoms	Past	Present
ENDOCRINE SYSTEM		
Increased thirst		
Night sweats, cold		
Night sweats, hot		
Perspiration, decreased		
Perspiration, increased		
Hair loss		

LIFE SCRIPT WORKSHEET

PERSONALITY TRAITS

Check everything on the following list that describes you.

☐Aggressive	☐Disorganized	☐Idealistic	☐Practical	☐Withdrawn
☐Animated	☐Easily excitable	☐Melancholic	☐Quiet	☐Worrier
☐Approachable	☐Easily irritable	☐Moody	☐Reserved	
☐Assertive	☐Enthusiastic	☐Optimistic	☐Self-confident	
☐Calm	☐Fearful	☐Organized	☐Self-conscious	
☐Compassionate	☐Feel anxious	☐Outgoing	☐Sensitive	
☐Decisive	☐Feel inferior	☐Perfectionist	☐Shy	
☐Dependable	☐Friendly	☐Pessimistic	☐Spontaneous	
☐Depressed	☐Highly emotional	☐Poised	☐Undependable	

Which of your personality weakness would you like to be strengthened?

What are your main interests or hobbies?

Describe your childhood.

Have you ever seriously considered suicide or attempted suicide? Explain.

How do you describe your life in general—satisfactory, unsatisfactory, fulfilling, boring, too demanding?

Have you experienced any recent traumatic, life-changing events? If so, describe how it has impacted you.

On a scale of 1-10 (1=very little stress, & 10=an extreme amount of stress), what is your stress level?

List 3 major sources of your stress. Describe.

What do you believe about God and His healing power?

FOOD JOURNAL

Keep a record of your food intake for three consecutive days, including one weekend day. If you do not work Monday through Friday, then include two workdays, and one off day.

Example:	Days	1	2	3	4
		Wed	Thurs	Fri	Sat
	OR				
		Sun	Mon	Tues	Wed

- Record all foods and beverages consumed immediately after eating, as accurately as possible including the amount.
- Consider the ingredients in sandwiches or mixed dishes as separate items.
- List all fats used, including those in cooking and frying, and on bread, potatoes, and vegetables.
- Indicate if food or beverage is fresh, frozen, or canned and whether it was eaten raw or cooked.
- **Be honest and do not change your regular eating pattern while you are keeping this diary.**

SUMMARY OF HOW TO RECORD PORTION SIZES

Beverages: Record in ounces (1 cup=8 ounces)

Meat: Record in ounces (1 ounce of meat is about the size of a matchbox)

Potatoes, rice, fruits and vegetables: Record in cups

Jam, gravies, salad dressing, margarine, butter: Record in teaspoons or tablespoons (3 tsp. = 1 Tbsp.)

Bread, raw fruits and vegetables, cookies, nuts: Record by number and size

Desserts: Record by servings (large or small)

Mixed dishes (such as stews, casseroles, etc.)**:** Record the total amount eaten, e.g. 1 cup chicken soup or 1 cup of a casserole

Sandwiches: List ingredients separately, e.g. a vege-sandwich: 2 slices whole wheat bread, 1 tsp. mayonnaise, 1 slice vege-meat, etc.

DAY ONE

Time of Day	Food & Amount	Feelings	Time Spent Eating	Activity While Eating	Specific Location

DAY TWO

Time of Day	Food & Amount	Feelings	Time Spent Eating	Activity While Eating	Specific Location

DAY THREE

Time of Day	Food & Amount	Feelings	Time Spent Eating	Activity While Eating	Specific Location

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PREPARING FOR THE HEALTH SESSION

Praise God that you are coming! We welcome the privilege of serving and pray that our Heavenly Father will bless you in your quest for better physical and spiritual health. Here is some important information to prepare you for the trip and the experience during your stay.

WHAT TO BRING/WHAT NOT TO BRING

The following list of items will help you in deciding what you should bring and should not bring.

To bring:

1. Personal toiletries, such as shampoo, toothpaste, soap, etc.
2. Sleepwear, robe, slippers, and shower shoes (or flip flops)
3. Bathing suit for hydrotherapy, if desired. Therapy gowns are available.
4. Modest, casual, and dress clothes suitable to the climate and according with Christian standards. No halter tops, tank tops, or tight-fitting pants.
5. Walking shoes, a hat to protect from the sun, rain gear, boots or waterproof shoes, especially in colder weather
6. A recording device if you would like to tape the health lectures
7. A Bible, if you own one
8. A positive attitude

Not to bring:

1. Televisions, radios, secular or gospel rock music
2. Secular readings, such as magazines, novels, etc.
3. Food, snacks, tobacco, alcohol, or hard drugs
4. Pets
5. Your own health program or agenda

TRAVELING ARRANGEMENTS

- If you need to make contact with us during your travel on Sunday, please call (876) 351-1779.
- When traveling by air, you will need to arrive at the Kingston Norman Manly airport on Sunday (the first day of session). It would be best if you could arrive between 10 am and 12 pm. Please be mindful that other health guests may be arriving also and that there may be a minimal wait. You will be picked up at the Baggage Claims area. There will be someone with a M.E.E.T. Ministry sign.
- For those traveling that may need to arrive before Sunday, you will need to contact us prior to your travel so we may make appropriate arrangements for accommodations and pick up. Please notify us with the appropriate information via email or phone for us to make the pickup arrangements.
- If you are driving, please plan to arrive at approximately 1 pm. You can get settled with your belongings and take care of your financial arrangements.
- Lunch is served at 2:00 pm, and orientation begins at 4 pm.

- For return flight, please arrange for the last day of session, which is Wednesday for 10-day session, and Thursday for 18-day session. Flight times should be between 12 noon and 2 pm. Please be mindful that there is a two-hour driving period and most airports request arrival 2-3 hours prior to departure.

THINGS TO KNOW WHILE YOU ARE HERE

MEAL SERVICE

Meals will be served at the following times:

Breakfast	7:30 am
Lunch	2:00 pm
Supper	5:00 pm (only if necessary and written on your program)

TELEPHONE CALLS

Cell phone usage is discouraged and should be minimized during this opportunity for physical, mental and spiritual renewal. However, if you must make or receive a call, all outgoing and incoming calls are made using your personal cellular phone. Please limit calls to no more than half an hour. We would appreciate no incoming calls during therapy, rest time after therapy, worship, and after 9 pm.

BUSINESS OFFICE

The business office is open at 9:00 am-2:00 pm and 3:00-5:00 pm, Monday through Thursday.

VISITORS

Visitors are welcome with the understanding that there can be no interruption of the scheduled activities. They are also invited to join you for any of the lectures that are given during the time they are here. We do request that visitors not stay beyond the evening meeting. We further request that one guest not have more than 3 or 4 visitors at once. Other guests may wish to have visitors too, or may just want to sit in the living room or lounge and relax.

VISITING BETWEEN GUESTS

For visiting with other guests, please feel free to use the lecture area or living room. After 9:00 pm most guests prefer quiet. Your cooperation is appreciated.

VIDEOS

During your free time you may want to take advantage of the educational videos that are on hand. Many health subjects are available for your further learning.

LITERATURE

You are welcome to read any of the books found in the library.

TELEVISION, RADIO AND RECORDERS

We discourage TVs on the campus and in the Health Center. The television is for viewing videos only. It is not to be used for viewing movies, soaps, game shows, or any other programming. Health lectures, sermons, and music are a few of the different types of DVD’s and CD’s available for your listening and viewing enjoyment.

DRESS AND SOCIAL STANDARDS

Since this institution is a health retreat, and not a spa or a resort, it is only to be expected that both men and women be modestly attired at all times. The association between men and women must be on a high level to maintain the good name of the institution and its Christian principles. A dignified reserve should be maintained.

LAUNDRY

A washing machine is available for health guests in the laundry room. You may do laundry before 6:00 am or after 6:00 pm.

TOWN TRIPS

We discourage all but very necessary town trips through Health Center personnel, because of loaded schedules. Please see a health center staff member if a trip is necessary.