



## NOURISHED LIVING LIFESTYLE ASSESSMENT FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Current Weight in kilogram: \_\_\_\_\_

Current Height in centimetre: \_\_\_\_\_

### Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing) to improve your health

Significantly modify your diet \_\_\_\_\_

Take several nutritional supplements each day \_\_\_\_\_

Keep a record of everything you eat each day \_\_\_\_\_

Modify your lifestyle (e.g. work demands, sleep habits) \_\_\_\_\_

Engage in regular exercise \_\_\_\_\_

Rate on a scale of 5 (very confident) to 1 (not confident at all) \_\_\_\_\_

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through?

\_\_\_\_\_

Rate on a scale of 5 (very supportive) to 1 (very unsupportive) \_\_\_\_\_

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact) \_\_\_\_\_

### NUTRITION:

How many times a day do you eat?

Are you following a special type of diet (specify)? \_\_\_\_\_

How many times do you eat out in a week? \_\_\_\_\_

What type of restaurant do you typically go?

\_\_\_\_\_

What food is your favourite? \_\_\_\_\_

Do you have food allergies (specify)? \_\_\_\_\_

Do you adversely react to:

\_\_\_ Monosodium glutamate (MSG) \_\_\_ Artificial sweeteners \_\_\_ Garlic/

Onion \_\_\_ Cheese \_\_\_ Citrus foods \_\_\_ Chocolate \_\_\_ Alcohol \_\_\_ Red wine \_\_\_ Sulfite-

containing foods (wine, dried fruit, salad bars) \_\_\_ Preservatives \_\_\_ Food

Colorings \_\_\_ Caffeine \_\_\_ Other food substances

Do you know how to cook or prepare food? \_\_\_\_\_

Who cooks or prepare the food? \_\_\_\_\_

Check the factors that apply to your current lifestyle and eating habits:

\_\_\_Fast eater\_\_\_Eat too much\_\_\_Late-night eating\_\_\_Dislike healthy foods\_\_\_Time constraints\_\_\_Travel frequently\_\_\_Eat more than 50% of meals away from home\_\_\_Healthy foods not readily available\_\_\_Poor snack choices\_\_\_Significant other or family members don't like healthy foods\_\_\_Significant other or family members don't like healthy foods\_\_\_Significant other or family members have special dietary needs\_\_\_Love to eat\_\_\_Eat because I have to\_\_\_Have negative relationship to food\_\_\_Struggle with eating issues\_\_\_Emotional eater (eat when sad, lonely, bored, etc.)\_\_\_Eat too much under stress\_\_\_Eat too little under stress\_\_\_Don't care to cook\_\_\_Confused about nutrition advice

How many servings do you eat in a typical week of these foods:

Fruits (not juice)\_\_\_\_\_Vegetables (not including white potatoes)\_\_\_\_\_  
Legumes (beans, monggo, peas, etc.)\_\_\_\_\_Red meat\_\_\_\_\_Chicken\_\_\_\_\_  
Egg\_\_\_\_\_Fish\_\_\_\_\_Milk\_\_\_\_\_Nuts/Seeds\_\_\_\_\_Fats/Oils\_\_\_\_\_Cans of  
soda\_\_\_\_\_  
Sweets (candy, cookies, cake, ice cream, etc.)\_\_\_\_\_Chips\_\_\_\_\_

#### FOOD RECALL

Provide examples of your typical meals (specify the type and amount):

Breakfast

(time): \_\_\_\_\_

Lunch

(time): \_\_\_\_\_

Dinner

(time): \_\_\_\_\_

Snacks

(time): \_\_\_\_\_

Fluids/Beverages: \_\_\_\_\_

List Vitamins/Supplements/Herbals you are currently taking (specify the brand/  
milligram/dosage per day):

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

List Vitamins/Supplements/Herbals you have tried before (specify the brand/milligram/dosage per day):

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

List medications you are currently taking (specify the name/milligram/dosage per day):

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

**EXERCISE:**

Type	# Times per Week	Time/Duration (Minutes)

How many hours do you spend sitting in a day? \_\_\_\_\_

Do you feel motivated to exercise (yes/a little/no)? \_\_\_\_\_

Are there any problems that limit exercise? Yes/No. If Yes, explain \_\_\_\_\_

**SLEEP**

How many hours of sleep do you get each night on average? \_\_\_\_\_

During the day how long do you take naps? \_\_\_\_\_

What time do you got to bed? \_\_\_\_\_ What time do you wake up? \_\_\_\_\_

Do you have problems falling asleep? \_\_\_\_\_ Staying asleep? \_\_\_\_\_

Do you snore? \_\_\_\_\_ Do you have sleep apnea (i.e. breathing stops for 10 seconds)? \_\_\_\_\_

Do you use sleeping aids (specify)? \_\_\_\_\_

## STRESS

What is (or was) your current job? \_\_\_\_\_

What time is (or was) your job start & ends? \_\_\_\_\_

Have you experienced any trauma (i.e. physical, mental, emotional, sexual) in the past (specify)? \_\_\_\_\_

What level of stress do you feel you are experiencing at this time (rate 1-10)? \_\_\_\_\_

What are the major causes or factors of your stress? \_\_\_\_\_

What do you use to deal with stress? \_\_\_\_\_

What techniques do you use (e.g. meditation, breathing, tai chi, yoga, prayer)? \_\_\_\_\_

Are you currently seeing a psychotherapist/counsellor? \_\_\_\_\_

Any hobbies or leisure activities that you like to do? \_\_\_\_\_

## RELATIONSHIP/SOCIAL CONNECTIONS

Marital status \_\_\_\_\_ With whom do you live? \_\_\_\_\_

How is your relationship with your spouse, children, partner, friends, parents, siblings and workmates in general? \_\_\_\_\_

Who is your source of emotional support? \_\_\_\_\_

Do you connect with family, friends, community and other people? \_\_\_\_\_

What is your religious or spiritual practice? \_\_\_\_\_

## SUBSTANCES/ENVIRONMENTAL TOXINS

Tell me about your smoking, alcohol and recreational drug habits (specify the age you start and stop including the kind, amount and frequency) \_\_\_\_\_

Have you had a significant exposure to any harmful chemicals (specify)? \_\_\_\_\_

In your home or work environment are you regularly exposed to (check all that apply)

\_\_\_ Mold \_\_\_ Water leaks \_\_\_ Renovations \_\_\_ Chemicals \_\_\_ Car smoke

\_\_\_ Electromagnetic radiation \_\_\_ Damp environments \_\_\_ Carpets/rugs \_\_\_ Dust

\_\_\_ Old paints \_\_\_ Stagnant/stuffy air \_\_\_ Smokers \_\_\_ Pesticides \_\_\_ Herbicides

\_\_\_ Harsh chemicals (solvents, glues, gas, acids, etc) \_\_\_ Cleaning chemicals

\_\_\_ Heavy metals (lead, mercury, etc) \_\_\_ Paints \_\_\_ Airplane travel \_\_\_ Animals/Pets

\_\_\_ Plastics/Bottles \_\_\_ Large fishes (e.g. Tuna) \_\_\_ Grilled Foods \_\_\_ Unfiltered tap

water

Do you eat organic foods and produce? \_\_\_\_\_

Do you eat street foods or eat raw meat/fish (e.g. kinilaw, sushi, sahim)? \_\_\_\_\_

Do you use natural and toxic free personal and body care products? \_\_\_\_\_  
Do you have silver-mercury dental fillings in your mouth? \_\_\_\_\_