NOURISHED LIVING LIFESTYLE ASSESSMENT FORM

Name:_____Date:_____
Age:_____ Gender: _____

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 know how to cook or prepare food?_____
Who cooks or prepare the food?_____
How many servings do you eat in a typical week of these foods:
Fruits (not juice)_____ Vegetables (not including white potatoes)_____
Legumes (beans, peas, etc.)_____ Red meat_____ Chicken_____ Egg_____
Fish_____Dairy ((cheese, butter, ice cream, milk)_____Dairy free alternatives (almond, soy, rice, hemp seed milk)_____Nuts/Seeds_____ Fats/Oils (butter, animal fat, olive, avocado, canola, coconut oil)_____Cans of soda_____Sweets (candy, cookies, cake, ice cream, kakanin, etc.)_____Chips_____
Coffee (cups per day)_____Tea (cups per day)_____Water (glasses per day)_____
Fruit juice (cups per day)_____

Provide examples of your typical meals (specify the amount & timing):
Breakfast
(time):_____
_____
Lunch
(time):_____
_____
Dinner
(time):_____
_____
Snacks
(time):_____
_____
Fluids/Beverages:_____
_____

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

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

EXERCISE/MOVEMENT:

Type	# Times per Week	Time/Duration (Minutes)

How many hours do you spend sitting in a day?_____

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 go 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?_____Meditation____Breathing____Tai chi____Yoga_____Prayer_____Other (specify)
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 occupational or 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____Hair dye/cosmetics/nail colors_____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?_____
Do you use natural and toxic free personal and body care products?_____
Do you have silver-mercury dental fillings in your mouth?_____