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 (i.e. pesticide or hormone free)?_____
Do you eat street foods or eat raw meat/fish (e.g. kinilaw, sushi, sahimi)?
_____

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