LIFESTYLE ASSESSMENT FORM

Name: _____

Date: _____ Age: _____ Sex: F / M Height: _____ Weight: _____

Please answer each of the following questions. If you require additional space, use the back of the page.

What is your purpose in coming here today? _____

_____

_____

What are your main health concerns/complaints? Please list in priority:

_____

_____

Have you experienced any major trauma in the past 5 years? _____

_____

What level of stress do you feel you are experiencing at this time? Please quantify on a scale of 1 (low) to 10 (high): 1 2 3 4 5 6 7 8 9 10

What are the major causes or factors of your stress? (rate all that apply on a scale of 1 (low) to 10 (high):

___financial ___career ___personal ___marriage ___health

___family ___spiritual ___unfulfilled expectations

___other (please elaborate) _____

How does your stress manifest itself? _____

_____

Do you use any coping mechanisms? _____

What do you do for exercise? (indicate type, frequency, time of day and duration) _____

_____

On a scale of 1 (low) to 10 (high), how would you describe your energy levels? _____

Do you experience any lulls or highs in your energy levels throughout the day? If so, at what time of day? _____

How many hours on average do you sleep daily? (include naps) _____

What time do you go to sleep? _____ Awaken? _____

Do you have trouble falling asleep? ☐ Staying asleep? ☐

Do you awaken feeling rested? Yes ☐ No ☐ Do you snore? Yes ☐ No ☐

What is your occupation? _____

Do you enjoy your work? Yes ☐ No ☐ Sometimes ☐

How many hours each day do you work? _____

At what times do you start and end work? _____

Do you work shifts or are you on a regular schedule? _____

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Do you smoke? Yes ☐ No ☐ If yes, how much and for how long?

_____

If no, does anyone in your household or workplace smoke? Yes ☐ No ☐

Do you wish to gain weight? ☐ lose weight? ☐ how much? _____

By when do you wish to reach your goal weight? _____

What is your main motivation to change your weight? _____

_____

How many hours do you spend daily, on average: driving _____

watching television _____ reading _____ in front of computer _____

What are your interests and hobbies? _____

_____

Do you vacation regularly? Yes ☐ No ☐

When was your last vacation? _____

Do you actively participate in any spiritual discipline (church, religious group, meditation, etc.)? Yes ☐ No ☐

MEDICAL HISTORY:

Are you currently taking any medication? Yes ☐ No ☐

List all medications and the reason(s) for each _____

_____

_____

Do you take: birth control pills ☐

Have you taken antibiotics over the past five years? Yes ☐ No ☐

Please list any vitamins, minerals, herbal or homeopathic remedies you are currently taking and the amounts/dosages: _____

_____

_____

Do you have any allergies or sensitivities? Yes ☐ No ☐

If so, please list: _____

_____

Do you have anaphylaxis (life-threatening allergy)? If so, please describe:

_____

Do you have any silver-mercury fillings? Yes ☐ No ☐

Have you ever been:

a) Diagnosed with an illness? Yes ☐ No ☐ If so, please explain

_____

b) Hospitalized? Yes ☐ No ☐ If yes, for what reason?

_____

Have you had surgery to remove your gall bladder? ☐ tonsils? ☐ appendix? ☐

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How often do you have a bowel movement? _____
Do you strain to have a bowel movement? Yes ☐ No ☐ Occasionally ☐
Related to particular food or circumstances? _____

_____

Do you have loose bowel movements? Yes ☐ No ☐ Occasionally ☐
Related to particular food or circumstances? _____

_____

Is there undigested food in your stools? Yes ☐ No ☐ Occasionally ☐

Do you use recreational drugs? Yes ☐ No ☐
If yes, how often and what type? _____

Have you ever been treated for drug and/or alcohol dependency? Yes ☐ No ☐
If yes, please circle which you have been treated for.

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FAMILY HISTORY:

Hereditary Diseases: Use "F" for father, "M" for mother, "S" sibling, "G" for grandparent, "O" for other(s):

	Allergies		Diabetes		Intestinal Disease
	Alcoholism		Drug Abuse		Kidney Dysfunction
	Arthritis		Gall Bladder Issues		Mental Illness
	Asthma		Heart Disease		Osteoporosis
	Autoimmune Disease		Hypertension		Skin conditions
	Cancer - type:				Ulcers

Other diseases (please list) _____

Have you experienced fungal infections (e.g. jock itch, athlete's foot)?
Yes ☐ No ☐ If yes, please describe: _____

Have you experienced a decline in sexual interest? Yes ☐ No ☐
If yes, please describe:

_____

Have you had kidney or gall stones? Yes ☐ No ☐
If yes, please describe:

_____

FEMALES:

Are you or could you be pregnant? Yes ☐ No ☐
Have you noticed any changes in menses, for example the frequency, duration, flow, clotting, or other changes? Yes ☐ No ☐
If so, please specify _____

Do you suffer from PMS symptoms? Please specify _____
Are you pre-menopausal? Yes ☐ No ☐ Post-menopausal? Yes ☐ No ☐
Are you experiencing any menopausal symptoms? Yes ☐ No ☐
If yes, please specify _____

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Have you had a bone density test? Yes ☐ No ☐
If yes, what was the result? _____

MALES:

Have you experienced any prostate problems (e.g. frequent urination, discomfort during urination)? Yes ☐ No ☐ If yes, please describe:

_____

DIETARY HABITS:

How many times a day do you eat:

Main Meals _____ Times of day: _____

Snacks _____ Times of day: _____

Do you eat meals: with family ☐ home alone ☐ on the run ☐
restaurant ☐ fast food ☐

Do you feel there are restrictions to your diet due to preferences of others such as family, roommates, etc? Yes ☐ No ☐ If yes, please explain:

_____

How many ½ cup servings of each do you typically eat in a day:

____ Fruit: Fresh ☐ Dried ☐ Canned ☐
____ Vegetables: Cooked ☐ Raw ☐
____ Whole Grains
____ Protein: Types _____
____ Dairy Products: Type _____
____ Other: Specify _____

Provide examples of your typical meals:

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

Do you eat or use (indicate "1" for "rarely", "2" for "regularly","3" for "often")

	Aluminum pans		Margarine		Candy
	Microwave		Fried foods		Fast foods
	Luncheon meats		Cigarettes		
	Artificial sweeteners (Nutra Sweet, aspartame, Splenda)				
	Refined foods (pastries, white bread/pasta/rice, etc.)				

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Please indicate how many cups of the following you drink per day:

	Tap water		Fresh vegetable juices
	Bottled or spring water		Prepared vegetable juices
	Coffee		Soft drinks *(diet)*
	Tea		Soft drinks *(regular)*
	Herbal tea		Red wine
	Fresh fruit juices		White wine
	Fruit juices *(prepared)*		Beer
	Milk *(1%, 2% or whole)*		Other alcoholic beverages
	Milk *(skim)*		Other _____

For Office use only:

Are you a: ☐ meat eater? ☐ vegetarian? ☐ vegan?
How often do you eat meat? ☐ daily ☐ 3-5/week ☐ once/week or less
How often do you consume dairy products?
☐ daily ☐ 3-5/week ☐ once/week or less

What are your favourite foods? _____

_____

How often do you eat them? _____

Which food(s) do you crave, and how often do you eat them? _____

_____

Do you avoid certain foods? Yes ☐ No ☐ If so, why?

_____

Do you experience any symptoms if meals are missed? Explain:

_____

Do you experience any symptoms after meals? Explain:

_____

Comments: _____

_____

CLIENT STATEMENT:

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.

Date: _____ Signature: _____

Name: (please print) _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Phone: (H) _____ (W) _____ (C) _____

Thank you for your cooperation.
All information contained on this form will be kept strictly confidential.