LIFESTYLE ASSESSMENT FORM

CLIENT/PATIENT INFORMATION	Date:	

Full Name:		Date of Birth:	

Occupation:	

LIFESTYLE ASSESSMENT

To help us see where we can make your life better, please check the following that are troublesome and/or persist over time:

WOMEN

- ☐ Low energy
- ☐ Low sex drive
- ☐ Fatigue / Burned out feeling
- ☐ Weight gain
- ☐ Thinning hair
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Headaches
- ☐ Depression / Anxiety
- ☐ Foggy brain / Memory lapse
- ☐ Irritable
- ☐ Breast tenderness
- ☐ Water retention
- ☐ Vaginal dryness
- ☐ Difficulty with orgasm
- ☐ Heavy or irregular cycle
- ☐ Cramps
- ☐ Fibrocystic breasts
- ☐ Menopause / Post-MP bleeding
- ☐ History of thyroid issues
- ☐ Chronic pain

MEN

- ☐ Low energy
- ☐ Low sex drive
- ☐ Fatigue / Burned out feeling
- ☐ Weight gain
- ☐ Thinning hair
- ☐ Headaches
- ☐ Decreased urine flow
- ☐ Increased urinary urge
- ☐ Exercise intolerance
- ☐ Difficulty sleeping
- ☐ Depression / Anxiety
- ☐ Irritable
- ☐ Chest/nipple sensitivity
- ☐ Erectile performance
- ☐ Night sweats
- ☐ Poor concentration
- ☐ Muscle cramps
- ☐ Chronic pain

SKIN (both men and women)

- ☐ Wrinkles / Fine lines
- ☐ Loose or sagging skin
- ☐ Sagging cheeks
- ☐ Acne, Rosacea
- ☐ Sunspots, hyperpigmentation

GASTROINTESTINAL

(both men and women)

- ☐ Bloating after meals
- ☐ Sugar cravings
- ☐ Constipation
- ☐ Upset stomach
- ☐ History of ulcer

MUSCULOSKELETAL

(both men and women)

- ☐ Muscle injury
- ☐ Broken bones
- ☐ Torn ligaments
- ☐ Back pain
- ☐ Joint pain

Any current prescriptions, allergies? _____

Any major surgeries or hospitalizations? _____

What treatments are you doing or have you done to make you look and feel better? _____

_____

Provider Signature:	