HOLISTIC NUTRITION

Adult Assessment Form

Name:

Date: Gender: Age: Height: Weight:

Relationship status:

Please answer each of the following questions.

What is your purpose in seeking nutritional guidance?

_____

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

_____

Have you experienced any major physical/emotional trauma in the past five years?

_____

*On a scale of 1 (low) to 10 (high) W*hat level of stress are you experiencing at this time? _____

What are the major causes of your stress? *Rate all that apply on a scale of 1(low) to 10 (high)*

Financial____ Career____ Personal____ Marriage____ Health____Family_____ Spiritual_____

Unfilled expectations_____ Other (please specify)_____

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 level? ____

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? _____ Do you snore? _____

What is your occupation? _____

Do you enjoy your work? _____ How many hours per week do you work _____ At what time do

you start and end work? _____ Do you work shifts or a regular schedule _____

Do you smoke tobacco? ____ If yes, in what form, how much, and for how long?_____

_____If no, are you in close contact with someone that does smoke?_____

Do you use marijuana or any other recreational drugs?_____ If yes, what type /purpose /

how often_____

Have you ever been treated for drug and/or alcohol dependency? _____ If yes, which have you

been treated for _____

Do you wish to: Gain weight? _____ Lose weight? _____ How much? _____ Neither _____

When do you wish to reach your goal weight? _____

What is the main motivation to change your weight?_____

On average, how many hours per day do you spend: Driving _____ Watching television_____

Reading _____ In front of a computer _____

Which type of body care and household products do you use? Conventional ____Natural_____

What are your interests and hobbies?

_____

Medical History

Are you currently taking any prescription medication? _____

List all medications including vitamins, minerals, herbal or homeopathic remedies you are currently taking including reason(s) and dosage.

_____

Do you take: Birth control pills? _____ IUD? _____ Birth control injection? _____

Have you taken antibiotics over the past five years? If yes, how often?

_____

Do you have allergies or sensitivities? If so, please list: _____

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

_____

Do you have any silver mercury fillings? _____

Have you ever been diagnosed with an illness? If yes, please explain.

_____

Have you ever been hospitalized? If yes, for what reason?

_____

Have you had surgery to remove: Gallbladder _____ Tonsils _____ Appendix _____

How often do you have a bowel movement? _____

Is there undigested food in your stool? _____

Do you strain to have a bowel movement? _____ If yes, is it related to a particular food or circumstance? _____

Do you have loose bowel movements? _____ If yes, is it related to a particular food or circumstance? _____

Family History

Hereditary diseases: Use 'F' for father, 'M' for mother, 'S' for sibling, 'G' for grandparent and 'O' for other (s):

Allergies _____ Cystic Fibrosis _____ Mental health disorder, Type? _____ Obesity _____

Alzheimer's _____ Asthma _____ Huntington's Disease _____ Parkinson's Disease _____

Autoimmune Disease, Type? _____ Intestinal Disease, Type ? _____

Type 1 Diabetes _____ Type 2 Diabetes _____ Cancer, Type? _____

Kidney Dysfunction _____ Cardiovascular Disease, Type? _____

Liver or gallbladder disease _____ Skin conditions, Type? _____

Other diseases (please list) _____

Have you experienced fungal infections? (ie. jock itch, athlete's foot). If yes, please describe.

_____

Have you experienced a decline in sexual interest? If yes, please describe.

_____

Have you had kidney or gallstones? If yes, please describe. _____

Females

Are you or could you be pregnant? _____ If yes, which trimester? _____

History of miscarriages? _____

Have you noticed any changes in menses? ie. frequency, duration, flow, clotting or other changes? If so, please describe. _____

Do you suffer from PMS symptoms? _____ If yes, please describe.

_____

Post menopausal? _____

Are you experiencing any menopausal symptoms? _____ If yes, please describe.

_____

Males

Have you experienced any prostate problems? (ie. frequent urination, discomfort during urination). _____ If yes, please describe. _____

Dietary Habits

Main meals per day _____ Times of day: _____

Snacks per day _____ Times of day: _____

What is your weekly food budget? _____

Rate your food preparation skills on scale of *1 (low) to 10 (advanced)*. _____

Do you eat meals with: Family _____ Home alone _____ On the run _____ Fast food _____

Do you feel there are restrictions to your diet due to preferences of others such as family, roommates etc.? _____ If yes, please explain _____

How many 1/2 cup servings of each do you typically have per day:

Fruit: _____ Fresh _____ Canned _____ Dried _____

Vegetables: _____ Cooked _____ Raw _____

Grains: _____ Whole _____ Refined _____

Protein: _____ Type: _____

Dairy: _____ Type: _____

Please provide examples of your typical meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you eat or use: *(indicate '1' for rarely, '2' for regularly and '3' for often)*

Aluminum pans: _____	Margarine: _____	Candy: _____
Microwave: _____	Fried foods: _____	Fast foods: _____
Deli meat: _____	Cigarettes: _____	Artificial Sweeteners: _____
Refined foods: _____		

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

Tap water: _____	Coffee: _____	Tea: _____
Soft drinks (diet): _____	Soft drinks (regular): _____	Fresh fruit juices: _____
Milk (1%, 2%, whole): ____	Milk (skim): _____	Fresh vegetable Juices: _____

Red wine: _____ White wine: _____ Beer: _____

Other alcoholic bev: _____ Bottled/spring water: _____ Herbal Tea: _____

Are you a: Meat eater? _____ Vegetarian? _____ Vegan? _____

How often do you eat meat? _____

How often do you consume dairy products? _____

What are your favourite foods and how often do you eat them?

_____

Which foods do you crave and how often do you eat them?

_____

Do you avoid certain foods? _____ If so, why? _____

Do you experience any symptoms if meals are missed? If yes, explain:

_____

Do you experience any symptoms after meals? If yes, explain:

_____

The information I have provided is true and complete to the best of my ability.

Signature: _____

Date: _____