LIFESTYLE ASSESSMENT FORM

Name: _____

Date: _____ Female ☐ Male ☐ Age: _____ Height: _____ Weight: _____

Relationship status: Married ☐ Single ☐ Divorced ☐ Common Law ☐ Widowed ☐

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?

_____

What level of stress do you feel you are experiencing at this time? Please quantify on a scale of 1 (low) to 10 (high): ___

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/week do you work? _____

At what times do you start and end work? _____

Do you work shifts? ☐ regular schedule? ☐

Have you changed employment within the last 12 months? Yes ☐ No ☐

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Do you smoke tobacco? Yes ☐ No ☐ If yes, in what form, how much and for how long? _____

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

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

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, which you have been treated for. Drug ☐ Alcohol ☐

How long ago? _____

Do you wish to: Gain weight? ☐ Lose weight? ☐ How much? _____

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 .

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

Natural ☐ Conventional ☐

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 prescription medication? Yes ☐ No ☐

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

_____

Are you currently taking any over the counter medication? Yes ☐ No ☐

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

_____

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

_____

Do you take: Birth control pills ☐ IUD ☐ Birth control injection ☐

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

How often? _____

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Name: _____

Do you have 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 yes, please explain: _____

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

_____

Have you had surgery to remove: Gall bladder? ☐ Tonsils? ☐ Appendix? ☐

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 ☐

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

Allergies		Cystic fibrosis		Mental health disorder, Type?	
Alzheimer's		Hemochromatosis		Obesity	
Asthma		Huntington's disease		Parkinson's disease	
Autoimmune disease, Type?		Intestinal disease, Type?		Type 1 diabetes	
Cancer, Type?		Kidney dysfunction		Type 2 diabetes	
Cardiovascular disease, Type?		Liver or gall bladder disease, Type?		Skin conditions, Type?	

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: _____

_____

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Name: _____

FEMALES:

Are you or could you be pregnant? Yes ☐ No ☐

If yes, which trimester? _____

History of miscarriages? _____

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 peri-menopausal? Yes ☐ No ☐ Menopausal? Yes ☐ No ☐

Post-menopausal Yes ☐ No ☐

Are you experiencing any menopausal symptoms? Yes ☐ No ☐

If yes, please specify _____

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: _____

What is your weekly food budget. _____

Rate your food preparation cooking skills: 1 (low) to 10 (advanced): ___

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 ☐

____ Grains: Whole ☐ Refined ☐

____ Protein: Type _____

____ Dairy Products: Type _____

____ Other: Specify _____

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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 (white sugar, pastries white bread/pasta/rice, etc.)

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

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

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/wk ☐ Once/or less/wk ☐

What are your favourite foods? _____

How often do you eat them? _____

Which food(s) do you crave? _____

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? Yes ☐ No ☐

Explain: _____

Do you experience any symptoms after meals? Yes ☐ No ☐

Explain: _____

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test

BODY – MIND CONNECTION:

What is the primary symptom that relates to the main health concern? If list multiple health concerns, please provide or refer to the symptom that is affecting you the most. _____

_____

What is the normal physiological function of the body area affected?

_____

How does the above symptom and main health concern affect you on the daily basis?

_____

Which emotion/feeling comes to mind when you think of the above symptom or the main health concern:

Check any below or list: _____

Anger	☐	Ashamed	☐	Nervous	☐
Sadness	☐	Annoyed	☐	Exhausted	☐
Hurt	☐	Guilty	☐	Irritated	☐
Resentment	☐	Frustrated	☐	Isolated	☐
Fearful	☐	Disappointed	☐	Betrayed	☐

List any positive changes in your life that has resulted from this symptom or health concern?

_____

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: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

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