

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 have you 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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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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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 (<i>diet</i>)	White wine
Soft drinks (<i>regular</i>)	Beer
Fresh fruit juices	Other alcoholic beverages
Fruit juices (<i>prepared</i>)	Bottled or spring water
Milk (<i>1%, 2%, or whole</i>)	Herbal tea
Milk (<i>skim</i>)	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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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	<input type="checkbox"/>	Ashamed	<input type="checkbox"/>	Nervous	<input type="checkbox"/>
Sadness	<input type="checkbox"/>	Annoyed	<input type="checkbox"/>	Exhausted	<input type="checkbox"/>
Hurt	<input type="checkbox"/>	Guilty	<input type="checkbox"/>	Irritated	<input type="checkbox"/>
Resentment	<input type="checkbox"/>	Frustrated	<input type="checkbox"/>	Isolated	<input type="checkbox"/>
Fearful	<input type="checkbox"/>	Disappointed	<input type="checkbox"/>	Betrayed	<input type="checkbox"/>

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.