LIFESTYLE ASSESSMENT FORM

Name: ____________________________________________

Date: ___________________________ Age: __________ Sex: __________

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 ever been diagnosed with an ailment related to your main health concern(s)?

Any trauma or loss in the last 5 years? _____________________________________________________________

What level of stress do you feel you are experiencing at this time? Please quantify on a scale of 1 to 10: __________

What are the major causes or factors of your stress? (Check all that apply)

☐ financial ☐ career ☐ personal ☐ marriage ☐ health
☐ family ☐ spiritual ☐ unfulfilled expectations
☐ other (please elaborate) _________________________________________________________________

How does your stress manifest itself? ______________________________________________________________

What coping mechanisms do you use? _______________________________________________________________

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

On a scale of 1-10, how would you describe your energy levels (1 indicating very low energy) __________

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 ☐

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 do work shifts or are you on a regular schedule? __________________________

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Name: ____________________________

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? ______________________

When, if ever, were you last at your 'ideal' weight? ______________________

Have you tried weight loss programs in the past (if so, please describe)?
______________________________________________________________

What were the results? _____________________________________________

What did you like/dislike about the program(s)? _______________________

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 □
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MEDICAL HISTORY:
Are you currently taking any medication(s)? Yes ☐ No ☐
Do you take: birth control pills ☐ antidepressants ☐
List any other medication(s) and reason(s) for taking each: ______________

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 any silver-mercury fillings? Yes ☐ No ☐
Have you ever been diagnosed with an illness? Yes ☐ No ☐ If yes, please explain: ______________

Have you ever been hospitalized? Yes ☐ No ☐ If yes, for what reason?

Have you had surgery to remove your gall bladder? ☐ appendix? ☐ tonsils? ☐
How often do you have a bowel movement? ______________
Do you strain to have a bowel movement? Yes ☐ No ☐ Occasionally ☐
If yes, is it related to a particular food or circumstance? ______________

Do you have loose bowel movements? Yes ☐ No ☐ Occasionally ☐
If yes, is it related to a particular food or circumstance? ______________

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 one.
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FAMILY HISTORY:

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Other (please list)_____________________________________________________

FEMALES:
Are you or could you be pregnant? Yes ☐ No ☐
Have you noticed any changes in your menses, for example, in the frequency, duration, flow, clotting, etc.? 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: ____________________________________________
Have you had a bone density test? Yes ☐ No ☐
If yes, what was the result? _______________________________________

DIETARY HABITS:
How many times a day do you eat?
Main Meals _______ Times of day: __________________________________
Snacks _________ Times of day: ____________________________________
How do you eat meals? With family ☐ Home alone ☐ On the run ☐
At a 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: __________________________________________
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How many ½ cup servings of each of the following do you typically eat in a day?

____ Fruit: Fresh □ Dried □ Canned □

____ Vegetables: Cooked □ Raw □

____ Whole Grains

____ Protein: Type ____________________________________________

____ Dairy Products: Type _____________________________________

____ Other: Specify __________________________________________

Give examples of your typical meals:

Breakfast: _______________________________________________________

________________________________________________________________

Lunch: _________________________________________________________

________________________________________________________________

Dinner: _________________________________________________________

________________________________________________________________

Snacks: _________________________________________________________

________________________________________________________________

Please indicate if you eat or use the following: (indicate “1” for “rarely”, “2” for “regularly”, ”3” for “often”)

□ Aluminum pans ______ □ Margarine ______ □ Candy ______

□ Microwave ______ □ Fried foods ______ □ Refined foods ______

□ Luncheon meats ______ □ Cigarettes ______ □ Fast foods ______

□ Nutra Sweet/Aspartame ______

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

____ Beer ______ Red wine

____ Coffee ______ White wine

____ Tap water ______ other alcoholic beverages

____ Soft drinks (diet) ______ Tea

____ Soft drinks (regular) ______ Fresh fruit juices

____ Fruit juices (prepared) ______ Bottled or spring water

____ Milk (1% or 2%) ______ Herbal tea

____ Milk (skim) ______ other _____________________________

____ Fresh vegetable juices

Are you a: □ meat eater? □ vegetarian? □ vegan?

How often do you eat meat? □ Daily □ 3-5/week □ Once/week or less
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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? _______________________________________

Do you avoid certain foods? 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: __________ P.C.: _________________

Phone: (H) ______________________ (B) ________________________________

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