

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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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:

Hereditary Diseases: Use “**F**” for father, “**M**” for mother, “**S**” sibling, “**G**” for grandparent, “**O**” for others

_____ Allergies	_____ Diabetes	_____ Kidney Dysfunction
_____ Alcoholism	_____ Drug Abuse	_____ Mental Illness
_____ Arthritis	_____ Gall Bladder Problems	_____ Osteoporosis
_____ Asthma	_____ Heart Disease	_____ Skin conditions
_____ Autoimmune Disease	_____ Hypertension	_____ Ulcers
_____ Cancer, type	_____ Intestinal Disease	

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: _____

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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.