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

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.

Diet Diary: Registered Holistic Nutrition

Name: ____ Date: ____________________

Please record 3 days of consecutive eating. No judgement here...this is simply info to find potential imbalances.

Day/Time	Food, Drink, Snack, and Portion Size (include everything including gum)	How you felt (symptoms, mood)
I.e. 7:00 am	Coffee (starbucks) with 2 cream, 2 tsp sugar, bagel with butter	Hungry, low mood

Balance Point
Health Centre Inc.

Day/Time	Food, Drink, Snack, and portion size (include everything including gum)	How you felt (symptoms, mood)

Balance Point
Health Centre Inc.