

LIFESTYLE ASSESSMENT FORM

Name: _____

Date: _____ Age: _____ Sex: F / M Height: _____ Weight: _____

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 experienced any major trauma in the past 5 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): 1 2 3 4 5 6 7 8 9 10

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 do you work? _____

At what times do you start and end work? _____

Do you 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? _____

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

MEDICAL HISTORY:

Are you currently taking any medication? Yes No

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

Do you take: birth control pills

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 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 so, please explain

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

Have you had surgery to remove your gall bladder? tonsils? appendix?

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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

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 you have been treated for.

FAMILY HISTORY:

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

<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Intestinal Disease
<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	Kidney Dysfunction
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Gall Bladder Issues	<input type="checkbox"/>	Mental Illness
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	Autoimmune Disease	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Skin conditions
<input type="checkbox"/>	Cancer - type:	<input type="checkbox"/>		<input type="checkbox"/>	Ulcers

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: _____

FEMALES:

Are you or could you be pregnant? Yes No

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 pre-menopausal? Yes No Post-menopausal? Yes No

Are you experiencing any menopausal symptoms? Yes No

If yes, please specify _____

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Have you had a bone density test? Yes No

If yes, what was the result? _____

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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: _____

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 1/2 cup servings of each do you typically eat in a day:

___ Fruit: Fresh Dried Canned

___ Vegetables: Cooked Raw

___ Whole Grains

___ Protein: Types _____

___ Dairy Products: Type _____

___ Other: Specify _____

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

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

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

For Office use only:

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/week once/week or less

What are your favourite foods? _____

How often do you eat them? _____

Which food(s) do you crave, and 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? 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: _____ Postal Code: _____

Phone: (H) _____ (W) _____ (C) _____

Thank you for your cooperation.

All information contained on this form will be kept strictly confidential.