LIFESTYLE ASSESSMENT FORM

Name: _____

Date: _____ Age: _____ Sex: _____

Please answer each of the following questions. Please use the back of the page for additional space.

What is your purpose in coming here today?

_____

What are your main health concerns/complaints?

_____

_____

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?

Minimal _____ Average _____ Considerable _____ Unbearable ____

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? _____

_____

Do you use any coping mechanisms? _____

What do you do for exercise? (indicate type, frequency and time) _____

_____

How many hours on average do you sleep daily? (include naps) _____

What time do you go to sleep? _____ Awaken? _____

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 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? _____

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? Yes _____ No _____
List Reason(s) _____

Please list any vitamins, minerals, herbal or homeopathic remedies you are currently taking and the amounts/dosages: _____

_____

_____

Do you have any allergies or sensitivities? If so, please list:

_____

Do you have any silver-mercury fillings? Yes _____ No _____

Have you ever been:
Diagnosed with an illness? Explain _____

_____

Hospitalized? Reason _____

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? _____

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.

FAMILY HISTORY:

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

_____ Heart Disease	_____ Diabetes	_____ Allergies
_____ Hypertension	_____ Arthritis	_____ Mental Illness
_____ Intestinal Disease	_____ Osteoporosis	_____ Alcoholism
_____ Kidney Dysfunction	_____ Ulcers	_____ Asthma
_____ Gall Bladder Problems	_____ Cancer, type: _____	

Other (please list) _____

FEMALES:

Are you or could you be pregnant? Yes _____ No _____
Are you pre-menopausal or 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? _____

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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 the preferences of others -
Family, roommates, etc? Yes ___ No ___ If yes, explain _____

_____

How many ½ cup servings of each 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: _____

_____

Do you eat or use (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:

____ bottled or spring water	____ tap water	____ milk *(1% or 2%)*
____ fresh fruit juices	____ beer	____ milk *(skim)*
____ fruit juices *(prepared)*	____ red wine	____ tea
____ fresh vegetable juices	____ white wine	____ herbal tea
____ soft drinks *(regular)*	____ other alcoholic	____ coffee
____ soft drinks *(diet)*	other (specify) _____	

LIFESTYLE ASSESSMENT FORM

Name: _____

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? _____

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.