

## 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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Name: \_\_\_\_\_

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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## LIFESTYLE ASSESSMENT FORM

Name: \_\_\_\_\_

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.)				

## LIFESTYLE ASSESSMENT FORM

Name: \_\_\_\_\_

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 _____

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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.*