

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) _____

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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? _____

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.*