

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.*