LIFESTYLE ASSESSMENT FORM

NAME: ________________________________ **AGE:** _________ **DATE:** __________________

Please answer each of the following questions. If you require additional space please use the back of the page.

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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)? ____

Do you wish to gain weight? ____ lose weight? ____ How much? ______

What level of stress do you feel you are experiencing at this time?
____ minimal ____ average ____ considerable ____ unbearable
What are your 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? _______________________________

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 type of work do you do? ___________________________________
Do you enjoy your work? ____Yes ____ No ____ Sometimes
How many hours each day do you work? ____________________________
At what time do you start and end work ? ___________________________

Do you smoke? ____ Yes ____ No If yes, how much? _______________
If no, does anyone in your household or workplace smoke? ____ Yes ____ No

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

____

How many hours a day do you spend on average:
driving ____ watching television ____ reading ____ in front of a computer ____

What are your interests and hobbies? _______________________________

____

Do you take vacations regularly? ____ Yes ____ No
When was your last vacation? _____________________________
Do you actively participate in any spiritual discipline
(church, religious group 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? If so please list: ____________________________

____

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

____

Hospitalized? For what 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 circumstance? ____________________________

Do you have loose bowel movements ? Yes ___ No ___ Occasionally ___

Related to particular food or circumstance? ____________________________

Have you ever been treated for drug dependency? ____ Yes ____ No

Have you ever been treated for alcohol dependency? ____ Yes ____ No

FAMILY HISTORY:

Hereditary Diseases:

Please use "F" for Father, "M" for Mother, "S" for Siblings, "G" for Grandparents, "O" for other relatives.

____ Heart disease ____ Diabetes ____ Allergies

____ Hypertension ____ Arthritis ____ Mental Illness

____ Intestinal disease ____ Osteoporosis ____ Cancer

Other (please list): ____

FEMALES OVER 40:

Are you pre-menopausal or menopausal? Yes ___ No ___

Are you experiencing any 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 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 ____________________________________

How would you typically combine these in an average day:

Breakfast: ____

____

Lunch: ____

____

Dinner: ____

____

Snacks: ____

____

Do you eat or use:

____ fried foods ____sugar ____ margarine
____ fast foods ____ candy ____ microwave
____ luncheon meats ____ Aspartame ____ aluminum pans
____ refined foods ____ Nutra-Sweet ____ cigarettes

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

____ bottled or spring water ____ tap water____ milk (skim)
____ fresh fruit juices ____ beer ____ milk (1% or 2%)
____ 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 a week/less

How often do you consume dairy products?

______ Daily ______ 3-5 / week ______ once a week / 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: ______________________________ Province: ________________ Postal Code: _______________

Telephone: (H): _________________________ (B): ______________________

Email: ____

Thank you for you cooperation.