LIFESTYLE ASSESSMENT FORM

This evaluation is designed to assess symptoms that may relate to nutritional imbalance. Its sole purpose is to educate and inform. It is not designed to diagnose diseases. If you suspect you have a problem that requires the attention of a medical practitioner, please see your physician or naturopath for medical care.

It will take approximately 20-30 minutes to complete this form. Please bring it with you to your first appointment.

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

GENERAL INFORMATION

Name: _____Date: _____

Date of Birth: _____Marital Status: _____ Number of Children: _____

Email Address: _____

Home Phone#: _____ Cell Phone#: _____

What is the main reason you made an appointment to come here today? _____

_____

What are your main health concerns in order of importance to you personally?

1. _____

2. _____

3. _____

How are you feeling?

_____

What are you doing for your health presently? [circle all that apply]:

Exercise	Vitamins	Minerals	Herbs
Chiropractor	Prescription Medication	Diet	Meditation
Medical Doctor	Relaxation Techniques	Acupuncture	Other:_____

What do you believe or suspect might be the underlying factors contributing to your present health concerns?

_____

Any trauma or loss in the last 5 years? _____

Height: _____ Weight: _____

Do you wish to: [circle one]: Gain weight Lose weight

How much weight would you like to gain or lose? _____

By when do you wish to reach your goal weight? _____

What is your main motivation to change your weight? _____

How is your blood pressure?_____

What level of stress do you feel you are experiencing at this time? Please quantify on a scale of 1 to 10: _____

What are the major causes or factors of your stress? [circle all that apply]

Financial Career Personal Marriage Health Family Spiritual

Unfulfilled Expectations Other [Please Specify]:_____

How does your stress manifest itself? _____

What coping mechanisms do you use? _____

On a scale of 1-10, how would you describe your energy levels (1 indicating very low energy)

_____

Do you experience any lulls or highs in your energy levels throughout the day? If so, at what time of day?

_____

How many hours do you sleep daily? [Average; 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 Sometimes

How many hours a day do you work? _____

What type of work do you do? _____

Do you enjoy your work? [circle one] Yes No Sometimes

Do you work shifts or are you on a regular schedule? _____

How many hours each day do you spend driving? [Average] _____

Do you smoke? [circle one] Yes No If yes, how much? _____

If no, are you often exposed to second-hand smoke? [circle one] Yes No

Describe what you do for exercise? (Indicate type, frequency, time of day and duration)

_____

_____

How many hours a day do you:

_____ Watch television _____ Read _____ Spend in front of a computer? _____

What are your interests/hobbies? _____

_____

Do you take vacations regularly? [circle one] Yes No

When was your last vacation? _____

How did you spend your last vacation? _____

Do you actively participate in a church or spiritual group? [circle one] Yes No

MEDICAL HISTORY

Are you currently taking any medication? [circle one] Yes No

List medication and Reasons(s): _____

_____

Do you take birth control pills? _____ antidepressants? _____

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

_____

_____

Do you have any allergies? If yes, please list: _____

_____

Have you ever been:

_____ Diagnosed with an illness? Explain: _____

_____ Hospitalized? For what reason: _____

Have you had surgery to remove your gall bladder? _____ tonsils? _____ appendix? _____

How often do you have a bowel movement? _____

Do you strain to have a bowel movement? [circle one] Yes No Sometimes

If yes, is it related to a particular food or circumstance? _____

FAMILY HISTORY

Hereditary Diseases: Please indicate "F" for Father, "M" for Mother,
"S" for Siblings, "G" for Grandparents, "O" for Other relatives.

_____ Heart Disease	_____ Diabetes	_____ Allergies
_____ Hypertension	_____ Arthritis	_____ Mental illness
_____ Cancer	_____ Osteoporosis	_____ Intestinal disease

Other [Please list]: _____

_____

Have you ever been treated for drug and/or alcohol dependency? [circle one] Yes No

Do you eat or use: [check all that apply]

_____ aluminum pans	_____ microwave	_____ margarine
_____ candy	_____ fried foods	_____ refined/processed foods
_____ luncheon meats	_____ cigarettes	_____ artifical sweetener
_____ fast foods	_____ air fresheners	_____ scented body products

Please indicate how many cups of the following, you drink per day or week		
Beverage	Number of cups per day	Number of cups per week
Coffee		
Tea (regular)		
Herbal tea/Green tea		
Tap water		
Bottled/Spring water		
Soft drinks (diet)		
Soft drinks (regular)		
Fruit juices (prepared)		
Fruit juices (freshly squeezed)		
Vegetables juices (freshly squeezed)		
Vegetables juices (prepared) Example: V8		
Milk (skim)		
Milk (1% or 2%)		
Beer		
Red wine		
White wine		
Other alcoholic beverage		
Other (Please Specify):		

Are you: [check one]

_____ A meat eater
_____ Lacto-ovo-vegetarian - eat dairy, and eggs, but exclude animal flesh
_____ Ovo-vegetarian - eat eggs, but no dairy or animal flesh
_____ Lacto-vegetarian - eat dairy, but no eggs or animal flesh
_____ Vegan - eat no animal foods of any type
_____ Semi-vegetarian - eat dairy, eggs, poultry and fish, but avoid red meat
_____ Flexi-tarian – eat dairy, eggs, fish and poultry, with some vegetarian meals

How often do you eat meat? [circle one] Daily 3-5 times week Once a week or less

How often do you consume dairy products? [circle one]

Daily 3-5 times week Once a week or less

What are your favourite foods? _____

How often do you eat them? _____

What foods do you crave, if any? _____

Do you experience any symptoms if meals are missed? Explain: _____

_____

Do you avoid certain foods? If so, what are they and why do you avoid them?

_____

_____

Do you experience any symptoms after meals? Explain: _____

_____

Is there anything else about your health that you would like to share with me?

_____

_____