

LIFESTYLE ASSESSMENT FORM

Greetings and congratulations for taking this important step in achieving and maintaining your personal health and wellness! Nutrition is one of many complimentary therapies that will help you on your path to a vibrant, balanced life. The following questionnaire will aid me, your nutritionist, in designing the optimal nutritional course of action for your unique needs and lifestyle. Please be as honest as possible. *If you require more space, use the back of the page.* The more accurate the information I receive, the better equipped I am to provide you with a complete assessment. **Please print this form out and complete it for our first appointment.** If you are unsure about a question, leave it blank and we can discuss it then. I look forward to meeting with you soon!

Name: _____ Date: _____
Sex: _____ Age: _____ Height: _____ Weight: _____
Marital Status: _____ Number of children: _____

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What are your main health concerns/complaints? _____

What is your main purpose in seeking out nutritional counseling? _____

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? _____

What coping mechanisms do you use? _____

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? _____

What times do you start and end work? _____

Do you smoke? Yes No If yes, how much and for how long? _____

Does anyone in your home or workplace smoke? Yes No

Do you wish to gain weight? Lose weight? How much? _____

On average, how many hours do you spend each day:
Driving ____ Watching TV ____ Reading ____ On Computer ____

What are your interests and hobbies? _____

What do you do for relaxation or for enjoyment? _____

Do you vacation regularly? Yes No

When was your last vacation? _____

Do you actively participate in any spiritual discipline (ex. church, meditation, religious group, etc?) Yes No

Are you currently working with a professional counselor, psychologist, social worker, pastor or therapist? Yes No

Are you being treated with any other holistic therapies? (ex. Chiropractor, massage, acupuncture, etc.) _____

Medical History:

Are you currently taking any medication? Yes No

List dosage/Reason(s): _____

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

How often do you take antibiotics? Rarely Regularly Often

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: _____

Been hospitalized? Reason: _____

Had surgery? 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? _____

Do you use recreational drugs? Yes No

If yes, what type and how often? _____

Have you ever been treated for drug/alcohol dependency? Yes No

Females:

Are you taking any kind of contraceptive? Yes No
Are you or could you be pregnant? Yes No
Are your periods: Regular Irregular Heavy Light
Do you experience PMS symptoms? If yes, please elaborate: _____

Are you pre-menopausal or menopausal? Yes No
Are you experiencing any symptoms? If yes, please elaborate:

Have you had a bone density test? If so what was the result? _____

Family History:

Hereditary Diseases: Use "F" for father, "M" for mother, "S" for sibling, "G" for grandparent, "O" for other

___ Heart Disease ___ Diabetes ___ Allergies
___ Hypertension ___ Arthritis ___ Mental Illness
___ Intestinal Disease ___ Osteoporosis ___ Alcoholism
___ Asthma ___ Ulcers ___ Gall Bladder Problems
___ Kidney Dysfunction ___ Cancer, type: _____

Other: _____

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
 At Restaurants Fast Foods

Do you feel there are restrictions to your diet due to preferences of others? (ex. Roommates, family, spouse, etc.) Yes No
If yes, explain: _____

Are you a: Meat Eater? Vegetarian? Vegan?
How often do you eat meat? daily 3-5x/week once/week or less
How often do you consume dairy? daily 3-5x/week once/week or less
How often do you eat fish? once a week or more once a month or less

Do you eat or use (indicate "1" for "rarely", "2" for "regularly", "3" for "often"):
 Aluminum pans Fried foods
 Microwave Candy/Junk food
 Luncheon meats Refined foods (ex. White bread, baked goods)
 Artificial sweeteners Fast foods
 Margarine Processed/packaged foods (ex. Microwave dinner, crackers, cereal, ketchup)

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How many cups of the following do you drink each day?

- | | |
|--|--|
| <input type="checkbox"/> Beer | <input type="checkbox"/> Milk (1% or 2%) |
| <input type="checkbox"/> Wine | <input type="checkbox"/> Milk (skim) |
| <input type="checkbox"/> Other alcoholic beverages | <input type="checkbox"/> Prepared fruit drinks |
| <input type="checkbox"/> Coffee | <input type="checkbox"/> Bottled water |
| <input type="checkbox"/> Black tea | <input type="checkbox"/> Tap water |
| <input type="checkbox"/> Green tea | <input type="checkbox"/> Filtered water |
| <input type="checkbox"/> Herbal tea | <input type="checkbox"/> Fresh fruit or vegetable juices |
| <input type="checkbox"/> Soft drinks (regular) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Soft drinks (diet) | |

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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: _____

Is there anything else you feel that I should know in order to better serve you?

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: _____

Name (please print): _____

Signature: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Telephone: _____

E-Mail Address: _____

** All information contained on this form will be kept confidential.*