
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: _____

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?

Height: _____ Weight _____

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

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

How is your blood pressure? _____

What level of stress do you feel you are experiencing at this time in your life? [circle one]

Minimal Average Considerable Unbearable

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 many hours do you sleep daily? [Average; include naps] _____

Do you wake feeling rested? [circle one] Yes No Sometimes

Describe your energy level? _____

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

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? _____

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/Reasons(s): _____

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: _____

How often do you have a bowel movement? _____

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

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

DIETARY HABITS

How many times a day do you eat:

Main meals _____ What times of the day: _____

Snacks _____ What times of the day: _____

On a typical day, what would you eat for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

At what time do you have your last meal or snack of the day? _____

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

_____ aluminum pans _____ microwave _____ margarine
_____ candy _____ fried foods _____ refined/processed foods
_____ luncheon meats _____ cigarettes _____ artificial 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?

CLIENT STATEMENT

I understand and acknowledge that the services hereby 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 diagnoses, 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. All information will be kept strictly confidential.

Today's date: _____

Name (Please print): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: (Home) _____ (Work) _____

E-mail: _____

Signature: _____