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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Name:

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:
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? _______
LIFESTYLE ASSESSMENT FORM

Name: ____________________________

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%)
□ 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) __________
LIFESTYLE ASSESSMENT FORM

Name: ________________________________

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: _____________________________________________.

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) ________________________________  (H) ________________________________

Thank you for your cooperation.
All information contained on this form will be kept strictly confidential.