

Name: _____

LIFESTYLE ASSESSMENT FORM

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: F M

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Email: _____

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

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 have 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?

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Name: _____

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

MEDICAL HISTORY:

Are you currently taking any medications? Yes No

List Reason(s) _____

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

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 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

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FAMILY HISTORY:

Heredity Diseases:

Use "F" for father, "M" for mother, "S" for sibling, "G" for grandparent, "O" for others

_____ Heart Disease _____ Diabetes _____ Allergies
_____ Hypertension _____ Arthritis _____ Mental
Illness _____ Intestinal Disease _____ Osteoporosis _____ Alcoholism
_____ Asthma _____ Ulcers
_____ Gall Bladder Problems
_____ Kidney Disfunction _____ 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?

DIETARY HABITS:

How many times a day do you eat:

Main Meals _____ Times of day: _____

Snacks _____ Times of day: _____

So 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 1/2 cup serving 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 _____

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Give examples of your typical meals:

Name: _____

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you eat or use (indicate "1" for rarely, "2" for regularly, "3" for often)

- | | | |
|--|--|--|
| <input type="checkbox"/> aluminum pans _____ | <input type="checkbox"/> margarine _____ | <input type="checkbox"/> candy _____ |
| <input type="checkbox"/> microwave _____ | <input type="checkbox"/> fried foods _____ | <input type="checkbox"/> refined foods _____ |
| <input type="checkbox"/> luncheon meats _____ | <input type="checkbox"/> cigarettes _____ | <input type="checkbox"/> fast foods _____ |
| <input type="checkbox"/> Nutra Sweet/Aspartame _____ | | |

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

- | | |
|---------------------------------------|--------------------------------|
| ____ beer | ____ red wine |
| ____ coffee | ____ white wine |
| ____ tap water | ____ other alcoholic beverages |
| ____ soft drinks (<i>diet</i>) | ____ tea |
| ____ soft drinks (<i>regular</i>) | ____ fresh fruit juices |
| ____ fruit juices (<i>prepared</i>) | ____ bottles or spring water |
| ____ milk (<i>1% or 2%</i>) | ____ herbal tea |
| ____ milk (<i>skim</i>) | ____ other _____ |
| ____ fresh vegetable juices | |

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 favorite 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: _____

Comments: _____

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