LIFESTYLE ASSESSMENT FORM

Name: _____

Date of birth: _____

What is your purpose in coming today?_____

_____

What are your main health concerns/complaints?

_____

Have you ever been diagnosed with an ailment related to your main health concerns?

_____

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** ☐ **Health**

☐ **Family** ☐ **Unfulfilled expectations**

☐ **Other (please elaborate)**

_____

How does your stress manifest itself?

☐ **Anger** ☐ **Anxiety** ☐ **Changes in eating habits** ☐ **Fatigue** ☐ **Gastrointestinal disturbances**

☐ **Headache** ☐ **Loss of enthusiasm or energy** ☐ **Mood changes** ☐ **Sleep disturbances**.

Do you use any coping mechanisms?

_____

What do you do for exercise? (Indicate type, frequency and time)

_____

What is your occupation?_____

Do you enjoy your work? **Yes** ☐ **No** ☐ **Sometimes**

How many hour each day do you work? _____

At what times do you start and end your work? _____

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

Does anyone in your household or workplace smoke? ☐ Yes ☐ No

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

How many hour you spend daily, on average:

Driving _____Watching television_____ Reading_____ In front of computer_____

What are your interests and hobbies?

_____

How often do you vacation? _____

When was your last vacation? _____

Do you participate in any spiritual discipline (church, religious group, meditation?) Yes☐ No☐

How many hours on average do you sleep? _____

What time do you go to sleep? _____ What time do you wake up? _____

Do you awaken feeling rested? ☐ Yes ☐ No

For office use

_____

_____

MEDICAL HYSTORY

Are you currently taking any medications? ☐ Yes ☐ No If yes, list reasons:

_____

Please list any vitamins, minerals, herbal or homeopathic remedies you are currently taking:

_____

_____

Do you have any allergies or sensitivities? If yes please list:

_____

Have you ever been diagnosed with illness? If yes, please explain:

_____

How often do you have a bowel movement?_____

FAMILY HYSTORY:

Hereditary Diseases: Use" F" for father, "M" for mother "S" for sibling

Heart Disease _____ **Diabetes** _____ **Allergies** _____

Hypertension _____ **Cancer** _____ **Mental illness** _____

Asthma _____ **Ulcers** _____ **Alcoholism** _____

Other (please list)

_____

Females:

Are you pregnant? ☐ **Yes** ☐ **No**

Are you pre-menopausal or menopausal? ☐ **Yes** ☐ **No**

Are you experiencing any menopausal symptoms ☐ **Yes** ☐ **No**

DIETRY HABITS:

Now many times a day do you eat? _____ **# Main meals** _____ **# Snacks** _____

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 preference of others-(Family, others?)

☐ **Yes** ☐ **No. If yes, explain**

_____

Examples of your typical meals:

Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks:

_____

Please indicate if you eat these food: "**D**" daily, "**W**" weekly, "**B**" biweekly, "**O**" occasionally.

Meats: Beef _____ Pork _____ Chicken _____

Please indicate others

_____

Fish and Shellfish:

Wild Atlantic salmon _____ Atlantic farmed raised salmon_____

Tuna (canned) _____ Tuna _____ Shark _____ Shrimp _____

Other (please indicate-)

_____

Grains: Wheat_____ Rye _____ Rice _____ Corn _____

Other (please indicate-)

_____

Dairy: Cheese _____ Milk _____ Yogurt _____ Ice cream _____ Butter _____

Oils: Sunflower _____ Canola _____ Corn _____ Olive _____ Coconut _____

Other (please list):

_____

Fruits: apples _____ Melons _____ Banana _____ Berries_____

Nuts and seeds: Peanuts _____ Walnut _____ Almonds _____ Sunflower _____

Vegetables: Potato _____ Cabbage _____ Beets _____ Carrot _____

Other (please list) _____

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

Beer _____ Wine_____ Coffee _____ Herbal tea _____ Tea _____ Soft drinks _____

Tap water _____ Bottled/spring water _____ Fresh Veg juice _____ Fresh fruit juices _____

Fruit juices (prepared) _____ Cow's milk-------- Milk alternates (almond, rice etc.) _____

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

Aluminum pans _____ Margarine _____ Refined foods _____

Microwave _____ Fried foods _____ Fast food _____

Luncheon meats _____ Cigarettes _____ Sugar _____

Nutra sweet/ Aspartame _____ Candy _____ Barbecue _____

Chemical cleaning products and disinfectants (please list) _____

Skin care products (please indicate brand) _____

For office use only:

_____

_____

_____

Please complete the following:

Indicate: 1 for mild or rarely occurring, **2** for moderate or regularly occurring, **3** for sever or often occurring, or **leave blank** if the symptom / statement does not apply.

General fatigue or weakness	
Difficulty losing weight	
Frequent illness/ infections	
High stress Lifestyle	
Smoking	
Drinking more 2 cups of coffee/ day	
Bad breath and body odour	
Constipation	
Bags under eyes	
Crave sugars, bread, alcohol	
Difficulty losing weight	
Have used antibiotics in past 10 years	

Allergies	
Poor concentration or memory	
Belching or burping after meals	
Skin/complexion problems	
Frequent constipation of red meat	
Regular use of dairy products	
Heavy alcohol consumption	
Exposure to toxins/chemicals	
Frequent mood swings	
Depressed and/or irritable	
Brittle fingernails	
Dry, brittle hair, split ends	
High fat/high cholesterol diet	
Nervousness/anxiety/tension/worry	
Insomnia/restless sleep	
Low fibre diet	
Muscle cramps	
Sleepy when sitting up	
Female: menstrual cramps	
Bronchitis/asthma/pneumonia/emphysema	

Cellulite	
Cold hands and feet	
Varicose veins	
Feeling out of control	
Food/chemical sensitivities	
Frequent yeast/fungus problems	
Bones break easily, osteoporosis	
Too little exercise	
Excessive mucous	
Short of breath climbing stairs	
Tingling in lips, fingers, arms, legs	
Chest pain	
Very rapid or slow heart beat	
Painful, hard or thin bowel movements	
Alternating constipation/diarrhea	
Recurrent bladder infections	
Female: PMS	
Difficult urination	
Swollen glands, puffy throat	
Lower abdominal pain	

Frequent need to urinate	
Joint pain	
Sinus inflammation/ discharge	
Arthritis	
Sudden weight loss / gain	
Headaches/ Migraines	
Female: Taking birth control pills	
Lower back pains	
Dry, flaky skin	
Drink less than 6 glasses of fluids/day	
Water retention	
Feeling heavy/ bloated after meal	
Chronic cough	
Anxiety	