LIFESTYLE ASSESSMENT E-FORM

Name:

Date: Age: Sex: F ☐ M ☐ Height: Weight:

What is your purpose in coming here today?

For Office use only:

What are your main health concerns/complaints? Please list in priority:

Have you experienced any major trauma in the past 5 years?

What level of stress do you feel you are experiencing at this time? Please quantify on a scale of 1 (low) to 10 (high):

What are the major causes or factors of your stress? *Rate all that apply on a scale of 1 (low) to 10 (high):*

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, time of day and duration)

On a scale of 1 (low) to 10 (high), how would you describe your energy levels?

Do you experience any lulls or highs in your energy levels throughout the day? If so, at what time of day?

How many hours on average do you sleep daily? (include naps)

What time do you go to sleep? Awaken?

Do you have trouble falling asleep? ☐ Staying asleep? ☐

Do you awaken feeling rested? Yes ☐ No ☐ Do you snore? 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 work shifts or are you on a regular schedule?

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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?

By when do you wish to reach your goal weight?

What is your main motivation to change your weight?

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 medication? Yes ☐ No ☐

List all medications and the reason(s) for each

Do you take: birth control pills ☐

Have you taken antibiotics over the past five years? Yes ☐ No ☐

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

Do you have any allergies or sensitivities? Yes ☐ No ☐

If so, please list:

Do you have anaphylaxis (life-threatening allergy)? If so, please describe:

Do you have any silver-mercury fillings? Yes ☐ No ☐

Have you ever been:

a) Diagnosed with an illness? Yes ☐ No ☐ If so, please explain

b) Hospitalized? Yes ☐ No ☐ If yes, for what reason?

Have you had surgery to remove your gall bladder? ☐ tonsils? ☐ appendix? ☐

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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?
Is there undigested food in your stools? Yes ☐ No ☐ Occasionally ☐

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?

FAMILY HISTORY:
Hereditary Diseases: Use "F" for father, "M" for mother, "S" sibling, "G" for grandparent, "O" for other(s):

	Allergies		Diabetes		Intestinal Disease
	Alcoholism		Drug Abuse		Kidney Dysfunction
	Arthritis		Gall Bladder Issues		Mental Illness
	Asthma		Heart Disease		Osteoporosis
	Autoimmune Disease		Hypertension		Skin conditions
	Cancer,	Type:			Ulcers

Other diseases (please list)

Have you experienced fungal infections (e.g. jock itch, athlete's foot)?
Yes ☐ No ☐ If yes, please describe:
Have you experienced a decline in sexual interest? Yes ☐ No ☐
If yes, please describe:

Have you had kidney or gall stones? Yes ☐ No ☐
If yes, please describe:

FEMALES:
Are you or could you be pregnant? Yes ☐ No ☐
Have you noticed any changes in menses, for example the frequency, duration, flow, clotting, or other changes? Yes ☐ No ☐
If so, please specify

Do you suffer from PMS symptoms? Please specify:

Are you peri-menopausal? Yes ☐ No ☐ menopausal? Yes ☐ No ☐

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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?

MALES:
Have you experienced any prostate problems (e.g. frequent urination, discomfort during urination)? Yes ☐ No ☐ If yes, please describe:

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 preferences of others such as family, roommates, etc? Yes ☐ No ☐ If yes, please 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		

Provide 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	Fast foods
Luncheon meats	Cigarettes	

Artificial sweeteners (Nutra Sweet, aspartame, Splenda)

Refined foods (pastries, white bread/pasta/rice, etc.)

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

Tap water	Prepared vegetable juices
Coffee	Fresh vegetable juices
Tea	Red wine
Soft drinks (*diet*)	White wine
Soft drinks *(regular)*	Beer
Fresh fruit juices	Other alcoholic beverages
Fruit juices *(prepared)*	Bottled or spring water
Milk *(1%, 2%, or whole)*	Herbal tea
Milk *(skim)*	other

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?

Which food(s) do you crave, and how often do you eat them?

Do you avoid certain foods? Yes ☐ No ☐ 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:

Address:

City: Prov: Postal Code:

Phone: (H) (W) (C)

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