

# LIFESTYLE ASSESSMENT FORM

Name: \_\_\_\_\_

Today's date: \_\_\_\_\_ Age: \_\_\_\_\_

*Please answer each of the following questions.*

1. What are your main health concerns and complaints? \_\_\_\_\_

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2. Your weight management desires (✓): Gain \_\_\_ Lose \_\_\_\_.  
How much and why? \_\_\_\_\_

3. What level of stress do you feel you are experiencing right now?  
Minimal \_\_\_ Average \_\_\_ Considerable \_\_\_ Unbearable \_\_\_  
Explain your symptoms: \_\_\_\_\_

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4. What are the major causes/factors of your stress? (✓ All that apply):  
Financial \_\_\_ Career \_\_\_ Personal \_\_\_ Marriage \_\_\_ Health \_\_\_  
Family \_\_\_ Unfulfilled Expectations \_\_\_ Spiritual \_\_\_

Other (describe) \_\_\_\_\_

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5. How many hours (average, incl. naps) do you sleep daily \_\_\_\_\_  
What time do you go to sleep? \_\_\_\_\_ Awaken? \_\_\_\_\_  
Do you awaken feeling rested, (Y or N)? \_\_\_\_\_

6. How many hours (average) each day do you spend driving? \_\_\_\_\_

7. Do you smoke cigarettes, (Y or N)? \_\_\_\_\_  
If yes, how many per day? \_\_\_\_\_
8. What do you do for exercise? Indicate type, frequency, and amount of time spent \_\_\_\_\_  
\_\_\_\_\_
9. List the number of hours (average) per day you spend reading \_\_\_\_\_, watching television \_\_\_\_\_, and using the computer \_\_\_\_\_

**MEDICAL HISTORY:**

10. Are you currently taking any medication, (Y or N)? \_\_\_\_\_  
If yes, identify the medications and reason(s) for taking them: \_\_\_\_\_  
\_\_\_\_\_
11. Identity any vitamins, minerals, and herbal or homeopathic remedies you are currently taking, the amount and dosage of each, and for what reason: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
12. Do you have any allergies? If yes, describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
13. Ever been diagnosed with an illness, (Y or N)? \_\_\_\_\_  
Explain: \_\_\_\_\_  
\_\_\_\_\_

14. Ever been hospitalized? (✓): Yes \_\_\_ No \_\_\_

Explain: \_\_\_\_\_  
\_\_\_\_\_

### **HEREDITARY DISEASES:**

15. Fill in below whatever is applicable, using "F" (father), "M" (mother), "S" (siblings), "G" (grandparents), and "O" (other relatives):

Heart disease \_\_\_ Intestinal disease \_\_\_ Mental Illness \_\_\_  
Cancer \_\_\_ Diabetes \_\_\_ Allergies \_\_\_ Hypertension \_\_\_  
Osteoporosis \_\_\_ Arthritis \_\_\_ Other : \_\_\_\_\_  
\_\_\_\_\_

16. Have you ever been treated for drug and/or alcohol dependency, (Y or N)? \_\_\_\_\_. If yes, circle which one(s).

### **DIETARY HABITS:**

17. How many times per day do you eat?

Main Meals \_\_\_\_\_ Times of day: \_\_\_\_\_

Snacks \_\_\_\_\_ Times of day: \_\_\_\_\_

18. What do you typically eat for:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks: \_\_\_\_\_

19. At what time do you have your last meal or snack of the day? \_\_\_\_\_

20. Do you eat or use (✓)

Fried foods \_\_\_\_\_ Refined foods \_\_\_\_ Candy \_\_\_\_  
Microwaved \_\_\_\_ Luncheon meats \_\_\_\_ Cigarettes \_\_\_\_  
Aluminum pans \_\_\_\_ Margarine \_\_\_\_  
Nutra-Sweet/Aspartame/Artificial Sweetener \_\_\_\_

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

Beer \_\_\_\_ Red wine \_\_\_\_ Coffee \_\_\_\_  
White wine \_\_\_\_ Tap water \_\_\_\_ Soft drinks (diet) \_\_\_\_  
Tea \_\_\_\_ Herbal tea \_\_\_\_ Fresh fruit juices \_\_\_\_  
Soft drinks (regular) Bottled water \_\_\_\_ Milk (2%) \_\_\_\_  
Other alcohol \_\_\_\_ Fresh vegetable juice \_\_\_\_  
Fruit juices (prepared)\_\_\_\_ Other beverages \_\_\_\_\_

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22. Which are you? (✓): Meat-eater \_\_\_\_ Vegetarian \_\_\_\_ Vegan \_\_\_\_

If a meat-eater, how times during a week do you consume meat? (✓):  
Daily \_\_\_\_ 1-2 \_\_\_\_ 3-5 \_\_\_\_ Other (describe): \_\_\_\_\_

If a vegetarian, how times during a week do you consume dairy  
products(✓):Daily \_\_\_\_ 1-2 \_\_\_\_ 3-5 \_\_\_\_ Other (describe): \_\_\_\_\_

23. List your favourite foods/beverages? \_\_\_\_\_

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24. How often do you eat them? \_\_\_\_\_

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25. Do you experience any symptoms if meals are missed (Y or N)? \_\_\_\_\_  
Explain: \_\_\_\_\_

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26. Do you avoid certain foods? If so, why? \_\_\_\_\_  
\_\_\_\_\_

27. Do you experience any symptoms after meals? \_\_\_\_\_  
Explain: \_\_\_\_\_

Your additional comments or questions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CLIENT ACKNOWLEDGMENT**

I, the below signed, 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 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: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ (H) \_\_\_\_\_ (B)

Email: \_\_\_\_\_ @ \_\_\_\_\_ .com

***THANK YOU FOR PATRONIZING OUR SERVICES!!***