

## LIFESTYLE ASSESSMENT FORM

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

Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

*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 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

*For Office use only:*



## LIFESTYLE ASSESSMENT FORM

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

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### 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 –  
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:

_____ 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> )	_____ bottled or spring water
_____ milk ( <i>1% or 2%</i> )	_____ herbal tea
_____ milk ( <i>skim</i> )	_____ other _____
_____ fresh vegetable juices	

**LIFESTYLE ASSESSMENT FORM**

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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) \_\_\_\_\_ (B) \_\_\_\_\_

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