

## LIFESTYLE ASSESSMENT FORM

Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: F / M Height: \_\_\_\_\_ Weight: \_\_\_\_\_

What is the purpose for coming to see a Holistic Nutritionist?

\_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

Rate your current stress levels: (Low) 1 2 3 4 5 6 7 8 9 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 \_\_\_\_\_

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)

\_\_\_\_\_

Rate your energy levels: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

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

On average, how many hours do you sleep daily? \_\_\_\_\_

What time do you go to sleep? \_\_\_\_\_ Awaken? \_\_\_\_\_

Do you have trouble falling asleep? \_\_\_\_\_ Staying asleep? \_\_\_\_\_

Do you awaken feeling rested? \_\_\_\_\_ Do you snore? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Do you enjoy your work? (circle one) Yes No Sometimes

Do you work shifts or regular schedule? \_\_\_\_\_

How many hours do you work each day? \_\_\_\_\_

Do you smoke? Yes No

If yes, how much and for how long? \_\_\_\_\_

If no, are you exposed to it either at home or in the workplace? Yes No

Do you wish to gain weight?  Lose weight?  How much? \_\_\_\_\_

What is your main motivation to change your weight?

\_\_\_\_\_

What are your interests and hobbies? \_\_\_\_\_

\_\_\_\_\_

## LIFESTYLE ASSESSMENT FORM

### MEDICAL HISTORY:

Are you currently taking any medication? If yes, list all medications and the reason(s) for each.

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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: \_\_\_\_\_

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Do you have any allergies, anaphylaxis (life-threatening allergy) or sensitivities? If yes, please list:

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Do you have any silver mercury fillings? Yes No

Have you ever been:

Diagnosed with an illness? If yes, please explain

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Hospitalized? If yes, please explain

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Have you had surgery to remove your, gallbladder  Tonsils  Appendix

Have you had kidney or gall stones? Yes No If yes, please explain

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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? \_\_\_\_\_

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Do you have loose bowel movements? Yes No Occasionally

Related to particular food or circumstances? \_\_\_\_\_

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Is there undigested food in your stools? Yes No Occasionally

Do you use recreational drugs? If yes, how often and what type

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Have you ever been treated for drug and/or alcohol dependency? Yes No

### FAMILY HISTORY:

Hereditary Diseases: Use "F" for father. "M" for mother, "s" for sibling. "G" for grandparents, "O" for other

\_\_\_\_\_ Allergies

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Intestinal Disease

\_\_\_\_\_ Alcoholism

\_\_\_\_\_ Drug Abuse

\_\_\_\_\_ Kidney Dysfunction

\_\_\_\_\_ Arthritis

\_\_\_\_\_ Gall Bladder Issues

\_\_\_\_\_ Mental Illness

\_\_\_\_\_ Asthma

\_\_\_\_\_ Heart Disease

\_\_\_\_\_ Osteoporosis

\_\_\_\_\_ Autoimmune Disease

\_\_\_\_\_ Hypertension

\_\_\_\_\_ Skin Condition

\_\_\_\_\_ Cancer, type \_\_\_\_\_

\_\_\_\_\_ Ulcers

Other diseases \_\_\_\_\_

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## LIFESTYLE ASSESSMENT FORM

### 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 yes, please specify

Do you suffer from PMS symptoms? Please specify

Are you pre-menopausal? Yes No Post-menopausal? Yes No

Are you experiencing any menopausal symptoms? Yes No 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 specify \_\_\_\_\_

Have you experienced fungal infections (e.g. jock itch, athlete's foot)? Yes No

If yes, please specify \_\_\_\_\_

### 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 specify \_\_\_\_\_

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: Type \_\_\_\_\_

Provide examples of your typical meals:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Do you eat or use (1=rarely, 2=regularly, 3=often)

\_\_\_\_ Aluminum pans \_\_\_\_\_ Margarine \_\_\_\_\_ Candy

\_\_\_\_ Microwave \_\_\_\_\_ Fried foods \_\_\_\_\_ Fast foods

\_\_\_\_ Luncheon meats \_\_\_\_\_ Cigarettes

\_\_\_\_ Artificial sweeteners (Nutra sweet, aspartame, Splenda)

\_\_\_\_ Refined food (pastries, white bread/pasta/rice, etc.)

### LIFESTYLE ASSESSMENT FORM

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

- |                             |                               |
|-----------------------------|-------------------------------|
| ___ Beer                    | ___ Red wine                  |
| ___ Coffee                  | ___ White wine                |
| ___ Tap water               | ___ Bottled or spring water   |
| ___ Soft drinks (diet)      | ___ Tea                       |
| ___ Soft drinks (regular)   | ___ Herbal Tea                |
| ___ Fruit juices (prepared) | ___ Fresh fruit juices        |
| ___ Milk (1% or 2%)         | ___ Fresh vegetable           |
| ___ Milk (skim)             | ___ Other alcoholic beverages |
| ___ 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 favorite foods, and how often do you eat them? \_\_\_\_\_

Which food(s) do you crave, and 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: \_\_\_\_\_

**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.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Tel: \_\_\_\_\_ Email: \_\_\_\_\_

*Thank you for your cooperation*

*All information contained on this form will be kept strictly confidential*

LIFESTYLE ASSESSMENT FORM

*If any of the following symptoms or activities have occurred within the past three months (unless otherwise specified), please indicate by checking: 1 for mild or rarely occurring, 2 for moderate or regularly occurring, 3 for severe or often occurring, or leave blank if the symptom/statement does not apply.*

General fatigue or weakness	Cold hands and feet
Difficulty losing weight	Varicose veins
Frequent illness/infections	Feeling out of control
High stress lifestyle	Food/chemical sensitivities
Smoking	Frequent yeast/fungus problems
Drink more than 2 cups of coffee/day	Bones break easily. osteoporosis
Bad breath and/or body odour	Too little exercise
Constipation	Excessive mucous
Bags under eyes	Short of breath climbing stairs
Crave sugars, bread, alcohol	Tingling in lips, fingers, arms, legs
Difficulty digesting certain foods	Chest pains
Have used antibiotics in the past 10 years	Very rapid or slow heart beat
Allergies	Painful, hard or thin bowel movements
Poor concentration or memory	Alternating constipation/diarrhea
Belching or burping after meals	Recurrent bladder infections
Skin/complexion problems	Menopause, hot flashes (female only)
Frequent consumption of red meat	PMS (female only)
Regular use of dairy products	Difficulty urinating
Heavy alcohol consumption	Swollen glands, puffy throat
Exposure to toxins/chemicals	Lower abdominal pain
Frequent mood swings	Frequent need to urinate
Depressed and/or irritable	Joint pain
Brittle fingernails	Sinus inflammation/discharge
Dry, brittle hair, split ends	Arthritis
High fat / high cholesterol diet	Sudden weight gain/loss
Nervousness/anxiety/tension/worry	Headaches/migraines
Insomnia/restless sleep	Taking birth control (Female only)
Low fibre diet	Lower back pains
Muscle cramps	Dry, flaky skin
Sleepy when sitting up	Drink less than 6 glasses of fluids/day
Menstrual cramps (female only)	Water retention
Bronchitis/asthma/pneumonia/emphysema	Low sex drive
Cellulite	Feeling heavy/bloated after meals
	Chronic cough

LIFESTYLE ASSESSMENT FORM

Please complete the following sub-questionnaires using the same rating system. Leave blank if symptom or activity does not apply. **1** for mild or rarely occurring. **2** for moderate or regularly occurring. **3** for severe or often occurring.

The Digestive System		
	Excessive gas, belching or burping after meals	Stomach pain 1 hour after eating or at night
	Stomach bloated after eating	Burning sensation in stomach
	Sleepy after eating	Pain aggravated by worry/tension
	Longitudinal striations on fingernails	Hiatal hernia
	Eat when rushed/in a hurry	Gastritis, gastric ulcer
	Full feeling after heavy meat meal	Nausea, vomiting
	Heavy, tired feeling after eating	Sensation of acidity in abdominal area
	Nausea after taking supplements	Heartburn, indigestion
	Undigested food in the stool	Blood in stool
	Yellow or pale fingernails	Lower back pain
	Skin oily on nose and forehead	Long term aspirin use
	Fat/greasy foods cause nausea, headaches	Severe abdominal pain
	Vertical white streaks on fingernails	Slow digestion; feel full for hours after eating
	Onions, cabbage, radishes, cucumbers cause bloating/gas	Fever
	Bad breath; bad taste in mouth	Alcohol addiction
	Excess body odor	Hungry up to 3 hours after eating
	High cholesterol/high cholesterol diet	Strong, sudden cravings for sweets, starches, coffee or alcohol
	Migraine headaches	Nervous/anxious feelings relieved by eating
	Discomfort underneath right ribcage	Irritable if late for or skip a meal
	Food allergies	Overweight
	Irritable, easily angered	Addicted to coffee with sugar and/or colas
	Weight gain around the abdomen	Frequent "midnight snacks"
	Yellow palms	Family history of diabetes
	Jaundice	Fatigue
	Poor concentration	Frequent headaches
	Difficulty losing weight	Fainting spells
	Acne, boils, rashes, psoriasis or eczema	Depression
	Constipation	Lose temper easily
	Gall stones; history of gall stones	
	Stool appears clay-coloured, foul odour	
	Severe pain in right upper abdomen	

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The Intestinal System	
Extreme Fatigue	Forgetfulness
F: Recurrent vaginal infections	Slow reflexes
Frequent use of antibiotics	Unclear thinking
White coated tongue, oral thrush	Loss of appetite
Crave sugars, bread and alcohol	Yellowish or pale face
Headaches	Fast heartbeat
Tonsillitis, recurrent strep throat	Heart pain
Itchy, watery or dry eyes	Pain in navel
Skin flushes	Eating more than normal but still feeling hungry
Chronic indigestion, frequently use or antacids	Blurry or unclear vision
Always cold, especially in extremities	Pain in the back, thighs, shoulders
F: PMS	Numb hands
Pain in pelvic area	Drizzling while sleeping
Gas and bloating	Damp lips at night
Loss of sex drive	Dry lips during the day
Cystitis, repeated bladder infection	Grind teeth while asleep
Increasing food and chemical sensitivities	Bedwetting
F: endometriosis/ovary problems	Dark circles under eyes
Chronic diarrhea	Cancer
Hives, psoriasis, acne, skin rashes	
Rectal itching	
Abnormal muscle aches from exercise	
Excessive wax in ears	
Unexpected/unexplained weight gain	
M: Impotence	
Canker sores	
Athlete's foot, finger/toenail fungus, ringworm	
Jock itch	
"Brain fog"	
Irritability	
Memory loss	
Mental confusion	
Depression or anger for no reason	
Anxiety/panic attacks	
Inability to concentrate	
Phobic/compulsive	
Lethargy: Chronic fatigue	
Mood swings	
Itchy ears, nose, anus	

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The Lymphatic System		
	Acne, psoriasis, dermatitis, eczema	Excessive sleep
	Raid pulse, heart irregularities	Very susceptible to infections
	Frequent headaches	Swollen glands: tonsils, throat, armpits
	Hay fever	History of cancer, MS, Parkinson's arthritis
	Frequent cravings for certain foods	Loss of appetite
	Periods of blurred vision	Headaches
	Repeated ear trouble	Soreness on both sides of neck at shoulder
	Hyperactivity	Feel puffiness in throat
	Dizzy spells	Look older than chronological age
	Periods of confusion	Flu-like symptoms often occur
	Poor concentration	Lupus
	Epilepsy	Excessive sleep
	Muscle cramps or spasms	Very susceptible to infections
	Abnormal body odour	Swollen glands: tonsils, throat, armpits
	Excessive sweating, night sweats	
	Bowel disease: IBS, IBD, Crohn's, etc.	
	Joint pains or stiffness	
	Frequent night urination	
	Wheezing	
	Pale face	
	Hives	
	Nose runs constantly	
	Noticeable changes in writing throughout day	
	Nosebleeds	
	Bloating or gas after eating certain foods	
	Canker sores	
	Dark circles under eyes	
	Stuffy nose	

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The Glandular / Endocrine System		
	Distinct, lethargic tiredness or sluggishness	Losing weight without trying
	Cold hands or feet	Heart races while at rest
	Mercury amalgams (fillings)	Feel warm/flushed at room temperature
	Gain weight easily, fail to lose on diets	Hands shake or tremble
	Constipation, less than one bowel movement a day	Protruding tongue
	Low energy in the morning	Heart palpitations
	Low pulse rate	Nervous behaviour, hyperactivity
	Low body temperature, especially bed rest	Insomnia
	Hair dry, brittle, dull, lifeless	Increased appetite
	Flaky, dry rough skin	Frequent bowel movements, diarrhea
	Feel stiff after sitting for some time	Excessive sweating without exercising
	Mood swings	Stress or emotional upsets cause exhaustion
	Usually square and wide fingernails	Blood pressure decreases when going from a lying position to a standing position
	High cholesterol	Neck and/or shoulder tension
	Diminished sex drive	Bow lines (depressed furrows) on fingernails
	Headaches one side of the head	Occasional cold sweats
	F: Loss of menstrual function	Tightness or lump in throat, especially when emotionally disturbed
	Moody	High or low blood pressure
	Overweight from waist down	Rapid pulse
	Overweight from waist up	Short temper
	Excessive urination	Puffy face
	Pain in little finger of left hand	
	Swelling in ankles, fingers, feet, or under	
	Cold hands or feet	
	Pain in left side of upper neck	

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The Structural-Muscular/Skeletal System		
	Pain, swelling, stiffness in joints	Muscles wasting in some parts of the body
	Joint inflammation (rheumatoid arthritis)	Numbness or loss of sensation
	Pain, stiffness, inflammation of spine	Mood swings and/or depression
	Facial pain	Blurred or double vision
	Joints make popping sounds	Tingling and/or numbness, especially in extremities
	Gout	Muscular stiffness
	Ankylosing spondylitis	Difficulty breathing
	Bones fracture easily	M: Impotence
	Gradual loss of height	Tremors
	Tooth loss; teeth "falling out"	Loss of peripheral vision
	Lack of exercise	Slurred speech
	Rounding of shoulders; stooping	Objects fall from hands, reach in wrong place
	F: Menopause	Hands tremble
	Pain in forearm or biceps	Impaired speech
	Cramps in calf muscle during sleep or exercise	
	Painful cramping of feet or toes	
	Teeth prone to decay, frequent toothaches	
	Malformation of bones	
	Insomnia	
	Muscles weak, weak grip, light objects feel heavy	
	Heart palpitations	
	Diet high in animal foods (meat, dairy, eggs)	
	Muscle pain	
	Muscle weakness	
	Sprains; muscle strains	
	Muscle(s) spasm	