



# LIFESTYLE ASSESSMENT FORM

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

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

*Please answer each of the following questions. Please use the back of the page for additional space.*

1. What is your purpose in coming here today?  
\_\_\_\_\_
2. What are your main health concerns/complaints?  
\_\_\_\_\_  
\_\_\_\_\_
3. Have you ever been diagnosed with an ailment related to your main health concern(s)? \_\_\_\_\_
4. Any trauma or loss in the last 5 years? \_\_\_\_\_
5. What level of stress do you feel you are experiencing at this time?  
Minimal    Average    Considerable    Unbearable
6. 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) \_\_\_\_\_
7. How does your stress manifest itself? \_\_\_\_\_  
\_\_\_\_\_
8. Do you use any coping mechanisms? \_\_\_\_\_
9. What do you do for exercise? (indicate type, frequency and time)  
\_\_\_\_\_
10. How many hours on average do you sleep daily? (include naps) \_\_\_\_\_
11. What time do you go to sleep? \_\_\_\_\_ Awaken? \_\_\_\_\_
12. Do you awaken feeling rested?    Yes    No

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13. What is your occupation? \_\_\_\_\_

14. Do you enjoy your work?    Yes    No    Sometimes

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

16. At what times do you start and end work? \_\_\_\_\_

17. Do you smoke?    Yes    No    If yes, how much and for how long?  
\_\_\_\_\_

18. If no, does anyone in your household or workplace smoke?    Yes    No

19. Do you wish to gain weight?    lose weight?    how much? \_\_\_\_\_

20. How many hours do you spend daily, on average:  
Driving \_\_\_\_\_ Watching TV \_\_\_\_\_ Reading \_\_\_\_\_ In front of computer \_\_\_\_\_

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

22. Do you vacation regularly?    Yes    No

23. When was your last vacation? \_\_\_\_\_

24. Do you actively participate in any spiritual discipline (church, religious group, meditation, etc.)    Yes    No

**MEDICAL HISTORY**

1. Are you currently taking any medication?    Yes    No  
List Reason(s) \_\_\_\_\_

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

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3. Do you have any allergies or sensitivities? If so, please list:

\_\_\_\_\_

4. Do you have any silver-mercury fillings? Yes No

5. Have you ever been:

Diagnosed with an illness? Explain \_\_\_\_\_

\_\_\_\_\_

Hospitalized? Reason \_\_\_\_\_

6. How often do you have a bowel movement? \_\_\_\_\_

7. Do you strain to have a bowel movement? Yes No Occasionally

8. Related to particular food or circumstances?

\_\_\_\_\_

9. Do you have loose bowel movements? Yes No Occasionally

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

10. Do you use recreational drugs? Yes No

11. If yes, how often and what type?

\_\_\_\_\_

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

**FAMILY HISTORY:**

1. Hereditary Diseases: Use "F" for father, "M" for mother, "S" for sibling, "G" for grandparent, "O" for others

\_\_\_\_ Heart Disease      \_\_\_\_ Diabetes      \_\_\_\_ Allergies

\_\_\_\_ Hypertension      \_\_\_\_ Arthritis      \_\_\_\_ Mental Illness

\_\_\_\_ Intestinal Disease      \_\_\_\_ Osteoporosis      \_\_\_\_ Alcoholism

\_\_\_\_ Kidney Dysfunction      \_\_\_\_ Ulcers      \_\_\_\_ Asthma

\_\_\_\_ Gall Bladder Problems      \_\_\_\_ Cancer, type: \_\_\_\_\_

Other (please list) \_\_\_\_\_

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Dinner: \_\_\_\_\_  
\_\_\_\_\_

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

6. 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 _____ |                   |                     |

7. Please indicate how many cups of the following you drink per day:
- |                               |                       |                       |
|-------------------------------|-----------------------|-----------------------|
| _____ bottled or spring water | _____ tap water       | _____ milk (1% or 2%) |
| _____ fresh fruit juices      | _____ beer            | _____ milk (skim)     |
| _____ fruit juices (prepared) | _____ red wine        | _____ tea             |
| _____ fresh vegetable juices  | _____ white wine      | _____ herbal tea      |
| _____ soft drinks (regular)   | _____ other alcoholic | _____ coffee          |
| _____ soft drinks (diet)      | other (specify) _____ |                       |

8. Are you a:    meat eater?    vegetarian?    vegan?

9. How often do you eat meat?    daily    3-5/week    once/week or less

10. How often do you consume dairy products?  
          daily            3-5/week            once/week or less

11. What are your favourite foods? \_\_\_\_\_

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

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

14. Do you experience any symptoms if meals are missed? Explain:  
\_\_\_\_\_



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15. Do you experience any symptoms after meals? Explain:

\_\_\_\_\_

16. 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.*







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**SYSTEMS RATING TABLE: For Office Use Only**

1	Digestive	
2	Intestinal	
3	Circulatory/Cardiovascular	
4	Nervous	
5	Immune/Lymphatic	
6	Respiratory	
7	Urinary	
8	Glandular/Endocrine	
9	Structural	
10	Reproductive	

**COMMENTS:**



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## DAILY FOOD LOG

NAME: \_\_\_\_\_ DATES: \_\_\_\_\_

DAY	BREAKFAST	LUNCH	DINNER	SNACK
SUN				
MON				
TUE				
WED				
THU				
FRI				
SAT				