Please print this document and bring it with you to your first consultation.

LIFESTYLE ASSESSMENT FORM

Name:

Date: Age:

Please answer each of the following questions.

What is your purpose of coming here today?

Have you ever been diagnosed with an ailment related to your main health concerns?

Do you wish to gain weight? ☐ Lose weight? ☐ How much?

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 level manifest itself?

Do you use any coping mechanisms?

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 type of work do you do?

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?

What do you do for exercise? (indicate type, frequency and time)

How many hours do you spend, on average:

Driving Watching Reading computer

What are your interest and hobbies?

Do you vacation regularly?

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 medication? Yes ☐ No ☐

List/Reason(s):

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

Do you have any allergies? If so, please list:

Have you ever been:

Diagnosed with a major illness? Explain

How is your bowel function?

Do you strain to have a bowel movement? Yes ☐ No ☐ Occasionally ☐
Do you have loose bowel movements? Yes ☐ No ☐ Occasionally ☐

Related to particular food or circumstances?

FAMILY HISTORY:

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	Cancer

Other (please list):

FEMALES OVER 40:

Are you peri-menopausal? Yes ☐ No ☐

Are you experiencing any symptoms? Yes ☐ No ☐

Please specify:

DIETARY HABITS

How many times a day do you eat:

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**

How would you typically combine these in an average day?

Breakfast:

Lunch:

Dinner:

Snacks:

Do you eat or use (indicate "1" for "rarely", "2" for "regularly", "3" for "often"):

☐ ☐ **margarine**

☐ **microwave** ☐ **refined foods**

☐ **luncheon meats**

☐ **Nutra-Sweet/Aspartame**

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

Alcohol
Coffee
Tap water
Soft drinks (diet)
Soft drinks (regular)
Fruit juices (prepared)
Milk

Tea
Bottled or spring water
Herbal tea
Other

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/work or less**

What are your favorite foods?

How often do you eat them?

Do you avoid certain foods? Is 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 purpose 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)**

Thank you for your co-operation

Adapted from ***Symptomatology A Handbook for CSNN Students, Author Danielle Perreault, RHN***

NSP CLIENT ASSESSMENT FORM

COMPLETE LEFT SIDE OF FORM ONLY: 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

Please complete this section				1	2	3	4	5	6	7	8	9	10
1	General fatigue or weakness												
2	Difficulty losing weight												
3	Frequent illness/infections												
4	High stress lifestyle												
5	Smoking												
6	Drink more than 2 cups of coffee/day												
7	Bad breath and/or body odour												
8	Constipation												
9	Bags under eyes												
10	Crave sugars, bread, alcohol												
11	Difficulty digesting certain foods												
12	Have used antibiotics in past 10 years												
13	Allergies												
14	Poor concentration or memory												
15	Belching or burping after meals												
16	Skin/complexion problems												
17	Frequent consumption of red meat												
18	Regular use of dairy products												
19	Heavy alcohol consumption												
20	Exposure to toxins/chemicals												
21	Frequent mood swings												
22	Depressed and/or irritable												
23	Brittle fingernails												
24	Dry, brittle hair, split ends												
25	High fat/high cholesterol diet												
26	Nervousness/anxiety/tension/worry												
27	Insomnia/restless sleep												
28	Low fiber diet												
29	Muscle cramps												
30	Sleepy when sitting up												
31	Female: menstrual cramps												
32	Bronchitis/asthma/pneumonia/emphysema												
33	Cellulite												
34	Cold hands and feet												
35	Varicose veins												
36	Feeling out of control												
37	Food/chemical sensitivities												
38	Frequent yeast/fungus problems												
39	Bones break easily, osteoporosis												
40	To little exercise												
41	Excessive mucous												
42	Short of breath climbing stairs												
43	Tingling in lips, fingers, arms, legs												
44	Chest pains												
45	Very rapid or slow heart beat												
46	Painful, hard or thin bowel movements												

Please complete this section				1	2	3	4	5	6	7	8	9	10
47	**Alternating constipation/diarrhea**												
48	**Recurrent bladder infections**												
49	**Female: Menopause, hot flashes**												
50	**Female: PMS**												
51	**Difficult urination**												
52	**Swollen glands, puffy throat**												
53	**Lower abdominal pain**												
54	**Frequent need to urinate**												
55	**Joint pain**												
56	**Sinus inflammation/discharge**												
57	**Arthritis**												
58	**Sudden weight gain/loss**												
59	**Headaches/Migraines**												
60	**Female: Taking birth control pills**												
61	**Lower back pains**												
62	**Dry, flaky skin**												
63	**Drink less than 6 glasses of fluids/day**												
64	**Water retention**												
65	**Low sex drive**												
66	**Feeling heavy/bloated after meals**												
67	**Chronic Cough**												
TOTAL SCORES													