LIFESTYLE ASSESSMENT FORM

Name:
Date: Age:

Please answer each of the following questions. If you require additional space use the back of the page.

What are your main health concerns?

Have you been diagnosed with any health conditions?

General Questions:

In your own words what do you consider to be healthy foods?

In your own words, how healthy do you think you are?

How do you think your health condition, if it stays as is, will impact your health?

On a scale of 1-5, how concerned are you about your health issues?
(not concerned) 1 2 3 4 5 (extremely concerned)

Have you made any lifestyle changes (diet, exercise etc.) to help with your health concern?
If so, list any changes:

If you change nothing about your lifestyle where would you see yourself in 5 years?

Regarding food and lifestyle, are there any changes that you haven't made but believe you should?

Regarding food and lifestyle, is there anything you believe you have tried to or should try to avoid?

What obstacles or challenges are you experiencing when making food and lifestyle changes?

Describe what goals would you like to achieve by the next 3 months?

By 6 months?

By 1 year?

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Productivity Questions

The following questions ask about the effect of your health problems (i.e. any physical or emotional problem or symptom) on your ability to work and perform regular activities, as well as your quality of life.

If you worked you full work week, hour many hours would that be? _____hours

During the past 7 days (not including today), how many hours did you miss from work because of your health problems? (Include hours you missed from sick days, times you went in late, left early, etc. because of your health problems). _____hours

During the past 7 days (not including today), how many hours did you miss from work because of any other reason, such as vacation, holidays, etc.? _____hours

In the following questions, rate how much your health problems affected your productivity while you were working (using a scale of 0 to 10, 0 means health problems had no effect on your work productivity, 10 means your health problems completely prevented you from work productivity):

During the past 7 days (not including today), how much did health problems affect your productivity by limiting the kind of work you can do or which duties/tasks you can do:
(no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely prevented the kind of work)

During the past 7 days (not including today), how much did your health problems prevent you from accomplishing your tasks?
(accomplished all tasks) 0 1 2 3 4 5 6 7 8 9 10 (accomplished no tasks)

During the past 7 days (not including today), how much did your health problems prevent you from doing your work as carefully as usual?
(no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely prevented carefulness)

During the past 7 days (not including today), how much did your health problems affect your ability to do your regular activities, other than work at a job? (the usual activities you do, such as work around the house, shopping, childcare, exercising, studying, etc.)
(no effect) 0 1 2 3 4 5 6 7 8 9 10 (completely prevented from daily activities)

During the past 7 days (not including today), how did your health problems affect your relationships at work with any of: co-workers, employers, customers and/or clients
(no effect) 0 1 2 3 4 5 6 7 8 9 10 (significant effect)

In what ways have your health problems affected your quality of life (e.g. do you choose to avoid social activities, does it affect relationships, does it affect things you would normally want to do, or how you normally feel)?
(no effect) 0 1 2 3 4 5 6 7 8 9 10 (significant effect)

If you have quality of life, describe what your ideal would be (describe what you would be doing and feeling):

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GENERAL LIFESTYLE QUESTIONS:

How would you describe your current level of stress? (minimal) 1 2 3 4 5 (unbearable)

What are the major causes of stress your stress? (circle all that apply)
Health Financial Personal Career School
Marriage Family Spiritual Unfulfilled expectations
Other (please elaborate):

How does your stress manifest itself?
(e.g./ headaches, sleeplessness, biting nails, anger, irritability etc…)

Do you use any coping mechanisms for stress? (circle): always often sometimes rarely never

Please list any coping mechanisms you will use (e.g./ napping, smoking, certain types of physical activity, music, meditation, alcohol etc.):

Have you experienced any trauma or loss in the past 5 years? Explain.

How many hours on average do you sleep daily? (circle): 3-5 6-7 8-9 10 or more

Do you have any naps during the day? How

long does it take you to fall asleep?

Do you awaken feeling rested? (circle) always often sometimes rarely never

Is your sleep often disrupted? (circle): always often sometimes rarely never

How do you help yourself fall asleep or fall back asleep?

Do you smoke? (circle): always often sometimes rarely never
Does anyone in your household or workplace smoke? (circle) always often sometimes rarely never

Do you exercise? (circle) 6-7x/week 4-5x/week 2-3x/week 1x/week less than 1x/week never

On average, indicate the type and length of physical activity you do (minutes or hours):

Yoga:	Tai Chi:	Zumba:
Walking:	Qi Qong:	Team sports (list):
Running:	Aquafit:	
Stretching:	Cycling:	
Weight training:	Resistance training (tubing, etc.):	
Other:		

Do you wish to gain weight? Lose weight? If so, how much?

On an average day, how many hours do you spend doing the following:
driving: watching television: reading: on the computer:

What type of work do you do?
Do you enjoy your work?

How many hours each day do you work?
Do you do shift work.? If yes, how often?

MEDICALHISTORY:

Have you ever been:

Diagnosed with an illness or condition? Explain:

Hospitalized? Reason:

List any medications you are currently taking with the reason, the dosage, and since how long:

Ones recommended by a doctor:

Any over the counter medications (aspirin, ibuprofen, tylenol, allergy medicines, antacids etc.):

Are you currently seeing (or have you seen in the past) any of the following (circle):

Naturopath	Chiropractor	Rheumatologist	Cardiologist
Homeopath	Osteopath	Physiotherapist	Kinesiologist
Holistic Nutritionist	Dietician	Ophthalmologist	Respirologist
Massage Therapist	Energy Therapist	Endocrinologist	Psychotherapist

List any vitamins, minerals, herbal or homeopathic remedies you are currently taking (with the amounts/dosages): Are these taken on a regular basis, or sporadically?

Do you have any known allergies? (environmental or food) If so, please list:

Are you aware of any food sensitivities?

How often do you have a bowel movement? (circle):

3 or more/day 2/day 1/day 3-4/week 1-2/week or less

Do you strain to have a bowel movement? always often sometimes rarely never
Related to particular food or circumstance?

Do you have loose bowel movements? always often sometimes rarely never
Related to particular food or circumstance?

Have you ever been treated for drug and/or alcohol dependency?
Please indicate for what:

Please indicate any of the following Diseases for yourself or other family members:
Use "S" for self, "F" for father, "M" for mother, "G" for grandparent, "O" for others:

Heart Disease:	High Blood Pressure:	High Cholesterol:
Diabetes Type 1:	Diabetes Type 2:	Allergies:
Arthritis:	Osteoporosis:	Intestinal Disease:
Cancer:	Mental Illness:	
Other (please list):		

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FEMALES:

Are you pre-menopausal or menopausal?

Are you experiencing any symptoms?

If yes, please specify:

(e.g./sudden surges of heat, mood swings, sporadic periods, sweats, edema, etc.)

Have you had a bone density test?

If yes, what was the result?

DIETARY HABITS:

How many times a day do you eat (circle):

Main Meals: 0 1 2 3 4 5 Times of day:

Snacks: 0 1 2 3 4 5 Times of day:

Do you plan the frequency and timing of your meals carefully? (circle)

always often sometimes rarely never

How often do you eat your meals.: (circle)

In the car: always often sometimes rarely never

In front of the computer at work: always often sometimes rarely never

With family: always often sometimes rarely never

Home alone: always often sometimes rarely never

On the run: always often sometimes rarely never

At sit down restaurants: always often sometimes rarely never

At fast food chains: always often sometimes rarely never

Do you feel there are restrictions to your diet due to preferences of others? (family, roommates, etc.) (circle): always often sometimes rarely never

If yes, explain:

Are you a: vegetarian? Y N vegan? Y N

If you are a meat eater, how often do you eat meat? (circle) daily 3-5/week once/week or less

What types of meat do you eat?

If applicable, how often do you eat fish? (circle) daily 3-5/week once/week or less

What types of fish do you eat?

How often do you consume dairy products? (milk, yogurt, cheeses, sour cream, ice cream, etc) (circle)

daily 3-5/week once/week or less

Indicate types of dairy products you eat:

What are your favourite foods?

How often do you eat them?

Do you dislike or avoid certain foods?

If so, what and why?

Do you experience any symptoms if meals are missed? Explain:

Do you experience any symptoms after meals? Explain:

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How many servings of each do you typically eat in a day:

Fruit: (e.g./ 1 serving = 1 medium size or ½ cup fruit)

Fresh: 0 1 2 3 4 5

Dried: 0 1 2 3 4 5

Canned: 0 1 2 3 4 5

Vegetables: (e.g./ 1 serving = ½ cup of vegetables or 1 cup of salad)

Cooked: 0 1 2 3 4 5

Raw: 0 1 2 3 4 5

Whole Grains: (e.g./ 1 serving = 1 slice bread, ½ cup rice or pasta)

0 1 2 3 4 5

Vegetable Proteins: (e.g./ 1 serving = 1 cup of beans, 2 tsp. of peanut butter, or ¾ cup of tofu)

0 1 2 3 4 5

Animal Proteins: (e.g./ 1 serving = a palm size piece of meat or fish, or 1 egg)

0 1 2 3 4 5

Dairy Products: 0 1 2 3 4 5

Other foods (please specify):

What fats/oils do you cook with?

What foods containing fats do you regularly consume? (e.g., nuts, meats) – be specific:

How often do you eat or use: (circle)

Microwave: never monthly biweekly weekly daily 2+ times/day

Margarine: never monthly biweekly weekly daily 2+ times/day

Luncheon meats: never monthly biweekly weekly daily 2+ times/day

Candy: never monthly biweekly weekly daily 2+ times/day

Chocolate: never monthly biweekly weekly daily 2+ times/day

Breath Mints: never monthly biweekly weekly daily 2+ times/day

Gum with sugar: never monthly biweekly weekly daily 2+ times/day

Gum (sugarless): never monthly biweekly weekly daily 2+ times/day

Refined foods (white flour/sugar): never monthly biweekly weekly daily 2+ times/day

White rice/pasta: never monthly biweekly weekly daily 2+ times/day

Fried foods: never monthly biweekly weekly daily 2+ times/day

Fast foods: never monthly biweekly weekly daily 2+ times/day

Nutra-Sweet/Aspartame: never monthly biweekly weekly daily 2+ times/day

Splenda/Sucralose: never monthly biweekly weekly daily 2+ times/day

Stevia: never monthly biweekly weekly daily 2+ times/day

I am aware of my water intake and am conscious of staying hydrated throughout the day:

always often sometimes rarely never

How many (8 oz/250mL) cups of fluid would you drink with your average meal?

¼ ½ ¾ 1 1½ 2+

Please indicate how many (8 oz/250mL) cups of the following you drink per day:

Bottled/spring water 0 1 2 3 4 5 6 7 8 9 10

tap water 0 1 2 3 4 5 6 7 8 9 10

coffee 0 1 2 3 4 5

tea	0	1	2	3	4	5
herbal tea	0	1	2	3	4	5
milk (1% or 2%)	0	1	2	3	4	5
milk (skim)	0	1	2	3	4	5
prepared fruit juices	0	1	2	3	4	5
fresh fruit juices	0	1	2	3	4	5
fresh vegetable juices	0	1	2	3	4	5
soft drinks (regular)	0	1	2	3	4	5
soft drinks (diet)	0	1	2	3	4	5
beer	0	1	2	3	4	5
red wine	0	1	2	3	4	5
white wine	0	1	2	3	4	5
other alcoholic beverages	0	1	2	3	4	5
other (list)	0	1	2	3	4	5

Any further Comments:

We appreciate your time and efforts, thank you!

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