Path to Health

LIFE STYLE ASSESSMENT FORM

Name:_____Date:_____
Age:_____ Sex: _____

Please answer each of the following questions. If you require additional space, there's a blank Page at the end of the form.

What is your purpose in coming today?

_____
_____

What are your main health concerns/complaints?
Please list in order of priority. When did you first notice the symptom?

1._____
2._____
3._____

What triggers these conditions? _____
_____

To what extent does this problem affect your daily life? (work, sleep, eating, family life, etc)

_____

Please list, if any, what treatments you have used for this condition._____
_____

Have you experienced trauma / loss in your life (work, family, friends) 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 factors of your stress? (Check all that apply)

Financial ☐ Career ☐ Personal ☐ Marriage ☐ Health ☐ Family ☐
Spiritual ☐ Unfulfilled expectations ☐ Other (please elaborate)_____

How does stress manifest itself?_____
_____

How do you cope with stress, what are your coping mechanisms?_____
_____

What do you do for exercise? (Indicate type, frequency and time of day)_____
_____

Do you wish to lose weight ☐ gain weight ☐ How Much?_____

How many hours do you spend daily, on average?
Driving____ Watching TV____ Reading____ In front of the computer _____
What are your hobbies and interests?_____
How often to you partake in them?_____
Do you vacation regularly? Yes ☐ No ☐ When was your last vacation?_____

Path to Health

How many hours on average do you sleep daily (include naps)_____ What time do you go to Sleep?_____ Awaken? _____ Do you feel well rested? Yes ☐ No ☐
Do you have problems falling asleep at night?_____
What do you enjoy most in your life?_____
What is your occupation?_____
Do you enjoy your work? Yes ☐ No ☐ Sometimes ☐
How many hours do you work each day?_____
At what times do you start and end work?_____

ENVIRONMENTAL FACTORS:

Do/ Did you smoke? Yes ☐ No ☐ If yes, how much and how long?
_____
If no, does anyone in your household or workplace smoke? Yes ☐ No ☐
Do you use recreational drugs? _____If Yes, how often_____
Do you have any silver amalgam fillings?_____ How Many? And for how long have you had them?
_____Have you had any root canals? If so how many and how long ago?_____

Please check if you use any of the following:

☐ Artificial sweeteners (diet pop, gum, yogurt, juice)
☐ Luncheon Meats
☐ Margarine
☐ Household Cleaners
☐ Non organic soaps, lotions, shampoos, cosmetics
☐ Fast Foods
☐ Aluminum cookware
☐ Microwave
☐ Spray deodorants/antiperspirants
☐ Annual Flu shot

MEDICAL HISTORY:

Have you ever been diagnosed with an ailment? If so, please list and include date of diagnosis.
_____
Are you currently taking medication? Yes ☐ No ☐
List Meds and reasons for them_____
_____
Please list any vitamin, minerals, herbal or homeopathic remedies you are currently taking including the brand name and the amounts/dosages: _____
_____
FAMILY MEDICAL HISTORY: Use " F" for Father, " M" for Mother, " S" for Sibling, " G" for Grandparent " O" for Others.

___ Arthritis
___ Allergies
___ Asthma
___ Alcoholism
___ Diabetes
___ Gallbladder Problems
___ High Blood Pressure
___ Heart Disease
___ Intestinal Disease
___ Kidney Dysfunction
___ Mental Illness
___ Osteoporosis
___ Ulcers
___ Cancer: Type(s)_____
___ Other_____

Have you had a bone density test?_____ if so what were the results?_____

Path to Health

FEMALES:
Are you or could you be pregnant?_____
Are you pre-menopausal?_____
Are you experiencing any menopausal symptoms?_____
If yes, please specify_____

DIETARY HABITS:

Are you a Vegan_☐__, Vegetarian _☐__
How often do you consume red meat (beef, pork, lamb)? Daily ☐ 3-5X/wk ☐ 1X/wk or less ☐
How often do you consume dairy products ? Daily ☐ 3-5X/wk ☐ 1X/wk or less ☐
What are your favourite foods?_____
How often do you have them?_____
What foods do you avoid and why?_____
Do you experience any symptoms after meals? (indigestion, bloating, gas, headache etc)_____
_____
If you miss a meal do you experience any symptoms?(headache, nausea, light-headedness, irritable, etc.)Explain?_____
_____
Do you eat late at night?_____
How often do you eat at restaurants?_____
Who usually does the grocery shopping and cooking?_____

Do you eat meals: With Family ☐ Home Alone ☐ On the Run ☐ In front of the TV ☐

How many ½ cup servings of each do you typically eat in one day:

____Fruit: Fresh ☐ Canned ☐ Dried ☐ ____ Vegetables: Cooked ☐ Raw ☐
____Whole Grains ____ Refined flour (white bread, rice or pasta)
____ Dairy Products: Type_____
Other for example Soy, almond or rice milk_____

Give example of your typical meals:

Breakfast: _____
_____
Lunch: _____
_____
Dinner:_____
_____
_____
Snacks:_____
_____

Path to Health

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

___Water	___Carbonated Water	___Milk, Skim	___ Other Alcohol
___Coffee	___ Pop	___Fresh Vegetable Juice	
___Decaf Coffee	___ Diet Pop	___Fresh Fruit Juice	
___ Black Tea	___ Fruit Juice	___ Red Wine	
___Green Tea	___Diet Fruit Juice	___ White wine	
___Herbal Tea	___Milk 1%, 2%	___ Beer	

If you only drink alcoholic beverages on the weekend please list amount and type:
Friday_____
Saturday_____
If drink during the week but not daily list amount and type for Mon.- Thursday_____
_____
If alcohol is not on your "regular" schedule please list amount and type:
Per Week _____**Or** Per Month:_____

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.

Signature: _____Date:_____

Name: _____(Please Print)

Address:_____
_____

Phone: (Home)_____(Business or Mobile)_____
Email:_____

Clear All Fields Send Form

Path to Health