LIFESTYLE ASSESSMENT FORM

Name: _____ **Date**: _____

Birthdate: _____ **Sex**: F / M **Height**: _____ **Weight**: _____

Email: _____ **Contact number**: _____

What is your **purpose** for seeking nutritional support?

_____
_____
_____
_____

What are your **main health concern/s**:

1. _____
2. _____
3. _____

Have you been **diagnosed** by your Medical Doctor for: **Chronic Fatigue** ☐ or **Fibromyalgia** ☐ ?

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

_____
_____

On a scale of **1 to 10** (*1 = low, 10 = high*), what is your **stress level** at this time? _____

What are the major causes/factors of your stress? [rate all that apply on a scale of 1(low) to 10 (high)]:

Financial		Relationships		Family	
Career		Health		Personal	
Spiritual		Other			

How does your **stress** manifest itself? _____

_____
_____

Do you use any coping mechanisms? _____

_____
_____

What do you do for **exercise**? (indicate *type, frequency* and *duration*): _____

_____
_____

ENERGY LEVELS:

How would you describe your daily energy levels? '*Check*' any that apply:

Low ☐ Average ☐ Exhausted ☐ Energized ☐ Unmotivated ☐ Hyperactive ☐ Other: _____

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

_____

SLEEP PATTERNS:

How many hours on average do you sleep at night? _____ Naps?_____

What time do you generally go to bed? _____ Awaken? _____

Do you awake feeling rested? Circle one: Yes / No / Sometimes

Do you snore? Yes ☐ No ☐

How would you describe your sleep? '*Chec*k' any that apply:

Sound or restful		Heavy		Difficulty falling asleep	
Frequent insomnia		Light		Difficulty staying asleep	
Intermittent insomnia		Restless		Night sweats	

LIFESTYLE AND WORK:

What is your **occupation**? _____

Do you enjoy work? Yes ☐ No ☐ Sometimes ☐

How many hours each day do you work? _____

Do you work *shifts* or are you on a *regular schedule*? _____

How many **hours** on average do you spend daily?

Working		Reading books		In front of computer	
Driving		Exercise		Watching TV	

What are your **interests** and **hobbies**? _____

_____

Do you **vacation** regularly? Yes ☐ No ☐ When was your last vacation? _____

Do you actively participate in any **spiritual discipline** (church, group, meditation, etc.)? Yes ☐ No ☐

Do you **smoke**? Yes ☐ No ☐

If yes, how much and for how long? _____

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

Do you have any **weight-loss goals**? _____

MEDICAL HISTORY:

In *what ways* do you currently **address** your **health concerns**? *Please provide details*:

Allopathic (*Western / evidence-based*) medicine: _____

_____

Naturopathic medicine: _____

Physiotherapist: _____

Acupuncture: _____

Chiropractor: _____

Therapist/counselor: _____

Massage therapist: _____

Personal trainer: _____

Herbal therapy: _____

Vitamin/Mineral supplements: Yes ☐ No ☐

Diet: _____

Exercise: _____

Other: _____

Do you regularly use any of the following? Please list **type**, **frequency** and **amount**.

Antibiotics: _____

Birth control pills: _____

Antacids: _____

Diuretics: _____

Laxatives: _____

Sleeping pills: _____

Pain killers (including *Tylenol*, *Aspirin*, etc.): _____

Other prescription medication: _____

_____

Alcohol: _____

Tobacco/Marijuana/recreational drugs/other: _____

_____

Silver-mercury fillings? Yes ☐ No ☐ How many? _____ How long? _____

Please list any **vitamins, minerals** or **herbal remedies** you are currently taking. (*dosage* and *brand*)

_____
_____
_____
_____

Do you have any **allergies** or **sensitivities**? Yes ☐ No ☐

If yes, please *list*: _____

Do you have any **anaphylaxis** (life-threatening allergy)? Yes ☐ No ☐

If yes, please *describe*: _____

Have you ever been **hospitalized**? Yes ☐ No ☐ If yes, what was the reason? _____

_____

DIGESTIVE HEALTH:

How *often* do you have a **bowel movement** (*frequency*)? _____

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

Related to a particular food or circumstances? _____

Please **describe stool**:

Consistency: _____

Color & smell: _____

Undigested food, mucus or blood in stool: _____

Diarrhea or constipation: _____

Excessive gas/bloating: _____

Anal itching: _____

Other: _____

FAMILY HISTORY:

Hereditary diseases: Use "**F**" for father, "**M**" for mother, "**S**" for sibling, "**G**" for grandparent, "**O**" for other relatives:

	Allergies		Diabetes		Intestinal disease

	Alcoholism		Drug abuse		Kidney dysfunction
	Arthritis		Gall bladder issues		Mental Illness
	Asthma		Heart disease		Osteoporosis
	Auto-immune disease		Hypertension		Skin condition
	Cancer – type:				Ulcers
	Other [please list]:				

FEMALES:

Are you or could you be **pregnant**? Yes ☐ No ☐

Do you suffer from **PMS symptoms**? Yes ☐ No ☐ Please specify: _____

Are you **pre-menopausal** or **menopausal**? _____

Are you experiencing any menopausal symptoms? Yes ☐ No ☐

If yes, please 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 describe: _____

DIETARY HABITS:

How many times a day do you eat: _____

Main meals: _____ Times of day: _____

Snacks: _____ Times of day: _____

What **factors** most significantly influence your diet ('*check*' any that apply & add comments if desired):

	Affordability		Health
	Other people (family members, roommates, etc.)		Ethics
	Convenience		Fat or calorie content
	Taste		Sugar content
	Other (please explain):		Salt content

Are you a: ☐ meat eater ☐ vegetarian ☐ vegan ☐ Other? Please specify: _____

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?

Please indicate the **frequency** of the following foods/items used in your diet. [**0** for never, **1** for infrequently/rarely, **2** for occasionally/moderately, and **3** for often/frequently]:

	Aluminum pans		Margarine		Cigarettes
	Processed foods (*lunch meats, hot dogs, etc.*)		Sugary foods (*candy, clear fruit juice, baked goods*)		Refined Foods (*white flour, white bread/pasta/rice, etc.*)
	Deep fried foods		Fast foods		Microwaved foods
	Artificial sweeteners (Aspartame, nutria-Sweet, Equal, Splenda)		Organic fruits & vegetables		Conventional (non-organic) fruits and vegetables.
	Organic, free range meats (beef, chicken, game, etc.)		Organic dairy (butter, cream, yoghurt)		Farmed fish
	Whole grains (quinoa, spelt, amaranth, whole wheat (not just "wheat"), kamut)		Cold-pressed, organic oils (olive, hemp, flax, coconut)		Wild Fish

Please indicate how many **cups** (250ml / 8oz) of the following you drink generally **in a day**:

	Tap water (*unfiltered*)		Red wine
	Filtered/pure/spring water		White wine
	Fresh fruit juices		Beer
	Clear fruit juices (*prepared*)		Other alcoholic beverages
	Fresh vegetable juices		Coffee
	Soft drinks (*regular*)		Tea (non-herbal)
	Soft drinks (*diet*)		Herbal tea
	Milk (*skim*)		Milk (*1%, 2% or whole*)
	Other (*specify*)		

What are your favourite foods & how often do you eat them? _____

_____

Which food (s) do you crave, and how often do you eat them? _____

_____

Do you avoid certain foods? Yes ☐ No ☐ If yes, please describe: _____

_____

Do you experience any **symptoms** if meals are missed? Yes ☐ No ☐ If yes, please describe: _____

_____

Do you experience any **symptoms** after meals? Yes ☐ No ☐ If yes, please describe: _____

_____

What do you consider to be your **major barriers** to having a healthy diet? _____

_____

What do you consider to be your **'bad' eating habits**? _____

_____

Additional comments (anything else to allow me to be of the best help to you): _____

_____

_____

_____

NUTRITIONAL AND LIFESTYLE COACHING:

Nutritional support is intended to raise nutritional awareness as well as enhance your dietary options, as it relates to your lifestyle. HM Frouws, R.H.N., does not provide diagnoses or medical advice. HM Frouws, R.H.N. advises that nutritional support be part of an integrated approach to healing with each client continuing to seek medical advice from other licensed or registered practitioners.

STATEMENT OF CONSENT:

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.

Name _____

Signature _____

Date _____

CANCELATION POLICY:

In signing this form, I also understand that cancellation of any appointment must be made **within 48 hours** of the scheduled appointment. If **48 hours' notice** is not given, the **charge for 50%** of the appointment will be applied.