SABRINA DONATO BA HONS, RHN
HOLISTIC NUTRITIONIST

LIFESTYLE ASSESSMENT FORM

Date:_____ Age:_____ Sex: F / M Height:_____ Weight:_____

What is the purpose for coming to see a Holistic Nutritionist?

_____

_____

What are your main health concerns/complaints? Please list in priority:

_____

_____

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

_____

_____

Rate your current stress levels: (Low) 1 2 3 4 5 6 7 8 9 10 (High)
What are the major causes or factors of your stress? (rate all that apply on a scale of 1 (low) to 10 (high)
Financial_____ Career_____ Personal____ Marriage_____ Health_____
Family_____ Spiritual____ Unfulfilled expectations____
How does your stress manifest itself?_____

_____

Do you use any coping mechanisms?_____

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

_____

_____

Rate your energy levels: (Low) 1 2 3 4 5 6 7 8 9 10 (High)
Do you experience any lulls or highs in your energy levels throughout the day? If so, at what time of day?_____
On average, how many hours do you sleep daily?_____
What time do you go to sleep?_____ Awaken?_____
Do you have trouble falling asleep?_____ Staying asleep?_____
Do you awaken feeling rested?_____ Do you snore?_____
What is your occupation?_____
Do you enjoy your work? (circle one) Yes No Sometimes
Do you work shifts or regular schedule?_____
How many hours do you work each day?_____

Do you smoke? Yes No
Is yes, how much and for how long?_____
If no, are you exposed to it either at home or in the workplace? Yes No
Do you wish to gain weight? ◯ Lose weight? ◯ How much?_____
What is your main motivation to change your weight?

_____

What are your interests and hobbies?_____

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MEDICAL HISTORY:

Are you currently taking any medication? If yes, list all medications and the reason(s) for each.

Have you taken antibiotics over the past five years? Yes No

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

Do you have any allergies, anaphylaxis (life-threatening allergy) or sensitivities? If yes, please list:

Do you have any silver mercury fillings? Yes No

Have you ever been:

Diagnosed with an illness? If yes, please explain

Hospitalized? If yes, please explain

Have you had surgery to remove your, gallbladder ◯ Tonsils ◯ Appendix ◯

Have you had kidney or gall stones? Yes No If yes, please explain

How often do you have a bowel movement?

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

Related to particular food or circumstances?

Do you have loose bowel movements? Yes No Occasionally

Related to particular food or circumstances?

Is there undigested food in your stools? Yes No Occasionally

Do you use recreational drugs? If yes, how often and what type

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

FAMILY HISTORY:

Hereditary Diseases: Use "F" for father. "M" for mother, "s" for sibling. "G" for grandparents, "O" for other

_____Allergies	_____Diabetes	_____Intestinal Disease
_____Alcoholism	_____Drug Abuse	_____Kidney Dysfunction
_____Arthritis	_____Gall Bladder Issues	_____Mental Illness
_____Asthma	_____Heart Disease	_____Osteoporosis
_____Autoimmune Disease	_____Hypertension	_____Skin Condition
_____Cancer, type_____		_____Ulcers

Other diseases

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FEMALES:

Are you or could you be pregnant? Yes No

Have you noticed any changes in menses, for example the frequency, duration, flow, clotting, or other changes? Yes No

If yes, please specify

Do you suffer from PMS symptoms? Please specify

Are you pre-menopausal? Yes No Post-menopausal? Yes No

Are you experiencing any menopausal symptoms? Yes No 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 specify _____

Have you experienced fungal infections (e.g. jock itch, athlete's foot)? Yes No

If yes, please specify_____

DIETARY HABITS

How many times a day do you eat?

Main Meals_____ Times of day_____

Snacks_____ Times of day_____

Do you eat meals: with family ◯ home alone ◯ on the run ◯ restaurant ◯ fast food ◯

Do you feel there are restrictions to your diet due to preferences of others such as family, roommates, etc? Yes No If yes, please specify_____

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: Type_____

Provide examples of your typical meals:

Breakfast_____

_____

Lunch_____

_____

Dinner_____

_____

Snacks_____

_____

Do you eat or use (1=rarely, 2=regularly, 3=often)

_____Aluminum pans ____Margarine _____Candy

_____Microwave ____Fried foods _____Fast foods

_____Luncheon meats ____Cigarettes

_____Artificial sweeteners (Nutra sweet, aspartame, Splenda)

_____Refined food (pastries, white bread/pasta/rice, etc.)

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

____Beer	____Red wine
____Coffee	____White wine
____Tap water	____Bottled or spring water
____Soft drinks (diet)	____Tea
____Soft drinks (regular)	____Herbal Tea
____Fruit juices (prepared)	____Fresh fruit juices
____Milk (1% or 2%)	____Fresh vegetable
____Milk (skim)	____Other alcoholic beverages

____Other_____

Are you a meat eater ◯ vegetarian ◯ vegan ◯

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 ◯

What are your favorite foods, and how often do you eat them?_____

_____

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

_____

Do you avoid certain foods? If so, why?_____

_____

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

_____

Do you experience any symptoms after meals? Explain:_____

_____

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.

Name:_____ Signature:_____ Date:_____

Tel:_____ Email:_____

Thank you for your cooperation

All information contained on this form will be kept strictly confidential

LIFESTYLE ASSESSMENT FORM

*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.*

	General fatigue or weakness			Cold hands and feet
	Difficulty losing weight			Varicose veins
	Frequent illness/infections			Feeling out of control
	High stress lifestyle			Food/chemical sensitivities
	Smoking			Frequent yeast/fungus problems
	Drink more than 2 cups of coffee/day			Bones break easily. osteoporosis
	Bad breath and/or body odour			Too little exercise
	Constipation			Excessive mucous
	Bags under eyes			Short of breath climbing stairs
	Crave sugars, bread, alcohol			Tingling in lips, fingers, arms, legs
	Difficulty digesting certain foods			Chest pains
	Have used antibiotics in the past 10 years			Very rapid or slow heart beat
	Allergies			Painful, hard or thin bowel movements
	Poor concentration or memory			Alternating constipation/diarrhea
	Belching or burping after meals			Recurrent bladder infections
	Skin/complexion problems			Menopause, hot flashes (female only)
	Frequent consumption of red meat			PMS (female only)
	Regular use of dairy products			Difficulty urinating
	Heavy alcohol consumption			Swollen glands, puffy throat
	Exposure to toxins/chemicals			Lower abdominal pain
	Frequent mood swings			Frequent need to urinate
	Depressed and/or irritable			Joint pain
	Brittle fingernails			Sinus inflammation/discharge
	Dry, brittle hair, split ends			Arthritis
	High fat / high cholesterol diet			Sudden weight gain/loss
	Nervousness/anxiety/tension/worry			Headaches/migraines
	Insomnia/restless sleep			Taking birth control (Female only)
	Low fibre diet			Lower back pains
	Muscle cramps			Dry, flaky skin
	Sleepy when sitting up			Drink less than 6 glasses of fluids/day
	Menstrual cramps (female only)			Water retention
	Bronchitis/asthma/pneumonia/emphysema			Low sex drive
	Cellulite			Feeling heavy/bloated after meals
				Chronic cough

LIFESTYLE ASSESSMENT FORM

Please complete the following sub-questionnaires using the same rating system. Leave blank if symptom or activity does not apply. ***1*** *for mild or rarely occurring.* ***2*** *for moderate or regularly occurring.* ***3*** *for severe or often occurring.*

The Digestive System			
	Excessive gas, belching or burping after meals		Stomach pain 1 hour after eating or at night
	Stomach bloated after eating		Burning sensation in stomach
	Sleepy after eating		Pain aggravated by worry/tension
	Longitudinal striations on fingernails		Hiatal hernia
	Eat when rushed/in a hurry		Gastritis, gastric ulcer
	Full feeling after heavy meat meal		Nausea, vomiting
	Heavy, tired feeling after eating		Sensation of acidity in abdominal area
	Nausea after taking supplements		Heartburn, indigestion
	Undigested food in the stool		Blood in stool
	Yellow or pale fingernails		Lower back pain
	Skin oily on nose and forehead		Long term aspirin use
	Fat/greasy foods cause nausea, headaches		Severe abdominal pain
	Vertical white streaks on fingernails		Slow digestion; feel full for hours after eating
	Onions, cabbage, radishes, cucumbers cause bloating/gas		Fever
	Bad breath; bad taste in mouth		Alcohol addiction
	Excess body odor		Hungry up to 3 hours after eating
	High cholesterol/high cholesterol diet		Strong, sudden cravings for sweets, starches, coffee or alcohol
	Migraine headaches		Nervous/anxious feelings relieved by eating
	Discomfort underneath right ribcage		Irritable if late for or skip a meal
	Food allergies		Overweight
	Irritable, easily angered		Addicted to coffee with sugar and/or colas
	Weight gain around the abdomen		Frequent “midnight snacks”
	Yellow palms		Family history of diabetes
	Jaundice		Fatigue
	Poor concentration		Frequent headaches
	Difficulty losing weight		Fainting spells
	Acne, boils, rashes, psoriasis or eczema		Depression
	Constipation		Lose temper easily
	Gall stones; history of gall stones		
	Stool appears clay-coloured, foul odour		
	Severe pain in right upper abdomen		

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The Intestinal System			
	Extreme Fatigue		Forgetfulness
	F: Recurrent vaginal infections		Slow reflexes
	Frequent use of antibiotics		Unclear thinking
	White coated tongue, oral thrush		Loss of appetite
	Crave sugars, bread and alcohol		Yellowish or pale face
	Headaches		Fast heartbeat
	Tonsillitis, recurrent strep throat		Heart pain
	Itchy, watery or dry eyes		Pain in navel
	Skin flushes		Eating more than normal but still feeling hungry
	Chronic indigestion, frequently use or antacids		Blurry or unclear vision
	Always cold, especially in extremities		Pain in the back, thighs, shoulders
	F: PMS		Numb hands
	Pain in pelvic area		Drooling while sleeping
	Gas and bloating		Damp lips at night
	Loss of sex drive		Dry lips during the day
	Cystitis, repeated bladder infection		Grind teeth while asleep
	Increasing food and chemical sensitivities		Bedwetting
	F: endometriosis/ovary problems		Dark circles under eyes
	Chronic diarrhea		Cancer
	Hives, psoriasis, acne, skin rashes		
	Rectal itching		
	Abnormal muscle aches from exercise		
	Excessive wax in ears		
	Unexpected/unexplained weight gain		
	M: Impotence		
	Canker sores		
	Athlete’s foot, finger/toenail fungus, ringworm		
	Jock itch		
	“Brain fog”		
	Irritability		
	Memory loss		
	Mental confusion		
	Depression or anger for no reason		
	Anxiety/panic attacks		
	Inability to concentrate		
	Phobic/compulsive		
	Lethargy: Chronic fatigue		
	Mood swings		
	Itchy ears, nose, anus		

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The Lymphatic System			
	Acne, psoriasis, dermatitis, eczema		Excessive sleep
	Raid pulse, heart irregularities		Very susceptible to infections
	Frequent headaches		Swollen glands: tonsils, throat, armpits
	Hay fever		History of cancer, MS, Parkinson's arthritis
	Frequent cravings for certain foods		Loss of appetite
	Periods of blurred vision		Headaches
	Repeated ear trouble		Soreness on both sides of neck at shoulder
	Hyperactivity		Feel puffiness in throat
	Dizzy spells		Look older than chronological age
	Periods of confusion		Flu-like symptoms often occur
	Poor concentration		Lupus
	Epilepsy		Excessive sleep
	Muscle cramps or spasms		Very susceptible to infections
	Abnormal body odour		Swollen glands: tonsils, throat, armpits
	Excessive sweating, night sweats		
	Bowel disease: IBS, IBD, Crohn's, etc.		
	Joint pains or stiffness		
	Frequent night urination		
	Wheezing		
	Pale face		
	Hives		
	Nose runs constantly		
	Noticeable changes in writing throughout day		
	Nosebleeds		
	Bloating or gas after eating certain foods		
	Canker sores		
	Dark circles under eyes		
	Stuffy nose		

LIFESTYLE ASSESSMENT FORM

The Glandular / Endocrine System			
	Distinct, lethargic tiredness or sluggishness		Losing weight without trying
	Cold hands or feet		Heart races while at rest
	Mercury amalgams (filings)		Feel warm/flushed at room temperature
	Gain weight easily, fail to lose on diets		Hands shake or tremble
	Constipation, less than one bowel movement a day		Protruding tongue
	Low energy in the morning		Heart palpitations
	Low pulse rate		Nervous behaviour, hyperactivity
	Low body temperature, especially bed rest		Insomnia
	Hair dry, brittle, dull, lifeless		Increased appetite
	Flaky, dry rough skin		Frequent bowel movements, diarrhea
	Feel stiff after sitting for some time		Excessive sweating without exercising
	Mood swings		Stress or emotional upsets cause exhaustion
	Usually square and wide fingernails		Blood pressure decreases when going from a lying position to a standing position
	High cholesterol		Neck and/or shoulder tension
	Diminished sex drive		Bow lines (depressed furrows) on fingernails
	Headaches one side of the head		Occasional cold sweats
	F: Loss of menstrual function		Tightness or lump in throat, especially when emotionally disturbed
	Moody		High or low blood pressure
	Overweight from waist down		Rapid pulse
	Overweight from waist up		Short temper
	Excessive urination		Puffy face
	Pain in little finger of left hand		
	Swelling in ankles, fingers, feet, or under		
	Cold hands or feet		
	Pain in left side of upper neck		

LIFESTYLE ASSESSMENT FORM

The Structural-Muscular/Skeletal System			
	Pain, swelling, stiffness in joints		Muscles wasting in some parts of the body
	Joint inflammation (rheumatoid arthritis)		Numbness or loss of sensation
	Pain, stiffness, inflammation of spine		Mood swings and/or depression
	Facial pain		Blurred or double vision
	Joints make popping sounds		Tingling and/or numbness, especially in extremities
	Gout		Muscular stiffness
	Ankylosing spondylitis		Difficulty breathing
	Bones fracture easily		M: Impotence
	Gradual loss of height		Tremors
	Tooth loss; teeth “falling out”		Loss of peripheral vision
	Lack of exercise		Slurred speech
	Rounding of shoulders; stooping		Objects fall from hands, reach in wrong place
	F: Menopause		Hands tremble
	Pain in forearm or biceps		Impaired speech
	Cramps in calf muscle during sleep or exercise		
	Painful cramping of feet or toes		
	Teeth prone to decay, frequent toothaches		
	Malformation of bones		
	Insomnia		
	Muscles weak, weak grip, light objects feel heavy		
	Heart palpitations		
	Diet high in animal foods (meat, diary, eggs)		
	Muscle pain		
	Muscle weakness		
	Sprains; muscle strains		
	Muscle(s) spasm		