

LIFESTYLE ASSESSMENT FORM

Name: _____ Age: _____ Date: _____

Please answer each of the following questions.

What are your main health concerns/complaints?

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Do you wish to ___ gain or ___ lose weight? If so, how much? _____

What level of stress do you feel you are experiencing right now?

___ 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 many hours do you sleep daily (average; 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? _____

How many hours each day do you spend driving (average)? _____

Do you smoke? Yes No If yes, how much? _____

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

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

How many hours a day do you:

___ watch television? ___ read? ___ work at a computer?

What are your interests and hobbies? _____

Do you take vacations regularly? Yes No

When was your last vacation? _____

Do you actively participate in any spiritual discipline
(church, religious group)? Yes No

MEDICAL HISTORY

Are you currently taking any medication? Yes No

List/Reason(s) _____

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

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

Have you ever been:

___ Diagnosed with an illness? Explain: _____

___ Hospitalized? For what reason: _____

FAMILY HISTORY

Hereditary Diseases:

Please check off "F" for Father, "M" for Mother, "S" for siblings,

"G" for grandparents, "O" for other relatives.

___ Heart Disease ___ Diabetes ___ Allergies

___ Hypertension ___ Arthritis ___ Mental Illness

___ Cancer ___ Osteoporosis ___ Intestinal Disease

Other (please list): _____

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

If yes, please circle which one.

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Name: _____

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DIETARY HABITS

How many times a day you eat:

Main Meals _____ Times of day: _____

Please list/describe what you would typically eat for:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

At what time do you have your last meal or snack of the day? _____

Do you eat or use:

- | | |
|--|--|
| <input type="checkbox"/> fried foods | <input type="checkbox"/> refined foods |
| <input type="checkbox"/> candy | <input type="checkbox"/> microwave |
| <input type="checkbox"/> luncheon meats | <input type="checkbox"/> cigarettes |
| <input type="checkbox"/> aluminum pans | <input type="checkbox"/> margarine |
| <input type="checkbox"/> Nutra-Sweet/Aspartame | <input type="checkbox"/> fast foods |

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

- | | |
|--|---|
| <input type="checkbox"/> beer | <input type="checkbox"/> red wine |
| <input type="checkbox"/> coffee | <input type="checkbox"/> white wine |
| <input type="checkbox"/> tap water | <input type="checkbox"/> other alcoholic beverage |
| <input type="checkbox"/> soft drinks (diet) | <input type="checkbox"/> tea |
| <input type="checkbox"/> soft drinks (regular) | <input type="checkbox"/> fresh fruit juices |
| <input type="checkbox"/> fruit juices (prepared) | <input type="checkbox"/> bottled or spring water |
| <input type="checkbox"/> milk (2%) | <input type="checkbox"/> herbal tea |
| <input type="checkbox"/> milk (skim) | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> fresh vegetable juices | |

Are you: A meat eater Vegetarian Vegan

How often do you eat meat? Daily 3-5/week once/week or less

If you are a vegetarian, how often do you consume dairy products?

___ Daily ___ 3-5/week ___ once/week or less

What are your favourite foods? _____

How often do you eat them? _____

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

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

Do you experience any symptoms after meals? Explain _____

Comments:

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CLIENT STATEMENT

I understand and acknowledge that the services hereby 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.

Date: _____ Signature: _____

Name (please print): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: (H) _____ (B) _____

Thank you for your cooperation.

NSP CLIENT ASSESSMENT FORM

Name: _____ Date: _____ Assessment #: _____

(Check: 1 for mild or rarely occurring, 2 for moderate or regulary occurring, 3 for severe or often occurring, or leave blank if the symptom/statement does not apply.)

		THIS SIDE FOR OFFICE USE ONLY									
		1	2	3	4	5	6	7	8	9	10
SUBTOTALS											
41 Excessive mucous											
42 Short of breath climbing stairs											
43 Tingling in lips, fingers, arms, legs											
44 Chest pains											
45 Very rapid or slow heartbeat											
46 Painful, hard or thin bowel movements											
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											

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SYSTEMS RATING TABLE

COMMENTS

1 Digestive	
2 Intestinal	
3 Circulatory/Cardiovascular	
4 Nervous	
5 Immune/Lymphatic	
6 Respiratory	
7 Urinary	
8 Glandular/Endocrine	
9 Structural	
10 Reproductive	