

*A Recipe For Life.....*  
Nutritional & Lifestyle Assessment Form

It will take approximately 15 minutes to complete this form. Please bring it with you to your first appointment.

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

**GENERAL INFORMATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Number of Children: \_\_\_\_\_

What are your main health concerns, in order of importance?

1. \_\_\_\_\_
2. \_\_\_\_\_

What are you doing for your health presently? [Circle those, which apply]

Exercise	Vitamin Supplements	Minerals	Herbs
Chiropractor	Prescription Medication	Diet	Meditation
Medical Doctor	Relaxation Techniques	Acupuncture	Other: _____

What do you feel may be the underlying factors contributing to your present health concerns?

\_\_\_\_\_  
\_\_\_\_\_

Height: \_\_\_\_\_ Weight \_\_\_\_\_

Do you wish to: [circle one]:      Gain weight      Lose weight

How much weight would you like to gain or lose? \_\_\_\_\_

Do you suffer from high or low blood pressure? If so, Please explain \_\_\_\_\_

What level of stress do you feel you are experiencing at this time in your life? [Circle one]

Minimal      Average      Considerable      Unbearable

What are the major causes or factors of your stress? [Circle all that apply]

Financial      Career      Personal      Marriage      Health      Family      Spiritual

Unfulfilled Expectations      Other [Please Specify]: \_\_\_\_\_

How many hours do you sleep daily? [Average; include naps] \_\_\_\_\_

Do you wake feeling rested? [Circle one]      Yes      No      Sometimes

Describe your energy level? \_\_\_\_\_

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How many hours a day do you work? \_\_\_\_\_ What type of work do you do? \_\_\_\_\_

Do you enjoy your work? [Circle one] Yes No Sometimes

How many hours each day do you spend driving? [Average] \_\_\_\_\_

Do you smoke? [Circle one] Yes No If yes, how much? \_\_\_\_\_

Describe what you do for exercise \_\_\_\_\_

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How many hours daily do you:

\_\_\_\_\_ Watch television \_\_\_\_\_ Read \_\_\_\_\_ Spend in front of a computer

What are your interests/hobbies? \_\_\_\_\_

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Do you take vacations regularly? [Circle one] Yes No

When was your last vacation? \_\_\_\_\_

How did you spend your last vacation? \_\_\_\_\_

Do you actively participate in a church or spiritual group? [Circle one] Yes No

**MEDICAL HISTORY**

Are you currently taking any medication? [Circle one] Yes No

List/Reasons(s): \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies or food intolerances? If yes, please list: \_\_\_\_\_

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Have you ever been:

\_\_\_\_\_ Diagnosed with an illness? Explain: \_\_\_\_\_

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\_\_\_\_\_ Hospitalized? For what reason: \_\_\_\_\_

How often do you have a bowel movement? \_\_\_\_\_

Do you strain to have a bowel movement? [Circle one]    Yes            No            Sometimes

**FAMILY HISTORY**

Hereditary Diseases: Please indicate "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/Digestive Issues

Other [Please list]: \_\_\_\_\_

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Have you ever been treated for drug and/or alcohol dependency? [Circle one]    Yes            No

**DIETARY HABITS**

Main meals \_\_\_\_\_ what time of the day: \_\_\_\_\_

Snacks \_\_\_\_\_ what times of the day: \_\_\_\_\_

Describe what you eat on a typical day:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

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

Do you eat or use: [check all that apply]

\_\_\_\_\_ Aluminum pans

\_\_\_\_\_ microwave

\_\_\_\_\_ margarine

\_\_\_\_\_ Candy

\_\_\_\_\_ fried foods

\_\_\_\_\_ refined/processed foods

\_\_\_\_\_ Luncheon meats

\_\_\_\_\_ cigarettes

\_\_\_\_\_ artificial sweetener

\_\_\_\_\_ Fast foods

\_\_\_\_\_ air fresheners

\_\_\_\_\_ scented body product

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Beverage	Number of Cups per day	Number of cups per week
Coffee		
Tea – regular or green tea		
Herbal tea		
Tap water		
Bottled/Spring water		
Soft drinks		
Fruit Juices (store bought)		
Fruit juices (freshly squeezed)		
Milk		
Vegetables juices (freshly squeezed)		
Vegetables juices (prepared) Example: V8		
Beer		
Wine		
Other alcoholic beverages		

How often do you eat meat? [Circle one]    Daily       3-5 times week       once a week or less

How often do you consume dairy products? [Circle one]

Daily       3-5 times week       once a week or less?

What are your favorite foods? \_\_\_\_\_

How often do you eat them? \_\_\_\_\_

What foods do you crave, if any? \_\_\_\_\_

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

Do you avoid certain foods? If so, what are they and why do you avoid them?

Do you experience any symptoms after meals? Explain: \_\_\_\_\_

Is there anything else about your health that you would like to share with me?

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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 well-being and optimal health. They are not meant to be a medical diagnoses of any disease or treatment for which a medical license is required. All information will be kept strictly confidential.

Name (Please print): \_\_\_\_\_ Date: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Email: \_\_\_\_\_ Signature \_\_\_\_\_

**Rate the following symptoms ( 1-3 ) depending on the severity experienced. Leave blank if the symptoms do not apply. 1 for mild or rarely occurring, 2 for moderate or regularly occurring, 3 for severe or occurring often.**

**The Digestive System**

**Underactive Stomach**

**Overactive Stomach**

Undigested food in stool		Stomach Pain 1 hour after eating or in the evening	
Stomach bloated after eating		Burning sensation in stomach	
Feeling tired or fatigue after eating		Pain aggravated by worry/tension	
Eat when rushed or in a hurry		Hiatal Hernia	
Heavy feeling and sleepy after eating		Gastritis or Gastric Ulcer	
Nausea after taking supplements		Acidity sensation in abdominal area	
Acne		Heartburn, Indigestion	
		Blood in Stool	
		Pain in lower back	
		Long term Aspirin use	

**Liver**

**Pancreas**

Yellow fingernails		Severe abdominal pain	
Oily nose and/or forehead		Nausea and vomiting	
Fats/greasy food causes nausea, headaches		Slow digestion, feel full hours after eating	
Vertical white streaks on fingernails		Fever	
Onions, cabbage, radishes or cucumbers cause gas and bloating		Alcohol addiction	
Bad breath, bad taste in mouth		Jaundice	
Dry, itchy or watery eyes		<b>Hypoglycemia</b>	
Excess body odor		Hungry up to 3 hours after eating	
High cholesterol/ High cholesterol diet		Strong, sudden cravings for sweets & starches	
Stiff, aching muscles		Strong, sudden cravings for coffee or colas	
Migraine headaches		Frequent « Midnight Snacks »	
Discomfort under right ribcage		Family history of Diabetes	
Food allergies		Fatigue	

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Irritable, easily angered		Frequent headaches	
Weight gain around the abdomen		Fainting spells	
Yellow palms		Depression	
Jaundice		Lose temper easily	
Poor concentration			
Difficulty losing weight			
Acne, boils, rashes, psoriasis or eczema			

**Gall Bladder**

Gallstones, history of gallstones	
Stool appears clay-coloured, foul odored	
Constipation	
High cholesterol diet	
Pain in right upper abdomen	
High blood cholesterol levels	

**The Intestinal System & The Lymphatic/Immune System**

**Candidiasis**

**Parasites**

Extreme fatigue		Forgetfulness	
Recurrent vaginal infections		Slow reflexes	
Frequent antibiotic use		Gas and bloating	
White coated tongue, or oral thrush		Unclear thinking	
Crave sugars, bread, alcohol or colas		Loss of appetite	
Headaches		Yellowish or pale face	
Tonsillitis, recurrent strep throat		Fast heartbeat	
Itchy, watery or dry eyes		Heart pain	
Skin flushes, redness or rash		Pain in navel	
Chronic indigestion, use antacids		Eating more than normal but still feeling hungry	
Always cold, especially in extremities		Blurry or unclear vision	
PMS		Pain in the back, thighs or shoulders	
Pain in pelvic area		Numb hands	
Abdominal gas and bloating		Drooling while asleep	
Loss of sex drive		Damp lips at night	
Cystitis, repeated bladder infections		Dry lips during the day	
Increasing food and chemical sensitivities-severe reaction to tobacco, perfume etc....		Grind teeth while asleep	
Endometriosis, Ovarian issues		Bed wetting	
Chronic diarrhea		Lethargy, chronic fatigue	
Hives, psoriasis, acne, skin rashes		Dark circles under eyes	
Rectal itching		Cancer	
Abnormal muscles aches from exercise		<b>Thymus (Immunity)</b>	
Excess wax in ears		Excessive sleep	
Unexpected/Unexplained weight gain		Very susceptible to infections	
Impotence		Swollen glands in tonsils, throat or armpit	
Cancer		History of cancer, MS, arthritis, Parkinson's etc...	
Athlete's foot, finger/toenail fungus		Loss of appetite	

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Jock itch		Headaches	
« Brain fog »		Soreness on both sides of neck- shoulder level	
Irritability		Feel puffiness in throat	
Memory loss		Look older than chronological age	
Mental confusion		Flu-like symptoms often occur	
Depression or anger for no reason		Lupus, autoimmune diseases	
Anxiety/panic attacks		Cold sores	
Inability to concentrate		HPV virus	
Phobic/compulsive behaviour		Abnormal Pap smear reading	
Lethargy		Cancer	
Mood swings			
Itchy ears or nose			

**The Lymphatic / Immune System & The Glandular / Endocrine System**

**Allergies**

**Underactive Thyroid / Hypothyroidism**

Acne, psoriasis, dermatitis, eczema		Tired, sluggish or lethargic	
Rapid pulse, heart irregularities		Cold hands and feet	
Frequent headaches		Nodules on thyroid – past or present	
Hay fever, seasonal allergies		Mercury amalgams (fillings)	
Frequent cravings for certain foods		Gain weight easily, fail to lose on diets	
Periods of blurred vision		Constipation, less than 1 bowel movement daily	
Repeated ear trouble		Low energy in the morning	
Hyperactivity		Low blood pressure	
Dizzy spells		Low body temperature	
Periods of confusion		Dry, brittle, dull or lifeless hair	
Poor concentration		Dry, flaky or rough skin	
Epilepsy		Feel stiff after sitting for sometime	
Muscle cramps or spasms		Mood swings	
Excessive sweating, night sweats		Unusually square and wide fingernails	
Bowel disease : IBS, IBD, Crohn's		High cholesterol	
Joint pain or stiffness		Low sex drive	
Frequent night urination		PMS	
Wheezing		<b>Overactive Thyroid/ Hyperthyroidism</b>	
Pale face		Weightloss without trying	
Hives		Heart races while at rest	
Runny nose		Feel warm / flushed at room temperature	
Nosebleeds		Hands shake or tremble	
Gas or bloating after meals		Protruding tongue	
Cold or mouth Sores		Heart palpitations	
Dark circles under eyes		Nervous behavior, hyperactivity	
Stuffy nose		Insomnia	
Blood in stool		Increased appetite	
Lower back pain		Frequent bowel movements, diarrhea	
Stiff spine		Excessive sweating	
Mood swings, irritability		<b>Pituitary</b>	
Dark circles under eyes or puffy eyes		Infertility or impotence	

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