LIFE STYLE ASSESSMENT

The Life Style Assessment is a confidential Health Assessment tool designed to provide insight into your personal health. When embarking on a personal health plan it is important to first have a benchmark of where you are, your personal and family history.

The following Life Style Assessment is **not** designed to give a medical diagnosis. It will identify current strengths of your health, and any risk factors that might be present.

This questionnaire will take about 30 minutes to complete. The Lifestyle Assessment is broken down into seven categories:

C. General Information
D. Family Medical History
E. Medications / Supplements
F. Nutrition
G. Exercise
H. Health Concerns
I. Review of Physical Symptoms

A. GENERAL INFORMATION

Please circle the response that is correct or fill in the blanks.

Current Date: _____

Name: _____

Date of Birth: _____

Occupation: _____

Number in household _____ Relationship to you? _____

Chief Concerns: _____

_____

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B. FAMILY MEDICAL HISTORY

Please indicate if any of your immediate family relatives has ever encountered the following health concerns:

Health Concern	Family Relative
Alzheimer's disease	
Arthritis	
Cancer *(indicate type)*	
Diabetes	
Glaucoma	
Heart disease	
Hypertension	
Osteoporosis	
Stroke	
Other	

C. MEDICATIONS / SUPPLEMENTS

Please circle any of the following medications that you are taking?

antacids diuretics (water pills) tranquillizers sleeping pills
aspirin / tylenol laxatives pain relievers

Any known allergies or drug sensitivities?

_____

Medications (if more space is needed please attach a separate sheet)

Listing of medications	Dosage	Reason for taking	Duration of use

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Vitamins, Supplements, Herbal or Homeopathic Remedies

Listing of medications	Dosage	Reason for taking	Duration of use

D. NUTRITION

What would you like to change about your diet? _____

_____

On average how many meals do you eat a day 1 2 3 4 5 + 5

What is usually your largest meal: breakfast lunch dinner

Do you crave any specific foods: Yes No

If yes, what food: _____

Please list what you would typically have for:

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Do you monitor your intake of FAT? YES NO
Do you add SALT to most meals? YES NO
Do you monitor your intake of FIBRE? YES NO

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E. EXERCISE

Do you belong to a gym? YES NO If yes, how often do you go? _____

What type of exercise(s) do you participate in and how frequent do you exercise?

_____

_____

F. HEALTH CONCERNS

Please list the injuries, hospitalizations, accidents, or medical concerns that you have had:

Event	When?	Treatments?

G. REVIEW OF PHYSICAL SYMPTOMS

On a scale of 1 (low) to 10 (high) rate your energy level? _____

_____

How is your sleep? _____

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How would you describe your breathing? _____

_____

What is your normal body temperature? _____

VASCULAR SYSTEM	*Concern check if Yes*	*Number of years*	*Comments*
Hot hands / feet			
Cold hands / feet			
Deep leg pain			
High blood pressure			
Low blood pressure			
Chest pain			
Extremity swelling			
Extremity numbness			
Extremity ulcers			
Angina			
Other circulatory / heart concerns?			

SKIN	*Concern check if Yes*	*Number of years*	*Comments*
Rashes			
Lumps / cysts			
Dry / cracked skin			
Jaundice (yellowing of skin)			
Skin cancer			
Other skin concerns			

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HEAD AND MOUTH	*Concern check if Yes*	*Number of years*	*Comments*
Frequent sore throats			
Gum problems			
Hoarseness			
Swollen glands			
Nose bleeds			
Loss of smell			
Dizziness / Vertigo			
Headaches			
Memory problems			
Other problems			

EYES AND EARS	*Concern check if Yes*	*# of year*	*Comments*
Eye-sight			
Blurred vision			
Dry eyes			
Eye pain			
Glaucoma			
Cataracts			
Diminished hearing			
Ear aches/infections			
Ringing in the ears			

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NERVOUS SYSTEM	*Concern check if Yes*	*Number of years*	*Comments*
Fainting			
Paralysis			
Tingling			
Numbness			
Involuntary movement			
Loss of balance			
Speech problems			
Other nervous system concerns			

DIGESTIVE SYSTEM	*Concern check if Yes*	*Number of years*	*Comments*
Food intolerances / allergies			
Trouble swallowing			
Nausea			
Vomiting			
Gas or belching			
Abdominal Bloating			
Heartburn / Reflux			
Constipation			
Diarrhea			
Liver Disease			

RESPIRATORY SYSTEM	*Concern check if Yes*	*Number of years*	*Comments*
Cough			
Spitting up blood			
Wheezing			
Shortness of Breath			
Bronchitis			

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Pneumonia			
Tuberculosis			
Smoking			
Other concerns			

URINARY SYSTEM	*Concern check if Yes*	*Number of years*	*Comments*
Urinary pain, burning			
Difficult urination			
Increased frequency			
Inability to hold urine			
Frequent infections			
Blood in urine			
Kidney Stones			

MUSCLE / BONES	*Concern check if Yes*	*Number of years*	*Comments*
Bones break easily			
Painful joints			
Swollen joints			
Muscle weakness			
Prolonged stiffness			
Low back pain			
Weak, sore knees			
Osteoporosis			
Arthritis			

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FEMALE REPRODUCTIVE SYSTEM	*Concern check if Yes*	*Number of years*	*Comments*
Pain during intercourse			
Hot flashes			
Night Sweats			
Frequent fungal / yeast infections			
Other concerns			

MALE REPRODUCTIVE SYSTEM	*Concern check if Yes*	*Number of years*	*Comments*
Hernias			
Testicular masses			
Testicular pain			
Sexual difficulties			
Prostatitis / BPH			

What are your health goals? _____

_____

Please list any other relevant health / personal information that you feel is missing.

_____

_____

Thank you.

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