LIFESTYLE ASSESSMENT

The Lifestyle Assessment Questionnaire is designed to provide insight into your personal health. When embarking on a personal health plan, it is important for you and your practitioner to have a benchmark of where you are, your personal and family history, and what your behaviours, concerns, and thoughts are with regards to your health.

The following **Lifestyle Assessment Questionnaire** is **not** designed to give a medical diagnosis. It identifies your current strengths, risk factors that might be present, and it highlights key areas of concern. It also assists in uncovering the factors that may be contributing to your symptoms or current concerns.

This questionnaire will take about 1 - 2 hours to complete. The time that it takes to answer the questions is completely up to you and has no bearing on the results.

General Guidelines to Follow when filling out the Lifestyle Assessment:

- Use the last three months as a guide to current symptoms when answering the questions.
- If you feel that something that pertains to you is missing in any section feel free to add it.

The Lifestyle Assessment is broken down into eight categories:

A. GENERAL INFORMATION
B. EXTERNAL FACTORS
C. FAMILY MEDICAL HISTORY
D. MEDICATIONS, SUPPLEMENTS & OTHER TREATMENTS
E. EXERCISE
F. PAST & PRESENT HEALTH CONCERNS
G. REVIEW OF PHYSICAL SYSTEMS
H. GENERAL INFORMATION ON DIET
I. PERSONAL VALUES
J. STRESS
K. HEALTH POSITIONING STATEMENTS

A. GENERAL INFORMATION

Name: _____ Today's date: _____

Date of birth: _____ Occupation: _____

Number in household: _____ Relationship to you? _____

Number of pets: _____ What kind of pets? _____

A TYPICAL DAY

List the amount of time you spend doing the following activities during a typical day
Note: The total time will probably add up to more than 24 hours due to the nature of the question.

Hours	Activity	Hours	Activity
_____	Sleeping	_____	Exercising
_____	Personal Hygiene	_____	Relaxing or meditating
_____	Driving a vehicle	_____	Reading
_____	Taking public transport or passenger	_____	Listening to music
_____	Working	_____	Watching television
_____	Computer related work	_____	Being outside
_____	House or yard work	_____	Time alone

SATISFACTION LEVEL ON DIFFERENT ASPECTS OF YOUR LIFE

Using the scale provided identify your level of satisfaction with respect to the categories listed.

Scale: 1 - not comfortable at all with current situation
2 - low level of comfort with current situation
3 - okay most of the time with current situation
4 - fairly comfortable with current situation
5 - high level of comfort with the current situation

Category	Satisfaction or Comfort Level with the Situation					Changed in Last 3 Months		Changed in Last Year	
DIET	1	2	3	4	5	YES	NO	YES	NO
EXERCISE	1	2	3	4	5	YES	NO	YES	NO
WELLNESS	1	2	3	4	5	YES	NO	YES	NO
LIFESTYLE	1	2	3	4	5	YES	NO	YES	NO
ENVIRONMENT	1	2	3	4	5	YES	NO	YES	NO
WORK	1	2	3	4	5	YES	NO	YES	NO
FAMILY	1	2	3	4	5	YES	NO	YES	NO
RELATIONSHIPS	1	2	3	4	5	YES	NO	YES	NO

B. EXTERNAL FACTORS

The following section identifies external and environmental factors that may be affecting your health. Please check the box that is the most appropriate, or fill in the blanks as indicated.

ENVIRONMENT

Where did you grow up? _____

Where do you live? ☐ city ☐ suburbs ☐ country ☐ farm

Type of home? ☐ apartment/condo ☐ semi/townhouse ☐ detached house

Do you live near hydro towers? ☐ YES ☐ NO ☐ In the past Number of years? _____

Do you live near a factory? ☐ YES ☐ NO ☐ In the past Number of years? _____

Please list any chemicals, toxins, or other factors in your environment that might be affecting your health:

_____

PERSONAL

What are your hobbies? _____

How much time do you spend in nature? _____

Do you smoke? ☐ YES ☐ NO ☐ In the past How many packs a day? _____

Does anyone in your family smoke? ☐ YES ☐ NO ☐ In the past

Do you use natural personal care products? ☐ YES ☐ NO If so, what brand? _____

Do you pay attention to the chemicals in personal care products? ☐ YES ☐ NO

Do you use sunscreen? ☐ YES ☐ NO If so, what brand? _____

Do you dye your hair? ☐ YES ☐ NO If so, what type? _____ How often? _____

Do you have any body piercings? ☐ YES ☐ NO If so, where? _____

Do you have any permanent tattoos? ☐ YES ☐ NO

Have you had any cosmetic surgery? ☐ YES ☐ NO If so, when? _____

What type of cosmetic surgery? _____

How many hours a day do you spend watching television? _____ On a computer? _____

Do you use wireless networks ☐ at home? ☐ at work? If so, how many hours daily? _____

What type of phones do you use? ☐ cord ☐ cordless ☐ cellular

How many hours a day are you on a cell-phone or PDA? _____

Do you wear an ear piece for your phone? ☐ YES ☐ NO If so, how many hours daily? _____

What types of Bluetooth devices do you use? _____

How many trips on an airplane do you take a year? _____

HOUSEHOLD

Type of house you grew up in? _____

Number of times you have moved homes? _____ How old is your current home? _____

Have there been any recent home renovations? ☐ YES ☐ NO If so, what type? _____

Is there a history of flooding in your home? ☐ YES ☐ NO ☐ In the past

Do you use natural cleaning products? ☐ YES ☐ NO If so, what brand/type? _____

What type of cooking utensils (pots and pans) do you use? _____

What type of storage containers do you use? _____

What type of container do you use to carry your drinking water? _____

WORK

Do you enjoy your work? ☐ YES ☐ NO Why? _____

Describe your work load: _____

On average how many hours do you work a day? _____ How many hours a week? _____

Do you bring your work home with you? ☐ YES ☐ NO If so, why? _____

How active is your work day? ☐ sedentary ☐ active Please describe: _____

_____

How would you describe the dynamics at work? _____

_____

Are there any other external or environmental factors that you feel may be affecting your health?

_____

_____

_____

C. FAMILY MEDICAL HISTORY

Please indicate which family relatives (mother, father, grandparents, siblings, aunts or uncles) have ever encountered the following health concerns:

Health Concern	Family Relative	Health Concern	Family Relative
Alcoholism		Hypertension	
Allergies		Infertility	
Alzheimer's disease		Intestinal disease	
Arthritis		Learning disability	
Asthma		Mental illness	
Cancer *(indicate type)*		Migraine headaches	
Diabetes		Neurological disorders	
Drug addiction		Obesity	
Eating disorder		Osteoporosis	
Genetic disorder		Stroke	
Glaucoma		Suicide	
Heart disease		Other	

# of siblings _____ Your birth order _____

D. MEDICATIONS / SUPPLEMENTS AND OTHER TREATMENTS

Please check any of the following medications that you are taking or have taken in the last 2 years:

☐ antacids ☐ appetite suppressants ☐ aspirin / tylenol ☐ birth control pills
☐ chemotherapy ☐ diuretics (water pills) ☐ laxatives ☐ pain relievers
☐ radiation ☐ recreational drugs ☐ sleeping pills ☐ tranquilizers

Any known allergies or drug sensitivities? _____

Number of times on antibiotics in the last 10 years? _____

Number of times on corticosteroids in the last 10 years oral? _____ topical? _____

DRUGS *(if more space is needed, please attach a separate sheet)*

Listing of Drugs	Dosage / Amount	Reason for Taking	Duration of Use

VITAMINS, SUPPLEMENTS, HERBAL OR HOMEOPATHIC REMEDIES

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

Listing of Medications	Dosage / Amount	Reason for Taking	Duration of Use

OTHER TREATMENTS

Please comment on other natural / alternative treatments that you have used.

Treatments	Past	Current	Comments / Effectiveness
Acupuncture / Chinese Medicine			
Aromatherapy			
Art Therapy			
Ayurvedic Medicine			
Biofeedback			
Chiropractic			
Colonics			
Cranial Sacral Therapy			
Energetic Therapies			
Herbal Therapies			
Homeopathic			
Hydrotherapy			
Hypnotherapy			
Iridology			
Magnetic Therapy			
Massage Therapy			
Music Therapy			
Naturopathic Medicine			
Osteopathy			
Physiotherapy			
Polarity Therapy			
Reflexology			
Reiki			
Shiatsu			
Other			

E. EXERCISE

Using the scale provided, identify the number of times a week that you engage in the following exercises. Scale: a (never), b (seldom or less than once per week), c (1 - 3 times per week), d (3 - 5 times per week), e (often or more than 5 times per week).

	Never	<1/wk	1-3/wk	3-5/wk	>5/wk
BODY / MIND EXERCISES					
Meditation / Prayer / Breathing Exercises	a	b	c	d	e
Visualizations (or similar)	a	b	c	d	e
Other _____	a	b	c	d	e
STRENGTH BUILDING					
Weight Training	a	b	c	d	e
Martial Arts (or similar)	a	b	c	d	e
Other _____	a	b	c	d	e
CARDIOVASCULAR EXERCISES					
High Impact Aerobics / Step	a	b	c	d	e
Running / Jogging	a	b	c	d	e
Low Impact Aerobics / Walking	a	b	c	d	e
Cycling / Rowing / Swimming	a	b	c	d	e
Other _____	a	b	c	d	e
FLEXIBILITY EXERCISES					
Yoga / Tai Chi / Qi Gong (or similar)	a	b	c	d	e
General Stretching / Lengthening	a	b	c	d	e
Other _____	a	b	c	d	e

How active is your day? _____

On average, how many hours do you exercise per week? _____

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

Do you prefer to exercise ☐ alone? ☐ with others? ☐ as part of a class?

What benefits have you found from exercising? _____

_____

Choose the statement that describes you best:

☐ I exercise because I have to (someone has advised an exercise program)

☐ I exercise because I want to exercise for my own health and wellness.

☐ I exercise because I enjoy exercising.

F. PAST AND PRESENT HEALTH CONCERNS

Did you have any health problems at birth? _____

How was your health as a child? _____

Describe your health during puberty / teenage years: _____

_____

Please list any injuries, hospitalizations, accidents or medical procedures that you have had:
(if required, attach a separate sheet)

Event	When?	Treatments?

Have you been diagnosed with any illnesses? Explain _____

_____

_____

What are your current health concerns? _____

_____

_____

When did you notice any changes to your health? _____

_____

_____

What have been the most traumatic events in your life? _____

_____

_____

_____

G. REVIEW OF PHYSICAL SYMPTOMS

ENERGY LEVEL

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

What time of the day is your energy the highest? _____

What time of the day is your energy the lowest? _____

What affects your energy? _____

SLEEP

How is your sleep? _____

Do you ever suffer from insomnia? _____ How often? _____

How many hours a day do you sleep? _____ Do you nap? _____

Are you a restful and sound sleeper? If not, please explain. _____

_____

Do you wake feeling rested? _____

Do you have frequent dreams and nightmares? _____

BREATHING

How would you describe your breathing? _____

Do you have shortness of breath on exertion? _____

What affects your breathing? _____

BODY TEMPERATURE

What is your normal body temperature? _____

Do you like to be warm or cool? _____

Do you become overly hot or cold throughout the day? _____

WEATHER

Are you affected by the weather? _____

What is favourite type of weather? _____

What is your least favourite type of weather? _____

GENERAL SIGNS and SYMPTOMS	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
fever				
rapid weight loss				
rapid weight gain				
overweight				
underweight				
sensitive to noise				
sensitive to light				
sensitive to odours				
other sensitivities				

Height? _____ ☐ inches ☐ centimetres Weight? _____ ☐ lbs ☐ kg

What do you think would be an acceptable body weight for you? _____ ☐ lbs ☐ kg

HEAD and MOUTH	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
dizziness/vertigo				
headaches				
migraines				
frequent sore throats				
hoarseness				
dry mouth				
sore tongue/mouth				
cold sores/herpes				
gum problems				
bad breath				
swollen glands				
lumps/goitre				
nose bleeds				
loss of smell				
other concerns				

Number of dental cavities? _____ Number of amalgams (silver fillings)? _____

Last dental check up? _____ Do you floss? _____ Do you brush regularly? _____

Have you had any extensive dental work? ☐ YES ☐ NO If so, please indicate:

☐ cosmetic dentistry ☐ oral surgery ☐ orthodontics ☐ periodontal therapy ☐ other _____

EYES and EARS	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
near sighted				
far sighted				
blurred vision				
dry eyes				
tearing				
itchy eyes				
eye pain				
redness in eyes				
eye discharge				
dark circles under eyes				
bothered by the sun				
eye infections				
glaucoma/cataracts				
diminished hearing				
ear aches				
ear infections				
ringing in ears (tinnitus)				
other eye/ear concerns				

Date of last eye exam? _____ Any eye procedures? _____ Any hearing aids? _____

RESPIRATORY SYSTEM	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
cough				
sputum/mucous				
sinus congestion				
spitting up blood				
wheezing				
shortness of breath				
difficulty breathing				
tonsillitis				
asthma				
bronchitis				
pneumonia				
tuberculosis				
other				

Date of last chest x-ray? _____

SKIN	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
dry/cracked skin				
moist/oily skin				
rashes				
eczema				
psoriasis				
dry scalp/dandruff				
hair thinning/loss				
acne/boils				
itching				
colour changes				
pale complexion				
changes in moles				
warts				
lumps/cysts				
stretch marks				
excess body odour				
excessive sweating				
jaundice				
skin cancer				
other skin concerns				

NERVOUS SYSTEM	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
fainting				
loss of balance				
tingling				
involuntary movements/twitches				
confusion				
speech problems				
memory problems				
seizures/convulsions				
paralysis				
other				

VASCULAR SYSTEM	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
hot hands/feet				
cold hands/feet				
deep leg pain				
leg cramps				
high blood pressure				
low blood pressure				
chest pain				
slow heart beat				
fast heart beat				
palpitations				
cyanosis (blue skin)				
extremity swelling				
extremity numbness				
varicose veins				
easy bleeding/bruising				
extremity ulcers				
anaemia				
heart murmurs				
other				

Have you ever had a heart stress test? _____

MUSCLES and BONES	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
broken bones				
painful joints				
swollen joints				
lack of joint mobility				
muscle strain/sprain				
muscle spasms				
prolonged stiffness				
heavy feeling in limbs				
muscle weakness				
muscle atrophy (deterioration)				
low back pain				
weak/sore knees				
arthritis				

Have you had any falls or injuries? ☐ YES ☐ NO If yes, describe: _____

_____

_____

How would you describe your posture? _____

Is there anything that affects your posture on an ongoing basis? _____

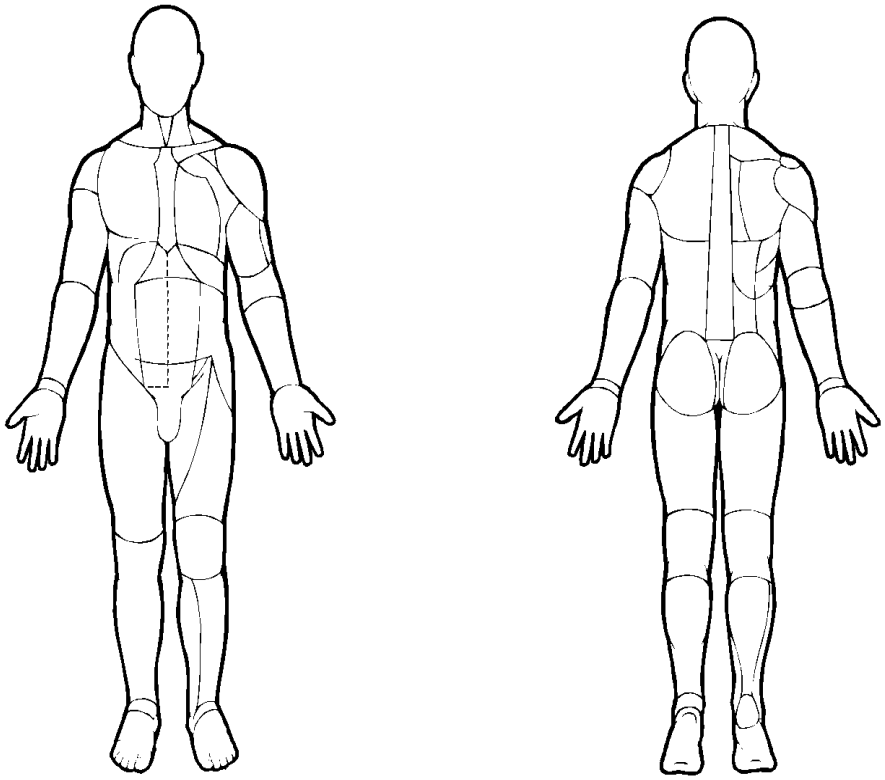
How would you describe your flexibility? _____

Do you have issues with the range of motion of any of your joints? ☐ YES ☐ NO If yes, describe:

_____

Date of last bone scan? _____ Results? _____

Please mark an 'x' to indicate areas where you feel pain, swelling or discomfort.



DIGESTIVE SYSTEM	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
change in appetite				
change in thirst				
change in taste				
trouble swallowing				
bitter taste				
nausea				
vomiting				
gas or belching				
abdominal bloating				
heartburn/reflux				
indigestion				
constipation				
diarrhea				
hemorrhoids				
undigested food in stool				
blood in stool				
other				

BOWEL MOVEMENTS

On average how many bowel movements do you have a day? _____

Do you strain to have a bowel movement? _____ What colour are your stools? _____

Describe the consistency / size of your bowel movements? _____

APPETITE

Describe your appetite: _____

Describe your digestion: _____

What makes your digestion worse? _____

What happens if you skip a meal? _____

What type of foods do you prefer? ☐ salty ☐ sweet ☐ spicy ☐ bitter ☐ sour

What temperature of food do you prefer? _____

Any food allergies or intolerances? _____

THIRST

Describe your thirst: _____

What temperature of drinks do you prefer? _____

What do you prefer to drink? _____

How much water do you drink in a day? _____

What type of water you drink? _____

URINARY SYSTEM	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
urinary pain/burning				
difficult urination				
increased frequency				
urgency/inability to hold urine				
frequent infections				
blood in urine				
kidney stones				
other				

Number of times a day you urinate? _____ Number of times you get up at night to urinate? _____

Is there any odour to your urine? ☐ YES ☐ NO If yes, please describe _____

MALE REPRODUCTIVE SYSTEM	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
hernias				
testicular masses				
testicular pain				
sexual difficulties				
premature ejaculation				
discharge or sores				
prostatitis				
venereal disease				

Are you currently sexually active? ☐ YES ☐ NO Sexual preference? _____

What is your sexual desire (rate on a scale of 1 (low) to 10 (high))? _____

FEMALE REPRODUCTIVE SYSTEM	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
bleeding between periods				
discharge between periods				
pain during intercourse				
PMS				
breast discomfort /changes				
fluid retention				
hot flashes				
night sweats				
frequent fungal/ yeast infections				

Age menses began: _____ Days flow lasts: _____ Days between periods: _____

Describe your flow: _____ When is it the heaviest? _____

What is the flow like (clots, colour)? _____

What symptoms are associated with your period? _____

Any pain with your menses? ☐ YES ☐ NO If so, when is it the worse? _____

Are you practising birth control? ☐ YES ☐ NO If so, what type and since when? _____

Number of pregnancies: _____ Number of live births: _____

Number of miscarriages: _____ Number of abortions: _____

Any problems conceiving? ☐ YES ☐ NO If yes, explain: _____

_____

_____

Have you done any fertility treatments? ☐ YES ☐ NO If yes, explain: _____

_____

Are you currently sexually active? ☐ YES ☐ NO Sexual preference? _____

What is your sexual desire (rate on a scale of 1 (low) to 10 (high))? _____

Have you ever been diagnosed with a venereal disease? ☐ YES ☐ NO If yes, what type? _____

Date of last PAP? _____ Last menstrual period? _____

Any menopausal symptoms? ☐ YES ☐ NO If yes, describe: _____

_____

EMOTIONAL/ INTELLECTUAL CONCERNS	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
no free time				
mood swings				
overly emotional				
fears/phobias				
depressed				
inability to let things go				
jealousy				
cry often				
anger				
irritable				
hyperactive				
grief				
worry				
nervousness				
anxiety				
anxiety about exams/ public speaking				
burnout				
feeling out of control				
lack of concentration				
learning disability				

Do you have an active mind? ☐ YES ☐ NO Describe your mind chatter: _____

_____

What kinds of tools have been helpful to you on a mental/emotional level? _____

_____

Do you have a support network? ☐ YES ☐ NO Please elaborate: _____

_____

H. GENERAL INFORMATION ON DIET

On a scale of 1 - 10 (low - high) how would you rate your diet? _____

Why? _____

Is there anything about your diet you would like to change? _____

_____

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

	Breakfast	Lunch	Dinner
How much time do your spend preparing?	_____	_____	_____
How much time you spend eating?	_____	_____	_____

Are there any foods that you crave? _____ Avoid? _____

Do you follow any specific diet regime? ☐ vegetarian ☐ vegan ☐ other

_____

Do you usually eat ☐ alone? ☐ with others?

Do you pay attention to the quality of the food that you eat? ☐ YES ☐ NO

Are you aware of any differences in how you feel with different foods? ☐ YES ☐ NO

What percentage of your diet is proteins? _____ carbohydrates? _____ fruit? _____

vegetables? _____ other? _____

Do you monitor your intake of ☐ fat? ☐ salt? ☐ fibre? ☐ sugar?

Do you add SALT to most meals? ☐ YES ☐ NO

Do you eat according to the season? ☐ YES ☐ NO

Do you enjoy food? ☐ YES ☐ NO

Do you enjoy preparing food? ☐ YES ☐ NO

Do you look forward to meal time / eating? ☐ YES ☐ NO

Which statement describes you best?

☐ I look for quick, convenient food choices when grocery shopping and making meals.

☐ I like to eat natural, whole and fresh food whenever I can.

☐ Someone else is usually responsible for what I eat.

☐ I eat out whenever I can.

Using the scale provided, identify the number of times a week that you engage in the following exercises. Scale: a (never), b (seldom or less than once per week), c (1 - 3 times per week), d (3 - 5 times per week), e (often or more than 5 times per week).

	Never	<1/wk	1-3/wk	3-7/wk	>7/wk
FRUITS					
citrus (oranges, grapefruit, pineapple)	a	b	c	d	e
berries (strawberries, blueberries)	a	b	c	d	e
plums, peaches, nectarines, mangoes	a	b	c	d	e
grapes, melons (cantaloupe, watermelon)	a	b	c	d	e
apples, pears	a	b	c	d	e
bananas	a	b	c	d	e
other fruits	a	b	c	d	e

Please specify _____

What percentage of the fruit you eat is raw? _____

VEGETABLES					
root veg (potatoes, carrots, beets, yams)	a	b	c	d	e
vine veg (tomatoes, cucumbers, zucchini)	a	b	c	d	e
broccoli, cauliflower, cabbage	a	b	c	d	e
greens (lettuce, swiss chard, spinach)	a	b	c	d	e
pickles (all types)	a	b	c	d	e
other fruits	a	b	c	d	e

Please specify _____

What percentage of the vegetables you eat is raw? _____

PROTEIN SOURCES / MEAT					
nuts / seeds	a	b	c	d	e
legumes / beans	a	b	c	d	e
fish / seafood	a	b	c	d	e
fowl (chicken, duck, turkey)	a	b	c	d	e
red (beef, pork, lamb)	a	b	c	d	e
luncheon meats / processed meat	a	b	c	d	e
other meats	a	b	c	d	e

Please specify _____

MILK PRODUCTS					
soya milk / almond milk/ rice milk	a	b	c	d	e
goat or sheep milk / cheese	a	b	c	d	e
cow's milk (1%, 2%, skim)	a	b	c	d	e
cheese / yogurt	a	b	c	d	e
ice cream	a	b	c	d	e
other milk products	a	b	c	d	e

Please specify _____

	Never	<1/wk	1-3/wk	3-7/wk	>7/wk
GRAINS					
millet / kamut / quinoa / barley	a	b	c	d	e
rye / spelt / pumpernickel	a	b	c	d	e
multi grain / wild rice	a	b	c	d	e
whole wheat / brown rice	a	b	c	d	e
white / processed bread / white rice	a	b	c	d	e
other grains	a	b	c	d	e

Please specify _____

OILS					
butter	a	b	c	d	e
margarine	a	b	c	d	e
olive oil / flax seed oil	a	b	c	d	e
canola oil	a	b	c	d	e
seed oil (sunflower, safflower, almond)	a	b	c	d	e
vegetable oil	a	b	c	d	e
other oils					

Please specify _____

HERBS / SPICES					
salt	a	b	c	d	e
pepper	a	b	c	d	e
garlic, onions, ginger	a	b	c	d	e
thyme, basil, oregano, sage	a	b	c	d	e
curry, turmeric, cardamom	a	b	c	d	e
other spices	a	b	c	d	e

Please specify _____

Do you use herbs and spices that are mostly ☐ dried? ☐ fresh?

CONDIMENTS					
ketchup, salsa	a	b	c	d	e
mustard	a	b	c	d	e
salad dressings (store bought)	a	b	c	d	e
mayonnaise	a	b	c	d	e
other condiments	a	b	c	d	e

Please specify _____

SWEETS / SWEETENERS					
white / brown sugar	a	b	c	d	e
honey, agave	a	b	c	d	e
artificial sweeteners (aspartame, sweet'n'low)	a	b	c	d	e
candy	a	b	c	d	e
chocolate	a	b	c	d	e
other sweets	a	b	c	d	e

Please specify _____

	Never	<1/wk	1-3/wk	3-7/wk	>7/wk
BEVERAGES					
Coffee	a	b	c	d	e
Tea	a	b	c	d	e
Herbal tea	a	b	c	d	e
Tap / Filtered water	a	b	c	d	e
Bottled / Spring water	a	b	c	d	e
Soft drinks (diet)	a	b	c	d	e
Soft drinks (regular)	a	b	c	d	e
Fruit / Vegetable juices (store bought)	a	b	c	d	e
Fruit / Vegetable juices (fresh)	a	b	c	d	e
Beer	a	b	c	d	e
Wine	a	b	c	d	e
Other alcoholic beverages	a	b	c	d	e
Other	a	b	c	d	e
Please specify _____					
OTHER FOOD CONSIDERATIONS					
Fried foods	a	b	c	d	e
Refined / Processed food (packaged)	a	b	c	d	e
Micro-waved	a	b	c	d	e
Use of aluminium pans	a	b	c	d	e
Fast foods	a	b	c	d	e
Eat watching television	a	b	c	d	e
Eat on the run	a	b	c	d	e
Eat in a quite, peaceful atmosphere	a	b	c	d	e
Chew food at least twenty times	a	b	c	d	e
Relax after eating	a	b	c	d	e
Other					
Please specify _____					

Please describe an average:

Breakfast: _____

Lunch: _____

Dinner: _____

Please list any other diet considerations that have not been included above: _____

_____

_____

I. PERSONAL VALUES

Check off all of the following values that are important to you.

☐ Accomplishments / Results	☐ Freedom	☐ Power
☐ Achievement	☐ Honesty	☐ Privacy / Solitude
☐ Adventure / Excitement	☐ Fun	☐ Recognition
☐ Aesthetics / Beauty	☐ Humour	☐ Risk - taking
☐ Aloneness	☐ Integrity	☐ Romance / Magic
☐ Altruism	☐ Intimacy	☐ Security
☐ Autonomy	☐ Joy	☐ Self-expression
☐ Clarity	☐ Leadership	☐ Sensuality
☐ Commitment	☐ Loyalty	☐ Service / Contribution
☐ Completion	☐ Mastery / Excellence	☐ Spirituality
☐ Connecting / Bonding	☐ Orderliness / Accuracy	☐ Trust
☐ Creativity	☐ Nature	☐ Vitality
☐ Environment	☐ Partnership	☐ Visionary
☐ Emotional Health	☐ Openness	☐ Other
☐ Forward Action	☐ Personal Growth / Learning	

List the top six values that you have. (You can add your own values if you would like)

_____ _____ _____

_____ _____ _____

What are your pet peeves? _____

_____

What do you want more of in life? _____

_____

What do you want less of in life? _____

_____

J. STRESS

Using the scale provided circle the level of stress that you feel for the following aspects of your life and the duration of this stress.

Category	None	Low	Avg.	High	Duration (years)
PERSONAL	0	I	2	3	
HEALTH	0	I	2	3	
FINANCIAL	0	I	2	3	
UNFULFILLED EXPECTATIONS	0	I	2	3	
RELATIONSHIPS	0	I	2	3	
MARRIAGE	0	I	2	3	
CAREER	0	I	2	3	
FAMILY	0	I	2	3	
SPIRITUAL	0	I	2	3	
OTHER	0	I	2	3	

Please specify _____

What steps have you taken to deal with your stress? _____

Have you ever engaged in counselling or psychotherapy? ☐ YES ☐ NO How long? _____

Do you take vacations regularly? ☐ YES ☐ NO Date of last vacation: _____

Which statement that describes you best?

☐ I am concerned about the level of stress in my life.

☐ I feel I have an average amount of stress compared to most people.

☐ I am not concerned about the stress in my life.

OTHER CONSIDERATIONS	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
abuse (emotional, physical, sexual)				
alcohol / drug abuse				
accidents / major falls				
change / loss of home				
change / loss of job				
change / addition to household				
serious family illness				
death of significant other				
other				

K. HEALTH POSITIONING STATEMENTS

Please answer YES (you agree with the comment), MAYBE (you feel the comment is sometimes right and sometimes wrong), NO (you don't agree with the comment), or NO COMMENT (you do not have an opinion, or do not wish to voice your opinion) to the following questions.

	Yes	Maybe	No	No Comment
Everything happens for a reason.	☐	☐	☐	☐
The body can heal itself.	☐	☐	☐	☐
You can make yourself sick based on what you think.	☐	☐	☐	☐
You can make yourself sick based on your emotions.	☐	☐	☐	☐
Routine is the only way to get things accomplished.	☐	☐	☐	☐
I can strongly influence my rate of recovery from an illness or injury.	☐	☐	☐	☐
Physical symptoms are often an indicator to change something in my life.	☐	☐	☐	☐
I experience love for many people and aspects of my life.	☐	☐	☐	☐
I don't think people should take themselves too seriously.	☐	☐	☐	☐
I can manage my stress.	☐	☐	☐	☐
My body is a mirror of my life.	☐	☐	☐	☐
I believe how I live my life is an important factor in determining my state of health, and I live it in a manner consistent with that belief.	☐	☐	☐	☐

What are your short-term health goals? _____

_____

What are your long-term health goals? _____

_____

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

_____

Thank you!