Real Earth Nutrition

LIFESTYLE ASSESSMENT FORM

ALL INFORMATION IS KEPT PRIVATE AND CONFIDENTIAL IN KEEPING WITH MY PRIVACY POLICY

Please answer all questions as honestly and completely as you can. You may leave any questions you don't feel comfortable answering. Write "NA" for any questions that do not apply to you.

Personal Information

Name: Date: Age: Gender:

Billing Address:

E-mail:

Contact me via: phone _____ E-mail _____ Either _____

Phone #: Work #:

Referred by:

Goals and Expectations

List up to 3 of your main health goals:

1_____
2_____
3_____

Have you made any diet or lifestyle changes to meet your health goals? (Diet, exercise supplements etc.) If so, list them:

Has your health improved since you made the above changes?

(Not at all) 1 2 3 4 5 (a great deal)

Regarding food and lifestyle, are there any changes that you haven't made but believe you should?

Regarding food and lifestyle, is there anything you believe you have tried to or should try to avoid?

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What obstacles or challenges are you experiencing when making food and lifestyle changes?

Do you have any diagnosed health conditions (diabetes, asthma, heart disease etc)?

On a scale of 1-5, how concerned are you that you have been diagnosed with health conditions?

(not concerned) 1 2 3 4 5 (extremely concerned)

GENERAL LIFESTYLE QUESTIONS:

How would you describe your current level of stress? (minimal) 1 2 3 4 5 (unbearable)

What are the major causes of stress your stress? (circle all that apply)
Health Financial Personal Career School
Marriage Family Spiritual Unfulfilled expectations
Other (please elaborate):

How does your stress manifest itself?
(eg/ headaches, sleeplessness, biting nails, anger, irritability etc…)

Do you use any coping mechanisms for stress? circle: always often sometimes rarely never

Please list any coping mechanisms you will use (eg/ napping, smoking, certain types of physical activity, music, meditation, alcohol etc…):

Have you experienced any trauma or loss in the past 5 years? Explain.

How many hours on average do you sleep daily? circle: 3-5 6-7 8-9 10 or more

Do you have any naps during the day? _____

How long does it take you to fall asleep? _____

Do you awaken feeling rested? (circle): always often sometimes rarely never

Is your sleep often disrupted? (circle): always often sometimes rarely never

How do you help yourself fall asleep or fall back asleep?

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Do you smoke? (circle): always often sometimes rarely never
Does anyone in your household or workplace smoke? always often sometimes rarely never

Do you exercise? 6-7x/week 4-5x/week 2-3x/week 1x/week less than 1x/week never
On average, indicate the type and length of physical activity you do:
Yoga:
Walking:
Running:
Stretching:
Weight training:
Other:

Do you wish to gain weight?_____ Lose weight? _____ If so, how much? _____

On an average day, how many hours do you spend doing the following:
driving: _____ watching television: _____ reading: _____ on the computer: _____

Do you enjoy your work? _____
How many hours each day do you work? _____
Do you do shift work?_____ If yes, how often? _____

MEDICAL HISTORY:

List any medications you are currently taking with the reason, the dosage, and since how long:
Ones prescribed or recommended by a doctor:

Any over the counter medications you take on a regular basis (aspirin, ibuprofen, tylenol, allergy medicines, antacids etc.):

Are you currently seeing (or have you seen in the past) any of the following (circle):

Naturopath	Chiropractor
Homeopath	Osteopath
Holistic Nutritionist	Dietician
Massage Therapist	Energy Therapist

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Have you ever consulted a medical doctor with regard to the issues you are seeing a nutritionist about?
YES _____ YEAR _____ NO _____
If yes, please briefly explain his/her diagnosis and recommendations.

Have you ever consulted a naturopathic doctor with regard to the issues you are seeing a nutritionist about?
YES _____ YEAR _____ NO _____
If yes, please briefly explain his/her diagnosis and recommendations.

List any vitamins, minerals, herbal or homeopathic remedies you are currently taking (with the amounts/dosages): Are these taken on a regular basis, or sporadically?

Have you ever consulted a nutritionist with regard to your health issues?
YES _____ YEAR _____ NO _____
If yes, please briefly explain his/her diagnosis and recommendations.

Do you have any known allergies? (environmental or food) If so, please list:

Are you aware of any food sensitivities?

How often do you have a bowel movement? (circle):
3 or more/day 2/day 1/day 3-4/week 1-2/week or less

Do you strain to have a bowel movement? always often sometimes rarely never
Related to particular food or circumstance?

Do you have loose bowel movements? always often sometimes rarely never
Related to particular food or circumstance?

Have you ever been treated for drug and/or alcohol dependency?
Please indicate for what:

Please indicate any of the following Diseases for yourself or other family members:
Use "S" for self, "F" for father, "M" for mother, "G" for grandparent, "O" for others:

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Heart Disease:	High Blood Pressure:	High Cholesterol:
Diabetes Type 1:	Diabetes Type 2:	Allergies:
Arthritis:	Osteoporosis:	Intestinal Disease:
Cancer:	Mental Illness:	
Other (please list):		

Do you have mercury fillings in your teeth? _____.
If Yes, how many and how long have you had them?

Have you ever had any organs removed (uterus, gallbladder, tonsils, appendix etc…)?
Yes _____ No_____

Organ: _____ Date: _____ Reason: _____
Organ: _____ Date: _____ Reason: _____
Organ: _____ Date: _____ Reason: _____

FEMALES:
Are you pre-menopausal or menopausal?
Are you experiencing any symptoms?
If yes, please specify:
(eg/sudden surges of heat, mood swings, sporadic periods etc…)

Have you had a bone density test?
If yes, what was the result?

Are you or could you be pregnant? Yes ____ No ____

Are you trying to get pregnant? Yes ____ No ____

Is each menstrual cycle a consistent length? YES ___ NO____

Do you experience cramping during your period? YES ____ NO ____

Do you experience mood changes around your period? YES ____ NO ____

Do you experience lack of energy around your period? YES ____ NO ____

Do you take any medication for PMS symptoms?
YES ____ NO ____If yes, what? _____

Describe your bleed:

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Are you on the birth control pill? YES _____ NO _____

Have you ever been on the birth control pill? YES ____ NO ____

If you have been on "the pill", for how long did you take it? _____

DIETARY HABITS:

How many times a day do you eat (circle):

Main Meals: 0 1 2 3 4 5 Typical Times of day:
Snacks: 0 1 2 3 4 5 Typical Times of day:

Do you plan the frequency and timing of your meals?
always often sometimes rarely never

How often do you eat your meals…:

In the car:	always	often	sometimes	rarely	never
In front of the computer at work:	always	often	sometimes	rarely	never
With family:	always	often	sometimes	rarely	never
Home alone:	always	often	sometimes	rarely	never
On the run:	always	often	sometimes	rarely	never
At sit down restaurants:	always	often	sometimes	rarely	never
At fast food chains:	always	often	sometimes	rarely	never

Do you feel there are restrictions to your diet due to the people you live with?
always often sometimes rarely never

If yes, explain:

If you are a meat eater, how often do you eat meat? daily 3-5/week once/week or less
What types of meat do you eat?

If applicable, how often do you eat fish? daily 3-5/week once/week or less
What types of fish do you eat?

How often do you consume dairy products (milk, yogurt, cheeses, sour cream, ice cream, etc) ?
daily 3-5/week once/week or less

Indicate types of dairy products you eat:

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Do you avoid any foods due to religious, ethical, allergy or sensitivity reasons (eg. vegetarian, kosher, lactose intolerance etc…)? If so, please list them:

Please List:

Foods you like to eat	Foods you avoid	Foods from your "avoid" list you are willing to consider

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

Do you experience any symptoms after meals? Explain:

What fats/oils do you cook with?

How often do you eat or use:

Microwave:	never	monthly	biweekly	weekly	daily	2+ times/day
Margarine:	never	monthly	biweekly	weekly	daily	2+ times/day
Luncheon meats:	never	monthly	biweekly	weekly	daily	2+ times/day
Candy:	never	monthly	biweekly	weekly	daily	2+ times/day
Chocolate:	never	monthly	biweekly	weekly	daily	2+ times/day
Breath Mints:	never	monthly	biweekly	weekly	daily	2+ times/day
Gum with sugar:	never	monthly	biweekly	weekly	daily	2+ times/day
Gum (sugarless):	never	monthly	biweekly	weekly	daily	2+ times/day
Refined foods (white flour/sugar):	never	monthly	biweekly	weekly	daily	2+ times/day
White rice/pasta:	never	monthly	biweekly	weekly	daily	2+ times/day
Fried foods:	never	monthly	biweekly	weekly	daily	2+ times/day
Fast foods:	never	monthly	biweekly	weekly	daily	2+ times/day
Nutra-Sweet/Aspartame:	never	monthly	biweekly	weekly	daily	2+ times/day
Splenda/Sucralose:	never	monthly	biweekly	weekly	daily	2+ times/day
Stevia:	never	monthly	biweekly	weekly	daily	2+ times/day
Fresh Fruit:	never	monthly	biweekly	weekly	daily	2+ times/day
Fresh Vegetables:	never	monthly	biweekly	weekly	daily	2+ times/day
Whole grains:	never	monthly	biweekly	weekly	daily	2+ times/day
Legumes (like kidney beans, Chic peas, Lentils, green peas…)	never	monthly	biweekly	weekly	daily	2+ times/day

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I am aware of my water intake and am conscious of staying hydrated throughout the day:
always often sometimes rarely never

How many (8 oz/250mL) cups of fluid would you drink with your average meal?
¼ ½ ¾ 1 1 ½ 2+

Please indicate how many (8 oz/250mL) cups of the following you drink per day:

Bottled/spring water	0	1	2	3	4	5	6	7	8	9	10
tap water	0	1	2	3	4	5	6	7	8	9	10
coffee	0	1	2	3	4	5	6	7	8	9	10
tea	0	1	2	3	4	5	6	7	8	9	10
herbal tea	0	1	2	3	4	5	6	7	8	9	10
milk (1%, 2%, or whole)	0	1	2	3	4	5					
milk (skim)	0	1	2	3	4	5					
prepared fruit juices	0	1	2	3	4	5					
fresh fruit juices	0	1	2	3	4	5					
fresh vegetable juices	0	1	2	3	4	5					
soft drinks (regular)	0	1	2	3	4	5					
soft drinks (diet)	0	1	2	3	4	5					
beer	0	1	2	3	4	5					
red wine	0	1	2	3	4	5					
white wine	0	1	2	3	4	5					
other alcoholic beverages	0	1	2	3	4	5					
other (list)	0	1	2	3	4	5					

Please indicate below if there is anything else about your food/eating habits you think it would be useful for me to know: