HOLISTIC HEALING ARTS

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VANDA GODFREE, RHN
LIFESTYLE ASSESSMENT FORM

For Office Use Only:

Name: _____ Date:_____
Age: _____ Date of Birth: _____ Sex: F M
Address:_____
City:_____ Postal Code:_____
Home Phone:_____Work Phone:_____
Email: _____

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

What is your purpose in coming here today? _____
_____
What are your main health concerns/complaints? _____
_____
_____
Have you ever been diagnosed with an ailment related to your main health concern(s)?
_____
Any trauma or loss in the last 5 years? _____
What level of stress do you feel you are experiencing at this time?
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 does your stress manifest itself? _____
_____
Do you have any coping mechanisms? _____
What do you do for exercise? (indicate type, frequency and time) _____
_____
How many hours on average do you sleep daily? (include naps) _____
What time do you go to sleep? _____ Awaken? _____
Do you awaken feeling rested? Yes ☐ No ☐

What is your occupation? _____
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? _____
Do you smoke? Yes ☐ No ☐ If yes, how much and for how long?
_____
If no, does anyone in your household or workplace smoke? Yes ☐ No ☐
Do you wish to gain weight? ☐ lose weight? ☐ how much? _____
How many hours do you spend daily, on average
Driving ____watching television ____reading ____in front of computer _____
What are your interests and hobbies? _____
_____
Do you vacation regularly? Yes ☐ No ☐
When was your last vacation? _____
Do you actively participate in any spiritual discipline (church, religious group, meditation, etc) Yes ☐ No ☐

MEDICAL HISTORY:
Are you currently taking any medications? 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 or sensitivities? If so, please list:
_____

Do you have any silver-mercury fillings? Yes ☐ No ☐

Have you ever been:
Diagnosed with an illness? Explain _____
_____
Hospitalized? Reason _____

How often do you have a bowel movement? _____

Do you strain to have a bowel movement? Yes ☐ No ☐ Occasionally ☐

Related to particular food or circumstances?_____

Do you use recreational drugs? Yes ☐ No ☐
If yes, how often and what type? _____

Have you ever been treated for drug and/or alcohol dependency? Yes ☐ No ☐
If yes, please circle which one

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FAMILY HISTORY:

Heredity Diseases:

Use "F" for father, "M" for mother, "S" for sibling, "G" for grandparent, "O" for others

_____Heart Disease	_____Diabetes	_____Allergies
_____Hypertension	_____Arthritis	_____Mental Illness
_____Intestinal Disease	_____Osteoporosis	_____Alcoholism
_____Asthma	_____Ulcers	
_____Gall Bladder Problems		
_____Kidney Disfunction	_____Cancer,	

type:_____

Other (please list)

_____

FEMALES:

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

Are you pre-menopausal or menopausal? Yes ☐ No ☐

Are you experiencing any menopausal symptoms? Yes ☐ No ☐

If yes, please specify

_____

Have you had a bone density test? Yes ☐ No ☐

If yes, what was the result?

_____

DIETARY HABITS:

How many times a day do you eat:

Main Meals _____ Times of day: _____

Snacks _____ Times of day: _____

So you eat meals: with family ☐ home alone ☐ on the run ☐ restaurant ☐ fast food ☐

Do you feel there are restrictions to your diet due to preferences of others--

Family, roommates, etc? Yes ☐ No ☐ If yes, explain _____

_____

How many 1/2 cup serving of each do you typically eat in a day:

____Fruit: Fresh ☐ Dried ☐ Canned ☐ _____Vegetables: Cooked ☐ Raw ☐

____Whole Grains _____Protein: Type_____

____Dairy Products: Type_____

____Other: Specify _____

Give examples of your typical meals:

Breakfast: _____

_____

Lunch: _____
_____
Dinner: _____
_____
Snacks: _____
_____

Do you eat or use (indicate "1" for rarely, "2" for regularly, "3" for often)

☐ aluminum pans ____ ☐ margarine ____ ☐ candy ____
☐ microwave ____ ☐ fried foods ____ ☐ refined foods ____
☐ luncheon meats ____ ☐ cigarettes ____ ☐ fast foods ____
☐ Nutra Sweet/Aspartame ____

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

____beer
____coffee
____tap water
____soft drinks (*diet*)
____soft drinks (*regular*)
____fruit juices (*prepared*)
____milk (*1% or 2%*)
____milk (*skim*)
____fresh vegetable juices
____red wine
____white wine
____other alcoholic beverages
____tea
____fresh fruit juices
____bottles or spring water
____herbal tea
____other_____

Are you a... Meat Eater ☐ Vegetarian ☐ Vegan ☐
How often do you eat meat? daily ☐ 3-5/week ☐ once/week or less ☐
How often do you consume dairy products?
daily ☐ 3-5/week ☐ once/week or less ☐
What are your favorite foods?_____
How often do you eat them? _____
Do you avoid certain foods? If so, why?_____
_____
_____
Do you experience any symptoms if meals are missed? Explain: _____
_____
Comments: _____
_____
_____
_____
_____
_____
_____

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