Divine Grace

Continuous Transformation

LIFESTYLE ASSESSMENT FORM

Name:_____ Age:_____
Email:_____

Relationship Status: Married/Single/Divorced (circle one)

What is your nationality and religion?

_____

_____

What are your hobbies/passions?

_____

_____

How is your relationship with your parents?

_____

_____

What are your main health concerns/ complaints?

_____

_____

Have you experienced any trauma / loss over the last 5 years?

_____

_____

Do you have fear / anxiety? If so please describe below

_____

_____

_____

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_____ Spiritual____
Marriage_____ Family_____Health_____ Other____

Do you use any stress coping mechanisms ie: Smoking/drinking or drugs? If so please list below and describe how long and often you use these coping mechanisms.

_____

_____

_____

Are you aware of any patterns in your life or family life? (Please describe)

_____

_____

Do you incorporate any exercise into your daily/weekly routine?
Yes_____ No _____
If so, what type of exercise do you do:

_____

_____

How many hours on average do you sleep daily?

_____

What time do you go to sleep?

_____

What time do you wake?

_____

Do you wake feeling rested?
Yes_____ No_____ Sometimes_____

What if your occupation?

_____

Do you enjoy work?
Yes_____ No_____ Sometimes_____
How many hours each day do you work?

_____

What time do you start and end work?

_____

Applicable for Nutrition Only

Family History

Hereditary Diseases:

___Heart Disease ____Diabetes ____Allergies ___Arthritis
___Hypertension ___Mental Illness ___Asthma ____Intestinal Disease
___Kidney ____Cancer (please specify) :
_____

Other (please specify):
_____

Please check any foods typically eaten in a day:

Fruit: Fresh _____ Dried _____ Canned _____
Vegetables: Raw _____ Cooked _____
Whole Grains: Rice _____ Pastsa _____ Breads _____ Cereals _____
Other _____
Protein: _____ Please Specify: _____

Dairy Products: _____ How often? _____

How often do you have a bowel movement daily?

_____

Do you experience constipation? ____ Diarrhea?____Id so, how often? _____

How many times a day do you eat?

_____

Main meals (include time of day)

_____

Snacks (include time of day)

_____

Do you eat meals:
With family_____ home alone _____ on the run _____ restaurant_____

Do you eat or use (use rating 0-3, 0=never, 1=rarely, 2= occasionally, 3=often)
_____Aluminum pans _____Margarine _____Candy/Sugar
_____Microwave _____Fried Food _____Refined/Processed Food
_____Luncheon Meats _____Cigarettes _____Fast Foods
_____Nutra-Sweet/ Aspartame

Do you have any allergies and/or allergic to any medicines?

_____

_____

Please indicate how many servings/cups of the following you have per day:

_____Beer
_____Coffee/Espresso
_____Tap Water
_____Soft Drinks (reg.____ diet____)
_____Fruit Juice (Fresh____Prepared_____)
_____Vegetable Juice (Fresh_____Prepared____)
_____Other _____

What are your favourite foods/cravings?

_____

_____

_____

Do you experience any symptoms if meals are missed?

_____

_____

_____

Do you experience any symptoms after meals?

_____

_____

Client Statement:

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purpose of medical diagnosis, treatment or prescribing of medicine for any disease, or any licenses or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily,

Name_____

Signature _____

Date _____

Dated: ____________________

Printed Name: __________________________ **Tel:** _________________

Address ____

City _________________ **Provence** ___________________

Postal Code ___________________ **Email Address** ___________________

\- -

\- *For office use only:*

Are you currently taking. medications? Yes ________ No _________

List/ Reason

____

____

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

____

____

Do you have any known allergies/sensitivities? If so, please list:

____

____

Females:
Are you or could you be pregnant? Yes____ No____
Are you pre-menopausal or menopausal Yes ____ No _____
If yes, please specify ___________________________________

DOB (year/month/day) _________________________________

Signature ____
divinegrace.ca

Notes: