**Lifestyle Assessment Questionnaire**

**\*\*\*Please circle all that apply when there is a multiple choice question\*\*\* CONFIDENTIAL – DONATIONS ACCEPTED**

**540-297-3593**

**I do not charge for this assessment, but donations are accepted as this takes time and work to do this for you. If you cannot afford to donate that is not a problem, but if you can please ask me how.**

**Please Note:** Due to the laws of the land, we are required to tell you that the health information received during this consultation is for general education and is not intended to be specific medical advice. No medical care, diagnosis, or treatment is provided during this consultation. **It is advisable** **to consult with ones personal health care provider before implementing any lifestyle changes.**

**I release all Lifestyle counselors or associated organizations from any and all liability. Participation in this consultation indicates acceptance of these terms.**

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_

**General Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: Home (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Age:** \_\_\_\_ yrs. **Sex**: Male Female

**Marital Status:** – (circle all that apply)

Single Married (1st / 2nd / 3rd or more) Divorced (1st /2nd or more) Widowed

**How long have you been married or divorced:** \_\_\_\_\_\_\_\_\_\_

**Weight:** \_\_\_\_\_\_\_ lbs. **Height:** \_\_\_\_\_\_\_ **Sedimentation Rate:** \_\_\_\_\_\_

**Blood Pressure:** Left Side \_\_\_\_/\_\_\_\_ Right Side \_\_\_\_/\_\_\_\_ Pulse \_\_\_\_\_\_\_

**Blood Glucose:** \_\_\_\_\_ **Cholesterol:** \_\_\_\_\_ HDL: \_\_\_ LDL: \_\_\_\_ Triglycerides \_\_\_\_\_\_

**Last BM you had?**\_\_\_\_\_\_\_\_\_\_\_ **Color**: Orng Blk Brn Other **Size:** S M L **Hard** or **Soft**

**On a Scale of 0-10, How serious are you about getting to the root of your problem/s?\_\_\_\_\_**

**On a Scale of 0-10, how willing are you to do whatever it takes to improve your condition/s?\_\_\_\_\_**(within realistic limits)

**Are you allergic to anything?** YES or NO

\*\*\*If yes, please list all that apply?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List any health concerns you have**:(physical, mental, social or spiritual):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When did you last consult a physician?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently being treated for any ailments?** YES or NO

\*\*\*If yes, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any surgery(ies) that you have had** (include the date)**:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What diseases/health condition(s) have you been diagnosed with?** (Please list all)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you suffer from any of the following emotional/mental disorders:** (please circle all that apply)

Bipolar

Chronic anxiety

Co-dependency

Depression

Manias

Obsessive compulsive disorder (OCD)

Panic Attacks

Phobias

Schizophrenia

Worry

**Are you presently experiencing any of the following?** (Please circle all that apply)

Anemia

Bad body odor

Bad Breath

Bleeding

Bloated Stomach

Blood in stool

Blood in Urine

Blurred vision

Chest Pain or Tightness

Chills

Clammy skin

Cold / Flu

Cold hands or feet

Confusion

Constipation

Cough

Diarrhea

Difficulty breathing

Difficulty Hearing

Dizziness

Earache

Excessive sweating

Fainting

Fatigue

Fever

Hair loss

Headaches

Heart palpitations

Hemorrhoids

Hives

Increased Hunger

Indigestion / Heartburn

Infections

Insomnia

Itching in Rectal area

Joint Pain

Loss of Appetite

Low Energy

Memory loss

Nausea/Vomiting

Neurosis

Numbness/Tingling

Pain

Pain in the Eyes

Painful Urination

Parasites / Worms

Rash

Ringing in the Ears

Seizures

Sensitivity to sunlight

Sexual dysfunction

Sores on Your body

Stuffy Nose

Swelling anywhere

Taste Problems

Vision Problems

Watery Eyes

Weight gain

Weight loss

Yellowing of Eyes

**What specific condition(s) would you like this consultation to address?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all medication** (prescribed or OTC) **you have taken in the last two months**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all herbs or supplements (**including vitamins) **you have taken in the last two** **months:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH QUESTIONS:**

1. Do you currently use tobacco in any form (smoke or chew)? YES or NO

How many cigs or cigars per day?

If No, have you ever smoked or chewed tobacco in the past? YES or NO

If so, how long ago did you quit?

1. Do you currently drink alcohol in any form (wine, beer, liquor)?

**Please list how often:**

If No, have you ever drunk in the past? YES or NO If so, how long ago did you quit?

1. Do you drink coffee, tea, or any caffeinated beverages (soda, diet soda, energy drinks, etc.)? YES or NO

How many cups OR cans each day?

**4.** Do you eat flesh in any form? (beef, pork, lamb, chicken, turkey, deer, fish, seafood, etc.) YES or NO

How many times a day? How many ounces each meal?

1. Do you eat any animal products such as eggs, milk, butter, cheese, yogurt, cream, etc.? YES or NO

When was the last time you ate any of these? How often?

**6.** How many times do you eat a day on average?

What time do you eat Breakfast: Lunch: Dinner:

Do you snack in between meals? YES or NO

**7.** How many pieces of fruit have you eaten today? Yesterday?

**8.** How many cooked green vegetables (peas and corn are not vegetables) did you eat yesterday?

Are you eating them raw or cooked?

**9.** How many days a week do you exercise at least 30 minutes INDOORS?\_\_\_\_days

How many days a week do you exercise at least 30 minutes OUTDOORS?\_\_\_days

What type of exercise (walking, running, jogging, weights, other equipment)

On average, what time of day do you exercise?\_\_\_\_\_\_am/pm

**10.** How much water did you drink in ounces yesterday? Today?

Do you SIP or GULP? Do you drink SOFT or HARD water?

**11.** How much direct sunlight did you get yesterday? Today?

What time of day did you get it? am or pm

**12.** Do you do deep breathing exercises every day? YES or NO

Do you sleep with your windows opened every night? YES or NO

**13**. What time do you wake up on average? am or pm

What time do you go to bed on average? am or pm

**14.** Do you use CRYSTAL LIGHT, SOY SAUCE, or any SUGAR SUBSTITUTE? YES or NO

**15.** What kind of salt to you use/cook with? Table Salt, White Sea Salt, Himalayan Sea Salt

**NAME:**

**EMAIL ADDRESS:**

**CONTACT NUMBER:**

**TODAY’S DATE:**