

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)

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

Anemia	Earache	Numbness/Tingling
Bad body odor	Excessive sweating	Pain
Bad Breath	Fainting	Pain in the Eyes
Bleeding	Fatigue	Painful Urination
Bloated Stomach	Fever	Parasites / Worms
Blood in stool	Hair loss	Rash
Blood in Urine	Headaches	Ringing in the Ears
Blurred vision	Heart palpitations	Seizures
Chest Pain or Tightness	Hemorrhoids	Sensitivity to sunlight
Chills	Hives	Sexual dysfunction
Clammy Skin	Increased Hunger	Sores on Your body
Cold / Flu	Indigestion / Heartburn	Stuffy Nose
Cold hands or feet	Infections	Swelling anywhere
Confusion	Insomnia	Taste Problems
Constipation	Itching in Rectal area	Vision Problems
Cough	Joint Pain	Watery Eyes
Diarrhea	Loss of Appetite	Weight gain
Difficulty breathing	Low Energy	Weight loss
Difficulty Hearing	Memory loss	Yellowing of Eyes
Dizziness	Nausea/Vomiting	

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

Bipolar	Depression	Obsessive compulsive disorder
Chronic anxiety	Manias	(OCD)
Co-dependency	Neurosis	Panic Attacks

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:

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)

HEALTH QUESTIONS:

1. Do you currently use tobacco in any form (smoke or chew)? YES or NO
How many cigs or cigars a day? _____ 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? _____
2. 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? _____
3. 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? _____ times How many ounces each meal? _____ oz.
5. Do you eat any animal products such as eggs, milk, butter, cheese, yogurt, cream, etc.? YES or NO
How often? _____ When was the last time you ate any of these? _____
6. How many times do you eat a day on average? _____ times
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? _____

9. How many days a week do you exercise at least 30 minutes? ____ 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?
11. How much direct sunlight did you get yesterday ____ min. today ____ min.
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 day? 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

*****These next two portions are in no way designed to judge or condemn; just simply to get an idea about each person*****

SPIRITUAL COMPONENT:

1. Do you believe in God? YES or NO
2. Do you pray to God? YES or NO ***If yes, how often a day? ____ x day
3. Do you believe the Bible is true? YES NO SOME OF IT
4. Do you read the Bible? YES or NO ***If yes, Which Version? _____
How Many Times? EVERY DAY ONCE A WEEK ONCE A MONTH ONCE A YEAR NEVER
5. Do you feel like God has been GOOD, BAD, or OKAY to you?
6. Do you feel you have been GOOD or NOT GOOD to God?
7. Do you trust God 100% implicitly? YES or NO
8. Do you believe God loves you? YES or NO
9. Do you believe God is LOVING and CARING or a MERCILESS TYRANT?
10. Do you take EVERYTHING to God when you have a problem or want some type of direction? YES or NO

SOCIAL: (Please answer as truthfully as possible)

1. Do you have a good family unit? YES or NO

2. Are you close to your parents? YES or NO
3. Are you close to your children? YES or NO
4. Were you raised by your Biological parents? MOTHER or FATHER or BOTH? YES or NO
5. Were you raised with SIBLINGS, COUSINS, AUNTS, UNCLES? YES or NO
6. Do you get along well with others? YES or NO
7. Do you feel you have been cheated in life? YES or NO
8. Do you feel people misunderstand you? YES or NO
***If yes...MOST OF THE TIME or SOME OF THE TIME?
9. Are you a SENSITIVE PERSON or THINGS DON'T BOTHER YOU EASILY?
10. Do you have a social circle that you are a member of? (Church, Senior Center, Club, etc.) YES or NO
11. Do you feel that you make good choices in picking friends and partners? YES or NO
12. Is there any unfulfilled promise you made that you wish you could fix? YES or NO
13. Is it easy for you to forgive others when they have wronged you? YES or NO
14. Are you willing to admit when you are wrong? YES NO SOMETIMES
15. Are you more SHY and TO YOURSELF or OUTGOING?
16. Are you an EMOTIONAL or SENSITIVE person, BOTH or NEITHER?
17. Do you feel your personality is ABRASIVE and HARSH or GENTLE and KIND?
18. Do you feel you are more of a LISTENER or TALKER?
19. Are you an OUTSPOKEN person or QUIET?
20. Would you consider yourself to be one who EXPRESSES YOURSELF & COMPLAIN when things don't go your way, or one who KEEPS IT IN TO YOURSELF?
21. Are you the type to tell all your personal business? YES or NO
22. Do you talk about others'? YES NO SOMETIMES
23. Are you more OPTIMISTIC or PESSIMISTIC?
24. On a scale of 0-100, what do you believe you are worth? _____

