

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?
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? How many ounces each meal?
5. 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 do you use/cook with? Table Salt, White Sea Salt, Himalayan Sea Salt

NAME:

EMAIL ADDRESS:

CONTACT NUMBER:

TODAY'S DATE: