INLET WELLNESS GALLERY

LIFESTYLE ASSESSMENT AND INTAKE FORM

CINDY FORS, RHN

Thank you and thank yourself for investing in your health! Please note that all information is kept strictly confidential and will not be shared with third parties. Please be as candid and open as possible to get the most out of your session.

Client Information:

Full Name: _____

Primary phone: _____ Email: _____

Date of birth: _____ Marital status: _____

Do you have any children? If yes, how many and what ages?

_____

Address: _____

City: _____ Province: _____

Postal code: _____ Country: _____

Main Health Concerns:

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

List your main health concerns (i.e. digestion, weight, skin issues, fatigue, headaches, etc.) Please list in priority:

_____

_____

_____

Personal Health History:

Have you ever received a diagnosis for a health concern or illness (as far back as childhood)? Yes ☐ No ☐

If yes, please explain: _____

_____

Are you seeking treatment from any other health care practitioners? Please list (i.e. Medical doctor, Naturopath, Chiropractor, Herbalist): _____

_____

List all medications you are currently taking, along with the reason for use, and dosage:

Medication:	Reason:	Dosage/duration:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you taken antibiotics over the past five years? _____

Please describe your antibiotic use:
_____
_____

List any vitamins, minerals, herbal or homeopathic remedies you are currently taking and the amounts/dosages. Please include the brand:

Supplement:	Reason:	Dosage/duration:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List your family history (grandparents, parents, siblings) of health issues (high blood pressure, diabetes, cancer, etc):
_____
_____
_____

Please indicate any symptoms you are currently experiencing:
_____
_____
_____

List any known allergies (food, environmental, medications) or suspected food sensitivities:
_____
_____

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

Have you ever been hospitalized? Yes □ No □

If yes, for what reason? _____
_____

Have you had surgery to remove your:

gall bladder? □ appendix? tonsils? □

If so, when? _____

How often do you have a bowel movement? _____

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

If yes, is it related to a particular food or circumstance? _____

Do you have loose bowel movements? Yes □ No □ Occasionally □

If yes, is it related to a particular food or circumstance? _____

Circle/indicate any other digestive concerns: bloating gas cramping diarrhea heartburn

indigestion other: _____

Emotional Health History:

Has there been any significant emotional trauma in your life (divorce, loss of a loved one, accident, abuse)? Please describe: _____

_____

On a scale of 1-10 (1 being lowest), how would you describe your:

Stress levels _____

Energy levels _____

Happiness _____

What are the major causes or factors of your stress? _____

_____

How does your stress manifest itself (i.e. fatigue, irritability)? _____

_____

What coping mechanisms do you use? _____

_____

Are all of your relationships happy and fulfilling? _____

Do you ever eat for emotional reasons? _____

Do you, or have you ever had an eating disorder? Please explain: _____

_____

Do you experience any lulls or highs in your energy levels throughout the day? If so, at what time of day?

_____

How many hours on average do you sleep daily? (Include naps) _____

What time do you go to sleep? _____ Awaken? _____

Do you have trouble: falling asleep? □ staying asleep? □ Do you awaken feeling rested? Yes □ No □

What do you do for exercise? (Indicate type, frequency, time of day and duration)

_____

_____

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 do work shifts or are you on a regular schedule? _____

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 have time for them? _____

Do you vacation regularly? Yes □ No □ When was your last vacation? _____

Please indicate your religion/personal philosophy: _____

Do you consume alcohol? Yes □ No □

If yes, how much and how often? _____

Do you smoke? Yes □ No □

If yes, how much and how often? _____

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 describe: _____

Reproductive Health History:

Do you have a healthy sex drive? If not, when was the last time you remember having one?

_____

Do you have any hormonal issues that you know of? Please explain if so:

_____

Females only:

Please circle any symptoms of PMS you experience:

Cramping Bloating Headaches Mood changes Breast tenderness Irritability

Please circle any symptoms of Menopause you experience:

Hot flashes Cravings Headaches Mood changes Weight Gain Irritability

Do you experience emotional upset consistently every month? If so, please describe (anxiety, depression, etc):

_____

_____

How often do you have a menstrual cycle? _____

Are you on birth control? If yes, for how long? _____

Are you using hormone replacement? If so, synthetic or natural, what type, and for how long? _____

_____

Have you given birth? If yes, how many times? _____

Have you had a miscarriage? If yes, how many? _____

Have you had an abortion? If yes, how many? _____

Have you had any fertility treatments? If yes, please describe: _____

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

Have you noticed any changes in your menses, for example, in the frequency, duration, flow, clotting, etc.? Please specify: _____

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

If yes, what was the result? _____

Dietary Health History:

How many times a day do you eat?

Main Meals _____ Times of day: _____

Snacks _____ Times of day: _____

How do you eat meals? With family □ Home alone □ On the run □ At a restaurant □ Fast food □

Do you feel there are restrictions to your diet due to preferences of others (family, roommates, etc)? Yes □ No □ If yes, please explain: _____

_____

How many servings of each of the following do you typically eat in a day? (ex: 1 serving = 1 apple, 1 cup broccoli)

____ Fruit: ____ Fresh □ ____ Dried □ ____ Canned □ ____ Frozen □

____ Vegetables: ____ Cooked □ ____ Raw □ ____ Canned □ ____ Frozen □

____ Grains: ____ Whole □ ____ Refined □

____ Protein: Type _____

____ Dairy Products: Type _____

____ Fats: Type _____

____ Other: Specify _____

Do you eat organic foods? If so, what foods and how often: _____

_____

Please indicate if you eat or use the following: (indicate "1" for "rarely", "2" for "regularly", "3" for "often")

□ Aluminum pans ____ □ Margarine _____ □ Candy _____

□ Microwave ____ □ Fried foods _____ □ Refined foods _____

□ Luncheon meats ____ □ Fast foods _____ □ Nutra Sweet/Aspartame _____

□ Large fish ____ □ Cell phone _____ □ Antiperspirant _____

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

_____ Coffee _____ Milk *(skim or 1%)* _____ Milk *(2% or higher)*

_____ Soft drinks (*diet)* _____ Tea (caffeinated) _____ Herbal tea

_____ Soft drinks *(regular)* _____ Fresh fruit juices _____ Fresh vegetable juices

_____ Fruit juices *(prepared)* _____ Water _____ Other_____

What is the source of your water (i.e. tap, filtered, bottled)? _____

Do you have any dietary restrictions? (vegan, vegetarian, no dairy, etc). Please explain and list all:
_____
_____
_____

How often do you eat meat? □ Daily □ 3-5/week □ Once/week or less □ Never

How often do you consume dairy products? _____

What are your favorite foods and/or cravings? _____
_____

Are there any foods you feel addicted to? _____

How often do you eat them? _____

What foods do you eat most often (list top five): _____
_____

Do you avoid certain foods? If so,why? _____
_____

Are there any foods you are not willing to give up? _____

Describe your relationship with food (excellent, good, poor, food is your enemy). Be specific:
_____
_____

Do you experience any symptoms if meals are missed? Explain: _____
_____

Do you experience any symptoms after meals? Explain: _____
_____

Your Nutritional Future:

Please describe your expectations from your nutrition program:
First visit: _____
_____

Long term: _____
_____

Do you wish to gain weight? □ Lose weight? □ How much? _____

By when do you wish to reach your goal weight? _____

What is your main motivation to change your weight? _____
_____

When, if ever, were you last at your 'ideal' weight? _____

Have you tried weight loss programs in the past (if so, please describe)?
_____
_____

What were the results? _____

_____

What did you like/dislike about the program(s)? _____

_____

What is your level of commitment to addressing underlying causes of your signs and symptoms?

(0 – 10, 10 being 100% committed) _____

Additional items you would like to cover in your nutrition session: _____

_____

_____

Thank you for taking the time to complete this form! I look forward to working with you to achieve better health!

Client Service Agreement:

I,_____, take full responsibility for my health, progress and healing on my nutrition plan. I acknowledge that changes in health take time and I am ready for a plan that is not about quick fixes but rather about smaller changes over a period of time that lead to sustainable change.

All information shared within this professional relationship will be held in strict confidence. Information may be shared at the client's request with a medical doctor, naturopathic physician or any other healthcare practitioner the client deems to be appropriate.

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 purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.

Date: _____

Signature: _____

Name: _____
(please print)