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Nutritional Assessment Form

Name: ____ Phone: _____________________________
Address: ____
Age: _____ Height: _______ Weight: _______ Marital Status: _______

This evaluation is designed to assist me in studying your present state of health. The questions provided are not designed to diagnose diseases. Information you provide will help me choose an appropriate direction in achieving your optimal level of health.

What are your main health concerns, in order of importance?:

1. ____
2. ____
3. ____

What level of stress are you experiencing at the present time?
Minimal ____ Average ____ Considerable ____ Unbearable ____

What are the causes or factors of your stress? (check all that apply)
Financial ___ Career ___ Personal ___ Marriage ___ Health ___ Family ___ Spiritual ___
Unfulfilled expectations ___ Other (Please Specify):_______________________________

How many hours, on average, do you sleep daily? _________________
Do you awaken feeling rested? ___________

How many hours each day do you work? _____________
Do you enjoy your work? ___________

Activity level: (circle one)

1. Sedentary (no exercise...house work)
2. Moderately active (3 to 5 times/week 20-30 minutes each time)
3. Active (3 to 5 times/week 60 minutes each time)
4. Very active (3 to 5 times/week 90 minutes each time. Competitive recreational athletes)
5. Extremely active (5 or more times/week 90 minutes plus per session. Pro athletic level)

What do you do for exercise? (indicate type, frequency and time)

____

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 vacation regularly? ____

When was your last vacation? ____________________

Please indicate if you eat, drink or use the following: (please circle those that apply)

Alcohol	Distilled Water	Sugar substitutes (Nutra Sweet etc.)
Candy	Fried foods	Chewing gum
Luncheon meats	Carbonated beverages	Fast foods
White flour	Margarine	Vitamins/minerals
Chocolate	Potato chips	Refined sugars
Spring water	Aluminum pans	Microwave oven

Please indicate how many cups/bottles/glasses of the following you drink per day:

____ Beer	____ Tea	____ Wine
____ Coffee	____ Tap water	____ Liquor
____ Soft drinks (diet)	____ Milk (1 or 2%)	____ Milk (skim)
____ Soft drinks (reg.)	____ Herbal tea	____ Vegetable juice
____ Fruit juice		

What are your favourite foods? ____

How often do you eat them? ____

What foods do crave, if any? ____

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

____

Do you experience any symptoms after meals? Explain: __________________________

____

How often do you have an alcoholic beverage? ____________________

Have you ever been treated for alcoholism? ______________________

Do you smoke? ____ If yes, how much and for how long? ________________________________
Does anyone else smoke in your household or workplace? ____

Are you currently taking any medication? ____
Have you been diagnosed with any illness or condition? Explain: ________________________________
____

Please list any vitamins, minerals, herbal/homeopathic remedies, or prescription medication you are currently taking? ____
____

Do you have any allergies? If yes, please list: ____
____

Family History:
Please list any hereditary diseases: ____
Please indicate "F" for Father, "M" for Mother, "S" for Siblings, "G" for Grandparents, "O" for Other relatives.

____ Heart Disease	____ Diabetes	____Allergies
____ Hypertension	____Arthritis	____Mental illness
____Intestinal disease	____Osteoporosis	____Alcoholism
____Asthma	____Ulcers	____Cancer

____Other: (please list)
____

Have you ever been hospitalized? ____
If yes, please indicate reason: ____

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 the 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.

Date: ____

Signature: ____