New Patient Lifestyle Assessment Form

Name________________________________ D.O.B ____/____/____ Age _____________
Height: ___′ ___ ″ Weight: ______ Sex: ____ Occupation _____________________________
Date of last physical exam ________________ Email:________________________________

GOALS AND READINESS ASSESSMENT

I would like to visit with the provider today because...
____
____
____

My food and nutrition related goals are...
____
____
____

My overall, health goals (sleep, stress, activity level) are...
____
____
____

If I could change three things about my health (sleep, stress, activity level) and nutritional habits, they would be...
1.____
____
____
2.____
____
____
3.____
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The biggest challenge(s) to reaching my goals is/are:
____
____

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

1. Significantly modify your diet
2. Take nutritional supplements each day
3. Keep a record of everything you eat each day
4. Modify your lifestyle (ex: work demands, sleep habits, physical activity)
5. Practice relaxation techniques
6. Engage in regular exercise/physical activity
7. Have periodic lab tests to assess your progress

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MEDICAL SYMPTOMS QUESTIONNAIRE

Please circle the following symptoms based upon your typical health profile for the past 30 days

HEAD:	Stuffy Nose	**GI:**	Fatigue/sluggish
Headache	Sinus problem	Nausea/vomiting	Lethargy/Apathy
Faintness	Sneezing	Diarrhea	Hyperactivity
Dizziness	Excessive mucous	Constipation	Restlessness
Insomnia	**MOUTH/THROAT**:	Bloated	**MIND:**
EYES:	Chronic cough	Belching/passing gas	Poor Memory
Watery/itchy	Clearing throat	Heartburn	Confusion
Swollen/ sticky/red	Swollen tongue/discolored	Stomach discomfort	Difficulty making decisions
Bags/dark circles	Soar throat	**JOINT/MUSCLE:**	Foggy
EARS:	**SKIN:**	Pain	**EMOTIONS:**
Ear infections	Acne	Stiffness	Mood swings
Drainage	Eczema	Tiredness	Anxiety
Ringing/hearing loss	Psoariasis	**WEIGHT:**	Irritability/aggressive
NOSE:	Dermatitis	Binge eat/drink	Depression
	Flushing/hot flashes	Food cravings	**OTHER:**
	LUNGS:	Excessive weight	Frequent Illness
	Congestion	Water retention	Urgent Urination
	Asthma	**ENERGY:**	Prostate problems

Medical Issues:____

____

Medication &Supplements:____

____

Allergies:____

____

Other things we should know about your health:_____________________________________

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LIFESTYLE

Using the table below, please describe your physical activity:

	# Days per week	Duration (minutes)
Stretching/yoga		
Cardio/Aerobic		
Strength Training		
Sports or leisure		
Other		

1. Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high):
   Work______ Family______Social______Financial______Health______Other______
2. Do you smoke?
   Never____ In the past____ Currently____ How long?_________
3. Alcohol use
   Never____ In the past _____Currently _____ Type/amount/frequency_________________
4. Drug use
   Never____ In the past _____ Currently _____ Type/frequency________
5. Water Intake _________ cups/day

Do you associate any digestive symptoms with eating certain foods YES NO

Please explain____

____

How often do you have a bowel movement? ____

Do you prepare your own meals YES NO

How many days per week do you eat out _______ days/week

Are processed foods a part of your typical diet? YES NO

Are you an emotional eater (stressed, bored, sad)? YES NO

Do you adhere to a certain style of eating (circle)? Paleo/GlutenFree/Low carb/ Low fat/Organic

Other____

Do You eat breakfast, lunch, dinner? YES NO explain____

Do you eat snacks? YES NO ____

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SLEEP HABITS

1. I have trouble falling asleep at night YES NO
2. I have trouble staying asleep at night YES NO I get up to urinate ______ times/night
3. I am sleepy all day YES NO
4. On weekdays I go to bed at _________ get _______ hours of sleep
5. On Weekends I go to bed at_________ get________ hours of sleep
6. My work schedule is Regular Irregular I work Shift YES NO
7. I exercise at __________ am/pm for __________ minutes
8. I take a nap on most days YES NO at what time__________
9. When I wake up from my nap I am refreshed YES NO I am groggy YES NO
10. I watch TV before bed YES NO I have a TV in my room YES NO
11. I am on my computer before bed YES NO
12. I have a bed time routine YES NO
13. I participate in some form of relaxation consistently YES NO
14. I use sleeping pills (herbal, prescription, OTC) to sleep YES NO

15. I drink alcoholic beverages during the week_____ Weekend_____
16. I consume caffeine ______ days per week Until what time of day _______ am/pm

Thank you for taking the time to fill out this questionnaire, as this will allow us to better understand your individual lifestyle and help to better serve you. If there is anything else you would like to add please feel free to do so here. We look forward to making a positive impact in your life!
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