New Patient Lifestyle Assessment Form

Name_____ D.O.B _____/_____/_____ Age _____
Height: __′ __″ Weight: ____ Sex: ____ Occupation: _____ Email: _____
Date of last physical exam _____ Primary MD _____Phone: _____

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._____
_____

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 __

MEDICAL QUESTIONNAIRE

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

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

Medical Issues: _____
_____

Medications and Supplements: _____
_____
_____

Allergies: _____

Other things we should know about your health: _____
_____
_____
_____
_____
_____

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/ Gluten Free/ Low carb/ Low fat/ Organic

Other_____

Do you eat breakfast, lunch, dinner? YES NO

explain_____

Do you eat snacks? YES NO _____

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. Weekdays I go to bed at _____and get _____ hours of sleep
5. Weekends I go to bed at_____ and get_____ hours of sleep
6. My work schedule is Regular Irregular I work shifts 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 bedtime 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 What? _____
15. I drink alcoholic beverages during the week YES NO Weekend YES NO
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!

AGE STRONG MD

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