

Name _____ Date _____
 Age _____ Height _____ Gender _____ Number of Children _____

Marital Status: Single Partner Married Separated Divorced Widow(er)

Have you tried any of the alternative therapies listed below for your current health concern(s)? Check all that apply

- Diet modification Fasting Vitamins/minerals Herbs Homeopathy Chiropractic Acupuncture Conventional drugs
 Other _____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, residence, or finances): _____

Do you consider yourself: Underweight Overweight Healthy weight _____

Have you lost weight in the past? How much? When? Is weight loss one of your current goals?

Occupation _____

Is your job associated with potentially harmful chemicals or conditions (e.g., pesticides, radioactivity, solvents) and/or life threatening activities (e.g., fire fighter, police officer, etc.)?

How many hours of sleep do you get per night on average? _____

Do you feel refreshed upon waking? _____

Have you ever fasted, completed a juice cleanse, or detox? Yes No If yes, how many days? _____

How ready and willing are you on a scale of 1 to 10 (1 being the lowest) to make lifestyle changes to improve your health? 1 2 3 4 5 6 7 8 9 10

Health Habits

- Tobacco/nicotine products _____/day
 Alcohol
 Wine _____ 5 oz glass(es)/day
 Liquor _____ 1.5 oz drink(s)/day
 Beer _____ 12 oz can(s)/day
 Other _____ oz/day
 Caffeine
 Coffee _____ 6 oz cup(s)/day
 Tea _____ 6 oz cup(s)/day
 Soda w/caffeine _____ 12 oz can(s)/day
 List other sources (i.e., energy drinks) and how much _____
 All other sweetened beverages (natural and artificial) _____ oz/day
 Water/sparkling water _____ oz/day

Exercise

- Walk _____ mins _____ days/wk
 Run/jog/other aerobic activity _____ mins _____ days/wk
 Weight lift _____ mins _____ days/wk
 Stretch _____ mins _____ days/wk
 Other activity _____ mins _____ days/wk

Nutrition and Diet

- Omnivore
 Vegetarian
 Vegan
 Salt restriction
 Fat restriction
 Starch/carbohydrate restriction
 Low glycemic diet
 Total calorie restriction
 Paleo diet

Specific food restrictions based on allergies/cultural preferences

- Dairy Wheat Eggs
 Soy Corn All gluten
 Other _____

Food Frequency

Number of servings per day
 Fruits _____
 Vegetables _____
 Grains _____
 Beans, peas, legumes _____
 Dairy _____
 Eggs _____
 Meat, poultry, fish _____

Eating Habits

- Skip meals (which ones) _____
 Graze (small frequent meals)
 Eat on the run
 Eat constantly whether hungry or not
 Dining out _____ times/wk
 Fast food _____ times/wk

Current Supplements

- Multivitamin/mineral
 Vitamin C
 Vitamin E
 Vitamin D
 Fish oil
 Evening primrose/GLA
 Calcium
 Magnesium
 Zinc

- Probiotics
 Digestive enzymes
 CoQ₁₀
 Antioxidants
 Fiber supplements
 Herbal products _____
 Homeopathic remedies _____
 Protein shakes _____
 Liquid meals _____
 Other _____

I would like to: (choose all that apply)

- Feel more vital
 Have more energy
 Have more endurance
 Be less tired after lunch
 Sleep better
 Be free of pain
 Get fewer colds and flu
 Get rid of allergies
 Not be dependent on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, acid blockers, etc.
 Stop using laxatives and stool softeners
 Improve my sex drive

Lose Weight or Improve Body Composition

- Lose weight
 Lose fat
 Be stronger
 Increase muscle tone
 Improve balance
 Be more flexible

Stress: Mental and Emotional

- Learn how to reduce stress
 Think more clearly and be more focused
 Improve memory
 Be less depressed
 Be less moody
 Be less indecisive
 Feel more motivated

Life Enrichment

- Reduce my risk of chronic disease
 Slow down accelerated aging
 Maintain a healthier life longer
 Reduce risk for diseases that run in my family

Which 3 are most important to you?

- 1) _____
 2) _____
 3) _____

Additional comments _____

