Sarah Beranger
HOLISTIC HEALTH + NUTRITION

CLIENT LIFESTYLE ASSESSMENT FORM

GENERAL LIFESTYLE QUESTIONS

Name:_____

Date: _____ **Age:** _____ **Sex:** F / M **Height:** _____ **Weight:** _____

What is your main health concern/purpose for this appointment?

_____

_____

_____

Do you have any other concerns that you would like addressed?

_____

_____

_____

From 1 to 10, what level of stress are you experiencing at this time? (10 being highest)

1 2 3 4 5 6 7 8 9 10

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

_____

_____

From 1 to 10, how would you describe your energy levels? (10 being highest)

1 2 3 4 5 6 7 8 9 10

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

_____

How many hours do you sleep on average? _____

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

Do you have trouble falling asleep? _____ **Staying asleep?** _____

What is your occupation? _____

How many hours do you spend daily, on average:

Being sedentary (driving, reading, screen time, desk job, relaxing etc): _____

Being active (walking, working out, active job, biking, yoga etc): _____

Do you smoke? Y / N **If so, how much/how long?** _____

DIETARY HABITS

From 1 to 10, how healthy do you think your dietary choices are? (10 being absolute healthiest)

1 2 3 4 5 6 7 8 9 10

How many times a day do you eat:

Main Meals: _____ Times of day:_____

Snacks: _____ Times of day:_____

How do you normally eat your meals? (with family, on the run, at your desk, alone, etc)

_____

How many 1/2 cup servings do you typically eat each day?

Fruit: _____ ☐ Fresh ☐ Dried Vegetables: _____ ☐ Raw ☐ Cooked

Whole Grains: _____ Protein: _____ Dairy: _____ Fats: _____

Other: _____

Do you eat: (indicate 1 for rarely, 2 for regularly, 3 for often)

Deli Meats: _____ Artificial sweeteners: _____ Margarine: _____ Fried Foods: _____

Refined Food (bread/pasta/pasteries): _____ Candy/Sweets: _____ Fast Foods: _____

Are you a: ☐ meat eater? ☐ vegetarian? ☐ vegan? Specify, if needed:_____

What foods do you crave?

_____

Do you have any symptoms if you miss a meal? Explain:

_____

Do you experience any symptoms after meals? Explain:

_____

Have you ever dieted before? If so, please specify what diet protocols:

_____

_____

Do you have any other concerns about your dietary habits you would like to address here?

_____

_____

_____

MEDICAL HISTORY

Are you currently taking any medications? Please list all medications and reasons for each:

_____

_____

_____

Please list any vitamins, minerals or herbal supplements you are taking and the dosage:

_____

_____

Have you taken antibiotics in the last five years? Y / N

Do you have any allergies or sensitivities? If so, please list:

_____

_____

Have you ever been diagnosed with an illness? If so, please explain:

_____

_____

Have you ever been hospitalized/had surgery? If so, please explain:

_____

_____

How often do you have a bowel movement? _____

Do you strain to have a bowel movement? YES / NO / OCCASIONALLY

Do you have loose bowel movements? YES / NO / OCCASIONALLY

Do you have undigested food in your stools? YES / NO / OCCASIONALLY

Have you ever been treated for drug and/or alcohol dependency? YES / NO

Do you have any hereditary diseases in your family? If so, please elaborate.

_____

_____

WOMEN ONLY **Are you:** PREMENOPAUSAL / MENOPAUSAL / POSTMENOPAUSAL / NONE

Do you have PMS symptoms? If so, please elaborate _____

_____