

LIFESTYLE ASSESSMENT FORM

Name: _____

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

Please answer each of the following questions. If you require additional space, use the back of the page.

What is your purpose in coming here today? _____

What are your main health concerns/complaints? Please list in priority:

Have you experienced any major trauma in the past 5 years? _____

What level of stress do you feel you are experiencing at this time? Please quantify on a scale of 1 (low) to 10 (high): 1 2 3 4 5 6 7 8 9 10

What are the major causes or factors of your stress? (rate all that apply on a scale of 1 (low) to 10 (high):

___ financial ___ career ___ personal ___ marriage ___ health

___ family ___ spiritual ___ unfulfilled expectations

___ other (please elaborate) _____

How does your stress manifest itself? _____

Do you use any coping mechanisms? _____

What do you do for exercise? (indicate type, frequency, time of day and duration) _____

On a scale of 1 (low) to 10 (high), how would you describe your energy levels? _____

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

How many hours on average do you sleep daily? (include naps) _____

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

Do you have trouble falling asleep? Staying asleep?

Do you awaken feeling rested? Yes No Do you snore? Yes No

What is your occupation? _____

Do you enjoy your work? Yes No Sometimes

How many hours each day do you work? _____

At what times do you start and end work? _____

Do you work shifts or are you on a regular schedule? _____

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Name: _____

Do you smoke? Yes No If yes, how much and for how long?

If no, does anyone in your household or workplace smoke? Yes No

Do you wish to gain weight? lose weight? how much? _____

By when do you wish to reach your goal weight? _____

What is your main motivation to change your weight? _____

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? Yes No

When was your last vacation? _____

Do you actively participate in any spiritual discipline (church, religious group, meditation, etc.)? Yes No

MEDICAL HISTORY:

Are you currently taking any medication? Yes No

List all medications and the reason(s) for each _____

Do you take: birth control pills

Have you taken antibiotics over the past five years? Yes No

Please list any vitamins, minerals, herbal or homeopathic remedies you are currently taking and the amounts/dosages: _____

Do you have any allergies or sensitivities? Yes No

If so, please list: _____

Do you have anaphylaxis (life-threatening allergy)? If so, please describe:

Do you have any silver-mercury fillings? Yes No

Have you ever been:

a) Diagnosed with an illness? Yes No If so, please explain

b) Hospitalized? Yes No If yes, for what reason?

Have you had surgery to remove your gall bladder? tonsils? appendix?

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Name: _____

How often do you have a bowel movement? _____
 Do you strain to have a bowel movement? Yes No Occasionally
 Related to particular food or circumstances? _____

Do you have loose bowel movements? Yes No Occasionally
 Related to particular food or circumstances? _____

Is there undigested food in your stools? Yes No Occasionally

Do you use recreational drugs? Yes No

If yes, how often and what type? _____

Have you ever been treated for drug and/or alcohol dependency? Yes No

If yes, please circle which you have been treated for.

FAMILY HISTORY:

Hereditary Diseases: Use "F" for father, "M" for mother, "S" sibling, "G" for grandparent, "O" for other(s):

	Allergies		Diabetes		Intestinal Disease
	Alcoholism		Drug Abuse		Kidney Dysfunction
	Arthritis		Gall Bladder Issues		Mental Illness
	Asthma		Heart Disease		Osteoporosis
	Autoimmune Disease		Hypertension		Skin conditions
	Cancer - type:				Ulcers

Other diseases (please list) _____

Have you experienced fungal infections (e.g. jock itch, athlete's foot)?

Yes No If yes, please describe: _____

Have you experienced a decline in sexual interest? Yes No

If yes, please describe: _____

Have you had kidney or gall stones? Yes No

If yes, please describe: _____

FEMALES:

Are you or could you be pregnant? Yes No

Have you noticed any changes in menses, for example the frequency, duration, flow, clotting, or other changes? Yes No

If so, please specify _____

Do you suffer from PMS symptoms? Please specify _____

Are you pre-menopausal? Yes No Post-menopausal? Yes No

Are you experiencing any menopausal symptoms? Yes No

If yes, please specify _____

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Have you had a bone density test? Yes No

If yes, what was the result? _____

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MALES:

Have you experienced any prostate problems (e.g. frequent urination, discomfort during urination)? Yes No If yes, please describe:

DIETARY HABITS:

How many times a day do you eat:

Main Meals _____ Times of day: _____

Snacks _____ Times of day: _____

Do you eat meals: with family home alone on the run
restaurant fast food

Do you feel there are restrictions to your diet due to preferences of others such as family, roommates, etc? Yes No If yes, please explain:

How many 1/2 cup servings of each do you typically eat in a day:

___ Fruit: Fresh Dried Canned

___ Vegetables: Cooked Raw

___ Whole Grains

___ Protein: Types _____

___ Dairy Products: Type _____

___ Other: Specify _____

Provide examples of your typical meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you eat or use (indicate "1" for "rarely", "2" for "regularly", "3" for "often")

	Aluminum pans		Margarine		Candy
	Microwave		Fried foods		Fast foods
	Luncheon meats		Cigarettes		
	Artificial sweeteners (Nutra Sweet, aspartame, Splenda)				
	Refined foods (pastries, white bread/pasta/rice, etc.)				

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Name: _____

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

	Tap water		Fresh vegetable juices
	Bottled or spring water		Prepared vegetable juices
	Coffee		Soft drinks (<i>diet</i>)
	Tea		Soft drinks (<i>regular</i>)
	Herbal tea		Red wine
	Fresh fruit juices		White wine
	Fruit juices (<i>prepared</i>)		Beer
	Milk (<i>1% 2% or whole</i>)		Other alcoholic beverages
	Milk (<i>skim</i>)		Other

For Office use only:

Are you a: meat eater? vegetarian? vegan?

How often do you eat meat? daily 3-5/week once/week or less

How often do you consume dairy products?

daily 3-5/week once/week or less

What are your favourite foods? _____

How often do you eat them? _____

Which food(s) do you crave, and how often do you eat them? _____

Do you avoid certain foods? Yes No If so, why?

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

Comments: _____

By signing this form, you agree that you have read thoroughly that the opinions, advice and services we / Alberta Health Institute health practitioner(s) offer are primarily educational and not medical advice and under no circumstances are to be considered by me as such;

- (i) **The opinions, advice and services that you offer are under no circumstances intended to modify, affect, or to be in lieu of any medical advice or treatment that I may require for any cause whatsoever, now or in the future.**
- (ii) You encourage me to consult with my doctor with reference to my particular problem and keep my doctor fully informed as to the opinions, advice and services you offer;
- (iii) Your opinions, advice and services fundamentally relate to an educational program with respect to the teaching of a macrobiotic diet, nutrition, foods and related principles which many people have found helpful for improving one's physical, mental and spiritual conditions, and thus attain a "healthy way of life";
- (iv) You have made no promises or representations, expressed or implied, as to any result I might obtain by adhering to your opinions, advice and services.
- (v) I, together with any and all accompanying persons, have completely read the above statements, and acknowledge that I fully understand them, and that I have received no promises of guarantees whatsoever.

In witness whereof, I here unto set my hand that _____ day of _____ 20 _____

Name: _____
(Please print name)

Client's Signature
(Parent/Guardian if under the age of 18)

Witness to Signature

Address: _____

City: _____ Prov: _____ Postal Code _____

Phone: (H) _____ (W) _____ (C) _____

Alberta Health Institute
101, 1422 Kensington Road NW
Calgary, AB T2N 3P9
Phone: (403) 521-5234
Fax: (403).521-5237

NSP CLIENT ASSESSMENT FORM

NAME: _____ AGE: _____ DATE: _____

COMPLETE LEFT SIDE OF FORM ONLY: If any of the following symptoms or activities have occurred *within the past three months* (unless otherwise specified), please indicate by checking: **1** for mild or rarely occurring, **2** for moderate or regularly occurring, **3** for severe or often occurring, or **leave blank** if the symptom/statement does not apply.

<i>Please complete this section</i>		1	2	3	4	5	6	7	8	9	10
1	General fatigue or weakness										
2	Difficulty losing weight										
3	Frequent illness/infections										
4	High stress Lifestyle										
5	Smoking										
6	Drinking more than 2 cups of coffee/day										
7	Bad breath and/or body odour										
8	Constipation <small>LN / GI</small>										
9	Bags under eyes										
10	Crave sugars, bread, alcohol										
11	Difficulty digesting certain foods										
12	Have used antibiotics in past 10 years										
13	Allergies										
14	Poor concentration or memory										
15	Belching or burping after meals										
16	Skin/complexion problems										
17	Frequent consumption of red meat										
18	Regular use of dairy products										
19	Heavy alcohol consumption										
20	Exposure to toxins/chemicals										
21	Frequent mood swings										
22	Depressed and/or irritable										
23	Brittle fingernails										
24	Dry, brittle hair, split ends										
25	High fat/high cholesterol diet										
26	Nervousness/anxiety/tension/worry										
27	Insomnia/restless sleep										
28	Low fibre diet										
29	Muscle cramps										
30	Sleepy when sitting up										
31	Female: menstrual cramps										
32	Bronchitis/asthma/pneumonia/emphysema										
33	Cellulite										
34	Cold hands and feet										
35	Varicose veins										
36	Feeling out of control										
37	Food/chemical sensitivities										
38	Frequent yeast/fungus problems										
39	Bones break easily, osteoporosis										
40	Too little exercise										
	SCORES SUBTOTAL										

Right Side for Office Use Only

NAME: _____ DATE: _____ ASSESSMENT# _____

(Check: 1 for mild or rarely occurring. 2 for moderate or regularly occurring 3 for severe or often occurring, or leave blank if the symptom/statement does not apply.)

Please complete this section				1	2	3	4	5	6	7	8	9	10
	SUBTOTALS												
41	Excessive mucous												
42	Short of breath climbing stairs												
43	Tingling in lips, fingers, arms, legs												
44	Chest pains												
45	Very rapid or slow heart beat												
46	Painful, hard or thin bowel movements												
47	Alternating constipation/diarrhea												
48	Recurrent bladder infections												
49	Female: Menopause, hot flashes												
50	Female: PMS												
51	Difficult urination												
52	Swollen glands, puffy throat												
53	Lower abdominal pain												
54	Frequent need to urinate												
55	Joint pain												
56	Sinus inflammation/discharge												
57	Arthritis												
58	Sudden weight gain/loss												
59	Headaches/Migraines												
60	Female: Taking birth control pills												
61	Lower back pains <i>O/A ST</i>												
62	Dry, flaky skin												
63	Drink less than 6 glasses of fluids/day												
64	Water retention												
65	Low sex drive												
66	Feeling heavy/bloated after meals												
67	Chronic cough												
SCORES TOTAL													

Right Side for Office Use Only

SYSTEMS RATING TABLE: For Office Use Only

1.	Digestive	
2.	Intestinal	
3.	Circulatory/Cardiovascular	
4.	Nervous	
5.	Immune/Lymphatic	
6.	Respiratory	
7.	Urinary	
8.	Glandular/Endocrine	
9.	Structural	
10.	Reproductive	

COMMENTS:

NSP SUBQUESTIONNAIRES

1. The Digestive System

NOW PLEASE COMPLETE THE FOLLOWING SUBQUESTIONNAIRES USING THE SAME RATING SYSTEM:
 Leave blank if symptom or activity does not apply, 1 for mild or rarely occurring, 2 for moderate or regularly occurring, 3 for severe or often occurring.

UNDERACTIVE STOMACH

Excessive gas, belching or burping after meals	
Stomach bloated after eating	
Sleepy after eating	
Longitudinal striations on fingernails	
Eat when rushed/in a hurry	
Halitosis	
Full feeling after heavy meat meal	
Heavy, tired feeling after eating	
Nausea after taking supplements	
Acne	
Undigested food in the stool	

OVERACTIVE STOMACH

Stomach pain 1 hour after eating or at night	
Burning sensation in stomach	
Pain aggravated by worry/tension	
Hiatal hernia	
Gastritis, gastric ulcer	
Nausea, vomiting	
Sensation of acidity in abdominal area	
Heartburn, indigestion	
Blood in stool	
Lower back pain	
Long term aspirin use	

LIVER

Yellow or pale fingernails	
Skin oily on nose and forehead	
Fats/greasy foods cause nausea, headaches	
Vertical white streaks on fingernails	
Onions, cabbage, radishes, cucumbers cause bloating /gas	
Bad breath; bad taste in mouth	
Excess body odour	
High cholesterol/high cholesterol diet	
Migraine headaches	
Discomfort underneath right ribcage	
Food allergies	
Irritable, easily angered	
Weight gain around the abdomen	
Yellow palms	
Jaundice	
Poor concentration	
Difficulty losing weight	
Acne, boils, rashes, psoriasis or eczema	
Constipation	

PANCREAS

Severe abdominal pain	
Nausea and vomiting	
Slow digestion; feel full for hours after eating	
Fever	
Alcohol addiction	
Jaundice	

DYSGLYCEMIA

Hungry up to 3 hours after eating	
Strong, sudden cravings for sweets, starches coffee or alcohol	
Nervous/anxious feelings relieved by eating	
Irritable if late for or skip a meal	
Overweight	
Addicted to coffee with sugar and/or colas	
Frequent "midnight snacks"	
Family history of diabetes	
Fatigue	
Frequent headaches	
Fainting spells	
Depression	
Lose temper easily	

GALL BLADDER:

Gall stones; history of gall stones	
Stool appears clay-coloured, foul odoured	
Constipation	
High cholesterol diet; High blood cholesterol levels	
Severe pain in right upper abdomen	

2. THE INTESTINAL SYSTEM

NAME: _____ DATE: _____

If any of the following symptoms or activities apply please indicate by checking:

1 - for mild or rarely occurring

2 - for moderate or regularly occurring

3 - for severe or often occurring

or leave **blank** - if the symptom / statement does not apply

CANDIDIASIS

134	Extreme fatigue, tiredness, sluggishness	
135	Recurrent vaginal infections	
136	Frequent use of antibiotics	
137	White coated tongue, oral thrush	
138	Crave sugars, bread, alcohol	
139	Headaches	
140	Tonsillitis, recurrent strep throat	
141	Itchy, watery or dry eyes	
142	Skin flushes	
143	Chronic indigestion, frequently use antacids	
144	Always cold especially in extremities	
145	Female : PMS	
146	Pain in pelvic area	
147	Abdominal gas and bloating	
148	Loss of sex drive	
149	Cystitis, repeated bladder infections	
150	Increasing food and chemical sensitivities: severe reaction to tobacco, perfume etc.	
151	Female: endometriosis/ovary problems	
152	Chronic diarrhea	
153	Hives, psoriasis, acne, skin rashes	
154	Rectal itching	
155	Abnormal muscle aches from exercise	
156	Excessive wax in ears	
157	Unexpected / unexplained weight gain	
158	Impotence	
159	Canker sores	
160	Athlete's foot, finger / toenail fungus, ringworm	
161	Jock itch	
162	"Brain fog"	
163	Irritability	
164	Memory loss	

CANDIDIASIS (cont.)

165	Mental confusion	
166	Depression or anger for no reason	
167	Anxiety / panic attacks	
168	Inability to concentrate	
169	Phobic / compulsive	
170	Lethargy, tiredness, sluggishness	
171	Mood swings	
172	Itchy ears, nose, anus	

PARASITES

173	Forgetfulness	
174	Slow reflexes	
175	Gas and bloating	
176	Unclear thinking	
177	Loss of appetite	
178	Yellowish or pale face	
179	Fast heartbeat	
180	Heart pain	
181	Pain in the navel	
182	Eating more than normal but still feeling hungry	
183	Periods of blurry or unclear vision	
184	Pain in the back, thighs, shoulders	
185	Numb hands	
186	Drooling while sleeping	
187	Damp lips at night	
188	Dry lips during the day	
189	Grind teeth while sleep	
190	Bedwetting	
191	Lethargy, chronic fatigue	
192	Dark circles under eyes	
193	Cancer	

5. THE LYMPHATIC / IMMUNE SYSTEM

NAME: _____ DATE: _____

If any of the following symptoms or activities apply please indicate by checking:

1 - for mild or rarely occurring

2 - for moderate or regularly occurring

3 - for severe or often occurring

or leave **blank** - if the symptom / statement does not apply

THYMUS (IMMUNITY)

194	Excessive sleep	
195	Very susceptible to infections	
196	Swollen glands: tonsils, throat, armpits	
197	History of cancer, MS, Parkinson's, arthritis	
198	Loss of appetite	
199	Headaches	
200	Soreness on both sides of neck at shoulder	
201	Feel puffiness in throat	
202	Look older than chronological age	
203	Flu-like symptoms often occur	
204	Lupus	

ALLERGIES

205	Acne, psoriasis, dermatitis, eczema	
206	Rapid pulse, heart irregularities	
207	Frequent headaches	
208	Hay fever	
209	Frequent cravings for certain foods	
210	Periods of blurred vision	
211	Repeated ear trouble	
212	Hyperactivity, nervous behaviour	
213	Dizzy spells	
214	Periods of confusion	
215	Poor concentration	
216	Epilepsy	
217	Muscle cramps or spasms	
218	Abnormal body odour	
219	Excessive sweating, night sweats	
220	Bowel disease: IBS, IBD, Crohn's etc.	
221	Joint pain or stiffness	
222	Frequent night urination	
223	Wheezing	
224	Pale face	
225	Hives	
226	Nose runs constantly	
227	Noticeable changes in writing during the day	
228	Nosebleeds	
229	Bloating or gas after eating certain foods	
230	Canker sores	
231	Dark circles under eyes	
232	Stuffy nose	

8. The Glandular / Endocrine System

NOW PLEASE COMPLETE THE FOLLOWING SUBQUESTIONNAIRES USING THE SAME RATING SYSTEM:
 Leave blank if symptom or activity does not apply, 1 for mild or rarely occurring, 2 for moderate or regularly occurring, 3 for severe or often occurring.

UNDERACTIVE THYROID/HYPOTHYROID

Distinct, lethargic tiredness or sluggishness	
Cold hands or feet	
Mercury amalgams (fillings)	
Gain weight easily, fail to lose on diets	
Constipation, less than one bowel movement a day	
Low energy in the morning	
Low pulse rate	
Low body temperature, especially bed rest	
Hair dry, brittle, dull, lifeless	
Flaky, dry rough skin	
Feel stiff after sitting still for some time	
Mood swings	
Usually square and wide fingernails	
High cholesterol	
Diminished sex drive	

OVERACTIVE THYROID/HYPERTHYROID

Losing weight without trying	
Heart races while at rest	
Feel warm/flushed at room temperature	
Hands shake or tremble	
Protruding tongue	
Heart palpitations	
Nervous behaviour, hyperactivity	
Insomnia	
Increased appetite	
Frequent bowel movements, diarrhea	
Excessive sweating without exercising	

PITUITARY

Headaches affecting one side of head	
F: loss of menstrual function	
Moody	
Overweight from waist down	
Overweight from waist up	
Excessive urination	
Pain in little finger of left hand	
Swelling in ankles, fingers and/or feet	
Cold hands or feet	
Pain in left side of upper neck	

ADRENALS

Stress or emotional upsets cause exhaustion	
Blood pressure decreases when going from a Lying position to a standing position	
Perspire excessively	
Neck and/or shoulder tension	
Frequent headaches	
Bow lines (depressed furrows) on fingernails	
Occasional cold sweats	
Tightness or lump in throat, especially when emotionally disturbed	
High or low blood pressure	
Rapid pulse	
Short temper	
Puffy face	

9. THE STRUCTURAL-MUSCULAR / SKELETAL SYSTEM

NAME: _____ DATE: _____

If any of the following symptoms or activities apply please indicate by checking:

1 - for mild or rarely occurring

2 - for moderate or regularly occurring

3 - for severe or often occurring

or leave **blank** - if the symptom / statement does not apply

SKELETAL

282	Pain, swelling, stiffness in joints	
283	Joint inflammation (rheumatoid arthritis)	
284	Pain, stiffness, inflammation of spine	
285	Facial pain	
286	Joints make popping sounds	
288	Gout	
289	Ankylosing spondylitis	
290	Bones fracture easily	
291	Gradual loss of height	
292	Tooth loss; teeth "falling out"	
293	Lack of exercise	
294	Rounding of shoulders; stooping	
295	Female: Menopause	
296	Pain in forearm or biceps	
297	Cramps in calf muscle during sleep or exercise	
298	Painful cramping of feet or toes	
299	Teeth prone to decay, frequent toothaches	
300	Malformation of bones	
301	Insomnia	
302	Muscles weak, weak grip, light objects feel heavy	
303	Heart palpitations	
304	Diets high in animal foods (meat, dairy, eggs)	

MUSCULAR

305	Muscle pain	
306	Muscle weakness	
307	Sprains; muscle strains	
308	Muscle(s) spasm	

NEUROMUSCULAR

309	Muscles wasting in some part of the body	
310	Numbness or loss of sensation	
311	Mood swings and / or depression	
312	Blurred or double vision	
313	Tingling and / or numbness, especially in extremities	
314	Loss of balance and / or coordination	
315	Muscular stiffness	
316	Difficulty breathing	
317	Male: impotence	
318	Tremors	
319	Loss of peripheral vision	
320	Slurred speech	
321	Objects fall from hands, reach in wrong place	
322	Hands tremble	
323	Impaired speech	