A Recipe For Life.....

Nutritional & Lifestyle Assessment Form

It will take approximately 15 minutes to complete this form. Please bring it with you to your first appointment.

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

GENERAL INFORMATION

Name: _____Date: _____

Date of Birth: _____Marital Status: _____ Number of Children: _____

What are your main health concerns, in order of importance?

1. _____

2. _____

What are you doing for your health presently? [Circle those, which apply]

Exercise	Vitamin Supplements	Minerals	Herbs
Chiropractor	Prescription Medication	Diet	Meditation
Medical Doctor	Relaxation Techniques	Acupuncture	Other: _____

What do you feel may be the underlying factors contributing to your present health concerns?

_____

_____

Height: _____ Weight _____

Do you wish to: [circle one]: Gain weight Lose weight

How much weight would you like to gain or lose? _____

Do you suffer from high or low blood pressure? If so, Please explain_____

What level of stress do you feel you are experiencing at this time in your life? [Circle one]

Minimal Average Considerable Unbearable

What are the major causes or factors of your stress? [Circle all that apply]

Financial Career Personal Marriage Health Family Spiritual

Unfulfilled Expectations Other [Please Specify]: _____

How many hours do you sleep daily? [Average; include naps] _____

Do you wake feeling rested? [Circle one] Yes No Sometimes

Describe your energy level? _____

A Recipe For Life *with* **Leanne Nolet** BA RHN ROHP CPCC
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"The maintenance & restoration of optimal health through the fusion of personalized meal plan programs, natural health protocols & detoxification"

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How many hours a day do you work? _____ What type of work do you do? _____

Do you enjoy your work? [Circle one] Yes No Sometimes

How many hours each day do you spend driving? [Average] _____

Do you smoke? [Circle one] Yes No If yes, how much? _____

Describe what you do for exercise_____

_____

How many hours daily do you:

_____ Watch television _____ Read _____ Spend in front of a computer

What are your interests/hobbies? _____

_____

Do you take vacations regularly? [Circle one] Yes No

When was your last vacation? _____

How did you spend your last vacation? _____

Do you actively participate in a church or spiritual group? [Circle one] Yes No

MEDICAL HISTORY

Are you currently taking any medication? [Circle one] Yes No

List/Reasons(s): _____

_____

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

_____

_____

Do you have any allergies or food intolerances? If yes, please list: _____

_____

Have you ever been:

_____ Diagnosed with an illness? Explain: _____

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_____ Hospitalized? For what reason: _____

How often do you have a bowel movement? _____

Do you strain to have a bowel movement? [Circle one] Yes No Sometimes

FAMILY HISTORY

Hereditary Diseases: Please indicate "F" for Father, "M" for Mother, "S" for Siblings, "G" for Grandparents, "O" for Other relatives.

_____ Heart Disease _____ Diabetes _____ Allergies

_____ Hypertension _____ Arthritis _____ Mental illness

_____ Cancer _____ Osteoporosis _____ Intestinal disease/Digestive Issues

Other [Please list]: _____

_____

Have you ever been treated for drug and/or alcohol dependency? [Circle one] Yes No

DIETARY HABITS

Main meals _____ what time of the day: _____

Snacks _____ what times of the day: _____

Describe what you eat on a typical day:
Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

At what time do you have your last meal or snack of the day? _____

Do you eat or use: [check all that apply]

_____ Aluminum pans _____ microwave _____ margarine

_____ Candy _____ fried foods _____ refined/processed foods

_____ Luncheon meats _____ cigarettes _____ artificial sweetener

_____ Fast foods _____ air fresheners _____ scented body product

Beverage	Number of Cups per day	Number of cups per week
Coffee		
Tea – regular or green tea		
Herbal tea		
Tap water		
Bottled/Spring water		
Soft drinks		
Fruit Juices (store bought)		
Fruit juices (freshly squeezed)		
Milk		
Vegetables juices (freshly squeezed)		
Vegetables juices (prepared) Example: V8		
Beer		
Wine		
Other alcoholic beverages		

How often do you eat meat? [Circle one] Daily 3-5 times week once a week or less

How often do you consume dairy products? [Circle one]

Daily 3-5 times week once a week or less?

What are your favorite foods? _____

How often do you eat them? _____

What foods do you crave, if any? _____

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

_____

Do you avoid certain foods? If so, what are they and why do you avoid them?

_____

_____

Do you experience any symptoms after meals? Explain: _____

_____

Is there anything else about your health that you would like to share with me?

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_____

_____

_____

CLIENT STATEMENT

I understand and acknowledge that the services hereby provided are at all times restricted to consultation on the subject of health matters intended for well-being and optimal health. They are not meant to be a medical diagnoses of any disease or treatment for which a medical license is required. All information will be kept strictly confidential.

Name (Please print): _____Date: _____

Telephone: (Home) _____ (Work) _____

Email: _____Signature_____

Rate the following symptoms (1-3) depending on the severity experienced. Leave blank if the symptoms do not apply. 1 for mild or rarely occuring, 2 for moderate or regularly occuring, 3 for severe or occuring often.

The Digestive System

Underactive Stomach		Overactive Stomach	
Undigested food in stool		Stomach Pain 1 hour after eating or in the evening	
Stomach bloated after eating		Burning sensation in stomach	
Feeling tired or fatigue after eating		Pain aggravated by worry/tension	
Eat when rushed or in a hurry		Hiatal Hernia	
Heavy feeling and sleepy after eating		Gastritis or Gastric Ulcer	
Nausea after taking supplements		Acidity sensation in abdominal area	
Acne		Heartburn, Indigestion	
		Blood in Stool	
		Pain in lower back	
		Long term Aspirin use	

Liver		Pancreas	
Yellow fingernails		Severe abdominal pain	
Oily nose and/or forehead		Nausea and vomiting	
Fats/greasy food causes nausea, headaches		Slow digestion, feel full hours after eating	
Vertical white streaks on fingernails		Fever	
Onions, cabbage, radishes or cucumbers cause gas and bloating		Alcohol addiction	
Bad breath, bad taste in mouth		Jaundice	
Dry, itchy or watery eyes		**Hypoglycemia**	
Excess body odor		Hungry up to 3 hours after eating	
High cholesterol/ High cholesterol diet		Strong, sudden cravings for sweets & starches	
Stiff, aching muscles		Strong, sudden cravings for coffee or colas	
Migraine headaches		Frequent « Midnight Snacks »	
Discomfort under right ribcage		Family history of Diabetes	
Food allergies		Fatigue	

Irritable, easily angered		Frequent headaches	
Weight gain around the abdomen		Fainting spells	
Yellow palms		Depression	
Jaundice		Lose temper easily	
Poor concentration			
Difficulty losing weight			
Acne, boils, rashes, psoriasis or eczema			

Gall Bladder

Gallstones, history of gallstones	
Stool appears clay-coloured, foul odored	
Constipation	
High cholesterol diet	
Pain in right upper abdomen	
High blood cholesterol levels	

The Intestinal System & The Lymphatic/Immune System

Candidiasis **Parasites**

Extreme fatigue		Forgetfulness	
Recurrent vaginal infections		Slow reflexes	
Frequent antibiotic use		Gas and bloating	
White coated tongue, or oral thrush		Unclear thinking	
Crave sugars, bread, alcohol or colas		Loss of appetite	
Headaches		Yellowish or pale face	
Tonsillitis, recurrent strep throat		Fast heartbeat	
Itchy, watery or dry eyes		Heart pain	
Skin flushes, redness or rash		Pain in navel	
Chronic indigestion, use antacids		Eating more than normal but still feeling hungry	
Always cold, especially in extremities		Blurry or unclear vision	
PMS		Pain in the back, thighs or shoulders	
Pain in pelivc area		Numb hands	
Abdominal gas and bloating		Drooling while asleep	
Loss of sex drive		Damp lips at night	
Cystitis, repeated bladder infections		Dry lips during the day	
Increasing food and chemical sensitivities-severe reaction to tobacco, perfume etc….		Grind teeth while asleep	
Endometriosis, Ovarian issues		Bed wetting	
Chronic diarrhea		Lethargy, chronic fatigue	
Hives, psoriasis, acne, skin rashes		Dark cicles under eyes	
Rectal itching		Cancer	
Abnormal muscles aches from exercise		**Thymus (Immunity)**	
Excess wax in ears		Excessive sleep	
Unexpected/Unexplained weight gain		Very susceptible to infections	
Impotence		Swollen glands in tonsils, throat or armpit	
Cancer		History of cancer, MS, arthritis, Parkinson's etc…	
Athlete's foot, finger/toenail fungus		Loss of appetite	

Jock itch		Headaches	
« Brain fog »		Soreness on both sides of neck- shoulder level	
Irritability		Feel puffiness in throat	
Memory loss		Look older than chronological age	
Mental confusion		Flu-like symptoms often occur	
Depression or anger for no reason		Lupus, autoimmune diseases	
Anxiety/panic attacks		Cold sores	
Inability to concentrate		HPV virus	
Phobic/compulsive behaviour		Abnormal Pap smear reading	
Lethargy		Cancer	
Mood swings			
Itchy ears or nose			

The Lymphatic / Immune System & The Glandular / Endocrine System

Allergies

Underactive Thyroid / Hypothyroidism

Acne, psoriasis, dermatitis, eczema		Tired, sluggish or lethargic	
Rapid pulse, heart irregularities		Cold hands and feet	
Frequent headaches		Nodules on thyroid – past or present	
Hay fever, seasonal allergies		Mercury amalgams (fillings)	
Frequent cravings for certain foods		Gain weight easily, fail to lose on diets	
Periods of blurred vision		Constipation, less than 1 bowel movement daily	
Repeated ear trouble		Low energy in the morning	
Hyperactivity		Low blood pressure	
Dizzy spells		Low body temperature	
Periods of confusion		Dry, brittle, dull or lifeless hair	
Poor concentration		Dry, flaky or rough skin	
Epilepsy		Feel stiff after sitting for sometime	
Muscle cramps or spasms		Mood swings	
Excessive sweating, night sweats		Unusually square and wide fingernails	
Bowel disease : IBS, IBD, Crohn's		High cholesterol	
Joint pain or stiffness		Low sex drive	
Frequent night urination		PMS	
Wheezing		**Overactive Thyroid/ Hyperthyroidism**	
Pale face		Weightloss without trying	
Hives		Heart races while at rest	
Runny nose		Feel warm / flushed at room temperature	
Nosebleeds		Hands shake or tremble	
Gas or bloating after meals		Protruding tongue	
Cold or mouth Sores		Heart palpitations	
Dark circles under eyes		Nervous behavior, hyperactivity	
Stuffy nose		Insomnia	
Blood in stool		Increased appetite	
Lower back pain		Frequent bowel movements, diarrhea	
Stiff spine		Excessive sweating	
Mood swings, irritability		**Pituitary**	
Dark circles under eyes or puffy eyes		Infertility or impotence	

Severe fatigue after eating certain foods		Headaches affecting 1 side	
Sinus congestion, pain or infection		Monthly cycle (period) gone	
Hypoglycemia		Moody	
		Overweight from the waist down	
		Overweight from the waist up	
		Excessive urination	
		Pain in little finger of left hand	
		Swelling in ankles, fingers, or feet	
		Cold hands or feet	
		Pain in left side of upper neck	

The Glandular / Endocrine System & The Structural / Muscular / Skeletal System

The Adrenals

Skeletal

Emotional upsets or stress cause exhaustion		Pain, swelling or stiffness in joints	
Blood pressure decreases when going from a lying position to a standing position		Muscles weak, weak grip, light objects feel heavy to lift	
Perspire excessively		Pain, stiffness, inflammation of the spine	
Neck or shoulder tension		Facial pain	
Frequent headaches		Joints make sounds like crinkling cellophane	
Bow lines		Joints make popping sounds	
Cold sweats		Gout	
Panic or anxiety attacks		Joint inflammation, Rheumatoid Arthritis	
Tightness or lump in throat, especially when emotionally disturbed		Cramps in calf muscle during sleep, exercise or otherwise	
High or low blood pressure		Bones fracture easily	
Rapid pulse		Gradual lose of height	
Short temper		Lack of exercise	
Puffy Face		Rounding of shoulders	
Neuromuscular		Menopause	
Muscle wasting in some part of the body		Pain in forearm or biceps	
Numbness or loss of sensation		Cramps in calf muscle during sleep or exercise	
Mood swings or depression		Painful cramping of feet or toes	
Blurred or double vision		Malformation of bones	
Loss of balance or coordination		Insomnia	
Tingling or numbness, especially in extremities		Heart palpitations	
Muscular stiffness		Diet high in animal foods (meat, dairy, eggs)	
Difficulty breathing		**Muscular**	
Impotence		Muscle pain	
Temors		Muscle weakness	
Loss of peripheral vision		Sprains	
Slurred speech		Muscle strains	
Sleep walking or bed wetting		Tendonitis	
Objects fall from hands, reach in wrong place		Muscle (s) spasm	
Hands tremble			