Andrea Bartels, NNCP, RNT Registered Nutritional Therapist
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LIFESTYLE ASSESSMENT FORM

This evaluation is designed to assess symptoms that may relate to nutritional imbalance. Its sole purpose is to educate and inform. It is not designed to diagnose diseases. If you suspect you have a problem that requires the attention of a medical practitioner, please see your physician or naturopath for medical care.

Please bring this completed questionnaire with you, or email it back to me at least 24 hrs. prior to your appointment. All information will be kept strictly confidential.

Name: _____Date: _____

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

Referring practitioner, if any: _____phone#: _____

What are your main health concerns, in order of importance to you personally:

1. _____

2. _____

3. _____

What are you doing for your health presently? [circle all that apply]:

Exercise	Vitamins/Minerals	Massage Therapy	Herbs
Chiropractor	Prescription Medication	Diet	Meditation
Medical Doctor	Relaxation Techniques	Acupuncture	Other:_____

Height: _____ Weight _____

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

Are you being treated for: high blood pressure?_____ high cholesterol? _____

Thyroid problems? _____ diabetes type 1/ type 2 _____

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]:_____

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

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

How many hours a day do you work? _____

What type of work do you do? _____

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

If no, are you often exposed to second-hand smoke? [circle one] Yes No

What do you do for exercise?_____

_____

_____

What are your interests/hobbies? _____

_____

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? If yes, please list: _____

_____

Have you ever been:

_____ Diagnosed with an illness? Explain: _____

_____ Hospitalized? For what reason: _____

How often do you have a bowel movement? _____

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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

Other [Please list]: _____

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

DIETARY PREFERENCES

How many times a day do you eat: _____

What are your favourite 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?

_____

Thank you for your co-operation!

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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 general well-being and are not meant for the purposes of medical diagnoses, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine.

I give permission to Andrea Bartels, NNCP, RNT to communicate with the following health care practitioner about my case:

(Dr.) _____Practitioner type:_____

Contact phone#: _____

Out of consideration for other clients, I will provide 24 hours notice for cancellation of my appointment; otherwise, I may be charged in full for the time slot I reserved.

Today's date: _____

Name (Please print): _____

Address: _____

City: _____Province: _____ Postal Code:_____

Telephone: (Home) _____ (Work) _____

Cellphone :_____

E-mail: _____

Signature: _____

Thank you for your co-operation!