# LIFESTYLE ASSESSMENT FORM

Marja Chow NUTRITION & FITNESS

Name: _____ Occupation: _____Email: _____

Age: _____ Sex: ☐M ☐F Height: _____ Weight: _____ Date: _____ Referral: _____

1. How did you hear about the us?
   ☐Friend ☐Website ☐Instagram ☐Facebook ☐Advertisement ☐Blog
2. Are you a ☐Meat Eater ☐Vegetarian ☐Vegan ☐Other?
3. Do you know how much you currently eat a day?

   _____
4. What are your health concerns/complaints?

   _____

   _____
5. How committed are you in achieving your goals?
   ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
6. Have you ever joined a nutrition program before ? which one?
   ☐Yes ☐No _____
7. List 3 things you liked about your previous program?

   _____

   _____
8. In the next 6 months, what would you like to improve?

   _____
9. Who is included in your support system?
   ☐Spouse ☐Child ☐Parent ☐Sibling ☐No One
10. Are you currently exercising? ☐Yes ☐No If so how often and what type?

    _____
11. What are you hoping to receive from your nutrition program?
    ☐More Energy ☐Gain Muscle ☐Reduce Disease Risk
    ☐Improve Health ☐Lose Weight ☐Hormonal Balance
    ☐Medical Recovery ☐Other
12. Do you purchase ☐Organic or ☐Conventional (Non-Organic) meats and produce or ☐Both?
13. Do you have any food allergies or sensitivities?

    _____
14. Have you had an eating disorder or do you currently have one?

    _____

**MARJA CHOW RHN**
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15. How often do you dine out? ☐Rarely ☐1 per week ☐2-3 per week ☐More than 3
16. How often do you eat fast food? ☐Rarely ☐1 per week ☐2-3 per week ☐More than 3
17. Do you sleep through the night on a regular basis? ☐Yes ☐No If no, why?

_____

18. Do you wake-up feeling rested? ☐Yes ☐No
19. On a scale of 1(low) to 10(high) how would you rate your current stress?
20. What Factors are causing you the most stress?

_____

21. Please check any of the following digestive symptoms you experience:

☐Heart Burn ☐Acid Reflex ☐Burping ☐Gas ☐Constipation ☐Diarrhea

22. How many daily bowel movements you have: ☐ 0 ☐1-2 ☐ 3-4
23. Please check any of the following symptoms you experience:

☐Headaches ☐Migraine ☐PMS ☐Hot Flashes ☐Aches/Pains ☐Eczema ☐Frequent Colds ☐Dry Skin

☐Brittle Hair ☐Seasonal Allergies ☐Mental Fog ☐Energy High's and Low's

24. Medical History : Please check all that apply

☐Diabetes ☐Cholesterol ☐High Blood Pressure ☐Depression ☐Osteoporosis ☐Arthritis ☐Cancer Type

25. Please list all Prescription Medications:

_____

_____

26. Please list all supplements:

_____

_____

27. Do you Smoke? ☐Yes ☐No
28. Do you practice Yoga or Meditation? ☐Yes ☐No
29. What has stopped you in the past from reaching your nutrition/fitness goals?

_____

_____

Statement of Consent:

I understand that the nutritional services provided are, at all restricted to consultation on the subject of health and nutrition intended for general well being and are not meant for the medical diagnosis, treatment or prescribing medicine for any disease. I understand and take the responsibility for my own wellbeing as it relates to my nutritional program.

Signature: _____ Date: _____