Focus Health with Susie Ponici, R.H.N. 250-300-5423 susieponici.com

Lifestyle and Nutritional Assessment

Name:_____

Date:_____ **Age:**_____ **Height:**_____ **Weight:**_____

Birthdate:_____

Phone #:_____

Email:_____

Occupation:_____

MEDICAL/PERSONAL HISTORY:

What is your purpose for seeking nutritional support?

_____

What are your most prominent health concerns?

_____

Have you experienced any major trauma in the past 5 years? (physical, emotional, mental, spiritual)

_____

Have you ever been diagnosed with an aliment or chronic disorder related to your health concerns?

_____

Have you been hospitalized and if so, for what reason?

_____

On a scale of 1-10 (1=low, 10=high) what is your stress level? _____

Circle main stress areas: Health, Financial, Work, Relationships, Spiritual, Personal, Family, Other…

How does your stress manifest itself?_____

Do you have any coping mechanisms?_____

In what ways do you currently address your health concerns? Please provide details:

Medical: _____

Naturopathic: _____

Chiropractic: _____

Chinese Medicine: _____

Diet: _____

Exercise: _____

Supplements: _____

Other:_____

Do you use any of the following?

Laxatives_____Diuretics_____Sleeping Pills_____Antacids_____Pain Killers_____

Antibiotics_____Birth Control_____Other Prescription Pills_____Alcohol_____

Please list any vitamins, minerals, herbal or homeopathic remedies you are currently taking including brand/dose.

_____
_____
_____
_____

Do you wish to GAIN or LOSE weight? How much?_____

How many hours on average do you spend daily:

Driving_____Watching TV_____Computers/Cell Phone_____Working_____Meditating_____

What do you do for exercise? (Indicate type/ frequency/duration)

_____

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

How many hours on average do you sleep each night?_____

Do you have trouble falling/staying asleep?_____Do you awake rested?_____

Do (did) you smoke?___Do you have mercury amalgams?___How many, how long?_____

Have you had surgery to remove: Gall Bladder?_____Appendix?_____Tonsils?_____Thyroid?_____

Do you have anaphylaxis (life-threatening allergy)? Explain:_____

Do you have any food/seasonal allergies or sensitivities? Explain:_____

FEMALES:

Do you suffer from PMS symptoms? Explain:_____

Are you experiencing menopausal symptoms? Explain:_____

Have you had a Bone Density test? If yes, what were the results?_____

GENERAL DIGESTIVE HEALTH:

How often do you have a bowel movement in a day?_____

Diarrhea?_____Constipation?_____Undigested food in stool?_____Gas?_____Bloating?_____

DIETARY HABITS:

How many times a day do you eat: Main meals?_____Snacks?_____

Do you feel there are restrictions to your diet due to:

Expense?___Roomates?___Family?___Convenience?___Taste?___Fat?___Sugar?___Salt?___

Other? Explain_____

Are you a: Meat eater?___Vegetarian?___Vegan?___Pescetarian?___Other_____

Where do you do the majority of your grocery shopping?_____

What foods do you crave frequently? Why?_____

Please indicate the following foods/items used in your diet:

0 = NEVER, 1 = RARELY, 2 = OCCASIONALLY, 3 = FREQUENTLY

___Organic fruits and vegetables

___Conventional (non-organic) fruits and vegetables

___Organic free-range meats (chicken, turkey, beef, wild game, etc)

___Processed meat (sausage, lunch meats, hot dogs, including non-organic meat)

___Commercial dairy (butter, cream, yogurt, milk)

___Whole grains (quinoa, spelt, amaranth, sprouted grains, millet, kamut, wild/brown rice)

___Wild fish

___Cold-pressed, unrefined oils (olive, hemp, flax, coconut, avocado)

___Margarine

___Fast foods

___Refined foods (white flour, white pasta, white bread, baked goods)

___Deep fried foods

___Sugary foods (candy, chocolate, concentrated fruit juice, white/brown sugar, glucose)

___Artificial sweeteners (aspartame, nutri-sweet, equal, splenda)

___Microwave foods

___Aluminum Pans/Teflon

Please indicate how many cups (8oz) of the following you drink per day:

pure filtered/ water___ tap water___ fresh fruit juices___ prepared fruit juices___

soft drinks (regular/diet___ fresh vegetable juices___ milk (skim, 1%, 2%)___herbal tea___

black tea_____ coffee_____ beer_____ red wine_____ white wine_____ other alcohol_____

Provide examples of your typical meals:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Do you eat meals: with family?_____ on the run?_____ at restaurants?_____ home alone?_____

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

Do you experience any symptoms after meals? Explain:_____

NUTRITIONAL AND LIFESTYLE COACHING:

Nutritional support is intended to raise awareness as well as enhance your dietary options as it relates to your lifestyle. I, Susie Ponici, R.H.N., do not provide a diagnosis or medical advice. Any nutritional support offered in each session may become part of an integrated approach to healing, while client continues to seek medical attention from other licensed or registered practitioners.

CLIENT STATEMENT:

I understand and acknowledge that the nutritional services provided are, at all times, restricted to consultation on the subject of health and nutrition intended for general well-being and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease. I undertake full responsibility for my own well-being as it relates to these session.

CANCELLATION POLICY:

As a sign of courtesy to my clients and business, please ensure a 48 hour cancellation prior to your scheduled appointment.

Signature:_____

Date: _____