SOMERSET HEALTH & WELLNESS CENTRE

190 Somerset St. W, Suite 210
Ottawa, ON• K2P 0J4
Phone: 613.656.9629 Fax: 1.888.530.4093
stephanie@ottawanaturopathic.ca

Stephanie Kay NUTRITION

LIFESTYLE ASSESMENT FORM

Name: _____ Date:_____

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

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

_____

_____

Have you experienced any major trauma in the past 5 years? If, so what?

_____

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

How does your stress manifest itself? Do you use any coping mechanisms?

_____

_____

What do you do for exercise? (Type, frequency, time of day & duration)

_____

_____

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

How many hours on average do you sleep daily? _____

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 ☐ How many hours each day do you work? _____

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

How many hours do you spend daily, on average:

Driving _____ Watching TV _____ Reading _____ In front of computer _____

What are your interests and hobbies? _____

When was your last vacation? _____

MEDICAL HISTORY:

Are you currently taking any medication? Yes ☐ No ☐

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

_____

_____

Do you have any allergies or sensitivities? Yes ☐ No ☐

If so, please list: _____

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Family history:

Hereditary diseases _____

Health of relatives:

Father: _____ Mother: _____

Siblings: _____

Have you ever been hospitalized? Yes ☐ No ☐

If yes, what was the reason? _____

How often do you have a bowel movement? _____

Do you strain to have a bowel movement? Yes ☐ No ☐ Occasionally ☐

Do you have loose bowel movements? Yes ☐ No ☐ Occasionally ☐

Is there undigested food in your stools? Yes ☐ No ☐ Occasionally ☐

DIETARY HABITS:

How many times a day do you eat:

Main Meals _____ Times of day: _____

Snacks _____ Times of day: _____

Circle if you eat, drink or use (even occasionally):

Alcohol	Distilled water	Sugar substitutes
Candy	Fried foods	Chewing gum
Luncheon meats	Carbonated beverages	Fast foods
White flour	Margarine	Vitamins/minerals
Chocolate	Potato chips	Refined sugars
Spring water	Aluminum pans	Microwave oven

How many cups/bottles/glasses do you drink, on average, per day?

_____ Coffee	_____ Soft drinks *(regular)*	_____ Milk *(1% or 2%)*
_____ Tea	_____ Soft drinks *(diet)*	_____ Milk *(skim)*
_____ Herbal Tea	_____ Fresh fruit juices	_____ Beer
_____ Tap Water	_____ Fruit juices *(prepared)*	_____ Wine
_____ Bottled water	_____ Fresh vegetable juices	_____ Liquor

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? _____

_____

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

_____

All of the information provided will be kept confidential.

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LIABILITY & CONSENT FORM

STATEMENT OF INTENT

I, Stephanie Kay, am a Registered Holistic Nutritionist (R.H.N.). As an R.H.N., I work to identify client's nutritional imbalances and lifestyle habits, and provide recommendations to support client's health goals. I work to create an individualized wellness programs which includes whole foods, nutrient-dense foods, menu plans, natural source supplements and lifestyle modifications. I am not a physician; I do not diagnose or treat disease.

My services in nutrition are complementary to those of other health care professionals. If you ever have any concerns about the nature of my services or our work together, please contact me right away. I also recommend that you inform your medical doctor that you are receiving holistic nutrition recommendations.

CLIENT INFORMED CONSENT

I, _____, the client, understand and acknowledge that these recommendations are restricted to consultation on the subject of health matters intended for general well-being, and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or for the purpose of performing a licensed or controlled act which may constitute the practice of medicine.

The nutrition advice given by Stephanie Kay is solely based on the information provided by the client. The nutrition information given is meant only for the client completing the nutrition questionnaire from. It is the sole responsibility of the client to provide complete and accurate information. Any misinformation, inaccurate or omitted information may affect the nutrition assessment and/or advice.

I, the client, certify that I am here solely on my own behalf, and that this statement is being signed voluntarily.

_____ _____

Client Signature Date

Name: (please print) _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Phone: (H) _____ (M) _____Email: _____

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Name: _____ Date: _____ Assesment #: ____

PLEASE COMPLETE THE FOLLOWING SUBQUESTIONNAIRES USING THE SAME RATING SYSTEM
(0) never (1) mild or rare (2) moderate or regularly (3) severe or often

			RIGHT SIDE FOR OFFICE USE ONLY	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 2+ cups or coffee/day							■					
7	Bad breath/body odour			■		■	■	■			■	■	■
8	Constipation			■		■	■	■	■	■		■	■
9	Bags under eyes			■	■	■	■				■	■	■
10	Craves sugar, bread, alcohol					■			■	■	■	■	
11	Difficulty digesting certain foods				■	■	■		■	■	■	■	■
12	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 prodcuts				■		■	■			■		
19	Heavy alcohol consumption				■	■		■	■	■	■		■
20	Exposure to toxins/chemicals			■	■	■	■				■	■	
21	Frequent mood swings			■	■	■		■	■	■	■	■	
22	Depressed and/or irritable			■	■	■		■	■	■		■	
23	Brittle nails				■	■	■	■	■	■	■		■
24	Dry, brittle hair, split ends			■	■	■	■	■	■	■			■
25	High fat/high cholesterol diet				■		■	■	■		■	■	
26	Nervous/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/etc			■	■	■	■	■		■	■	■	■
33	Cellulite				■	■	■		■	■	■	■	■
34	Cold hands and feet			■	■		■	■	■	■		■	■
35	Varicose veins			■			■	■	■	■	■	■	■
36	Feeling out of control			■	■	■		■	■	■		■	■
37	Food/chemical sensitivities					■	■			■	■	■	■
SUBTOTALS													

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				1	2	3	4	5	6	7	8	9	10
SUBTOTALS													
38	Frequent yeast/fungus problems		RIGHT SIDE FOR OFFICE USE ONLY										
39	Bones break easily/osteoporosis												
40	Too little exercise												
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 or hard bowel movements												
47	Alternating constipation/diarrhea												
48	Recurrent bladder infections												
49	Female: menopause, hot flashes												
50	Female: PMS												
51	Difficult urination												
52	Slowllen glands, puffy throat												
53	Lower abdominal pain												
54	Frequent need to urinate												
55	Joint pain												
56	Sinus inflammation/discharge												
57	Arthritis												
58	Sudden weight loss/gain												
59	Headaches/migraines												
60	Female: Birth Control Pills												
61	Lower back pains												
62	Dry, flaky skin												
63	Less than 6 glasses of fluid/day												
64	Water retention												
65	Low sex drive												
66	Feeling heavy/bloated after meals												
67	Chronic cough												
TOTALS													

FOR OFFICE USE ONLY

SYSTEMS RATINGS

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

Comments:

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PART 1

Section A

Excessive gas, belching or burping after meals	0	1	2	3
Stomach bloated after eating	0	1	2	3
Sleepy after eating	0	1	2	3
Longitudinal striations on fingernails	0	1	2	3
Eat when rushed/in a hurry	0	1	2	3
Halitosis	0	1	2	3
Full feeling after heavy meat meal	0	1	2	3
Heavy, tired feeling after eating	0	1	2	3
Nausea after taking supplements	0	1	2	3
Acne	0	1	2	3
Undigested food in the stool	0	1	2	3
Total				

Section B

Stomach pain 1 hour after eating or at night	0	1	2	3
Burning sensation in stomach	0	1	2	3
Pain aggravated by worry / tension	0	1	2	3
Hiatal hernia	0	1	2	3
Gastritis, gastric ulcer	0	1	2	3
Nausea, vomiting	0	1	2	3
Sensation of acidity in abdominal area	0	1	2	3
Heartburn, indigestion	0	1	2	3
Blood in stool	0	1	2	3
Lower back pain	0	1	2	3
Long term aspirin use	0	1	2	3
Total				

Section C

Yellow or pale fingernails	0	1	2	3
Skin oily on nose and forehead	0	1	2	3
Fats/greasy foods cause nausea, headaches	0	1	2	3
Vertical white streaks on fingernails	0	1	2	3
Onions, cabbage, radishes, cucumbers cause b	0	1	2	3
Bad breath; bad taste in mouth	0	1	2	3
Excess body odour	0	1	2	3
High cholesterol / high cholesterol diet	0	1	2	3
Stiff, aching muscles	0	1	2	3
Migraine headaches	0	1	2	3
Discomfort underneath right ribcage	0	1	2	3
Food allergies	0	1	2	3
Irritable, easily angered	0	1	2	3
Weight gain around the abdomen	0	1	2	3
Yellow palms	0	1	2	3
Jaundice	0	1	2	3
Poor concentration	0	1	2	3
Difficulty losing weight	0	1	2	3
Acne, boils, rashes, psoriasis or eczema	0	1	2	3
Constipation	0	1	2	3
Total				

Section D

Severe abdominal pain	0	1	2	3
Nausea and vomiting	0	1	2	3
Slow digestion; feel full for hours after eating	0	1	2	3
Fever	0	1	2	3
Alcohol addiction	0	1	2	3
Jaundice	0	1	2	3
Total				

Section E

Gall stones; history of gall stones	0	1	2	3
Stool appears clay-coloured, foul odoured	0	1	2	3
Constipation	0	1	2	3
High cholesterol diet;	0	1	2	3
High blood cholesterol levels	0	1	2	3
Severe pain in right upper abdomen	0	1	2	3
Total				

Section F

Hungry up to 3 hours after eating	0	1	2	3
Strong, sudden cravings for sweets, starches cc	0	1	2	3
Nervous/anxious feelings relieved by eating	0	1	2	3
Irritable if late for, or skip, a meal	0	1	2	3
Overweight	0	1	2	3
Addicted to coffee with sugar and/or colas	0	1	2	3
Frequent "midnight snacks"	0	1	2	3
Family history of diabetes	0	1	2	3
Fatigue	0	1	2	3
Frequent headaches	0	1	2	3
Fainting spells	0	1	2	3
Depression	0	1	2	3
Lose temper easily	0	1	2	3
Total				

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PART 2

Section A		**Section B**	
Extreme fatigue	0 1 2 3	Forgetfulness	0 1 2 3
Recurrent vaginal infections	0 1 2 3	Slow reflexes	0 1 2 3
Frequent use of antibiotics	0 1 2 3	Gas and bloating	0 1 2 3
White coated tongue, oral thrush	0 1 2 3	Unclear thinking	0 1 2 3
Crave sugars, bread, alcohol	0 1 2 3	Loss of appetite	0 1 2 3
Headaches	0 1 2 3	Yellowish or pale face	0 1 2 3
Tonsillitis, recurrent strep throat	0 1 2 3	Fast heartbeat	0 1 2 3
Itchy, watery or dry eyes	0 1 2 3	Heart pain	0 1 2 3
Skin flushes	0 1 2 3	Pain in navel	0 1 2 3
Chronic indigestion, frequently use antacids	0 1 2 3	Eating more than normal but still feeling hungry	0 1 2 3
Always cold, especially in extremities	0 1 2 3	Blurry or unclear vision	0 1 2 3
F: PMS	0 1 2 3	Pain in the back, thighs, shoulders	0 1 2 3
Pain in pelvic area	0 1 2 3	Numb hands	0 1 2 3
Abdominal gas and bloating	0 1 2 3	Drooling while sleeping	0 1 2 3
Loss of sex drive	0 1 2 3	Damp lips at night	0 1 2 3
Cystitis, repeated bladder infection	0 1 2 3	Dry lips during the day	0 1 2 3
Increasing food and chemical sensitivities	0 1 2 3	Grind teeth while asleep	0 1 2 3
F: endometriosis / ovary problems	0 1 2 3	Bedwetting	0 1 2 3
Chronic diarrhea	0 1 2 3	Lethargy; chronic fatigue	0 1 2 3
Hives, psoriasis, acne, skin rashes	0 1 2 3	Dark circles under eyes	0 1 2 3
Rectal itching	0 1 2 3	Cancer	0 1 2 3
Abnormal muscle aches from exercise	0 1 2 3	Total	_____
Excessive wax in ears	0 1 2 3		
Unexpected / unexplained weight gain	0 1 2 3		
Impotence	0 1 2 3		
Canker sores	0 1 2 3		
Athlete's foot, finger / toenail fungus, ringworm	0 1 2 3		
Jock itch	0 1 2 3		
"Brain fog"	0 1 2 3		
Irritability	0 1 2 3		
Memory loss	0 1 2 3		
Mental confusion	0 1 2 3		
Depression or anger for no reason	0 1 2 3		
Anxiety / panic attacks	0 1 2 3		
Inability to concentrate	0 1 2 3		
Phobic / compulsive	0 1 2 3		
Lethargy	0 1 2 3		
Mood swings	0 1 2 3		
Itchy ears, nose, anus	0 1 2 3		
Total	_____		

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PART 5

Section A

Excessive sleep	0 1 2 3
Very susceptible to infections	0 1 2 3
Swollen glands: tonsils, throat, armpits	0 1 2 3
History of cancer, MS, Parkinson's arthritis	0 1 2 3
Loss of appetite	0 1 2 3
Headaches	0 1 2 3
Soreness on both sides of neck at shoulder	0 1 2 3
Feel puffiness in throat	0 1 2 3
Look older than chronological age	0 1 2 3
Flu-like symptoms often occur	0 1 2 3
Lupus	0 1 2 3
Total	_____

Section B

Acne, psoriasis, dermatitis, eczema	0 1 2 3
Rapid pulse, heart irregularities	0 1 2 3
Frequent headaches	0 1 2 3
Hay fever	0 1 2 3
Frequent cravings for certain foods	0 1 2 3
Periods of blurred vision	0 1 2 3
Repeated ear trouble	0 1 2 3
Hyperactivity	0 1 2 3
Dizzy spells	0 1 2 3
Periods of confusion	0 1 2 3
Poor concentration	0 1 2 3
Epilepsy	0 1 2 3
Muscle cramps or spasms	0 1 2 3
Abnormal body odour	0 1 2 3
Excessive sweating, night sweats	0 1 2 3
Bowel disease: IBS, IBD, Crohn's, etc.	0 1 2 3
Joint pains or stiffness	0 1 2 3
Frequent night urination	0 1 2 3
Wheezing	0 1 2 3
Pale face	0 1 2 3
Hives	0 1 2 3
Nose runs constantly	0 1 2 3
Noticeable changes in writing throughout day	0 1 2 3
Nosebleeds	0 1 2 3
Bloating or gas after eating certain foods	0 1 2 3
Canker sores	0 1 2 3
Dark circles under eyes	0 1 2 3
Stuffy nose	0 1 2 3
Total	_____

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PART 8

Section A

Distinct, lethargic tiredness or sluggishness	0	1	2	3
Cold hands or feet	0	1	2	3
Mercury amalgams (fillings)	0	1	2	3
Gain weight easily, fail to lose on diets	0	1	2	3
Constipation, less than one bowel movement a	0	1	2	3
Low energy in the morning	0	1	2	3
Low pulse rate	0	1	2	3
Low body temperature, especially at bed rest	0	1	2	3
Hair dry, brittle, dull, lifeless	0	1	2	3
Flaky, dry rough skin	0	1	2	3
Feel stiff after sitting still for some time	0	1	2	3
Mood swings	0	1	2	3
Unusually square and wide fingernails	0	1	2	3
High cholesterol	0	1	2	3
Diminished sex drive	0	1	2	3
Total				

Section B

Losing weight without trying	0	1	2	3
Heart races while at rest	0	1	2	3
Feel warm / flushed at room temperature	0	1	2	3
Hands shake or tremble	0	1	2	3
Protruding tongue	0	1	2	3
Heart palpitations	0	1	2	3
Nervous behaviour, hyperactivity	0	1	2	3
Insomnia	0	1	2	3
Increased appetite	0	1	2	3
Frequent bowel movements, diarrhea	0	1	2	3
Excessive sweating without exercising	0	1	2	3
Total				

Section C

Infertility or impotence	0	1	2	3
Headaches affecting one side of head	0	1	2	3
F: loss of menstrual function	0	1	2	3
Moody	0	1	2	3
Overweight from waist down	0	1	2	3
Overweight from waist up	0	1	2	3
Excessive urination	0	1	2	3
Pain in little finger of left hand	0	1	2	3
Swelling in ankles, fingers, feet	0	1	2	3
Cold hands or feet	0	1	2	3
Pain in left side of upper neck	0	1	2	3
Total				

Section D

Stress or emotional upsets cause exhaustion	0	1	2	3
Blood pressure decreases- lying to standing	0	1	2	3
Perspire excessively	0	1	2	3
Neck and/or shoulder tension	0	1	2	3
Frequent headaches	0	1	2	3
Bow lines (depressed furrows) on fingernails	0	1	2	3
Occasional cold sweats	0	1	2	3
Tightness or lump in throat	0	1	2	3
High or low blood pressure	0	1	2	3
Rapid pulse	0	1	2	3
Short temper	0	1	2	3
Puffy face	0	1	2	3
Total				

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PART 9

Section A

Pain, swelling, stiffness in joints	0	1	2	3
Joint inflammation (rheumatoid arthritis)	0	1	2	3
Pain, stiffness, inflammation of spine	0	1	2	3
Facial pain	0	1	2	3
Joints make popping sounds	0	1	2	3
Gout	0	1	2	3
Joints make sounds like crinkling cellophane	0	1	2	3
Ankylosing spondylitis	0	1	2	3
Bones fracture easily	0	1	2	3
Gradual loss of height	0	1	2	3
Tooth loss; teeth "falling out"	0	1	2	3
Lack of exercise	0	1	2	3
Rounding of shoulders; stooping	0	1	2	3
F: Menopause	0	1	2	3
Pain in forearm or biceps	0	1	2	3
Cramps in calf muscle during sleep or exercise	0	1	2	3
Painful cramping of feet or toes	0	1	2	3
Teeth prone to decay, frequent toothaches	0	1	2	3
Malformation of bones	0	1	2	3
Insomnia	0	1	2	3
Muscles weak, weak grip, light objects feel heav	0	1	2	3
Heart palpitations	0	1	2	3
Diet high in animal foods (meat, dairy, eggs)	0	1	2	3
Total				

Section B

Muscle pain	0	1	2	3
Muscle weakness	0	1	2	3
Sprains; muscle strains	0	1	2	3
Muscle(s) spasm	0	1	2	3
Total				

Section C

Muscles wasting in some part of the body	0	1	2	3
Numbness or loss of sensation	0	1	2	3
Mood swings and/or depression	0	1	2	3
Blurred or double vision	0	1	2	3
Tingling and/or numbness, especially in	0	1	2	3
extremities	0	1	2	3
Muscular stiffness	0	1	2	3
Difficulty breathing	0	1	2	3
M: impotence	0	1	2	3
Tremors	0	1	2	3
Loss of peripheral vision	0	1	2	3
Slurred speech	0	1	2	3
Objects fall from hands, reach in wrong place	0	1	2	3
Hands tremble	0	1	2	3
Impaired speech	0	1	2	3
Total				

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FOOD LOG

NAME: _____ DATE: _____

DAY	BREAKFAST	LUNCH	DINNER	SNACK(S)
MONDAY				
TUESDAY				
WEDNESDAY				
THURSDAY				
FRIDAY				
SATURDAY				
SUNDAY				