LIFESTYLE FORM

NAME: _____

Preferred method of contact:

PHONE: _____

Email __ Phone call __ Text ___

EMAIL: _____

DATE OF EVALUATION: _____

Basic Session | Meal plan & Supplements only **($99)**

LET'S GET TO KNOW YOU:

Do you take any medications? ***Please also list any medical conditions here***

_____
_____
_____
_____
_____

Do you have any allergies?

_____
_____
_____
_____
_____

Do you take any vitamins or supplements? ***Please list the brand and amount taken daily.***

_____
_____
_____
_____
_____

How often do you exercise? This includes walking!

_____
_____
_____
_____
_____

How often do you get sunlight exposure?

_____
_____
_____
_____
_____

How much water do you drink daily?

_____
_____
_____

Do you drink soda or juice? If yes, how much and how often of each?

_____
_____
_____
_____
_____

Do you drink coffee or tea? If yes, how much and how often of each?

_____
_____
_____
_____
_____

Do you drink alcohol? If yes, how much and how often?

_____
_____
_____
_____

Do you smoke cigarettes? If yes, how often?

_____
_____
_____
_____
_____

Do you use any candles / plug ins / air fresheners / room sprays? If yes, how often?

_____
_____

Do you use cleaning products? If yes, how often and what kind?

_____
_____
_____

Do you smoke Marijuana / Hookah / Vape pens? If yes, how often?

_____
_____
_____
_____
_____

How do you feel when you wake up in the morning?

_____
_____
_____
_____
_____
_____

What are your energy levels like throughout the day?

_____
_____
_____
_____

Do you get headaches? ***Please describe how often & how intense they are.***

_____
_____
_____
_____
_____

Do you feel sluggish/ tired / fatigued often? ***Please describe how often & what part of the body.***

_____
_____
_____
_____
_____

Do you eat vegetables? If yes, how often? ***(Please also list any vegetables you dislike)***

_____
_____
_____
_____
_____

Do you eat fruit? If yes, how often? ***(Please also list any fruit you dislike)***

_____
_____
_____
_____

Do you eat meat? If yes, how often?

_____
_____
_____
_____
_____

Do you eat dairy? If yes, how often?

_____
_____
_____
_____
_____

Do you have any specific health goals?

_____
_____
_____
_____
_____

Do you air out your house? ***(open windows or have an air purifier)***

_____
_____
_____
_____

How many meals do you eat a day?

How many snacks do you eat a day? What is an average snack for you?

Do you eat sugar / sweets? If yes, how often?

Do you have access to a blender or juicer?

Do you use electronics? How often?

How well do you sleep at night? How many hours of sleep do you get each night?

_____
_____
_____
_____
_____

How often do you eat out?

_____
_____
_____
_____
_____

Are you interested in meal prepping?

_____
_____
_____

Are you interested in learning about meditation?

_____
_____
_____

Do you have any past (or present) emotional or physical trauma?

Yes _____ *No* _____

Do you know how to express emotions in a healthy way?

Yes _____ *No* _____

Special requests / accommodations / notes:

_____
_____
_____

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NAME (print): _____

NAME (sign): _____

DATE: _____

(Office use only)

Date received: _____

Payment received: Yes ___ **No** ____ **Amount:** _____

Signature: _____