Daily Life-style Evaluation Form

(Print and fill in this form and bring it to your consultation, also attach a recent photograph of yourself)

NAME (please give full name) _____

NICKNAME (Or the name you prefer to be addressed by): _____

DATE_____ D.O.B: _____(compulsory)

TEL_____ MOBILE_____

E-MAIL_____ OCCUPATION:_____

ADDRESS_____

MARITAL STATUS_____ HEIGHT_____(compulsory)

WEIGHT_____ (compulsory) SEX_____ (compulsory)

PRESENT MEDICAL HISTORY / MEDICAL TEST REPORTS / X-RAY ETC
(Please attach copies of any recent medical reports)

MEDICATION, PRESENT:

Patient Information Form

The following questions will greatly assist in our being able to correctly identify your imbalances. Please circle the option that best describes you and give detail where required.

1. Bowel Movements

Do you move your bowels daily?	Yes	/	No			
Is your bowel movement roughly at the same time of day?	Yes	/	No			
When?	Morning			Afternoon		Evening
Would you say you are constipated?	Yes	/	No			
Do you have Diarrhea	Yes	/	No			
Do your stools:	float	/	sink			

Have you observed the color?

Could you describe the odor?

2. Appetite

How many meals do you have daily	1	2	3	4

Which is your main meal?

When do you get hungry?

Do you eat most meals at:	home	out

What are the foods you eat regularly?

What time do you eat your last meal (usually)?

3. Sleep

How many hours sleep do you get a night?

Do you	dream	have nightmares	
How would you say you sleep? ……..			
Do you wake in the night to go to the toilet?		Yes	No
Do you wake up feeling -	fresh	tired	still sleepy

What time do you go to sleep?

4. Periods/ reproductive information

Is your monthly period regular? Yes / No

Do you suffer any P.M.S? ……..

If so briefly state how this affects you… …….

Are you sexually active Yes / No

5. Exercise

What kind of exercise or games do you participate in?

……
How often do you exercise?

……

6. Emotional state

What words would you use to describe your current state of mind?

What words would you use to describe your emotions?

7. Fluid intake

How many glasses of water do you drink in the day?

Do you wake in the night to drink water? Yes / No

8. Physical Pains

Are you suffering form aches or pains in any part of your anatomy? If so state where

9. Nature of work

How active are in your job? Describe briefly if you interact with others if you sit or are on the move all day etc…

10. Travel

Do you have to travel as part of your work Yes / No Often

Do you travel a lot for holidays Yes / No