Adult Assessment Form

Name: ______________________
Address: ______________________
Email: ______________________
Phone: ______________________
Date of Birth: ______________________
Height/Weight: ______________________
Marital Status: ______________________
Children/Ages: ______________________

Personal and Family Medical History

_______ Arthritis
_______ Autoimmune Disorders
_______ Cancer
_______ Heart Disease
_______ High Blood Pressure
_______ High Cholesterol
_______ Immune Compromise
_______ Neurological Deterioration (Ex. Alzheimer's, ALS, MS Parkinson's, Huntington's, Organic Brain Syndrome)
_______ Obesity

If you checked any of the above, please explain:

____
____

Current Medications: ______________________
____

Supplements: ______________________
____

Allergies to Medications: ______________________
____

General Assessment

How healthy do you feel? (check)

1	2	3	4	5	6	7	8	9	10

Not Very ... Very

Please explain: ______________________

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Do you smoke cigarettes?	
If yes, how many per day?	
How many alcoholic beverages do you consume weekly? (circle)	0-2 3-6 7-10 More than 10
Rate your daily energy level: (check)	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Low … High

Fitness and Exercise

How many times per week do you exercise?	
Describe your current exercise routine:	
Describe your ideal exercise routine:	
What is your ideal realistic weight?	
Do you know your target heart rate?	
Do you have a personal fitness trainer?	

Nutrition

Describe your overall nutritional status: (check)	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Don't ask … Great
How many glasses of water do you drink each day? (circle)	0-2 3-6 7-10 More than 10
How many servings of raw vegetables do you eat daily? (circle)	0-1 2-3 3-4 5 or more
How many servings of raw fruits do you eat daily? (circle)	0-1 2-3 3-4 5 or more
How many fast food meals do you each per week? (circle)	0-1 2-3 3-4 5 or more
Do you eat breakfast everyday?	
Do you crave sweets?	
How many servings of caffeine do you	

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consume daily?
Do you have any known food allergies?
Do you experience heartburn?
Do you think you would benefit from taking nutritional supplements?
If yes, please explain:

Do you know what free radicals are?

Stress Management

How stressful is your lifestyle? (check)

1	2	3	4	5	6	7	8	9	10
No stress						Very stressful			

Please explain:

Are you happy? (check)

1	2	3	4	5	6	7	8	9	10
Not at all							Very happy		

Please explain:

Do you know how to relax on demand?
How do you relax?

Do you know how to turn off your mind chatter?
Are you mindful?
Are you more punctual or tardy?
Do you lose your car keys?

What symptoms do you experience under tremendous amounts of stress?

Do you feel you are in control of your life?

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Why?

____

____

Are you prone to depression? ______________________
If yes, how do you treat it? ______________________

Sleep Hygiene

How many hours of sleep do you need each night to feel rested? __________
How many hours of sleep do you actually get each night? __________
Do you awaken in the morning feeling tired? __________
Do you experience insomnia? __________
If you experience insomnia, what puts you to sleep, if anything? __________
Do you take sleeping pills? ______________________

Spirituality

Do you consider yourself a spiritual person? ______________________
Do you consider yourself a religious person? ______________________
Do you have purpose in your life? ______________________
Please explain:

____

____

____

Do you feel connected to your community? ______________________
Do you feel a connection to the Earth? ______________________
Do you believe in a higher power? ______________________
Please explain:

____

____

____

List 3 things you like about yourself: ______________________

____

____

List 3 things you like about your life: ______________________

____

____

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If you could change 3 things about yourself or your life, what would they be?

____

____

____

Complementary Healthcare

Do you receive any of the following complementary healthcare practices?

____ Acupuncture	____ Hyperbaric oxygen	___ Reflexology
____ Chelation therapy	____ Massage therapy	___ Reiki
____ Chiropractics	____ Naturopathy	___ Other, please list:
____ Enhanced external cardiac pacing	____ Polarity therapy	________________________
____ Homeopathy	____ Psychotherapy	________________________

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