

# LIFESTYLE ASSESSMENT

## Daily Routines

### Morning:

1. I wake up at:

4-5:30 6-7:30 8-8:30 9-10:30. (other)

2. My usual morning routine includes?

3. My usual breakfast choices include:

3. Typical exercise include length of time practiced & days per week

4. How many cups of caffeinated beverages do you drink per day?

5. Type(s) of caffeinated beverage: Coffee/Tea/Soda/Energy Drinks/Other

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**6. How many ounces of Water do you drink per day?**

**7. Do you consume alcohol? Y/N ? Preference: Wine, beer, spirits?**

**8. Lunch: Typical food/Time eaten**

**9. How do you feel after you've eaten?**

**10. Typical food/snacks between lunch & dinner or state if no snacks**

# LIFESTYLE ASSESSMENT

## Daily Routines

**11. Typical Dinner Time?**

**12. Typical food choices**

**13. Do you generally eat:  
At the table/table with TV/Couch in front of TV/Standing up/on the run?**

**14. Typical foods/snacks/drinks between dinner & bedtime**

**9. How do you feel after you've eaten? EG: satisfied, bloated, tired?**

**10. Add anything you would like to include?**

# LIFESTYLE ASSESSMENT

## Evening Activities

**11 What books are you currently reading?**

**Spiritual, Mystery, Sci fi, Action, Self Improvement, other: Not a typical reader.**

**12. When do you read? Day/Evening?(please specify)**

**13. Computer time: AM and PM about how long? Length of time:**

**14. Typical Bed time:**

**15. Sleep patterns:**

**Wake between 12-2am/ 2-4am /sleep soundly all night long/ no sleep issues**

# LIFESTYLE ASSESSMENT

## *Digestion & Elimination*

### OVER THE PAST FEW WEEKS

**16. Do you have digestive issues?  
Gas, Bloating, heartburn, other?**

**17. Do you have a regular bowel movement each day? How many?**

**18. BM are typically in Morning/evening?**

**19. How many times do you urinate each day/night? No guessing.  
Please take a couple of days to fully observe. Specify if night urination an issue.**

**Additional Information:**

# LIFESTYLE ASSESSMENT

## Stress Levels

### OVER THE PAST FEW WEEKS

**20. Overall current Stress level? High Medium Low?**

**21. Stress is typically related to work? Home? School?**

**22. Stress level Scale: 1 -10  
(10 high stress level)**

**23. Anything you'd like to share?**

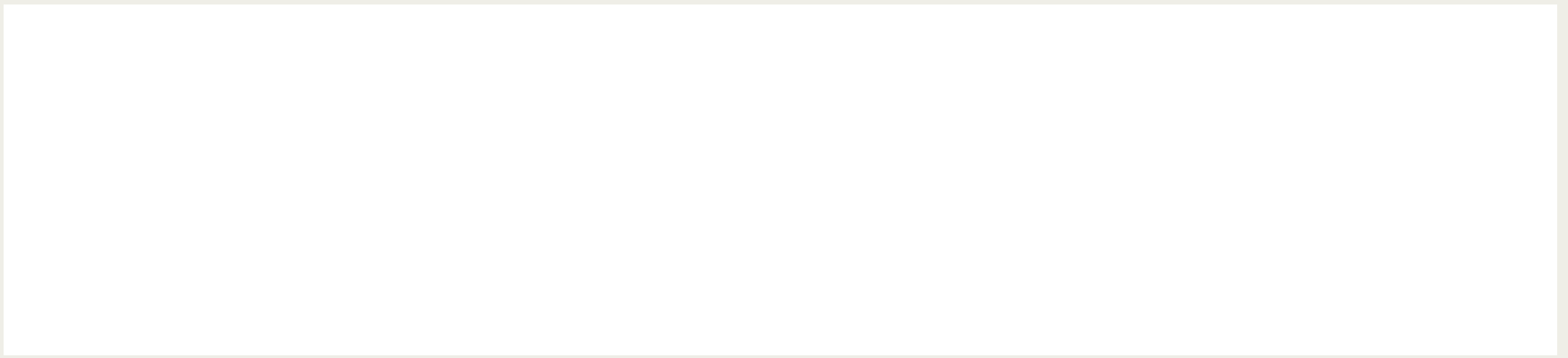
# LIFESTYLE ASSESSMENT

## Self Assessment

WITHIN THE PAST FEW WEEKS OR MONTH

**Choose the words that you can relate to at this moment or within the past month to present:**

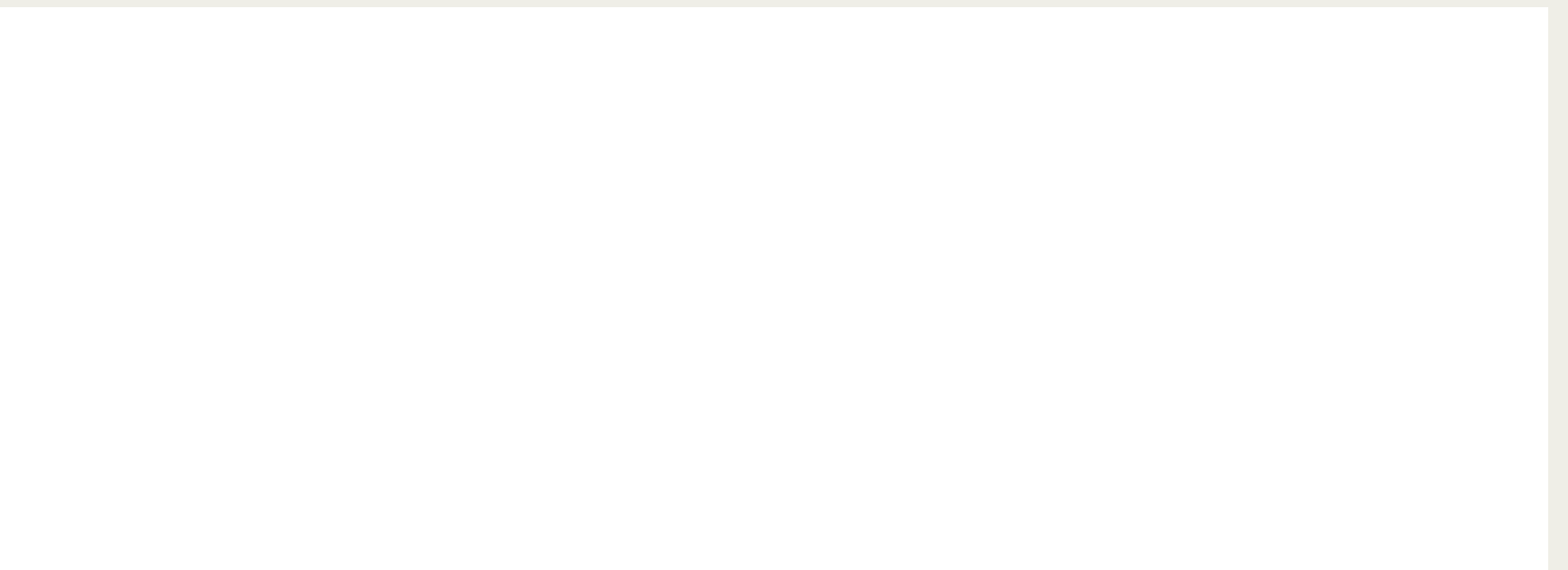
**Sadness, bitterness, resentment, 'dont care', depression, guilt, shame?**



**Anger, frustration, judgment of self or others, excessive problem solving?**



**Fear (future, current, past), anxiety, stress, overwhelm, excessive thinking?**



# LIFESTYLE ASSESSMENT

## Goals

NAME TWO SELF-CARE GOALS YOU WOULD LIKE TO ACCOMPLISH

**Goal 1:**

**Goal 2:**



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## *Additional Information*

PLEASE SHARE ANY ADDITIONAL INFORMATION  
YOU FEEL IS IMPORTANT