BOWL of LIGHT
LIFESTYLE MEDICINE

WELLNESS COMPREHENSIVE LIFESTYLE INTAKE

PATIENT NAME:_____ Date of Birth: _____/_____/_____

If you had a magic wand and could erase three problems, what would they be?
1._____
2._____
3._____

Is there a particular dream/goal you are or would like to work towards?

_____

If you did not have limitations, what would be your perfect day?

_____

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel better? _____

What makes you feel worse? _____

Please list your current health problems in order of importance to you.
Include any recent surgeries and/or hospitalizations:

_____

Please list the prescription medications you are currently *taking* (please bring meds w/ you to your visit)

Name of medication Dose/Frequency

_____
_____
_____
_____
_____
_____

Please list any over-the-counter medications, vitamins, supplements; herbs, etc. (please bring w/ you to your visit)

_____

Please list any current and/or past health care providers (*e.g.* medical doctor, naturopathic doctor, chiropractor, nurse midwife, acupuncturist, physical therapist, etc.)

Name of provider	Specialty/Type of care	Date(s) of care	Address/Phone

Please list any serious health problems in *your family:*

_____

Please list any current and/or prior occupation(s)

_____

Please describe any allergies to food, medication, environment, etc:

_____

FOOD

What do you believe is the most important thing you should change about what you eat to improve your health?

_____

3-Day Diet Diary Instructions

- Please complete the following diet diary before your scheduled appointment.
- We understand that this takes some time to do right and we would like to thank you for your cooperation. This information is very helpful to us.
- Please do not change your eating habits. We'd like to get a sense of what you eat on an average, normal day.
- Please be sure to include any beverages or drinks you have on each day.
- Please be as specific as possible about the type and amount of each food eaten.
- Please also note bowel movements and consistency (hard, soft, loose, regular).
- If your diet is very different on the weekend, please include one weekend day.
- Please also make note of any exercise/activity/stress management you did on each day.

~Thank you! ☺

Day 1…

TIME	Food/Beverage/Amount	Comments

Day 2…

TIME	Food/Beverage/Amount	Comments

Day 3…

TIME	Food/Beverage/Amount	Comments

EXERCISE & MOVEMENT:

Are you currently exercising? ☐ YES ☐ NO …if 'yes' please describe below:

What do you do?	How Long do you do it?	How many times per week?

…if you are not currently exercising, please describe why below:

_____

HABITS

Do you Smoke? ☐ YES ☐ NO …if 'yes' would you like to quit? ☐ YES ☐ NO

Do you drink Alcohol? ☐ YES ☐ NO …if 'yes' how many drinks per week? _____

Have you ever been told you should cut down? ☐ YES ☐ NO

Do you get annoyed when people ask you about your drinking? ☐ YES ☐ NO

Do you feel guilty about your alcohol consumption? ☐ YES ☐ NO

Do you ever have an 'eye-opener'? ☐ YES ☐ NO

Do you use any Recreational drugs? ☐ YES ☐ NO
…if 'yes', please describe: _____

Do you drink caffeinated beverages *(coffee, tea, sodas)?* ☐ YES ☐ NO
…if 'yes', how many drinks per day: _____

Do you watch television? ☐ YES ☐ NO …if 'yes', how many hours per day: _____

Do you use the internet? ☐ YES ☐ NO …if 'yes', how many hours per day: _____

SLEEP

Do you sleep well at night? ☐ YES ☐ NO …if 'no', why not? *(please check below or describe)*

☐ Trouble Falling Asleep ☐ Wake up during night ☐ Wake up too early

Other: _____

How many hours of sleep do you get each night *(on average)*? _____

SPIRITUALITY

Do you have a religious affiliation? ☐ YES ☐ NO
…if 'yes', please describe: _____

Do you follow a spiritual practice? ☐ YES ☐ NO
…if 'yes', please describe: _____

Do you spend time outdoors on a regular basis? ☐ YES ☐ NO
…if 'yes', please describe: _____

MENTAL HEALTH & STRESS MANAGEMENT

In the past month have you often felt down, depressed or hopeless? ☐ YES ☐ NO

In the past month have you felt little interest in doing things you once enjoyed? ☐ YES ☐ NO

Do you feel your life has meaning and purpose? ☐ YES ☐ NO

Do you feel that you have too much stress in your life? ☐ YES ☐ NO

What do you do to cope with your stress? *(please describe)*

_____

CONNECTION

Who are the important people in your life?

_____

How satisfied are you with your relationships with the important people in your life? *(please check)*
☐ Totally *Not* Satisfied ☐ Somewhat *Not* Satisfied
☐ Somewhat Satisfied ☐ Totally Satisfied

…if not satisfied, please describe why: _____

Who or What in your life provides you with emotional support? *(please check)*

☐ Spouse
☐ Family
☐ Friends
☐ Spirit/Religion/God
☐ Pets
☐ Counselor
☐ Other:_____

Are you currently satisfied with your sexual health? ☐ YES ☐ NO
…if "no", please explain:

_____

READINESS & INTERESTS

To live a healthier life, how willing are you to: *(please check answer)*

Change what you eat? ☐ Not ready ☐ Mostly not ready ☐ Mostly ready ☐ Ready

Engage in regular exercise? ☐ Not ready ☐ Mostly not ready ☐ Mostly ready ☐ Ready

Practice a relaxation technique? *(yoga, meditation, chi gong, deep breathing, etc.)*

☐ Not ready ☐ Mostly not ready ☐ Mostly ready ☐ Ready

Change your habits? *(tobacco, alcohol, drugs, television, etc.)*

☐ Not ready ☐ Mostly not ready ☐ Mostly ready ☐ Ready

ARE THERE ANY TOPICS YOU WOULD LIKE MORE INFORMATION ON?

_____