



88 Lakeshore Road East, Mississauga, L5G1E1 Tel: 905-278-4242 www.hoopershealth.com  
April Kabe, BSc, CNP Certified Nutritionist

Nutritional Assessment Form: Date \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth \_\_\_\_\_ sex: male/Female  
Address \_\_\_\_\_ E-mail \_\_\_\_\_ Tel \_\_\_\_\_  
Occupation \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

What are your main health concerns/complaints in order of importance?

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

What level of stress do you feel you are experiencing now? \_\_\_\_\_ Minimal \_\_\_\_\_ Average \_\_\_\_\_ High

What are the major causes or factors of your stress?

\_\_\_\_\_ financial \_\_\_\_\_ Career \_\_\_\_\_ Personal \_\_\_\_\_ Marriage \_\_\_\_\_ Health \_\_\_\_\_ Family \_\_\_\_\_  
Spiritual \_\_\_\_\_ Unfulfilled expectation \_\_\_\_\_ Other \_\_\_\_\_

How many hours do you sleep daily? \_\_\_\_\_ What time do you go to sleep? \_\_\_\_\_ Awaken? \_\_\_\_\_

Do you awaken feeling rested? Yes \_\_\_\_\_ no \_\_\_\_\_ Do you enjoy your work? \_\_\_\_\_ How many hours? \_\_\_\_\_

How many hours each day do you spend driving? \_\_\_\_\_ Do you smoke? Yes No Do you exercise? \_\_\_\_\_

How many hours a day do you: \_\_\_\_\_ watch television \_\_\_\_\_ Read \_\_\_\_\_ on computer \_\_\_\_\_

What are interests and hobbies? \_\_\_\_\_

Do you take vacations regularly? Yes No When was our last vacation? \_\_\_\_\_

Do you belong to a spiritual discipline? Yes No

**Medical History:**

How is your health in general? Excellent Good Fair Poor

Are you currently taking any medications? Yes No

Please list all medications \_\_\_\_\_

Please list all vitamins, herbs, homeopathic remedies and any other natural supplements you are taking:

Do you frequently use any of the following?

Aspirin Laxatives Antacids Diet pills Birth control pills Sleeping pills  
Alcohol: Daily Weekly Recreational drugs: what and how often \_\_\_\_\_

How many times have you been treated with antibiotics? \_\_\_\_\_

Do you have any allergies? If so please list: \_\_\_\_\_

Have you been diagnosed with an illness? Please explain \_\_\_\_\_

Have you ever been hospitalized? Reason? \_\_\_\_\_

Please indicate what immunizations you have had? DDT MMR Small pox Flu Polio Hepatitis A  
Hepatitis B Tetanus shot Other Please describe any adverse reactions: \_\_\_\_\_



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Have you ever been treated for drug and/or alcohol dependency? Yes No  
 Which of the following conditions have you had?

Abscesses	Depression	Heart Disease	Ulcers	Gout	Tuberculosis
Arthritis	Diabetes	Hepatitis	Mononucleosis	Fibroids	Hay fever
Asthma	Emphysema	Genital Herpes	mumps	Warts	Whooping Cough
Cancer	Epilepsy	Influenza	Parasites	Measles	Miscarriage
Chicken pox	Gall stones	Kidney Disease	Pneumonia	Prostatitis	Stroke
Cold sores	Goiter	Eczema	Scarlet fever	Jaundice	Sinusitis

Do you have any of the following? (Circle)

Amalgam fillings                      Dental implants?  
 Root canal                              Orthodontics  
 Periodontal disease

Family History:

\_\_\_\_\_ Heart disease    \_\_\_\_\_ Diabetes    \_\_\_\_\_ Allergies    \_\_\_\_\_ Hypertension    \_\_\_\_\_ Arthritis    \_\_\_\_\_  
 \_\_\_\_\_ Cancer    \_\_\_\_\_ Osteoporosis    \_\_\_\_\_ Mental Illness    \_\_\_\_\_ Intestinal Disorders    \_\_\_\_\_  
 Other \_\_\_\_\_

**General Diet: please circle if you presently consume or use any of the following**

Fried food    fast food    refined food    refined sugars    artificial sweetener    candy  
 margarine    carbonated drinks    aluminum pots    luncheon meats    microwave    coffee

**Environmental:** Please circle those apply to you

Which water do you drink? Tap    bottled    filtered  
 Which lighting do you use most during the day? Fluorescent                      plain light bulbs                      naturally lit  
 Which air are you exposed to? Smog                      industrial                      cigarette smoke                      office building  
 What chemicals are you exposed to? Pesticides                      paint/lacquers                      cell phone                      household cleaners  
 What is the approximate age of your house? \_\_\_\_\_ building you work in? \_\_\_\_\_  
 Do you live close to any high voltage power lines? \_\_\_\_\_ If so how close \_\_\_\_\_  
 Do you sleep on a water bed or use electric blankets? \_\_\_\_\_ How long \_\_\_\_\_  
 Do you diet often? \_\_\_\_\_ Do you get frequent headache? \_\_\_\_\_ How often? \_\_\_\_\_  
 Do you suffer from frequent digestive complaints? \_\_\_\_\_  
 What are your favourite foods? \_\_\_\_\_  
 How often do eat them? \_\_\_\_\_ Do you avoid certain foods \_\_\_\_\_  
 \_\_\_\_\_ If so why? \_\_\_\_\_  
 Do you experience any symptoms after meals? Explain \_\_\_\_\_  
 How many complete bowel movements do you have daily \_\_\_\_\_

**Thank you for answering all the questions. This is a confidential record of your medical history and will be kept in the office.**



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**Client Statement:**

**I understand and acknowledge that the services hereby provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purpose of medical diagnosis, treatment or prescribing of medicine for any disease or any licensed or controlled act may constitute the practice of medicine. This statement is being signed voluntarily.**

**Date** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Name (Please print)** \_\_\_\_\_

**Thank You for your cooperation.**