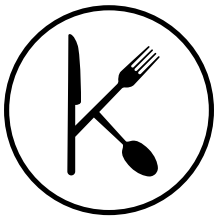
Current Health Evaluation



Name

Email

Address

Occupation

Phone number

Date of birth

1. Personal history

Please check the conditions that apply to you. Feel free to add any details that you think might be important.

- ◯ Cholesterol
- ◯ Triglycerides
- ◯ Hypertension
- ◯ Other cardiovascular diseases
- ◯ Hypoglycemia
- ◯ Heavy consumption of a food type or beverage (sugar or soft drinks)
- ◯ Gastrointestinal diseases or digestive disorders
- ◯ Alcoholism
- ◯ Smoking
- ◯ Caffeine addiction (more than 3 regular coffees per day)
- ◯ Hard and soft drugs and medication
- ◯ Allergies and intolerances
- ◯ Cancer
- ◯ Diabetes
- ◯ Inflammatory diseases
- ◯ Other :

Other details :

2. Family history

What is your family history? Are these conditions present in your immediate family (parents, siblings, grandparents)?

Please check the existing family history diseases or conditions and provide the relation. Feel free to add any details that you feel may be important.

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- ◯ Other cardiovascular diseases
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- ◯ Cancer
- ◯ Diabetes
- ◯ Inflammatory diseases
- ◯ Other :

Relation(s) :

Other details :

3. Questionnaire

A. Did you receive all childhood vaccines? Did you get any vaccines as an adult and if so, which ones?

B. Which diseases have you had from childhood until present?

C. Have you had any accidents or surgeries (dental included)?

D. What physical activities do you practice and how often do you practice them? How long is one session?

3. Questionnaire (cont.)

E. What is your stress level on a scale of 1 to 10? Please explain.

F. How many consecutive hours of sleep do you get every day? On a scale of 1 to 10, what is the quality of your sleep?

G. Are there any foods that give you a discomfort? Do you suspect any intolerances or allergies?

H. Are there any foods that you dislike and that you do not want to see in your menu suggestions?

3. Questionnaire (cont.)

I. Are there any foods that you love and that you cannot live without?

J. Please identify which life phase you belong to: (growing phase, adult, pregnancy, lactation, senior...)

K. What is your actual state of health?

L. What are your goals towards your eating habits? What would you like to achieve by modifying your diet? (Increased energy levels, better physical shape, stronger immune system, better mental health, weight loss, athletic challenge…). Please be as precise as possible.

4. Food journal

For 3 to 5 days, record everything you eat and drink. Please try and be as precise as possible, include portions, ingredients, timing, etc.

If the 3 first days are very representative of your eating habits, 3 days is enough. If however within these 3 days there were some meals or days that didn't represent the way you normally eat, try and record your food for an additional 2 days so that a total of 5 days is recorded.

It is sometimes helpful to have 2 week days and one weekend day to get the true picture.

Date :

Date :

Date :

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Date :

Date :

Date :

5. Physical assessment

Your weight (kg or lbs)

Your height (cm or in)

The size of your waist (cm or in)

Measure the smallest part of the waist, right above the highest hip bone, with a measuring tape.

Thank you for completing the Current Health Evaluation form.

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