NEW REHABILITATION SERVICES

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PERPETUATING LIFESTYLE FACTORS

Patient Name_____ Date_____

NUTRITION
Do you take dietary supplements or vitamins? ___No ___Yes, please list below

Vitamins	Minerals	Herbals	Nutrients	Foods	Other	Other

Do you consider your diet balanced? ___Yes ___ No Is it nutritious? ___Yes ___No
Do you see a Nutritionist? ____Yes ____No Name_____
Do you see a Homeopathic practitioner? ___Yes ___No Name_____
Do you eat 5 to 9 servings of fruit and vegetables daily? ___Yes ___No
Would you like to eat 5 to 9 servings of fruit and vegetables daily? ____Yes ____No

Would you complete a daily food chart for a 7-day period? ___Yes ___No

Which foods do you crave? _____

Which foods do you like? _____

Are you on a special/controlled diet? ___Yes ___No If yes, please explain_____

_____

_____

NOTES _____

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PHYSICAL ACTIVITIES

Do you exercise daily? ___Yes ___No
Do you enjoy exercising? ___Yes ___No

What type of exercises do you do and how often? List Below:

Aerobics	**Biking**	**Lift Weights**	**Running**	**Swimming**	**Walking**

Did you recently start exercising? ___Yes ___No OR stop exercising? ___Yes ___No
If yes, Why? _____

List past and current recreational activities_____

_____

List past and current sports activities_____

_____

List any other factors you feel cause a change in your lifestyle_____

_____

Do you play a musical instrument? ___Yes ___No If yes, what? _____

EMOTIONAL STRESS

Are you under stress at ___ work___ school ___home?

Would you consider your stress level ___low ___moderate ___high ___extremely high?

Do you sleep well at night? ___Yes ___No, please list why_____

Do you sleep on your ___back ___stomach ___left side ___right side ___fetal position?

What type of mattress do you sleep on? ___firm ___moderate firmness ___extra firm
___pillow topped cushion ___futon ___featherbed ___waterbed
___Other, please explain/describe_____

NOTES_____
_____

OTHER PERPETUATING FACTORS

Do you or did you ever smoke? ___Yes ___No If yes, how much per day? _____
What name brand? _____ When did you quit? _____

Do you have ___bunions ____corns ___calluses on feet or toes?

Do you have a long second toe? ___Yes ___No Do you have a short leg? ___Yes ___No

Do you wear orthotics? ___Yes ___No Do you wear heal lifts? ___Yes ___No

Do you have a small pelvis? ___Yes ___No Can you touch your toes? ___Yes ___No

Do you have cold hands? ___Yes ___No Do you have cold feet? ___Yes ___No

Do your hands tingle? ___Yes ___No Do your feet tingle? ___Yes ___No

Do you ever feel numbness in your hands? ___Yes ___No In your feet? ___Yes ___No

Do you have pain while sitting? ___Yes ___No While standing? ___Yes ___No

The next series of questions pertain to the female gender.
Do you have menstrual discomfort? ___none ___mild ___moderate ___severe ___other
How many pregnancies have you had? _____ Was your pregnancy normal? ___Yes ___No
Was your delivery normal? ___Yes ___No Are you pregnant now? ___Yes ___No
Are you in ___menopause ___pre-menopausal ___post-menopausal

OCCUPATIONAL
What is your current occupational title? _____
Are you in a post-secondary education program now? ___Yes ___No, If yes, please describe___
_____
List your past occupations_____
_____
What gives you pain while performing your occupation? _____
_____
While at work, on a daily basis do you mostly ___sit ___stand ___lean over/bend
Do you use a computer on a regular or daily basis? ___Yes ___No

NOTES_____

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