LIFESTYLE ASSESSMENT

The Avisio Naturopathic Lifestyle Assessment is a *confidential* Health Assessment tool created to gain insight into your personal health status. The information provided will assist your naturopathic doctor in developing a personal health plan, specifically for you.

When embarking on a personal health plan with your naturopathic doctor, it is important to start off with a benchmark of where you are currently. The Lifestyle Assessment is not designed to give a medical diagnosis. Rather, it will identify strengths in your health, any risk factors that may be present, and highlight recommendations that you may want to consider adding to your daily routine.

Our doctors will review the assessment along with all submitted medical records, lab test results, scans, etc., prior to your first consultation. Each case is thoroughly researched and treatment plans begins from there. Therefore, it is to your advantage to return this form along with any other medical records in advance of your initial appointment.

Submit the completed form ***at least 48 hours*** prior to your appointment by email to info@avisio.com. You may also fax or drop the form off, in person, during regular clinic hours.

Guidelines to follow when filling out the Lifestyle Assessment:

- When answering the questions, **use the last 3 months as a guide.**
- Read each question carefully before answering.
- Write in any response that is not provided on the questionnaire, e.g., if you perform other exercises.
- Included in your personal history, please state your family history, your personal habits, concerns, and thoughts with respect to your health.

The 9 Categories of the Avisio Naturopathic Lifestyle Assessment

A. GENERAL INFORMATION
B. CURRENT AND PAST HEALTH CONCERNS
C. EXTERNAL FACTORS
D. FAMILY MEDICAL HISTORY
E. MEDICATIONS/SUPPLEMENTS
F. EXERCISE
G. REVIEW OF PHYSICAL SYSTEMS
H. DIETARY FACTORS
I. STRESS

A. GENERAL INFORMATION

Name: _____ Date: _____
Extended Health Insurance Plan (EHP): YES_____ NO_____ Plan #:_____
Provider: _____ Care Card #:_____
Birth Date (MM/DD/YYYY):_____ Age: _____ Sex: M F
Occupation: _____ Marital Status: S M D W
Address: _____ City_____ Postal Code: _____
Email: _____ Phone: H: _____W: _____ Mobile: _____
May we leave messages relating to your visits? YES_____ NO_____

Do you prefer appointment reminders by PHONE or EMAIL?
If by phone, which phone number(s) is best for reminders? HOME WORK MOBILE (Circle all that apply)

Emergency Contact: Name: _____ Telephone: _____ Relation: _____
Number in household: _____ Relationship to you? _____
How did you hear about our clinic? _____
Referred by: _____

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Other health care providers you are seeing:

Medical Doctor
Name _____
Address _____
_____
Phone number _____
Fax number _____

Specialist *(pls specify)* _____
Name_____
Address _____
_____
Phone number _____
Fax number _____

Other Health Care Providers
Name _____
Address _____
_____
Phone number _____
Fax number _____

Name _____
Address _____
_____
Phone number _____
Fax number _____

B. CURRENT AND PAST HEALTH CONCERNS

What are your current health concerns in order of importance to you?
1. _____
2. _____
3. _____
4. _____
5. _____

When did you notice changes to your health? _____
_____

Have you been diagnosed with any illnesses? Explain. _____
_____

List any health problems at birth._____

How was your health during childhood? _____
_____

Describe your health during your teenage years. _____
_____

List any injuries, hospitalizations, or accidents that you have had:

Event	When	Treatments

What has been the most traumatic event in your life? _____
_____
_____
_____
_____

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C. EXTERNAL FACTORS

Using the scale provided, identify your known personal exposure to the following external products and substances. Also indicate your level of concern about these exposures on your health.

Environment	Concern?	Personal Exposure				
		Never	<1/wk	1-3X/wk	3-7X/wk	>7X/wk
Gas fumes	YES NO					
Pollution	YES NO					
Near hydro towers	YES NO					
Live near a factory	YES NO					
Water pollution	YES NO					
Chemical Sprays	YES NO					
Other, Please specify	YES NO					
Personal	Concern?	Personal Exposure				
		Never	<1/wk	1-3X/wk	3-7X/wk	>7X/wk
Smoking	YES NO					
Second hand smoke	YES NO					
Makeup, body creams	YES NO					
Perfumes, cologne	YES NO					
Acrylic Nails	YES NO					
Other, Please specify	YES NO					
Household	Concern?	Personal Exposure				
		Never	<1/wk	1-3X/wk	3-7X/wk	>7X/wk
Cleaning products	YES NO					
Household deodorizers	YES NO					
Paint fumes	YES NO					
Other, Please specify	YES NO					

What steps, if any, have you taken to minimize the effects of the above external factors? _____

_____

D. FAMILY MEDICAL HISTORY

Please indicate if any of your family members (e.g. mother, father, maternal/paternal grandparents, siblings, aunts, and uncles) has ever encountered any of the following health concerns. Include only blood relatives.

Health Concern	Family Relative	Health Concern	Family Relative
Alcoholism		High blood pressure	
Allergies		Infertility	
Alzheimer's disease		Intestinal disease	
Arthritis		Learning disability	
Asthma		Mental illness	
Cancer (indicate type)		Migraine headaches	
Diabetes		Neurological disorders	
Drug addiction		Obesity	
Eating disorder		Osteoporosis	

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Genetic disorder		Stroke	
Glaucoma/cataracts		Suicide	
Heart disease		Liver disease	
Kidney disease		Other	

☐ I don't know my family medical history # of siblings: _____ Your birth order: _____

E. MEDICATIONS/SUPPLEMENTS AND OTHER TREATMENTS

Circle any of the following that you are taking/using.

Antacids	Birth control pills	Diuretics (water pills)	Radiation	Tobacco
Appetite suppressants	Chemotherapy	Laxatives	Recreational drugs	Tranquilizers
Aspirin/Tylenol	Diet pills	Pain relievers	Sleeping pills	

Any known allergies or drug sensitivities? _____
Number of times on antibiotics in the last 10 years: _____

Medications (attach a separate sheet of paper if you need more space)

Medication Name	Dosage/Amount	Reason for taking	Duration of use

Vitamins, Supplements, Herbal or Homeopathic Remedies

List of medications	Dosage/Amount	Reason for taking	Duration of use

F. EXERCISE

Use the scale provided to identify the number of times a week that you engage in the following exercises.

Body/Mind Exercises	Frequency				
	Never	<1/wk	1-3X/wk	3-5X/wk	>5X/wk
Meditation/Prayer/Breathing Exercises					
Visualizations (or similar)					
Other, Please specify					

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Strength Building	Frequency				
	Never	<1/wk	1-3X/wk	3-5X/wk	>5X/wk
Weight Training					
Martial Arts (or similar)					
Other, Please specify					
Cardiovascular Exercise	Frequency				
	Never	<1/wk	1-3X/wk	3-5X/wk	>5X/wk
High Impact Aerobics, Step					
Running/Jogging					
Walking, Low Impact Aerobics					
Cycling, Rowing, Swimming					
Other, Please specify					
Flexibility	Frequency				
	Never	<1/wk	1-3X/wk	3-5X/wk	>5X/wk
Yoga, Tai Chi, Qi Gong (or similar)					
General Stretching/Lengthening					
Other, Please specify					

Do you belong to a gym? YES NO If yes, how often do you go? _____

What benefits have you found from exercising? _____

Circle the statement that best describes you.

A. I exercise because I have to (someone has advised me to do so)
B. I exercise for health and wellness
C. I exercise because I enjoy exercising

G. REVIEW OF PHYSICAL SYSTEMS

Energy Level

On a scale from 1 to 10, rate your energy level, where 1 is low and 10 is high. _____

What time of day is your energy at its peak? _____

What time of day is your energy at its lowest? _____

What affects your energy? _____

Sleep

How is your sleep? _____

Do you suffer from insomnia? YES NO How often? _____

How many hours a day do you sleep? _____ Do you nap? YES NO

Do you sleep soundly throughout the whole night? YES NO If no, please explain. _____

_____

Do you wake up feeling refreshed? YES NO Other _____

Do you have frequent dreams and nightmares? YES NO Other _____

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Breathing

How would you describe your breathing? _____

Body Temperature

Does your body temperature usually feel hot or cold? HOT COLD Other _____

Do you like to be warm or cool? WARM COOL Other _____

Perspiration

Describe your perspiration? _____

Are there any unusual circumstances that cause you to perspire? _____

_____

Is there anything unusual about your perspiration? _____

Weather

Are you affected by the weather? YES NO Describe _____

What is your *favourite* type of weather? _____

What is your *least favourite* type of weather? _____

***Height*:** _____feet ____inches or _____ cm ***Weight*:** _____lbs or _____kg

What do you consider to be an appropriate body weight for you? _____ lbs/kg

General Signs and Symptoms	(Pr) Present (P) Past (N) never a concern	Current Intensity 0 1 2 3 4 Low High	Length of Time (years)	Comments
Dizziness/vertigo	Pr P N	0 1 2 3 4		
Headaches	Pr P N	0 1 2 3 4		
Migraines	Pr P N	0 1 2 3 4		
Fever	Pr P N	0 1 2 3 4		
Frequent infections	Pr P N	0 1 2 3 4		
Rapid Weight loss	Pr P N	0 1 2 3 4		
Rapid Weight Gain	Pr P N	0 1 2 3 4		
Underweight	Pr P N	0 1 2 3 4		
Overweight	Pr P N	0 1 2 3 4		
Sensitive to noise	Pr P N	0 1 2 3 4		
Sensitive to light	Pr P N	0 1 2 3 4		
Sensitive to odours	Pr P N	0 1 2 3 4		
Other sensitivities	Pr P N	0 1 2 3 4		
Skin	(Pr) Present (P) Past (N) never a concern	Current Intensity 0 1 2 3 4 Low High	Length of Time (years)	Comments
Rashes	Pr P N	0 1 2 3 4		
Eczema	Pr P N	0 1 2 3 4		
Psoriasis	Pr P N	0 1 2 3 4		
Dry scalp, dandruff	Pr P N	0 1 2 3 4		
Hair thinning/loss	Pr P N	0 1 2 3 4		
Acne/boils	Pr P N	0 1 2 3 4		
Itching	Pr P N	0 1 2 3 4		

Colour Changes	Pr P N	0 1 2 3 4		
Pale complexion	Pr P N	0 1 2 3 4		
Changes in moles	Pr P N	0 1 2 3 4		
Warts	Pr P N	0 1 2 3 4		
Lumps/cysts	Pr P N	0 1 2 3 4		
Dry/Cracked skin	Pr P N	0 1 2 3 4		
Moist/oily skin	Pr P N	0 1 2 3 4		
Stretch marks	Pr P N	0 1 2 3 4		
Excess body odor	Pr P N	0 1 2 3 4		
Excessive sweating	Pr P N	0 1 2 3 4		
Jaundice (yellowing of skin)	Pr P N	0 1 2 3 4		
Skin cancer	Pr P N	0 1 2 3 4		
Head and Mouth	(Pr) Present (P) Past (N) never a concern	Current Intensity 0 1 2 3 4 Low High	Length of Time (years)	Comments
Frequent sore throats	Pr P N	0 1 2 3 4		
Sore tongue/mouth	Pr P N	0 1 2 3 4		
Sores in the mouth	Pr P N	0 1 2 3 4		
Cold sores/herpes	Pr P N	0 1 2 3 4		
Gum problems	Pr P N	0 1 2 3 4		
Bad breath	Pr P N	0 1 2 3 4		
Dental cavities	Pr P N	0 1 2 3 4		
Hoarseness	Pr P N	0 1 2 3 4		
Lumps/goiter	Pr P N	0 1 2 3 4		
Swollen glands	Pr P N	0 1 2 3 4		
Nose bleeds	Pr P N	0 1 2 3 4		
Hay fever	Pr P N	0 1 2 3 4		
Loss of smell	Pr P N	0 1 2 3 4		
Excess mucus	Pr P N	0 1 2 3 4		
Eyes and Ears	(Pr) Present (P) Past (N) never a concern	Current Intensity 0 1 2 3 4 Low High	Length of Time (years)	Comments
Near sighted	Pr P N	0 1 2 3 4		
Far sighted	Pr P N	0 1 2 3 4		
Blurred Vision	Pr P N	0 1 2 3 4		
Dry Eyes	Pr P N	0 1 2 3 4		
Tearing	Pr P N	0 1 2 3 4		
Itchy eyes	Pr P N	0 1 2 3 4		
Eye Pain	Pr P N	0 1 2 3 4		
Redness in eyes	Pr P N	0 1 2 3 4		
Eye discharge	Pr P N	0 1 2 3 4		
Dark circles under eyes	Pr P N	0 1 2 3 4		
Bothered by the sun	Pr P N	0 1 2 3 4		
Eye infections	Pr P N	0 1 2 3 4		
Glaucoma	Pr P N	0 1 2 3 4		
Cataracts	Pr P N	0 1 2 3 4		
Other eye concerns	Pr P N	0 1 2 3 4		

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Diminished hearing	Pr P N	0 1 2 3 4		
Ear aches	Pr P N	0 1 2 3 4		
Ear infections	Pr P N	0 1 2 3 4		
Vascular System	(Pr) Present (P) Past (N) never a concern	Current Intensity 0 1 2 3 4 Low High	Length of Time (years)	Comments
Hot hands/feet	Pr P N	0 1 2 3 4		
Cold hands/feet	Pr P N	0 1 2 3 4		
High blood pressure	Pr P N	0 1 2 3 4		
Low blood pressure	Pr P N	0 1 2 3 4		
Chest pain	Pr P N	0 1 2 3 4		
Slow heart beat	Pr P N	0 1 2 3 4		
Fast heart beat	Pr P N	0 1 2 3 4		
Palpitations	Pr P N	0 1 2 3 4		
Irregular heart beats	Pr P N	0 1 2 3 4		
Cyanosis (blue skin)	Pr P N	0 1 2 3 4		
Extremity swelling	Pr P N	0 1 2 3 4		
Extremity Numbness	Pr P N	0 1 2 3 4		
Varicose Veins	Pr P N	0 1 2 3 4		
Leg cramps	Pr P N	0 1 2 3 4		
Deep leg pain	Pr P N	0 1 2 3 4		
Easy bleeding bruising	Pr P N	0 1 2 3 4		
Extremity ulcers	Pr P N	0 1 2 3 4		
Anaemia	Pr P N	0 1 2 3 4		
Angina	Pr P N	0 1 2 3 4		
Heart murmurs	Pr P N	0 1 2 3 4		
Other circulatory/heart concerns	Pr P N	0 1 2 3 4		
Nervous System	(Pr) Present (P) Past (N) never a concern	Current Intensity 0 1 2 3 4 Low High	Length of Time (years)	Comments
Fainting	Pr P N	0 1 2 3 4		
Seizures/Convulsions	Pr P N	0 1 2 3 4		
Paralysis	Pr P N	0 1 2 3 4		
Tingling	Pr P N	0 1 2 3 4		
Numbness	Pr P N	0 1 2 3 4		
Involuntary movements/tics	Pr P N	0 1 2 3 4		
Loss of balance	Pr P N	0 1 2 3 4		
Speech problems	Pr P N	0 1 2 3 4		
Other nervous system concerns	Pr P N	0 1 2 3 4		
Digestive System	(Pr) Present (P) Past (N) never a concern	Current Intensity 0 1 2 3 4 Low High	Length of Time (years)	Comments
Change in appetite	Pr P N	0 1 2 3 4		
Change in thirst	Pr P N	0 1 2 3 4		
Food Intolerances/allergies	Pr P N	0 1 2 3 4		

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Trouble swallowing	Pr P N	0 1 2 3 4		
Loss of taste	Pr P N	0 1 2 3 4		
Taste sensitivity	Pr P N	0 1 2 3 4		
Bitter taste	Pr P N	0 1 2 3 4		
Nausea	Pr P N	0 1 2 3 4		
Vomiting	Pr P N	0 1 2 3 4		
Gas or belching	Pr P N	0 1 2 3 4		
Abdominal bloating	Pr P N	0 1 2 3 4		
Heartburn/reflux	Pr P N	0 1 2 3 4		
Indigestion	Pr P N	0 1 2 3 4		
Diarrhea	Pr P N	0 1 2 3 4		
Constipation	Pr P N	0 1 2 3 4		
Undigested food in the stool	Pr P N	0 1 2 3 4		
Blood in stool	Pr P N	0 1 2 3 4		
Liver disease	Pr P N	0 1 2 3 4		
Gallstones	Pr P N	0 1 2 3 4		
High cholesterol	Pr P N	0 1 2 3 4		
Diabetes	Pr P N	0 1 2 3 4		
Ulcers	Pr P N	0 1 2 3 4		
Hemorrhoids	Pr P N	0 1 2 3 4		
Hernias	Pr P N	0 1 2 3 4		

Appetite Describe your appetite _____
Describe your digestion _____
What makes your digestion worse? _____
What happens when you skip a meal? _____
What type of foods do you prefer? salty sweet spicy bitter sour
What temperature of food do you prefer?

Thirst Describe your thirst. _____
What temperature of drinks do you prefer? _____
How many glasses of water do you drink in a day? _____
What do you prefer to drink? _____

Bowel Movements
On average how many bowel movements do you have a day? _____
Do you strain to have a bowel movement? _____ What colour are your stools? _____
Describe the consistency/size of your bowel movements. _____

Urinary System	(Pr) Present (P) Past (N) never a concern	Current Intensity 0 1 2 3 4 Low High	Length of Time (years)	Comments
Urinary pain, burning	Pr P N	0 1 2 3 4		
Difficult urination	Pr P N	0 1 2 3 4		
Increased frequency	Pr P N	0 1 2 3 4		
Frequency at night	Pr P N	0 1 2 3 4		
Frequent infections	Pr P N	0 1 2 3 4		
Blood in urine	Pr P N	0 1 2 3 4		
Urgency/inability to hold urine	Pr P N	0 1 2 3 4		

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Hesitancy	Pr P N	0 1 2 3 4		
Kidney Stones	Pr P N	0 1 2 3 4		

Number of daily urinations _____ How many times at night do you get up to urinate? _____
What is the colour of your urine? clear light yellow dark yellow other _____
Is there any unusual odour to your urine? NO YES If yes, please describe: _____

Respiratory System	(Pr) Present (P) Past (N) never a concern	Current Intensity 0 1 2 3 4 Low High	Length of Time (years)	Comments
Cough	Pr P N	0 1 2 3 4		
Sputum	Pr P N	0 1 2 3 4		
Nasal discharge	Pr P N	0 1 2 3 4		
Sinus congestion	Pr P N	0 1 2 3 4		
Spitting up blood	Pr P N	0 1 2 3 4		
Wheezing	Pr P N	0 1 2 3 4		
Shortness of Breath	Pr P N	0 1 2 3 4		
Difficulty breathing	Pr P N	0 1 2 3 4		
Tonsillitis	Pr P N	0 1 2 3 4		
Asthma	Pr P N	0 1 2 3 4		
Bronchitis	Pr P N	0 1 2 3 4		
Pneumonia	Pr P N	0 1 2 3 4		
Tuberculosis	Pr P N	0 1 2 3 4		
Smoking	Pr P N	0 1 2 3 4		
Other concerns	Pr P N	0 1 2 3 4		
Muscles/Bones	(Pr) Present (P) Past (N) never a concern	Current Intensity 0 1 2 3 4 Low High	Length of Time (years)	Comments
Broken Bones	Pr P N	0 1 2 3 4		
Bones break easily	Pr P N	0 1 2 3 4		
Painful joints	Pr P N	0 1 2 3 4		
Swollen joints	Pr P N	0 1 2 3 4		
Lack of joint mobility	Pr P N	0 1 2 3 4		
Muscle strain	Pr P N	0 1 2 3 4		
Muscle spasm	Pr P N	0 1 2 3 4		
Muscle tension	Pr P N	0 1 2 3 4		
Muscle weakness	Pr P N	0 1 2 3 4		
Muscle atrophy (deterioration)	Pr P N	0 1 2 3 4		
Prolonged stiffness	Pr P N	0 1 2 3 4		
Heavy feeling in limbs	Pr P N	0 1 2 3 4		
Low back pain	Pr P N	0 1 2 3 4		
Weak, sore knees	Pr P N	0 1 2 3 4		
Osteoporosis	Pr P N	0 1 2 3 4		
Arthritis	Pr P N	0 1 2 3 4		
Other muscle or bone concerns	Pr P N	0 1 2 3 4		

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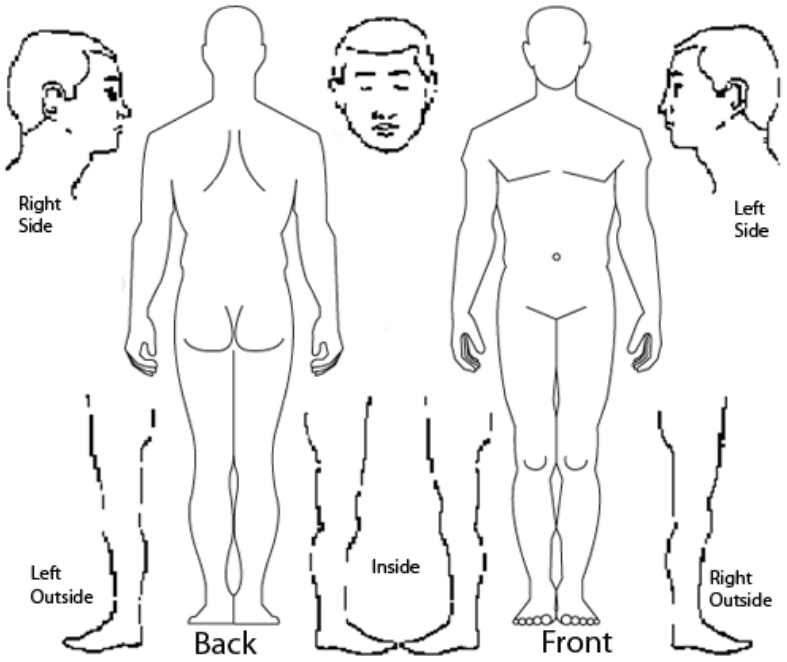
Musculoskeletal System

Please shade in the areas where you feel pain, swelling or discomfort.



Female Reproductive System

Age menses began: ____ Average number of days: _____ Length of cycle: _____
Describe your flow: _____ When is it the heaviest? _____
What is the flow like (clots, colour)? _____
What symptoms do you have before your period? _____
Any pain with your menses? YES NO If yes, when is it the worst? _____
Are you practising birth control? YES NO If yes, what type and since when: _____
Are you currently pregnant? YES NO Number of pregnancies: _____ Number of live births: _____
Number of miscarriages: _____ Number of abortions: _____
Are you currently sexually active? YES NO Sexual preference: _____
Rate your sex drive on a scale from 1 (low) to 10 (high): _____

Female Reproductive System	(Pr) Present (P) Past (N) never a concern	Current Intensity 0 1 2 3 4 Low High	Length of Time (years)	Comments
Bleeding between periods	Pr P N	0 1 2 3 4		
Discharge between periods	Pr P N	0 1 2 3 4		
Pain during intercourse	Pr P N	0 1 2 3 4		
PMS	Pr P N	0 1 2 3 4		
Breast discomfort/changes	Pr P N	0 1 2 3 4		
Difficulty conceiving	Pr P N	0 1 2 3 4		
Uterine prolapse	Pr P N	0 1 2 3 4		
Fluid retention	Pr P N	0 1 2 3 4		
Sexually transmitted	Pr P N	0 1 2 3 4		

infections/diseases				
Hot flushes	Pr P N	0 1 2 3 4		
Night sweats	Pr P N	0 1 2 3 4		
Frequent fungal/yeast infections	Pr P N	0 1 2 3 4		
Male Reproductive System	(Pr) Present (P) Past (N) never a concern	Current Intensity 0 1 2 3 4 Low High	Length of Time (years)	Comments
Hernias	Pr P N	0 1 2 3 4		
Testicular masses	Pr P N	0 1 2 3 4		
Testicular pain	Pr P N	0 1 2 3 4		
Sexual difficulties	Pr P N	0 1 2 3 4		
Premature ejaculation	Pr P N	0 1 2 3 4		
Discharge or sores	Pr P N	0 1 2 3 4		
Prostatitis	Pr P N	0 1 2 3 4		
Sexually transmitted infections/diseases	Pr P N	0 1 2 3 4		

(Male) Are you sexually active? YES NO Rate your sex drive on scale from 1 (low) to 10 (high) _____
Sexual preference: _____

Emotional/Intellectual Concerns	(Pr) Present (P) Past (N) never a concern	Current Intensity 0 1 2 3 4 Low High	Length of Time (years)	Comments
No free time	Pr P N	0 1 2 3 4		
Mood swings	Pr P N	0 1 2 3 4		
Overly emotional	Pr P N	0 1 2 3 4		
Fears, phobias	Pr P N	0 1 2 3 4		
Grief	Pr P N	0 1 2 3 4		
Worry	Pr P N	0 1 2 3 4		
Irritable	Pr P N	0 1 2 3 4		
Anxiety	Pr P N	0 1 2 3 4		
Anxiety about exams, public speaking	Pr P N	0 1 2 3 4		
Anger	Pr P N	0 1 2 3 4		
Depressed	Pr P N	0 1 2 3 4		
Cry often	Pr P N	0 1 2 3 4		
Nervousness	Pr P N	0 1 2 3 4		
Hyperactive	Pr P N	0 1 2 3 4		
Burnout	Pr P N	0 1 2 3 4		
Inability to let things go	Pr P N	0 1 2 3 4		
Confusion	Pr P N	0 1 2 3 4		
Lack of concentration	Pr P N	0 1 2 3 4		
Learning disability	Pr P N	0 1 2 3 4		
Feeling out of control	Pr P N	0 1 2 3 4		

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H. DIETARY FACTORS

On a scale from 1 (poor) to 10 (very healthy) how would you rate your diet? _____ Why? _____

_____

Is there anything in your diet you would like to change? _____

_____

Do you follow any specific diet regime? ___vegetarian ___vegan other _____

I. STRESS

Using the scale provided, indicate the level of stress you feel for the following aspects of your life and the stress duration.

Stress Induction	None	Low	Average	High	Duration (years)
Health					
Financial					
Unfulfilled Expectations					
Relationships					
Marriage					
Career					
Family					
Spiritual					
School bullying					
Other, Please specify					

What steps have you taken to deal with your stress? _____

Have you ever engaged in counselling or psychotherapy? YES NO How long? _____

Do you take vacations regularly? YES NO Date of last vacation: _____

Circle the statement that best describes you:

A. I am concerned about the level of stress in my life
B. I feel I have an average amount of stress compared to most people
C. I am not concerned about the stress in my life

What are your *short term health goals*? _____

What are your *long term health goals*? _____

Please add any other relevant health/personal information that you feel is missing. _____

_____

Thank you. Please submit this completed form ***at least 48 hours*** prior to your appointment by email to info@avisio.com. You may also fax or drop the form off, in person, during regular clinic hours.

Recommended items to bring to your first appointment.

1. Copy of Extended Health Insurance Plan and card
2. Recent medical records, laboratory tests, blood work, imaging, etc. can be submitted with this form or at any time.

Note: Access your BC BioMedical lab results via our website www.Avisio.com in the 'Patient Area' tab.