Lay of the Landscape Lifestyle Assessment Form

* Feel free to make guesstimates, write N/A or Unsure, or skip. Use the back of the paper for extra space if needed.

Name: ____Date:________________________ Age: ___________

Sex__________ Height _________ Weight____________

What is your purpose in completing this assessment?

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Do you have specific (mental/physical) health concerns?

____

____

____

Medical history

Are you currently taking any meds? Y/N

List reasons:

List supplements, vitamins, minerals, herbal or homeopathic remedies currently taking.

Do you have any allergies or sensitivities?

Have you ever been diagnosed with an illness?

Been Hospitalized? Reason:

Sensory Sensitivities

Do you have sensory sensitivities to light, noise, weight, smells or problems with balance (proprioceptive/vestibular). Explain.

Do you smoke or live with a smoker? Y/N

Do you use recreational drugs? If yes, how often and type:

Have you ever been treated for drug or alcohol dependency? Which one.

Have you experienced trauma or loss? If so, how recently?

Relationships

Are your parents living? Y/N / not sure Are you in contact with your parents or primary caregiver(s)? Y/N

Do you have siblings? List ages, gender, birth order.

What is your "intimate" relationship status?

Married? Y/N Separated/divorced? Y/N Remarried? Y/N (#)

Actively dating? Y/N Single by intentional choice? Y/N Temporarily single? Y/N?

If complicated, please explain:

Friendships/social

Do you have a best friend or friends? Y/N

Do you have a social group you engage with regularly (text, phone, online, in person e.g. club, worship, community org, gym, etc)? Y/N If yes, please list.

Do you have an In Case of Emergency person? Y/N

Do you have a person or persons in your life in the role of mentor or spiritual guide? Y/N

How has the covid-19 pandemic impacted your relationships and social experiences?

Current living situation:

Who do you live with?

What is your relationship to the people you live with?

How long?

Do you have pets?

Environmental

List the environments where you spend the most time on a daily basis.

Describe the PLACES where you spend most of your time (briefly) and how much time you spend in each (e.g. home environment, outdoors, workplace, school, church, friend's homes, yoga studio, gym, other.)

Are there environmental factors that you are aware of or suspect are affecting your health (+/-) ? Explain on back if needed.

How much time do you spend in nature?

Are you affected (+/-) by the weather?

List your Favorite to least Favorite weather and seasons:

Do you take regular vacations? Briefly explain.

Do you travel? If so, explain why and how often.

Stress

Write *your* definition of stress here:

Rate your baseline stress level on a scale of 1-10 (1=lowest to 10=highest). *This is your stress level a majority of the time.

How does stress manifest in your experience?

What do you suspect may be the causes of your stress?

Do you use coping mechanisms? Y/N If so, list them.

Energy & Focus

Rate your generally experienced baseline energy level on a scale of 1-10 (1=lowest to 10=highest)

Do you have lulls throughout the day? Y/N If yes, What times?

Have you noticed any patterns or rhythm associated with your energy levels/movement throughout the day, weeks, seasons? If Y, explain.

How does your energy manifest in your experience? For e.g. How do you experience high energy and low energy?

What do suspect are the causes of fluctuations in your energy?

Do you practice with or pay deliberate attention to your energy levels (or only attend to it when the extremes get your attention)? Explain.

Do you have trouble focusing/concentrating your attention narrowly? Y/N If Yes, Explain.

Do you have trouble sustaining focus and attention for longer periods of time? Y/N If yes, explain.

About how long can you work at a task you enjoy without losing focus?

About how long can you work at tasks you don't enjoy but must be completed before you lose focus?

Do you ever get into a "flow" state?

About how long will you typically persist to problem solve or when learning something new?

Emotional Health

List any Emotional/intellectual concerns past and present (e.g. memory, racing or automatic negative thoughts, anger/resentment, sadness/grief, shame, suicidal ideation, depression, anxiety, obsessive compulsive)

We all have good and bad habits. Do you have behavioral health concerns or interests related to habits? Y/N If yes, explain.

How resilient do you think you are?

Do you have a spiritual or religious practice? Y/N

Are you involved in service projects/practices or volunteering, pro-bono work? Y/N

HOW YOU SPEND YOUR TIME, ATTENTION, AND ENERGY

In a 24-hour period how much time do you spend (It will equal more than 24 hours, not to worry!)

	Hours Spent		Hours Spent
social media sites		Taking public transport or passenger	
web searching		Listening to music	
gaming		Exercising/Sports	
Cell phone (snap, text, apps)		Time alone	
Computer related work		Being outside	
Working		School	
Watching television		Reading / Writing e.g. journaling	
Spiritual Practice		Service to others/volunteeing	
Personal hygiene e.g. grooming		Driving a vehicle	
Sleeping		OTHER	

You may need extra space to add…

Dietary Health

How many times a day do you eat?

Main Meals Times of day:

Snacks Times of day:

Do you eat meals: with family? Y/N home alone? Y/N on the run? Y/N

Restaurant? Y/N fast food? Y/N

Do you feel there are restrictions to your diet due to preferences of others such as family, roommates, etc…? Yes / No If yes, please specify.

Using the items below, please list, in order, foods you eat most often:

Fruit: Fresh (Dried, Canned) Vegetables: (Cooked, Raw) Whole Grains

Protein: Type? Dairy Products: Type? Fats: type? Other: Type

Provide examples of your typical meals:

Breakfast

Lunch

Dinner

Snacks

Do you eat or use (1=rarely, 2=regularly, 3=often)

Artificial sweeteners (Nutra sweet, aspartame, Splenda) Refined food (pastries, white bread/pasta/rice, etc.)

Meat? Y/N If so, types: Vegan? Y/N Vegetarian? Y/N

*Other?

Sleep

On average, how many hours do you sleep daily?

What time do you go to sleep? Awaken?

Do you have trouble falling asleep? Y/N Do you have trouble staying asleep? Y/N

Do you snore?

Do you sleep with your mouth open or closed?

Do you awaken feeling rested? All the time most of the time sometimes hardly ever

Do you dream? Do you remember your dreams and talk about them or write them down?

Breathing

Do you breathe with your mouth open or closed throughout the day?

Do you do conscious breathing exercises? (e.g. yoga, meditation)

Have you experienced panic attacks? Y/N If yes, explain.

Exercise

What do you do for exercise? (Indicate type, frequency, time of day and duration)

BODY / MIND EXERCISES
Meditation / Prayer / Breathing Exercises Other ______________________________

STRENGTH BUILDING
Weight Training
Martial Arts (or similar)
Other ______________________________

CARDIOVASCULAR EXERCISES
High Impact Aerobics / Running / Jogging Low Impact Aerobics / Walking
Cycling / Rowing / Swimming
Other ______________________________

FLEXIBILITY EXERCISES
Yoga / Tai Chi / Qi Gong (or similar) General Stretching / Lengthening
Other ______________________________

How active is your day? _____________________

How many hours do you exercise per week? ___________

Do you belong to a gym, boxing club, yoga studio or the like? Y/N

If so, how often do you go? ________________________ with others? Y/N as part of a class/team? Y/N

Work/ career/ school

What is your occupation?

Do you enjoy your work? Y/N

Do you work shifts or regular schedule?

How many hours do you work each day?

Where do you work? Briefly describe the environment and your work relationships.

Do you have passion projects/hobbies/interests?

CLIENT STATEMENT:

I understand and acknowledge that the services 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 purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.

Signature: _________________________________ Date ________________

Email/phone____

Thank you for attempting to get a lay of the landscape of you!
If you decide to share this form with me for a FREE consultation, rest assured that all information contained on this form will be kept strictly confidential.

Maureen Bakis
Educator, Mental Health Counselor & Coach
Owner, Landscapes for Learning, LLC.