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Clear Skin Diet Assessment Form

Name _____ date of birth_____ male__ female__ Date _____

Age at which acne appeared / worsened _____

Distribution of acne back____ chest____ forehead____ cheeks____ nose____ chin ____ neck____

Type of acne lesions comedones____ papules____ pustules____ nodules____ scars____

Degree of acne mild____ moderate____ severe____

Sleep Hours per night_____ Interruptions per night_____ For what reasons?_____

Stress none 1 2 3 4 5 6 7 8 9 10 unbearable Reasons_____

_____

Exercsie Strength training Times per week_____ Duration_____

Cardiovascular Times per week_____ Duration_____

Flexibility Times per week_____ Duration_____

Stress management / Relaxation Response Activity _____

Times per week_____ Duration_____

Bowel movements per week_____

Typical Diet
veggies fruit carbohydrates protein fat sweets

breakfast_____

snack _____

lunch _____

snack _____

dinner_____

snack _____

Cups per day Milk_____ Sodas_____ Coffee/Tea_____

Beer/Wine/Liquor_____ Fruit Juice_____ Veggie Juice_____

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Women only

Unwanted facial hair yes____ no____

Birth control pills never____ now____ in the past____ number of years____

Date started_____ Date stopped_____

Menstrual cycle regular____ irregular____

Breast tenderness___ bloating____ mood changes____ perimenstrual acne flare____