Healthy Living Questionnaire

Patient Name: _____ **Date:** _____

Age:_____ **Gender:** ❑ **Male** ❑ **Female**

Current Weight: _____

Do you consider yourself:
❑ **underweight** ❑ **overweight** ❑ **just right**

Unintentional weight loss or gain of 10 pounds or more in the last three months: Yes ❑ **No** ❑

Recent changes in your ability to:
❑ **see** ❑ **hear** ❑ **taste**
❑ **smell** ❑ **feel hot/cold sensations**

1. Check the Following Statements That Apply:
- ❑ Occasionally or frequently skip meals
- ❑ Suffer from fatigue
- ❑ Currently overweight
- ❑ Crave sweets or carbohydrates
- ❑ Crave stimulants, such as caffeine or soft drinks
- ❑ Suffer from chronic pain
- ❑ Suffer from headaches

2a. Activity Level – Check Your Current Level of Work or Lifestyle:
- ❑ **Level 1 – Very Light Work:** Sitting, standing, driving, reading, computer, etc.
- ❑ **Level 2 – Light Work:** Light housework, labor, childcare, mechanic, some sitting, etc.
- ❑ **Level 3 – Moderate Work:** Heavy gardening, housework, labor, no sitting, etc.
- ❑ **Level 4 – Heavy Work:** Heavy manual labor, construction, digging, etc.

2b. Exercise Level – Check Your Current Level of Exercise:
- ❑ **None**
- ❑ **Level A – Light Exercise:** 1-3 times per week, easy pace, stretching, walking, etc.
- ❑ **Level B – Moderate Exercise:** 2-3 times per week, moderate pace, some weights, etc.
- ❑ **Level C – Heavy Exercise:** 3-4 times per week, vigorous pace, weights, fast running, etc.

3. Balance Eating – Check Which Apply:
- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt Restriction
- ❑ Fat Restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction
- ❑ Specific food restrictions of:
  - ❑ dairy ❑ wheat ❑ eggs
  - ❑ soy ❑ corn ❑ all gluten
- ❑ Other_____

Servings per day:
Fruits (citrus, melons, etc.)_____
Dark green or deep yellow/orange vegetables_____
Grains (unprocessed)_____
Beans, peas, legumes _____
Dairy, eggs_____
Meat, poultry, fish_____

4. Eating Frequency – Check Which Apply:
- ❑ Skip breakfast or other meals_____
- ❑ Three meals/day
- ❑ Two meals/day
- ❑ One meal/day
- ❑ Graze-small frequent meals (how many/day) _____
- ❑ Generally eat on the run

5. Exercise Frequency and Schedule – Check Which Apply:
- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 min or more duration per workout
- ❑ 30-45 min or more duration per workout
- ❑ Less than 30 min
- ❑ Use of personal trainer
- ❑ Member of fitness club
- ❑ Own exercise equipment
- ❑ Walk: days/week _____
- ❑ Run, jog, jump rope, other aerobic: days/week_____
- ❑ Weight lift: days/week_____
- ❑ Stretch: days/week_____
- ❑ Yoga: days/week_____
- ❑ Other_____ days/week_____

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6. Stimulant Use Habits – Check Which Apply:

❑ Tobacco:
- Cigarettes: #/day_____
- Cigars: #/day_____
- Pipe: #/day_____

❑ Alcohol:
- Wine: # glasses/day or week_____
- Liquor: # ounces/day or week_____
- Beer: # glasses/day or week_____

❑ Caffeine:
- Coffee: # of 6 oz cups/day _____
- Tea: # of 6 oz cups/day _____
- Soda w/caffeine: # of cans/day _____
- Soda w/o caffeine: # of cans/day _____
- Other sources_____

❑ Water:
- # glasses/day _____

7. Stress Habits – Check Which Apply:

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Is your job associated with potentially harmful chemicals, pesticides, radioactivity or solvents: Y ❑ N ❑

Do you suffer from insomnia/sleep disorders? Y ❑ N ❑

Do you often abruptly awake from sleep? Y ❑ N ❑

Do you suffer from depression/mood swings? Y ❑ N ❑

8. Supplement Use Habits – Check Which Apply:

❑ Multivitamin/mineral
❑ Vitamin C
❑ Vitamin E
❑ EPA/DHA
❑ GLA (Evening primrose)
❑ Calcium, source_____
❑ Magnesium
❑ Zinc
❑ Minerals, describe_____
❑ Friendly flora (acidophilus)
❑ Digestive enzymes
❑ Amino acids
❑ CoQ10
❑ Antioxidants (lutein, resveritol, etc.)
❑ Herbs – teas
❑ Herbs – extracts
❑ Chinese herbs
❑ Ayurvedic herbs
❑ Homeopathy
❑ Bach flowers
❑ Superfoods (bee pollen, phytonutrient blends)
❑ Liquid meals (Ensure)
❑ Other_____

9. Energy – Vitality

I'd like to:

❑ Have more energy
❑ Have longer endurance
❑ Have more motivation
❑ Sleep better
❑ Be less tired after lunch
❑ Feel more vital
❑ Regain vitality and vigor of my younger years
❑ Get less colds and flu
❑ Get rid of allergies
❑ Not use so many over the counter drugs
❑ Stop using laxatives
❑ Be free of pain

10. Longevity – Life Enrichment

I'd like to:

❑ Reduce my risk of degenerative disease
❑ Slow down accelerated aging
❑ Monitor biomarkers of aging
❑ Have less facial wrinkles
❑ Maintain a healthier life longer
❑ Change from a "treating-illness" orientation to a creating wellness lifestyle

11. Body Composition – Fat/Muscle

I'd like to:

❑ Be stronger
❑ Be thinner
❑ Be more muscular
❑ Burn more body fat
❑ Be more flexible
❑ Lose weight

12. Stress Reduction – Mental/Emotional

I'd like to:

❑ Be happier
❑ Be less depressed
❑ Be less moody
❑ Be less indecisive
❑ Be more focused
❑ Think more clearly
❑ Improve my memory
❑ Learn how to reduce stress
❑ Learn how to meditate

COMMENTS