Lifestyle Questionnaire

Name _____ Date _____

Age _____ Height _____ Gender _____ Number of Children _____

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Have you tried any of the alternative therapies listed below for your current health concern(s)? Check all that apply

☐ Diet modification ☐ Fasting ☐ Vitamins/minerals ☐ Herbs ☐ Homeopathy ☐ Chiropractic ☐ Acupuncture ☐ Conventional drugs

☐ Other _____

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

Identify the major causes of stress (e.g., changes in job, residence, or finances): _____

Do you consider yourself: ☐ Underweight ☐ Overweight ☐ Healthy weight _____

Have you lost weight in the past? How much? When? Is weight loss one of your current goals?

_____

Occupation _____

Is your job associated with potentially harmful chemicals or conditions (e.g., pesticides, radioactivity, solvents) and/or life threatening activities (e.g., fire fighter, police officer, etc.)?

_____

How many hours of sleep do you get per night on average? _____

Do you feel refreshed upon waking? _____

Have you ever fasted, completed a juice cleanse, or detox? Yes ☐ No ☐ If yes, how many days? _____

How ready and willing are you on a scale of 1 to 10 (1 being the lowest) to make lifestyle changes to improve your health? 1 2 3 4 5 6 7 8 9 10

Health Habits

☐ Tobacco/nicotine products____/day
☐ Alcohol
Wine____5 oz glass(es)/day
Liquor____1.5 oz drink(s)/day
Beer____12 oz can(s)/day
Other____oz/day
☐ Caffeine
Coffee____6 oz cup(s)/day
Tea____6 oz cup(s)/day
Soda w/caffeine____12 oz can(s)/day
List other sources (i.e., energy drinks) and how much_____
☐ All other sweetened beverages (natural and artificial) ____oz/day
☐ Water/sparkling water____oz/day

Exercise

☐ Walk ____mins ____days/wk
☐ Run/jog/other aerobic activity ____mins ____days/wk
☐ Weight lift ____mins ____days/wk
☐ Stretch ____mins ____days/wk
☐ Other activity _____ ____mins ____days/wk

Nutrition and Diet

☐ Omnivore
☐ Vegetarian
☐ Vegan
☐ Salt restriction
☐ Fat restriction
☐ Starch/carbohydrate restriction
☐ Low glycemic diet
☐ Total calorie restriction
☐ Paleo diet

Specific food restrictions based on allergies/cultural preferences
☐ Dairy ☐ Wheat ☐ Eggs
☐ Soy ☐ Corn ☐ All gluten
Other _____

Food Frequency

Number of servings per day
Fruits _____
Vegetables _____
Grains _____
Beans, peas, legumes _____
Dairy _____
Eggs _____
Meat, poultry, fish _____

Eating Habits

☐ Skip meals (which ones)_____
_____
☐ Graze (small frequent meals)
☐ Eat on the run
☐ Eat constantly whether hungry or not
☐ Dining out ____times/wk
☐ Fast food ____times/wk

Current Supplements

☐ Multivitamin/mineral
☐ Vitamin C
☐ Vitamin E
☐ Vitamin D
☐ Fish oil
☐ Evening primrose/GLA
☐ Calcium
☐ Magnesium
☐ Zinc
☐ Probiotics
☐ Digestive enzymes
☐ CoQ_{10}
☐ Antioxidants
☐ Fiber supplements
☐ Herbal products _____
☐ Homeopathic remedies_____
☐ Protein shakes _____
☐ Liquid meals _____
Other _____
_____
_____

I would like to: (choose all that apply)

☐ Feel more vital
☐ Have more energy
☐ Have more endurance
☐ Be less tired after lunch
☐ Sleep better
☐ Be free of pain
☐ Get fewer colds and flu
☐ Get rid of allergies
☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, acid blockers, etc.
☐ Stop using laxatives and stool softeners
☐ Improve my sex drive

Lose Weight or Improve Body Composition

☐ Lose weight
☐ Lose fat
☐ Be stronger
☐ Increase muscle tone
☐ Improve balance
☐ Be more flexible

Stress: Mental and Emotional

☐ Learn how to reduce stress
☐ Think more clearly and be more focused
☐ Improve memory
☐ Be less depressed
☐ Be less moody
☐ Be less indecisive
☐ Feel more motivated

Life Enrichment

☐ Reduce my risk of chronic disease
☐ Slow down accelerated aging
☐ Maintain a healthier life longer
☐ Reduce risk for diseases that run in my family

Which 3 are most important to you?

1) _____
2) _____
3) _____

Additional comments _____
_____
_____
_____
_____

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