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 _____
_____
_____
_____
_____

FirstLine Therapy®
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Health Symptoms Questionnaire

Name: _____ Date: _____

Rate each of the following symptoms based on the last week using the point scale below:

0 Never or rarely have the symptom
1 Occasionally have it, effect is not severe
2 Occasionally have it, effect is severe
3 Frequently have it, effect is not severe
4 Frequently have it, effect is severe

Digestive Tract	Nausea, vomiting	0 1 2 3 4	
	Diarrhea	0 1 2 3 4	
	Constipation	0 1 2 3 4	
	Bloated feeling	0 1 2 3 4	
	Heartburn	0 1 2 3 4	
	Intestinal, stomach pain	0 1 2 3 4	
	Digestive Total:		o
Joints/Muscles	Pain or aches in joints	0 1 2 3 4	
	Arthritis, joint swelling	0 1 2 3 4	
	Stiff or limitation of movement	0 1 2 3 4	
	Pain or aches in muscles	0 1 2 3 4	
	Feeling of weakness or tired	0 1 2 3 4	
	Joints/Muscles Total:		o
Emotional	Mood swings	0 1 2 3 4	
	Anxiety, fear, nervousness	0 1 2 3 4	
	Anger, irritability, aggression	0 1 2 3 4	
	Depression	0 1 2 3 4	
	Emotional Total:		o
Weight/Food	Binge eating, drinking	0 1 2 3 4	
	Craving certain foods	0 1 2 3 4	
	Excessive weight	0 1 2 3 4	
	Compulsive eating, food addictions	0 1 2 3 4	
	Water retention	0 1 2 3 4	
	Underweight	0 1 2 3 4	
	Weight/Food Total:		o
Energy/Sleep	Fatigue, sluggishness	0 1 2 3 4	
	Apathy, lethargy	0 1 2 3 4	
	Hyperactivity	0 1 2 3 4	
	Restlessness, achiness	0 1 2 3 4	
	Sleep disturbances	0 1 2 3 4	
	Energy/Sleep Total:		o
Skin	Acne	0 1 2 3 4	
	Hives, rashes, dry skin, redness	0 1 2 3 4	
	Hair loss	0 1 2 3 4	
	Flushing, hot flashes	0 1 2 3 4	
	Excessive sweating	0 1 2 3 4	
	Skin Total:		o
Heart	Irregular or skipped heartbeat	0 1 2 3 4	
	Rapid or pounding heartbeat	0 1 2 3 4	
	Chest pain	0 1 2 3 4	
	Heart Total:		o
Other	Frequent illness	0 1 2 3 4	
	Frequent or urgent urination	0 1 2 3 4	
	Genital itch or discharge	0 1 2 3 4	
	Other Total:		o

Respiratory	Chest congestion	0 1 2 3 4	
	Asthma, bronchitis	0 1 2 3 4	
	Shortness of breath	0 1 2 3 4	
	Difficulty breathing	0 1 2 3 4	
	Respiratory Total:		o
Eyes	Watery or itchy eyes	0 1 2 3 4	
	Swollen, red, or sticky eyelids	0 1 2 3 4	
	Bags or dark circles under eyes	0 1 2 3 4	
	Blurred or restricted vision	0 1 2 3 4	
	Eyes Total:		o
Nose	Stuffy nose	0 1 2 3 4	
	Sinus problems or dripping nose	0 1 2 3 4	
	Hay fever	0 1 2 3 4	
	Sneezing attacks	0 1 2 3 4	
	Excessive mucus	0 1 2 3 4	
	Nose Total:		o
Mouth/Throat	Frequent, consistent coughing	0 1 2 3 4	
	Gagging, need to clear throat	0 1 2 3 4	
	Sore throat, hoarse, loss of voice	0 1 2 3 4	
	Swollen or discolored tongue, gums, or lips	0 1 2 3 4	
	Canker sores, other mouth sores	0 1 2 3 4	
	Mouth/Throat Total:		o
Ears	Itchy ears	0 1 2 3 4	
	Earaches, ear infections	0 1 2 3 4	
	Drainage from ear, waxy buildup	0 1 2 3 4	
	Ringing in ears, hearing loss	0 1 2 3 4	
	Ears Total:		o
Head	Headaches	0 1 2 3 4	
	Faintness or lightheadedness	0 1 2 3 4	
	Dizziness	0 1 2 3 4	
	Head Total:		o
Cognitive	Poor memory, recall	0 1 2 3 4	
	Confusion, poor comprehension	0 1 2 3 4	
	Poor concentration	0 1 2 3 4	
	Poor physical coordination	0 1 2 3 4	
	Difficulty making decisions	0 1 2 3 4	
	Stuttering, stammering	0 1 2 3 4	
	Slurred speech	0 1 2 3 4	
	Learning disabilities	0 1 2 3 4	
	Cognitive Total:		o

Grand Total _____

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GI Health Assessment

Name _____ Date _____

This questionnaire asks you to assess how you have been feeling **during the last four months.** This information will help you keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

For each question, circle the number that best describes your symptoms. Some questions require a YES or NO response.

0 = No or Rarely—You have never experienced the symptom or the symptom is familiar to you but you perceive it as insignificant (monthly or less)

1 = Occasionally—Symptom comes and goes and is linked in your mind to stress, diet, fatigue or some identifiable trigger

4 = Often—Symptom occurs 2-3x/week and/or with a frequency that bothers you enough that you would like to do something about it

8 = Frequently—Symptom occurs > 4x/week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis

SECTION A

1. Indigestion, food repeats on you after you eat	0 1 4 8
2. Excessive burping, belching and/or bloating following meals	0 1 4 8
3. Stomach spasms and cramping during or after eating	0 1 4 8
4. A sensation that food just sits in your stomach creating uncomfortable fullness, pressure and bloating during or after a meal	0 1 4 8
5. Bad taste in your mouth	0 1 4 8
6. Small amounts of food fill you up immediately	0 1 4 8
7. Skip meals or eat erratically because you have no appetite	0 1 4 8
TOTAL POINTS	0

SECTION B

1. Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt	0 1 4 8
2. Feel hungry an hour or two after eating a good-sized meal	0 1 4 8
3. Stomach pain, burning and/or aching over a period of 1-4 hours after eating	0 1 4 8
4. Stomach pain, burning and/or aching relieved by eating food; drinking carbonated beverages, cream or milk; or taking antacids	0 1 4 8
5. Burning sensation in the lower part of your chest, especially when lying down or bending forward	0 1 4 8
6. Digestive problems that subside with rest and relaxation	(0) YES (8) NO
7. Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache	0 1 4 8
8. Feel a sense of nausea when you eat	0 1 4 8
9. Difficulty or pain when swallowing food or beverage	0 1 4 8
TOTAL POINTS	0

SECTION C

1. When massaging under your rib cage on your left side, there is pain, tenderness or soreness	0 1 4 8
2. Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal	0 1 4 8
3. Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement	0 1 4 8
4. A sensation that food just sits in your stomach creating uncomfortable fullness, pressure and bloating during or after a meal	0 1 4 8
5. Specific foods/beverages aggravate indigestion	0 1 4 8
6. Stool odor is embarrassing	0 1 4 8
7. Undigested food in your stool	0 1 4 8
8. Three or more large bowel movements daily	0 1 4 8
9. Diarrhea (frequent loose, watery stool)	0 1 4 8
10. Bowel movement shortly after eating (within 1 hour)	0 1 4 8
TOTAL POINTS	0

SECTION D

1. Discomfort, pain or cramps in your colon (lower abdominal area)	0 1 4 8
2. Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas	0 1 4 8
3. Generally constipated (or straining during bowel movements)	0 1 4 8
4. Stool is small, hard and dry	0 1 4 8
5. Pass mucus in your stool	0 1 4 8
6. Alternate between constipation and diarrhea	0 1 4 8
7. Rectal pain, itching or cramping	0 1 4 8
8. No urge to have a bowel movement	0 1 4 8
9. An almost continual need to have a bowel movement	(0) YES (8) NO
TOTAL POINTS	0