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

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 ____________________________

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.

© 2002 Wellness Watchers International, Inc.
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

© 2002 Wellness Watchers International, Inc.