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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Healthy Living Questionnaire~Page 2

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

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