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

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