Lifestyle Questionnaire

Name _____ Date _____

Age _____ Gender _____ Height _____ Weight _____

Marital status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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.)?

_____

Please list any alternative or conventional therapies you have tried for your current health concern(s).

_____

_____

Please list current supplements and medications: _____

_____

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

Do you have trouble: ☐ Falling asleep ☐ Staying asleep

Do you use a device to assist and/or monitor your sleep? ☐ Yes ☐ No Please list: _____

Do you feel refreshed upon waking? ☐ Yes ☐ No Do you sleep an average of 7-9 hrs/night? ☐ Yes ☐ No Do you snore? ☐ Yes ☐ No

Rate your daily stressors on a scale of 1-10 (1 being the lowest): Work _____ Family _____ Social _____ Financial _____ Health _____

Other (please indicate stressor) _____

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

Physical activity vital sign (PAV)

On average, how many days/week do you perform physical activity or exercise?
_____ days/week
X _____ minutes/day
= _____ total minutes/week
Describe the intensity of your physical activity or exercise
☐ Light = casual walk
☐ Moderate = brisk walk
☐ Vigorous = jogging

Nutrition and diet

☐ Omnivore
☐ Vegetarian/vegan
☐ Paleo
☐ Ketogenic
☐ Low-fat
☐ Low-carb
☐ High-protein
☐ Salt restriction
☐ Low-glycemic

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

Food frequency

Number of servings per day
Grains & starches _____
Fruit _____
Nonstarchy vegetables _____
Starchy vegetables_____
Legumes _____
Dairy/dairy alt. _____
Animal protein _____
Plant protein _____
Oils & fats _____
Nuts & seeds _____

Eating habits and meal planning

☐ _____ meals per day
☐ _____ snacks per day
☐ Fasting schedule
_____ time of last food/drink intake of the day
_____ time of first food/drink intake of the day
☐ Dining out _____ times/week
☐ Fast food _____ times/week
☐ Grocery shopping _____ times/week
☐ Homecooking _____ times/week
Do you read food labels? ☐ Yes ☐ No
Does stress affect your eating habits? ☐ Yes ☐ No

How often do you move your bowels?

☐ 0 times/day
☐ 1 time/day
☐ 2 or more times/day

What is the consistency?
☐ Separate or lumpy stool
☐ Sausage or snake-like
☐ Mushy or liquid

I would like to: (choose all that apply)

☐ Feel more vital
☐ Have more energy
☐ 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 sex drive

Improve body composition

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

Stress: mental and emotional

☐ Improve resilience to stress
☐ Be more focused
☐ Improve memory
☐ Be less depressed
☐ Be happier
☐ Be more decisive
☐ Be more motivated

Life enrichment

☐ Reduce my risk of chronic disease
☐ Slow down accelerated aging
☐ Increase my healthspan
☐ Reduce risk for diseases that run in my family
☐ Enhance brain function

List 3 areas you'd like to focus on starting today.

1. _____
_____
_____
2. _____
_____
_____
3. _____
_____
_____

Readiness to change
Scale of 1-5 (1 being the lowest)
How willing are you to:

- Make modifications to your daily food choices_____
- Take nutritional supplements daily_____
- Modify your lifestyle habits (sleep, stress, activity)_____
- Incorporate techniques for relaxation_____
- Engage in regular physical activity_____
- Obtain periodic lab tests to assess progress_____

Are you currently using any monitors or apps to track your lifestyle habits?

☐ Yes ☐ No
Please list: _____
_____

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