



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 _____

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

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

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

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 _____

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