

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: _____
