



Healthy Living Lifestyle Assessment Questionnaire - Page 1 of 4

This form asks you a variety of questions about your lifestyle habits, and takes about 3 minutes to complete. Please fill in the information requested, or place a check in the appropriate space. We thank you for your time and effort in completing this questionnaire.

Personal Information

Today's Date: ____ / ____ / ____

Your Name: _____

Address:

Phone:

Work Phone:

Cell Phone:

E-Mail:

Age: _____

Date of Birth:

Sex: Male

Female

Height: _____ (without shoes) Weight: _____

What is the most you have ever weighed? _____ pounds

Are you NOW trying to:

Lose weight

Gain weight

Stay about the same

Not trying to do anything

Occupation:

Personal Physician(s)

Emergency Contact Information:

Name: _____

Phone: _____



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Medical History

Yes No

Has your father or brother had a heart attack or died suddenly of heart disease before age 55 years; has your mother or sister experienced these heart problems before age 65 years?

Has a doctor told you that you have high blood pressure (more than 140/90 mm Hg), or are you on medication to control your blood pressure?

OR

If you know your blood pressure, please check the appropriate category:

Less than 120/80 mm Hg 140/90 to 159/99 Do not know

120/80 to 129/84 160/100 to 180/110

130/85 to 139/89 More than 180/110

Is your total blood cholesterol greater than 240 mg/dl, or has a doctor told you that your cholesterol is at a high risk level?

OR

If you know your blood cholesterol, please check the appropriate category:

Less than 160 mg/dl 200-219 More than 260

160-179 220-239 Do not know

180-199 240-260

Do you have diabetes? If Yes, please explain age of onset and current treatment:

During the past year, would you say that you experienced enough stress, strain, and pressure to have a significant effect on your health?

If you answered "Yes" to any of the above questions, then please answer the following:

Have you recently consulted your physician about increasing your physical activity and/or participating in a fitness evaluation?

If you answered no, will you agree to consult your physician prior to increasing your physical activity and/or participation in a fitness evaluation?

Health and Nutrition

When was the last time you saw your doctor?

Why did you seek your doctor's advice?

Have you had surgery in the last 6 months?

Yes No If yes, for what?

Are you pregnant or postpartum less than six weeks?

Yes No



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Lifestyle Habits

How have you been feeling in general during the past month?

- In excellent spirits In good spirits mostly In low spirits mostly
 In very good spirits I've been up & down in spirits a lot In very low spirits

On average, how many hours of sleep do you get in a 24-hour period?

- Less than 5 5 to 6.9 7 to 9 More than 9

How would you describe your cigarette smoking habits?

- Never smoked
 Used to smoke

How many years has it been since you smoked?

- less than 1 year 6-15
 1-5 More than 15

- Still smoke

How many cigarettes a day do you smoke on average?

- 1-10 21-30 More than 40
 11-20 31-40

How many alcoholic drinks do you consume? (A "drink" is a glass of wine, a wine cooler, a bottle/can of beer, a shot glass of liquor, or a mixed drink).

- Never use alcohol Less than 1 per week 1 to 6 per week
 1 per day 2 to 3 per day More than 3 per day

When driving or riding in a car, do you wear a seat belt:

- All or most of the time Some of the time Once in awhile Rarely or never

Thank you for taking the time to fill out this questionnaire!