Elite Wellness and Anti-Aging's Lifestyle Questionnaire

Name _____ Date _____

Age _____Height _____ Weight _____ Gender _____ # of Children _____

Have you tried any tried any of the alternative therapies listed below for your current health concerns(s)? Check all that apply

☐ Diet Modification ☐ Fasting ☐ Vitamins/Minerals ☐ Herbs ☐ Homeopathy ☐ Chiropractic ☐ Acupuncture ☐ Conventional drugs

☐ Other _____

The level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest) _____

Identify the major causes of stress (e.g., changes in job, residence, finances, etc.) _____

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

Have you lost weight in the past? How much? When? Is weight loss one of your current goals?

_____

Occupation _____

Is your job associated with potentially harmful chemicals or conditions (e.g., pesticides, radioactivity, solvent(s) and/or life-threatening activities (e.g fire fighter, police officer, etc.)? _____

How many hours of sleep do you get per night on average? _____

Do you feel refreshed upon waking? _____

Have you ever fasted, completed a juice cleanse or detox? Yes ☐ No ☐ If yes, how mnay days? _____

How read and willing are you on a scale of 1 to 10 (1 being the lowest) to make lifestyle changes to improve your health? _____

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_____6oz cups/day
Tea_____6 oz cups/day
Soda w/ caffeine_____12 oz cans/day
List others (i.e., energy drinks) and how much
_____
☐ All other sweetened beverages (natural and artificial_____oz/day
☐ Water/sparking water_____oz/day

Exercise

☐ Walk _____mins ____days/wk
☐ Run/jog/other aerobic activity _____mins ____days/wk
☐ Weight lift _____mins ____days/wk
☐ Stretch _____mins ____days/wk
☐ Other activity _____mins ____days/wk

Nutrition and Diet

☐ Omnivore
☐ Vegetarian
☐ Vegan
☐ Salt restriction
☐ Fat restriction
☐ Starch/carbohydrate restriction
☐ Low glycemic diet
☐ Total calorie restriction
☐ Paleo diet
Specific food restrictions based on allergies/cultural preferences
☐ Dairy ☐ Wheat ☐ Eggs
☐ Soy ☐ Corn ☐ All gluten
Other_____

Food Frequency

Number of servings per day
Fruits_____
Vegetables_____
Grains_____
Beans, peas, legumes_____
Dairy_____
Eggs_____
Meat, poultry, fish_____
Eating Habits
☐ Skip meals (which ones)_____
_____
☐ Graze (small frequent meals)
☐ Eat on the run
☐ Eat constantly whether hungry or not
☐ Dining out ____times/wk
☐ Fast food ____times/wk

Current Supplements

☐ Multivitamin/mineral
☐ Vitamin C
☐ Vitamin E
☐ Vitamin D
☐ Fish oil
☐ Evening primrose/GLA
☐ Calcium
☐ Magnesium
☐ Zinc
☐ Probiotics

☐ Digestive enzymes
☐ CoQ_{10}
☐ Antioxidants
☐ Fiber supplements
☐ Herbal products_____
☐ Homeopathic remedies_____
☐ Protein shakes_____
☐ Liquid meals_____
Other
_____
_____
_____
_____

I would like to: (choose all that apply)

☐ Feel more vital
☐ Have more energy
☐ Have more endurance
☐ 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 my sex drive

Lose Weight or Improve Body Composition

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

Stress: Mental and Emotional

☐ Learn how to reduce stress
☐ Think more clearly and be more focused
☐ Improve memory
☐ Be less depressed
☐ Be less moody
☐ Be less indecisive
☐ Feel more motivated

Life Enrichment

☐ Reduce my risk of chronic disease
☐ Slow down accelerated aging
☐ Maintain a healthier life longer
☐ Reduce risk for diseases that run in my family

Which 3 are most important to you?

1)_____
2)_____
3)_____

Additional comments
_____
_____
_____