

Healthy Life Styles Questionnaire

1. Date: _____ DOB _____

2. Name _____

Race _____ Sex M F

3. Phone# _____

4. Address _____

City _____ State _____ Zip _____

5. Primary Insurance _____

6. Primary Physician _____ Phone # _____

7. Do you have any food allergies or non food allergies?
If so, what are they?

8. Do you require assistance to schedule and attend
appointments Y N

9. Names of individuals who assist you/emergency contact:

10. Chronic Disease: Heart, Cancer, Diabetes, High Blood Pressure, High Cholesterol

11. Infectious Disease: HIV, Hepatitis

12. Mobility limitations: Y N

13. Able to schedule own transportation to classes Y N

14. How is your general health?

Very poor/ Poor/Fair/ Good/ Excellent (please circle)

15. Number of days you have been sick in the last month _____

Life Style Questions

1. Do you smoke Y N
2. Do you drink alcohol Y N
3. Is your weight within the expected range Y N
4. Do you engage in healthy eating practices (5 servings fruits and vegetables per day)

1X a week _____ 2X a week _____ 3 X a week _____

5. Do you engage in physical activity(30 min per day)

0-3 X per month _____ 4-7 X per month _____

8-12 X per month _____

Identify Activities: _____

6. When do you want to start the program?

ASAP/May _____ After summer/September _____

Next winter/January 2007 _____

7. Any additional questions/comments: _____
