

Lifestyle Questionnaire

1. Does your work or daily activity primarily involve:

- a. Sitting
- b. Standing
- c. Walking
- d. Heavy Labor
- e. Other

2. On the average how many times per day do you lift objects which weigh more than 25 pounds?

- a. Rarely
- b. 1 – 4 times
- c. 5 – 14 times
- d. 15 – 24 times
- e. 25 times or more

3. How many times in the last year have you experienced back or neck pain?

- a. None
- b. Once or twice
- c. 3 – 6 times
- d. 7 or more times

4. Have you ever experienced back or neck pain which was severe enough to interfere with your normal activities for more than 3 days?

- a. Yes – How many times
- b. No

5. How many hours of sleep do you get a night on average?

- a. Less than 6
- b. 6 – 7
- c. 8 – 9
- d. 10+

6. How often does your day include planned periods of relaxation?

- a. Never
- b. Rarely
- c. Sometimes
- d. Usually
- e. Frequently

7. How often do you feel worried, tense or upset about something?

- a. Several times per day
- b. A few times per day
- c. Several times per week
- d. A few times per week
- e. A few times per month
- f. Rarely or never

8. Considering your age, how would you consider your overall health?

- a. Excellent
- b. Good
- c. Fair
- d. Poor

9. How have you been feeling in general?

- a. Excellent
- b. Very good
- c. Good mostly
- d. Up and down
- e. Low
- f. Very low

10. Have you been anxious, worried or upset?

- a. Extremely
- b. Very much so
- c. Quite a bit
- d. Some
- e. A little bit
- f. Not at all

11. Have you been waking up feeling fresh and rested?

- a. Every day
- b. Most every day
- c. Fairly often
- d. Less than half the time
- e. Rarely

f. None of the time

12. Have you felt tired, worn out, used-up or exhausted?

a. All of the time

b. Most of the time

c. A good bit of the time

d. Some of the time

e. A little of the time

f. None of the time

13. Have you been bothered by illness, pain or fears about your health?

a. All the time

b. Most of the time

c. A good bit of the time

d. Some of the time

e. A little of the time

f. None of the time

14. How satisfied are you with your physical appearance?

a. Very satisfied

b. Mostly satisfied

c. Somewhat satisfied

d. Only slightly satisfied

e. Not satisfied at all

15. Are you a cigarette smoker? If so, how many per day?

Previously a cigarette smoker? If so, when did you quit?

How many years have you smoked or did you smoke before quitting?

Do you/did you smoke (Select one): Cigarettes Cigars Pipe

Please Rate Your Daily Stress Levels (select one):

Low Moderate High but I enjoy the challenge

High: sometimes difficult to handle

High: often difficult to handle.

Do you drink alcoholic beverages?

How many units of alcohol do you consume per week: (see Alcohol Units Calculator below)

Alcohol Units Table

Type of Drink	Units
½ pint of beer	1
1 glass of wine	1

1 pub measure of spirits (Gin, Vodka etc.)	1
1 can of beer	1.5
1 bottle of strong lager	2.5
1 can of strong lager	4
1 bottle of wine	7
1 liter bottle of wine	10
1 bottle of fortified wine (port, sherry etc.)	14
1 bottle of spirits	30

Dietary Habits. Please Select All That Apply.

- | | |
|--|--|
| <input type="checkbox"/> I seldom consume red or high-fat meats. | <input type="checkbox"/> I eat at least 5 servings of fruits/vegetables per day. |
| <input type="checkbox"/> I pursue a low-fat diet. | <input type="checkbox"/> I almost always eat a full, healthy breakfast. |
| <input type="checkbox"/> My diet includes many high-fiber foods. | <input type="checkbox"/> I rarely eat high-sugar or high-fat desserts. |

Thank you for answering this questionnaire. It will help in the development of your fitness program and overall wellness.