

# Wellness Questionnaire

Name \_\_\_\_\_

Date \_\_\_\_\_

Please rate your overall physical health (0 = Poor to 5 = Excellent):

Please rate your overall emotional health (0 = Poor to 5 = Excellent):

Please rate your overall spiritual health (0 = Poor to 5 = Excellent):

## **The Essentials of Life**

- 1) Oxygen
  - a. Have you ever been told you have emphysema, COPD, or asthma?
  - b. Do you participate in activities that focus on proper breathing (yoga, tai chi)?
  - c. Do you perform controlled breathing exercises?
  
- 2) Water
  - a. How much water do you drink per day?
  - b. What type of water do you drink (bottled, filtered, tap)?
  - c. If you don't drink water, what types of fluids do you drink?
  
- 3) Nutrition:
  - a. Are you currently trying to lose weight?
  - b. What type of diet do you follow?
  - c. How many servings per day do you eat per day of the following?
    - i. Calcium rich foods/beverages:
    - ii. Fruits/Vegetables:
    - iii. Whole grains:
  - d. How many servings per week do you have the following:
    - i. Meals at a restaurant
    - ii. Fast Food
    - iii. Fish
    - iv. Red Meat
  - e. What types of fats do you eat/cook with (butter, margarine, type of oil)?
  - f. How many meals do you usually eat per day?
  - g. How many snacks do you usually eat per day?
  - h. What is your largest meal of the day?
  - i. Do you eat breakfast every day?
  - j. Do you take any vitamins or supplements (if yes, please provide separate list with brand, name of vitamin/supplement, and dosage)
  
- 4) Sleep
  - a. On average, how many hours do you sleep?
  - b. Do you feel rested during the day?
  - c. How many times do you wake at night?

## **Avoiding Environmental Toxins**

- 1) Do you smoke?  
If yes, packs per day \_\_\_\_\_ since what year \_\_\_\_\_

**continued on Next Page**

- 2) “Anti-Nutrients”
- a. Do you read food labels before you buy/eat?
  - b. Do you know how to identify whether foods have trans-fats?
  - c. Do you know how to identify whole grain products?
  - d. Do you know what foods contain High Fructose Corn Syrup?
  - e. Do you eat organic foods? If yes, which of the following do you buy organic?
    - i. Produce
    - ii. Meats
    - iii. Dairy
    - iv. Coffee/tea

### **Fitness**

How often do you participate in the following:

Cardio/aerobic exercise:

Strength training:

Flexibility (stretching, yoga, etc...):

### **Avoiding Damage from Stress**

Do you drink alcohol?                      Type:    Drinks per week:

Do you experience physical pain on a daily basis?

If yes, does it limit your activity or cause you emotional stress?

Please rate your overall stress level (0 - Very little to 5 - Severe):

Please list any major/traumatic events in your life (divorce, death of close friend/family, abuse, major illness, etc...)

Current/Recent:

Past:

Do you still have unresolved anger, resentment, or sadness from any of these events?

Do you “self medicate” your stress or negative emotions with alcohol, over-the counter or prescription medications, tobacco, drugs, or food?

Do you think that stress or emotional issues are affecting your physical health?

What relaxation techniques do you use to relieve stress in your life (controlled breathing, yoga, Tai Chi, meditation, prayer, etc...)?

### **Spiritual Health:**

Do you believe in a God or creator?

Do you attend a church or synagogue?

Do you identify with a specific religion?

