

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 _____

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