Institute of Complementary Medicine
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Lifestyle Questionnaire

Personal Details

First Name *

Last Name *

Date of Birth * / / (MM/DD/YYYY)

Gender * ☐ Male ☐ Female

Blood Group

Language

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed ☐ Retired

Marital Status ☐ Single ☐ Married ☐ Others

Smoking Status ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker ☐ Smoker, current status unknown ☐ Unknown if ever smoked

Have you tried any of the alternative therapies listed below for your current health concern(s)? Check all that apply. * ☐ Diet Modification ☐ Fasting ☐ Vitamins/Minerals ☐ Herbs ☐ Homeopathy ☐ Chiropractic ☐ Acupuncture ☐ Conventional drugs ☐ Others _____

Select the level of stress you are experiencing on a scale from 1 to 10 (1 being the lowest): * ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Identified the major causes of stress (e.g. changes in job, residence or finances): *

☐ Underweight ☐ Overweight

Do you consider yourself * ☐ 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, solvents) and/or life threatening activities (e.g., fire fighter, police office, 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 many days? _____

How ready and willing are you on a scale of 1 to 10 (1 being the lowest) to make lifestyle changes to improve your health? * ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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____ 6 oz cup(s)/day

Tea____ 6 oz cup(s)/day

Soda w/caffeine _____ 12 oz can(s)/day

List other sources (i.e., energy drinks) and how much

All other sweetened beverages (natural and artificial)

___ oz/day

Water/sparkling water ____ oz/day * _____

Nutrition and Diet *

☐ Omnivore ☐ Vegetarian
☐ Vegan ☐ Salt restriction
☐ Fat restriction ☐ Starch/Carbohydrate restriction

- [ ] Low glycemic diet
- [ ] Total calorie restriction
- [ ] Paleo diet
- [ ] Others _____

Specific food restrictions based on allergies/cultural preferences *

- [ ] Dairy
- [ ] Wheat
- [ ] Eggs
- [ ] Soy
- [ ] Corn
- [ ] All gluten
- [ ] Others _____

Food Frequency

Number of servings per day

Fruits_____

Vegetables_____

Grains_____

Beans, peas, legumes_____

Dairy_____

Eggs_____

Meat, poultry, fish_____ *

Eating Habits

Skip meals (which ones)_____

Current Supplements *

- [ ] Mutlivitamin/Mineral
- [ ] Vitamin C
- [ ] Vitamin E
- [ ] Vitamin D
- [ ] Fish oil
- [ ] Evening primrose/GLA
- [ ] Calcium
- [ ] Magnesium
- [ ] Zinc
- [ ] Probiotics
- [ ] Digestive enzymes
- [ ] CoQ10
- [ ] Antioxidants
- [ ] Fiber supplements
- [ ] Herbal products
- [ ] Homeopathic remedies
- [ ] Protein shakes
- [ ] Liquid meals
- [ ] Others _____

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 softners
- [ ] Improve my sex drive
- [ ] Others _____

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

Life Enrichment *

- ☐ Improve memory
- ☐ Be less moody
- ☐ Feel more motivated
- ☐ Others _____
- ☐ Be less depressed
- ☐ Be less indecisive
- ☐ Reduce my risk of chronic disease
- ☐ Slow down accelerated aging
- ☐ Maintain a healthier life longer
- ☐ Reduce risk for diseases that run in my family
- ☐ Others _____

Which 3 are most important to you?

1)_____

2)_____

3)_____

Additional comments:_____ *