Roper St. Francis Healthy Lifestyle Program Questionnaire

Name _____ Date of Birth_____ Today's Date _____

Who referred you to us? _____

Who is your primary medical doctor? _____

MEDICAL DIAGNOSES AND CONDITIONS:

Other than your prescription medications, please list all of your Vitamins / Herbs / Supplements:_____

_____

Do you have, or have you ever had the following: (Answer "yes" even if it is controlled with medicine)

	Yes	No	Explain:
High Cholesterol			
High Blood Pressure			
Congestive Heart Failure			
Stroke			
Seizures			
Emphysema / COPD			
Asthma or Wheezing			
Stomach Ulcer(s)			
Thyroid Problems			
Diabetes			
Neuropathy			
Sleep Apnea			
Osteoporosis			

SOCIAL HISTORY:

Are you married? Yes / No Spouse's name _____

Do you live alone? Yes / No Who is in household _____

Employment_____

Highest grade completed in school _____

Have you ever smoked cigarettes or cigars? Current smoker / Previous smoker / Never

If previous, when did you quit? _____ If current, how much? _____

How old were you when you started?_____

Do you drink alcohol? Yes / No How many drinks per week /or month_____

Did you used to drink, but quit? Yes / No When did you quit? _____

Do you use any recreational drugs? (e.g. marijuana, cocaine) Yes / No

If yes, which?_____

NUTRITION HISTORY:

Who buys groceries? _____ How often? _____

Where do you eat your meals? _____

Who cooks meals? _____

Do you read food labels? _____ If yes, explain _____

Please list all the beverages you drink and how much (tea, milk, juice, sodas, etc.)_____

_____

Please list the snack foods you eat: _____

When during the day are you hungriest? _____

Do you ever feel that your eating is out of control? _____

How often do you eat at a restaurant? Where?_____

Have there been any recent changes to your eating?_____

Do you follow any certain nutrition guidelines? (e.g. avoid gluten, artificial sweeteners, choose organic)

_____

What is the most you've ever weighed?_____ When was that? _____

What would you like to weigh?_____ What is attractive about this weight to you? _____

_____

Have you ever followed a specialized diet plan before? If so, describe _____

_____

_____

EXERCISE HISTORY:

What are your exercise-related goals? Check all that apply:

__ Appearance
__ Cardiovascular
__ Fat Reduction
__ Flexibility
__ Health
__ Muscle Definition
__ Muscular Endurance
__ Muscular Size
__ Strength
__ Power
__ Self Esteem
__ Speed
__ Sports
__ Stress
__ Toning
__ Weight
__ Posture
__ Other: _____

How are you going to feel when you've achieved these goals? _____

_____

List any other specific fitness goals (e.g. run 5K, get back into your old jeans, play soccer with your kids)

_____

Rate your overall activity level: (circle one) Sedentary Moderately Active Active Very Active

What exercise, if any, do you currently do? _____

_____

What exercise, if any, have you done in the past? How long ago? _____

_____

If you have an existing resistance training regimen, please list the exercises you have regularly performed in the past month: _____

_____

What is your current cardiovascular fitness level, or your ability to perform aerobic exercise like cycling, brisk walking, jogging? (circle one) Very low Fair Average Good Excellent

How would you rate your experience with exercise? _____

What (if anything) intimidates you about exercise? (Check all that apply)

__ I feel intimidated or embarrassed in an exercise setting
__ Upcoming holidays or planned vacation may make it difficult to fit in exercise
__ I travel extensively for work or fun
__ Work demands may make it difficult to exercise
__ I might get frustrated if I don't see results right away
__ Family obligations may make it difficult to exercise
__ My family or friends may not support my attempts to exercise
__ Exercise is not enjoyable or fun for me
__ I get bored easily when I exercise
__ It's hard for me to exercise when I'm tired or fatigued
__ I may forget or lose track of my goal
__ I may have to exercise alone
__ The exercise setting available to me may not meet my needs
__ I don't enjoy exercising in bad weather (rainy, hot, humid, cold, snow)
__ I have no personal obstacles in adhering to an exercise program

Below, please tell us about some experience(s) in your life where you have worked hard for a goal—and achieved it. Perhaps it was an athletic event, or maybe you learned a new language, etc. And then, how did you feel once you accomplished it. Please be as specific as you can.

_____

_____

_____

PROGRAM GOALS

What are your goals? What do you want the Healthy Lifestyle Program to do for you? _____

_____

_____

What do you think will be the challenges you might face? _____

_____

How motivated are you to make changes to **the way you eat**? (circle one)

1 2 3 4 5 6 7 8 9 10
Very low motivation Very high motivation

How motivated are you to make changes to the **way you exercise**? (circle one)

1 2 3 4 5 6 7 8 9 10
Very low motivation Very high motivation

How confident are you that you can make the changes we recommend? (circle one)

1 2 3 4 5 6 7 8 9 10
Very low confidence Very high confidence

COMMUNICATION

May we contact you by email to send appointment reminders, newsletters? If yes, please provide email address: _____

What is the BEST phone number for us to reach you? _____

If this is a cell phone, may we send you a text message? _____

If you would you like an invitation to join our closed group Facebook page, list the name would we search for: _____

Please list two people we could call in case of emergency:

Name	Relationship	Home	Work/Cell

I agree that the information given on this form is true based on my current knowledge.

Signature _____ Date _____