Fit Life Questionaire

Personal Information:

Name: _____Age: _____Date:_____

Gender: __Male__Female Phone: _____ Email: _____

Would you like to improve your current state of health and fitness? ☐ Yes ☐ No

Medications:

☐ **Allergy**
Allegra, Benadryl, Claritin, Flonase, Zyrtec, and others

☐ **Antacids/Ulcer/Digestion**
Pepcid, tagamet, zantac, prevacid, prilosec, magnesium, aluminum antacids, & protonix

☐ **Antibiotics**
Gentomycin, neomycin, streptomycin, cephalosporins, penicillins, tetracyclines & gentamicin,fluoroquinolones, cipco, leuaquin, aneiox

☐ **Anticonvulsants**
Phenobarbital & barbiturates, dilantin, tegretol, mysoline, depakane/depakote

☐ **Anti-Depressants**
Adapin, aventyl, elavil, pamelor, & others. Major tranquilizers (thorazin, mellaril, prolixin serentil & others)

☐ **Anti-inflammatories**
Corticosteriods: prednisone, medrol, aristocort, decadron, NSAIDS: (motrin, aleve, advil, anaprox, dolobid, feldene naprosyn, aspirin & salicylates

☐ **Antiviral Agents**
Zidovudine (Retrovir, AZT & other related drugs) & zovirax, foscarnet

☐ **Blood Thinners / Coumadin/Warfarin**
Alteplase, Danaparoid, and others

☐ **Cardiovascular / Blood Pressure**
Antihypertensives (Catapres, aldomet), ACE inhibitors (Capoten, Vasotec, Monopril, & others) beta blockers (Inderal, corgard, lopressor and others)

☐ **Cholesterol**
Lipitor, crestor, zocor, and others

☐ **Diabetic**
Metformin, sulfonylureas (dymelor, tolinase, micronase/glynase/diabeta)

☐ **Diuretics**
Loop diuretics (lasix, buinex, edecrin) tzide diuretics (HCTZ, enduron, diuril, lozol, zaroxolyn, hygroton and others). Potassium sparing diuretics

☐ **Female Hormones/Male Hormones**
Estrogen/hormone replacement, oral contraceptives, Testosterone, Bio-indentical hormones

☐ **Pain**
Aleve, Aspirin, Vicodin, Hydrocodone-acetaminophen, oxycodone, and others

☐ **Sleep**
Ambien, Lunesta, Rozerem, Sonata, Silenor, and others

☐ **Thyroid**
Levothroid, Levoxyl, Synthroid, Cytomel, and others

Others:

_____

_____

_____

Supplements:

☐ Multivitamin/mineral
☐ Vitamin C
☐ Vitamin E
☐ Fish Oils
☐ GLA (evening primose)
☐ Calcium, source _____
☐ Magnesium
☐ Zinc
☐ Minerals, describe _____
☐ Friendly Flora (Acidophilus)
☐ Digestive enzymes
☐ Amino Acids
☐ Antacids

☐ Cholesterol
☐ Antibiotics
☐ CoQ10
☐ Antioxidants (Lutein, resveratrol, etc.)
☐ Herbs-teas
☐ Herbs-extracts
☐ Chinese herbs
☐ Ayurvedic herbs
☐ Homeopathy
☐ Bach flowers
☐ Superfoods (bee pollen, phytonutrient blends)
☐ Liquid meals
☐ Other: _____

☐ Antidepressants
☐ Female hormones
☐ Anti-inflammatories
☐ Diuretics
☐ CVD
☐ Diabetic
☐ Blood pressure
☐ Pain
☐ Blood Thinners
☐ Digestion
☐ Heart
☐ Sleep
☐ Other Meds: _____

Goals:

- ☐ Have more energy and longer endurance
- ☐ Have more motivation
- ☐ Be less tired
- ☐ Get less colds and flu
- ☐ Get rid of allergies
- ☐ Stop using laxatives
- ☐ Be free of pain
- ☐ Reduce my risk of degenerative disease
- ☐ Slow down my accelerated aging
- ☐ Monitor biomarkers of aging
- ☐ Change from a "treating illness" orientation to creating a wellness lifestyle.
- ☐ Be stronger
- ☐ Be more flexible
- ☐ Get Leaner
- ☐ Be happier
- ☐ Be less moody
- ☐ Be more focused
- ☐ Improve my memory
- ☐ Learn how to reduce stress
- ☐ Learn how to meditate

Would you be interested in a gentle cleansing program to help you achieve your health and fitness goals? ☐Yes ☐No

Food:

1) Check the following statements that apply:

- ☐ Occasionally or frequently skip meals
- ☐ Currently overweight
- ☐ Crave sweets or carbohydrates
- ☐ Crave stimulants such as coffee/tea/ soda
- ☐ Suffer from chronic pain
- ☐ Suffer from headaches
- ☐ Use artificial sweeteners/diet drinks or diet products
- ☐ Eat fast food/fried foods

2) Balanced eating- Check the following statements that apply:

- ☐ Mixed food diet (animal & vegetable sources)
- ☐ Vegetarian/Vegan
- ☐ Salt Restriction
- ☐ Fat Restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction
- ☐ Specific food restriction
  - ☐ Dairy ☐ Wheat ☐ Eggs
  - ☐ Soy ☐ Corn ☐ All Gluten
  - ☐ Other: _____

3) Eating Frequency- Check the following statements that apply:

- ☐ Skip breakfast or other meals

Meals Per Day:

☐ Five ☐ Four ☐ Three ☐ Two ☐ One

- ☐ Graze-small frequent meals (How many/day): _____
- ☐ Generally eat on the run
- ☐ Eat fruits everyday
- ☐ Eat Vegetables every day
- ☐ Eat at least one salad per day

Activity:

1) Activity Level:

- ☐ Level 1- Very light work: sitting, standing, driving, reading, computer.
- ☐ Level 2- Light work: Light housework, labor, childcare, mechanic, some sitting.
- ☐ Level 3- Moderate work: Heavy gardening, housework, labor, no sitting.
- ☐ Level 4- Heavy work: Heavy manual labor, construction, digging.

2) Exercise Frequency & Schedule:

- ☐ Number of days per week:_____
- ☐ Duration of workout:_____
- ☐ Use of personal trainer
- ☐ Member of a fitness club
- ☐ Own exercise equipment
- ☐ Walk: days/week _____
- ☐ Run, Bike, Stairmaster, Eliptical
- ☐ Weight lift
- ☐ Stretch
- ☐ Yoga

3) Digestion:

# of bowel movements per day:_____

- ☐ Bloating
- ☐ Gas
- ☐ Diarrhea
- ☐ Indigestion
- ☐ Pain
- ☐ Heartburn
- ☐ Acid Reflux

Stress:

1) Stimulant Use Habits

- ☐ Sugar
- ☐ Tobacco
- ☐ Cigarettes: #/day _____
- ☐ Cigars: #/day _____
- ☐ Alcohol
  - Wine: # glasses/day or week _____
  - Liquor: # glasses/day or week _____
  - Beer: # glasses/day or week_____
- ☐ Caffeine:
  - Coffee/tea: # of 6oz. cup/day _____
  - Soda w/ caffeine: # of cans/day _____
  - Soda w/o caffeine: # of cans/day _____
  - Other sources: _____
- ☐ Water:
  - # of 8oz. glasses/day _____

Circle the level of stress you are experiencing on a scale from 1to 10 (1 being the lowest)

1 2 3 4 5 6 7 8 9 10

Sleep:

Average hours per night of sleep: _____

Are you able to fall asleep?	☐Y ☐N
Do you suffer from insomnia or sleep disorders?	☐Y ☐N
Do you remember your dreams?	☐Y ☐N
Do you sleep with any electronic devices on (including: light, TV, radio, computer, etc.)	☐Y ☐N
Do you often abruptly awake from sleep?	☐Y ☐N
Do you suffer from depression or mood swings?	☐Y ☐N