

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**LIFESTYLE QUESTIONNAIRE**

**EXERCISE**

Do you exercise?

What kind(s) of exercise do you do?

How often do you exercise?

Do you feel pain after exercising? Where?

Do you feel the exercise you are doing is good for you?

**NUTRITION**

What kinds of food do you eat?

List the foods/liquids you consumed in the last three days:

Day one

Breakfast:

Lunch:

Dinner:

Day two

Breakfast:

Lunch:

Dinner:

Day three

Breakfast:

Lunch:

Dinner:

Do you think that everything you are consuming/drinking is good for you?

If not, what in particular?

**SUPPLEMENTS**

List all supplements you take:

Are they helping you? Do you believe they are good for you?

**ALCOHOL/DRUG CONSUMPTION**

Please list what you consumed during the last week (please note: if you feel uncomfortable listing anything, please tell the doctor in person.) Anything you tell us is strictly confidential!

Do you believe that what you are drinking/taking is good for you? Harming you? Is it a problem?