

HEALTH QUESTIONNAIRE

Please read through all of the questions first, then go back and answer the ones that you don't mind answering. No names, please. I am NOT a doctor or other healthcare professional.

How would you describe a healthy lifestyle? _____

Do you feel healthy, or is there room for improvement? _____

NUTRITION

List your typical month's diet (just the items, not quantity) to include all meals, snacks, and drinks. Someone's might look like this: milk, cheese, yogurt, apples, grapes, lettuce, carrots, onions, pinto beans, cornbread, wheat rolls, cereal, oatmeal, pasta, beef, chicken, walnuts, olive oil, crackers, cookies, snack cakes, water, coffee, egg rolls. This is a general list because meals vary, but, for example, this person never eats a burger with fries and never drinks soda, so these are not listed. Don't worry too much about which group to put the items in; the groupings are just a guide. Think of your grocery list—if you buy caviar and Fruit Loops, then list them!

DAIRY _____

FRUIT _____

VEGETABLES/LEGUMES _____

GRAINS _____

MEATS/FATS/OILS _____

PROCESSED FOODS _____

OTHER _____

How often do you eat out, and what types of food do you usually order when dining out? _____

Please describe your mealtime. Do you eat at regular times? Are you sitting down with family relaxing and conversing, sitting down with others in front of a television, sitting alone, or running around working while stuffing your face? _____

Food usually represents to you: Nutrition Comfort (other or both) _____

Think about how your diet has changed over the years. For example, did your family eat out of your own garden years ago but not now, or now but not then? Do you eat more fresh foods or processed foods now? Have you switched to a gluten-free diet or other restriction? Cut out fried food? Lowered sugar intake? Please list any changes that come to mind and about how long ago you made the changes. _____

If you take vitamins or use any other form of supplemental nutrition, please list them (optional) or write "yes." _____

PHYSICAL/EMOTIONAL HEALTH

If you take prescribed or over-the-counter medicines, please list them (optional) or write "yes."

Please list any illnesses or non-traumatic medical conditions you have or have had (optional).

If you've never experienced stress, depression, grief, or anger, then you must be inside the womb or in denial! When you are really being pounded by life, do you usually find that your emotions affect your health, or do you mostly weather the storms like a steady, solid rock?

_____ Do you sometimes try to find relief by lowering your health standards and, if so, in what ways? _____

_____ Please complete the exercise at the end of this questionnaire to help dig further into your level of freedom in this area.

If you smoke, how much for how long? _____ If you used to smoke, how much for how long? _____

What's your approximate amount of sleep each night/day? _____ Is your sleep typically uninterrupted? _____ Do you usually feel well rested when you wake up? _____

How often do you exercise (include strenuous work or activity)? _____

Would you describe your usual daily activity level as low, medium, or high? _____

FOOD FOR THOUGHT

Your age ____ Number the following according to how much they affect your health (1 the most to 5 the least): ____age ____stress ____toxins ____lifestyle choices ____diet

Do you ever feel convicted or sense God directing you about your health choices? _____

Do you ever let peer pressure determine your choices instead of wisdom? _____

Do you pray for wisdom about your choices? _____ How could poor choices (not just health but in all of life) negatively affect a person's witness? _____

Do you feel this is important to God and why or why not? _____

How does your doctor address your diet, sleep, or exercise habits when assessing your health?

Please list any other information about yourself that you feel would be helpful in determining what you can do to improve your health. _____

