HEALTH & LIFESTYLE QUESTIONNAIRE

<table>
<tr><th colspan="3">A. PERSONAL INFORMATION</th></tr>
<tr><td>NAME</td><td colspan="2"></td></tr>
<tr><td>ADDRESS</td><td colspan="2"></td></tr>
<tr><td>DATE OF BIRTH</td><td colspan="2"></td></tr>
<tr><td>HOME PHONE</td><td colspan="2"></td></tr>
<tr><td>MOBILE PHONE</td><td colspan="2"></td></tr>
<tr><td>EMAIL ADDRESS</td><td colspan="2"></td></tr>
<tr><td>GENDER AT BIRTH M/F</td><td colspan="2"></td></tr>
<tr><td rowspan="3">WEIGHT</td><td>CURRENT WEIGHT</td><td></td></tr>
<tr><td>LOWEST ADULT WEIGHT</td><td></td></tr>
<tr><td>HIGHEST ADULT WEIGHT</td><td></td></tr>
<tr><td>FRAME SIZE S/M/L</td><td colspan="2"></td></tr>
<tr><td>BLOOD TYPE</td><td colspan="2"></td></tr>
<tr><td rowspan="2">REGISTERED MEDICAL PRACTICE</td><td colspan="2">ADDRESS</td></tr>
<tr><td colspan="2">TELEPHONE</td></tr>
<tr><td>MARITAL STATUS</td><td colspan="2"></td></tr>
<tr><td>WHO LIVES WITH YOU</td><td colspan="2"></td></tr>
<tr><td>HOW MANY CHILDREN DO YOU HAVE</td><td colspan="2"></td></tr>
<tr><td>CURRENT OCCUPATION</td><td colspan="2"></td></tr>
<tr><td>HOW WOULD YOU RATE YOUR HEALTH</td><td colspan="2"></td></tr>
<tr><td>WHAT IS YOUR HEALTH-RELATED GOAL</td><td colspan="2"></td></tr>
<tr><td>WHAT ARE YOUR MOST IMPORTANT EXPETATIONS AS A PATIENT</td><td colspan="2"></td></tr>
<tr><td>MEDICAL HISTORY</td><td colspan="2"></td></tr>
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B. MEDICAL HISTORY		
PLEASE LIST ANY SURGICAL PROCEDURES YOU HAVE HAD AND APPROXIMATE DATES. (INCLUDING COSMETIC SURGERY)		
PLEASE LIST ANY HISTORY OF TRAUMA THAT YOU HAVE EXPERIENCED (CAR ACIDENTS, HEAD INJURIES, BROKEN BONES ETC)		
PLEASE LIST ANY DRUG ALLERGIES YOU HAVE, ALONG WITH THE REACTION YOU EXPERIENCE.		
PLEASE LIST ANY EXPOSURE YOU HAVE EXPERIENCED TO ENVIRONMENTAL RISKS.		
PLEASE LIST ANY DIAGNOSTIC PROCEDURES YOU HAVE HAD		
HAVE YOU EVER HAD A TRANSFUSION? IF SO, PLEASE LIST WHEN AND FOR WHAT REASON?		
PLEASE LIST ALL MEDICATIONS (PRESCRIPTION OTHERWISE) YOU ARE CURRENTLY TAKING AND FOR WHAT REASON:		
PLEASE LIST ALL SUPPLEMENTS (VITAMINS, HERBS, NUTRITIONAL SUPPLEMENTS) YOU ARE CURRENTLY TAKING AND FOR WHAT CONDITION.	(OR YOU CAN COPY LABELS AND SEND IN WITH QUESTIONNNAIRE)	
PLEASE DESCRIBE ANY CURRENT RECREATIONAL DRUG USE.		
ARE YOU CURRENTLY RECEIVING	RADIOTION THERAPY	

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	CHEMOTHERAPY	

C. CURRENT SYMPTOMS	
FOR THE FOLLOWING CATEGORIES, PLEASE CHECK THE SYMPTOMS THAT YOU ARE EXPERIENCING TO A DEGREE THAT YOU FEEL IS SUBSTANTIAL OR UNUSUAL.	
SKIN AND HAIR	
ALLERGIES	
CARDIOPULMONARY	
METABOLIC	
KIDNEY, BOWELS, BLADDER AND GASTROINTESTINAL	
NEUROLOGICAL	
EYES, EARS, NOSE OR THROAT	
JOINTS, MUSCLE AND BONE	
MIND	
MISCELLANEOUS	
FOR WOMEN ONLY	
FOR MEN ONLY	

D. LIFESTYLE SUMMARY

E. EXERCISE SUMMARY	
HOW OFTEN DO YOU ENGAGE IN AEROBIC EXERCISE E.G. WALKING, JOGGING, CYCLING OR SWIMMING?	
TIMES PER WEEK	
LENGTH OF EACH SESSION	
PLEASE DESCRIBE ROUTINE	
HOW OFTEN DO YOU PARTICIPATE IN RESISTANCE/STRENGTH TRAINING EXERCISES (FREE WEIGHTS, WEIGHT MACHINES, BODY PUMP CLASSES OR WATER AEROBICS?	
TIMES PER WEEK	
LENGTH OF EACH SESSION	
PLEASE DESCRIBE ROUTINE	

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F. DIETARY SUMMARY		
ARE YOU A VEGETARIAN, IF YES WHAT TYPE?	VEGAN	
	LACTOVEGETARIAN	
	OVOLACTOVEGETARIAN	
	FRUITARIAN	

G. FOOD SUMMARY	
CONSIDER YOUR AVERAGE HEALTHY EATING DAY AND YOUR AVERAGE UNHEALTHY EATING DAY. THIS WILL GIVE US AN IDEA OF YOUR STRENGTHS AND WEAKNESSES AND HELP US MAKE SUGGESTIONS FOR POSITIVE CHANGE. PLEASE BE SPECIFIC WITH PORTION SIZES.	
BREAKFAST	
LUNCH	
EVENING MEAL	
SNACKS	
DO YOU HAVE ANY SPECIFIC PROBLEM FOODS YOU CONSISTENTLY OVEREAT?	
LIST FOODS	
HAVE YOU NOTICED ANY SITUATION, MOODS, OR OCCAISIONS THAT CAUSE YOU TO EAT OR DRINK MORE THAN YOU SHOULD (E.G. WHEN YOU ARE STRESSED)?	
PLEASE DESCRIBLE?	