nuSTARThealth

Lifestyle Questionnaire

Name: _____ Date of Birth _____ Age: _____

What are you actively doing to improve your health and wellbeing? _____

_____

_____

_____

Are you ready to adopt lifestyle changes (nutrition, sleep, exercise, stress management, etc)? (please circle)

Absolutely yes!	Yes, but I'm very nervous.	I think so.	No, I don't think I can.	No, I don't need to make any changes

Please describe your health goals & improvements you wish to make: _____

_____

_____

_____

What do you need to be as successful as possible in accomplishing your health goals and improvements?

_____

_____

_____

What barriers will keep you from succeeding? _____

_____

On a scale of 1-10, How confident are you in succeeding? _____ Why?_____

_____

How will you define your success? Initially: _____

_____

Over time: _____

_____

On a scale of 1-10, What is the importance of changing your actions within your lifestyle? _____

Why? _____

_____

What is your underlying motivation to change & why? _____

_____

_____

Your Daily Routines

Explain a regular weekday's activity routine—(getting ready, occupation tasks, T.V., reading, etc.):

_____

_____

_____

_____

Explain a regular weekend's activity routine—(getting ready, occupation tasks, T.V., reading, etc.):

Describe your usual energy level:

Who lives in your home & ages:

Do you have any questions or is there anything else we should know about?

Your Nutrition

How often do you eat restaurant food/fast food per week? (please circle)

0-2 times 3-4 times 5-6 times 7-more times

What restaurants do you eat at the most? _____

_____

How often do you….	Always	Sometimes	Never	Please explain
Eat breakfast				When? What?
Eat deep fried foods				Where? What?
Plan ahead when eating				How?
Late night snacking				What? Why?

Drink cola, juice or sugary drinks (please include any drinks with zero calorie or low calorie sweeteners)				When? What?
Alcohol: wine, beer, liquor				When? What?
Drink coffee or tea				Anything added into it?
Read food labels carefully				What part?
Cook meals at home				Who in the family does?
Resist craving temptations				What cravings? When?

Typical Breakfast	Typical Lunch	Typical Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten:_____	Time eaten:_____	Time eaten:_____

Explain your snacking tendancies: _____

_____

What are your worst food habits? _____

_____

Are there any foods you are allergic to?_____

_____

Are there any dietary supplements &/or vitamins you take? _____

_____

What 3 foods do you absolutely love and not want to give up?

1) _____ 2)_____ 3)_____

What 3 foods do you absolutely dislike and will not eat?

1) _____ 2)_____ 3)_____

What comfort foods do you choose when you are under stress or not feeling well?_____

_____

Your Environment (Stress, Sleep, & Exercise)

How often do you experience "negative stress" from each of the following:

	Never	Frequently	Always	Please Explain
Work:	_____	_____	_____	_____
Home or Family:	_____	_____	_____	_____
Financial:	_____	_____	_____	_____
Social:	_____	_____	_____	_____

To de-stress what do you do? _____

Explain your night time routine (tv, read, length to fall asleep, sleep, etc.): _____

_____

Do you feel refreshed when you wake up?_____ Why? _____

_____

Do you complete any sort of physical activity throughout the week? Please explain: _____

_____

Write the number that best describes how you feel:

1-Strongly Disagree 2-Disagree Somewhat 3-Occasionally 4-Agree Somewhat 5-Strongly Agree

I am impatient: _____

I am extremely time-conscious: _____

I am a hard-driving individual, not easily willing to give up: _____

I am calm & easy going: _____

Wellbeing Survey

Please circle the answers that best describe how you have felt over the last 3 months:

	Very Poor	Poor	Neutral	Good	Excellent
In general, how have you felt about YOURSELF in the past 3 months?	1	2	3	4	5
In general, how have you felt about your HEALTH in the past 3 months?	1	2	3	4	5

In the last 3 months most of the time	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
…I have felt sure about myself	1	2	3	4	5
…I felt liked by others	1	2	3	4	5
…I liked who I am	1	2	3	4	5
…I felt I am successful	1	2	3	4	5
…I felt I have good self-esteem	1	2	3	4	5
…I felt I am satisfied with myself	1	2	3	4	5
…I felt I would not change myself	1	2	3	4	5
…I felt I have a number of good qualities	1	2	3	4	5
…I fell asleep easily	1	2	3	4	5
…I slept through the night	1	2	3	4	5
…I awake rested	1	2	3	4	5
…I felt happy	1	2	3	4	5
…I felt hopeful about the future	1	2	3	4	5
…I felt in control of my life	1	2	3	4	5
…I felt I enjoyed my life	1	2	3	4	5

For Office Coding _____ + _____ + _____ + _____ + _____

Total = _____

Patient Health Questionnaire – 9 (PHQ – 9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
For Office Coding:		_____ +	_____ +	_____
			Total =	_____

I If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not Difficult	Somewhat Difficult	Very Difficult	Extremely Difficult
	☐	☐	☐	☐