

## Lifestyle Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ ext \_\_\_\_\_

Cellular \_\_\_\_\_ Other \_\_\_\_\_

Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender M / F

Marital Status:      single              married              common law

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Hours of work per week \_\_\_\_\_ Do you travel for work? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If yes, how much per day/week? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If yes, how much per day/week? \_\_\_\_\_

Do you drink tea or coffee? \_\_\_\_\_ If yes, how much per day? \_\_\_\_\_

How well do you sleep? good    average    poor    How many hours per night? \_\_\_\_\_

How would you rate your overall stress level, on a scale of 1 – 10? \_\_\_\_\_

Are you currently exercising? \_\_\_\_\_ If yes, what are you doing and how often? \_\_\_\_\_

\_\_\_\_\_

Have you been treated by a Chiropractor or Physiotherapist? Please specify \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please specify any ailments and or physical conditions: \_\_\_\_\_

\_\_\_\_\_

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What are your personal health and fitness goals over the next;

For the next 3 months? \_\_\_\_\_

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6 months? \_\_\_\_\_

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1 year? \_\_\_\_\_

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Please elaborate on any additional information that you think may be relevant \_\_\_\_\_

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