Attach small piece of hair
or bring in
$60

Whangamata Wellness
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LIFESTYLE QUESTIONNAIRE

Name .... Blood Group .... Date of Birth........

Date .... Weight .... Height ....

1. Describe your typical breakfast: ....

....

2. Describe your typical lunch: ....

....

3. Describe your typical dinner: ....

....

4. Describe any snacks you have: ....

5. Do you smoke? Yes / No If so, how much? .... How long? ....

6. Do you drink alcohol? Yes / No If so, how much? ....

7. Do you drink coffee? Yes / No If so, how many cups? ....

8. Do you drink tea? Yes / No If so, how many cups per day? .... If so what kind? ....

9. Do you react adversely when you consume caffeinated beverages? Yes / No ....

10. Do you drink cola, fizzy or sports drinks? Yes / No If yes, how much? ....

11. What kind of sweets do you eat? ....

12. How much salt do you use? .... In cooking? ....

13. How often do you eat red meat? .... per week, white meat? .... per. week

14. How much raw food do you eat on a daily basis? (i.e. fruit, veges)........

15. How many glasses of water do you drink each day? ....

16. How much sleep do you get? .... Do you have any problems sleeping? ....

17. How often do your bowels eliminate? ....per day. Constipation ....

18. How much physical exercise do you get? .... Sport? ....

19. Are you under a doctor's care for any illness? Yes / No if so what? ....

20. Are you taking any medications? Yes / No If yes, what? ....

....

21. What long-term medication have you been on previously?(e.g. the pill) ....

P.T.O

LIFESTYLE QUESTIONNAIRE (continued)

22. Are you taking any nutritional supplements? Yes / No If yes, what and how long? ....

23. On a scale of 1 to 10. rate your energy level.............. Does it fluctuate? ....

24. Describe your current state of health (Symptoms) ....

25. What surgery have you had? ....

26. Have you received treatment from Natural Therapists before? ....

27. Do you use over-the-counter medication? e.g. Antacids, Aspirin..............................

.... If so how often? ....

28. If in a relationship - What is it's current and long term state? ....

29. Do you enjoy your work? Yes / No ....

30. Do you live in a pleasant environment? ....

31. How do you relax/ get away? ....

32. Do you regularly practice any form of stress reduction, yoga, or meditation? Yes / No ....

33. Are you prepared to persevere at getting well? Yes / No ....

34. Did another person refer you? Yes / No ....

35. Do you sit at the table or TV for meals? ....

36. How often do you have takeaways? ....

37. Are you religious / philosophical beliefs important to you? Yes / No ....

38. Are you very sensitive to fragrances, exhaust fames or strong odours? Yes / No ....

39. Are you significantly bothered by video display terminals and fluorescent lights? Yes / No ....

40. In your work or home environment, are you exposed to any chemicals or electromagnetic radiation? Yes / No

....

41. Do you eat microwaved food? Yes / No .... how often? ....

42. Do you have a known history of significant exposure to any harmful chemicals like herbicides,insecticides, pesticides, styrofoam, solvents or other harmful substances? Yes / No ....

43. Do you use any hormonal medications, in the form of pills, patches or creams? Yes / No ....