History of Present Lifestyle:

Vitals: Wt:_______ Ht:________ BMI:_______ BP:_________ Pulse:______ WC:______ A1c________
Overweight: BMI 26-30 || Obese: BMI >30

Part 1: Food as Medicine:

1.. How many servings of fruits and vegetables do you eat each day? ***(1 serving is approximately 1/2 cup)***
a) 2 or less b) 3-6 c) more than 9

3. How often do you eat foods that contain processed, preserved, or artificial ingredients?
a) rarely or never b) once daily c) 2-4x a day d) most of the time

4. How often to you drink fluids that contain sugar (including alcohol) or artificial ingredients?
a) rarely or never b) once daily c) 2-4x a day d) daily mostly all the time

5. Do you eat daily breakfast? What do you eat?________________________________

6. Are you or have you been on any weight loss plan? If so, which one? ___________________

Part 2: Stress Management

1. How many minutes of meditation/praying do you do daily?
a) 0 mins b) 5-10 mins c) 20-30 mins d) more than 30 mins

2. Do you do any relaxation activities daily? Yes____ No___

3. Do you suffer from any stress: (Y/N) Physical____ Mental____ Emotional ____ Trauma_____

Part 3: Physical Activity

3. How many minutes per week do you spend doing moderate physical activity (e.g. yard work, brisk walk, exercise, sports)?
a) less than 30 min b) 30-75 min c) 75-150 min d) over 150 min

Part 4. Sleep

1. How many hours of sleep do you sleep without interruption?
a) less than 6 hours b) 7-9 hours c) 9 hours or more
2. Do you snore or stop breathing while asleep? Yes___ No____
3. Do you have problems falling asleep: Yes____ No____ Staying asleep? Yes____ No___
4. Do you drink caffeinated drinks after 1 pm? Yes___ No____
5. Do you drink alcohol/smoke? Yes___ No___

Current Symptoms **(check all that apply)**
fatigue chest pain with exercise___ joint pain or swelling in legs/ankles___ acid reflux ____
snoring___ weight gain (last 3 mo):_____ weight loss (last 3 mo):_____ gas___
constipation____ diarrhea___ headaches___ fatigue___ stress/anxiety____ dizziness____

Medical conditions related to: (Check all that apply)
Diabetes __High cholesterol ___Heart problems__ Arthritis___ Blood Pressure___ Weight gain/loss___ Bladder problems____ GI issues__ Thyroid ____ Depression/Anxiety_____ Hormones_____ Autoimmune disease ____Respiratory issues____ Memory___ Balance___ Mobility____ Allergy/Food sensitivity____
Other________

On a scale of 1-10, how motivated or committed are you to changing your lifestyle?
0 1 2 3(not)_____ 4 5 6 7 (so-so)_____ 8 9 10(very) ______

________________ ________ ________________ ________
Patient/Client Date Anisha Shukla, FMCHC Date