Lifestyle Assessment Questionnaire – Young Adult

LIFESTYLE ASSESSMENT – YOUNG ADULT

The following questionnaire is a confidential health assessment tool designed to provide insight into your health and behaviour. The following questions will assist in providing the best possible care for you and in understanding the factors that may be playing a role in your health.

The following Lifestyle Assessment Questionnaire is **not** designed to give a medical diagnosis. It identifies current strengths of your health, any risk factors that might be present, and it highlights key areas of concern.

This questionnaire will take about 1 hour to complete. The length of time that you take to answer the questions is completely up to you and has no bearing on the results.

General guidelines to follow when filling out the Lifestyle Assessment:

- Select the answer that is best suited to each question
- Read all questions carefully prior to answering
- Write in any response that is not provided on the questionnaire (e.g. if you do other exercises)
- Use the last three months as a guide when answering the questions

The Lifestyle Assessment for Young Adults is broken down into eight categories:

A. General Information
B. School / Work Environment
C. Family History and Information
D. Medication/Supplements & Treatments
E. Exercise
F. Past and Present Health Concerns
G. Review of Physical Symptoms
H. General Information on Diet

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Today's Date: _____

Your Name: _____ Nick Name: _____

Date of Birth: _____ Age: _____

How many people do you live with?: _____

Relationship with you: _____

A. GENERAL INFORMATION

Please circle the response that is correct or fill in the blanks.

Mother's/Guardian's name: _____ Occupation: _____

Father's/Guardian's name: _____ Occupation: _____

Your birth order: _____

Number of siblings: _____ Ages of other siblings: _____

Number of pets: _____ What type of pets: _____

Do you live in the country, farm, suburb or the city: _____

Type of home? ☐ apartment/condo ☐ semi/townhouse ☐ detached house

How many years have you lived in your home? _____

Are there any power lines / power stations etc. near your home: YES / NO

Do you live near a factory? ☐ YES ☐ NO ☐ In the past number of years? _____

Age of the home: _____ How is your home heated: _____

Type of flooring used in the home: _____

Any recent renovations *(what type and when):* _____

B. SCHOOL / WORK ENVIRONMENT

List the amount of time you spend doing the following activities during a typical day.
Note: The total time will probably add up to more than 24 hours due to the nature of the question.

Hours	Activity	Hours	Activity
_____	Sleeping	_____	Exercising/Sports
_____	Personal hygiene e.g. grooming	_____	Listening to music
_____	Driving a vehicle	_____	Taking public transport or passenger
_____	Reading	_____	Watching television
_____	School	_____	Working
_____	Being outside	_____	Computer related work
_____	Time alone	_____	Cell phone, gaming, web searching

INFORMATION ABOUT YOUR SCHOOL / WORK PLACE

What type of buildings are your classes generally held in? Typical permanent school building / portable building / other _____

Describe your work environment: _____

How many hours a day do you spend in these buildings? < 2hours / < 6 hours / < 8 hours / > 12 hours

PERSONAL

What are your hobbies? _____

Do you play any sports? If so, what type and how often?_____

How much time do you spend in nature? _____

Do you smoke? ☐ YES ☐ NO ☐ In the past How many packs a day? _____

Does anyone in your family smoke? ☐ YES ☐ NO ☐ In the past

Do you use natural personal care products? ☐ YES ☐ NO If so, what brand? _____

Do you pay attention to the chemicals in personal care products? ☐ YES ☐ NO

Do you use sunscreen? ☐ YES ☐ NO If so, what brand? _____

Do you dye your hair? ☐ YES ☐ NO If so, what type? _____ How often? _____

Do you have any body piercings? ☐ YES ☐ NO If so, where?_____

How many hours a day do you spend watching television? _____ On a computer? _____

Do you use wireless networks ☐ at home? ☐ at work? If so, how many hours daily? _____

How many hours a day are you on a cell-phone or PDA? _____

Where do you carry your cell phone? _____

Are there any other external or environmental factors that you feel may be affecting your health?

_____

_____

_____

_____

_____

C. FAMILY HISTORY and INFORMATION

Please indicate which family relatives (mother, father, grandparents, siblings, aunts or uncles) have ever encountered the following health concerns:

Health Concern	Family Relative	Health Concern	Family Relative
Alcoholism		Hypertension	
Allergies		Infertility	
Alzheimer's disease		Intestinal disease	
Arthritis		Learning disability	
Asthma		Mental illness	
Cancer *(indicate type)*		Migraine headaches	
Diabetes		Neurological disorders	
Drug addiction		Obesity	
Eating disorder		Osteoporosis	
Genetic disorder		Suicide	
Heart disease/Stroke		Other	

D. MEDICATIONS / SUPPLEMENTS AND OTHER TREATMENTS

Please check any of the following medications that you are taking or have taken in the last 2 years:

☐ antacids ☐ appetite suppressants ☐ aspirin / tylenol ☐ birth control pills
☐ chemotherapy ☐ diuretics (water pills) ☐ laxatives ☐ pain relievers
☐ radiation ☐ recreational drugs ☐ sleeping pills ☐ tranquilizers

Any known allergies or drug sensitivities? _____

Number of times on antibiotics in the last 5-10 years? _____

Number of times on corticosteroids in the last 5-10 years oral? _____ topical? _____

DRUGS *(if more space is needed, please attach a separate sheet)*

Listing of Drugs	Dosage / Amount	Reason for Taking	Duration of Use

SUPPLEMENTS *(if more space is needed, please attach a separate sheet)*

Listing of Supplements	Dosage / Amount	Reason for Taking	Duration of Use

E. EXERCISE

Using the scale provided, identify the number of times a week that you engage in the following exercises. Scale: a (never), b (seldom or less than once per week), c (1 - 3 times per week), d (3 - 5 times per week), e (often or more than 5 times per week).

	Never	<1/wk	1-3/wk	3-5/wk	>5/wk
BODY / MIND EXERCISES					
Meditation / Prayer / Breathing Exercises	a	b	c	d	e
Other _____	a	b	c	d	e
STRENGTH BUILDING					
Weight Training	a	b	c	d	e
Martial Arts (or similar)	a	b	c	d	e
Other _____	a	b	c	d	e
CARDIOVASCULAR EXERCISES					
High Impact Aerobics / Running / Jogging	a	b	c	d	e
Low Impact Aerobics / Walking	a	b	c	d	e
Cycling / Rowing / Swimming	a	b	c	d	e
Other _____	a	b	c	d	e
FLEXIBILITY EXERCISES					
Yoga / Tai Chi / Qi Gong (or similar)	a	b	c	d	e
General Stretching / Lengthening	a	b	c	d	e
Other _____	a	b	c	d	e

How active is your day? _____ How many hours do you exercise per week? _____

Do you belong to a gym? ☐ YES ☐ NO If so, how often do you go? _____

Do you prefer to exercise ☐ alone? ☐ with others? ☐ as part of a class/team?

F. PAST AND PRESENT HEALTH CONCERNS

Please circle the following vaccinations that you had:

Diphtheria Pertussis Tetanus Hib Polio MMR

Chickenpox Influenza HPV Meningococcal Rota virus

Or all vaccines according to schedule

Have you experienced any reactions? _____

Please list any childhood injuries, hospitalizations, accidents or procedures that you have had:
(if required, attach a separate sheet)

Event	When?	Treatments?

Have you been diagnosed with any illnesses? Explain

_____

_____

What are your current health concerns?

_____

_____

When did you notice any changes to your health?

_____

_____

What have been the most traumatic events in your life?

_____

_____

Have you recently experienced changes in your weight? If so, please explain:

_____

G. REVIEW OF PHYSICAL SYMPTOMS

ENERGY LEVEL

On a scale of 1 (low) to 10 (high) rate your energy level _____

What time of the day is your energy the highest? _____

What time of the day is your energy the lowest? _____

What affects your energy? _____

SLEEP

How is your sleep? _____

Do you ever suffer from insomnia? _____ How often? _____

How many hours a day do you sleep? _____ Do you nap? _____

Are you a restful and sound sleeper? If not, please explain. _____

_____

Do you wake feeling rested? _____

Do you have frequent dreams and nightmares? _____

BREATHING

How would you describe your breathing? _____

Do you have shortness of breath on exertion? _____

What affects your breathing? _____

BODY TEMPERATURE

What is your normal body temperature? _____

Do you like to be warm or cool? _____

Do you become overly hot or cold throughout the day? _____

WEATHER

Are you affected by the weather? _____

What is favourite type of weather? _____

What is your least favourite type of weather? _____

GENERAL SIGNS and SYMPTOMS	**Past Concern?**	**Current Intensity** 1 2 3 4 low high	**Length of Time** (years)	**Comments**
fever				
rapid weight loss				
rapid weight gain				
overweight				
underweight				
sensitive to noise				
sensitive to light				
sensitive to odours				
other sensitivities				

Height? _____ ☐ inches ☐ centimetres Weight? _____ ☐ lbs ☐ kg

What do you think would be an acceptable body weight for you? _____ ☐ lbs ☐ kg

HEAD and MOUTH	**Past Concern?**	**Current Intensity** 1 2 3 4 low high	**Length of Time** (years)	**Comments**
dizziness/vertigo				
headaches				
migraines				
frequent sore throats				
hoarseness				
dry mouth				
sore tongue/mouth				
cold sores/herpes				
gum problems				
bad breath				
swollen glands				
lumps/goitre				
nose bleeds				
loss of smell				
other concerns				

Number of dental cavities? _____ Number of amalgams (silver fillings)? _____

Last dental check up? _____ Do you floss? _____ Do you brush regularly? _____

Have you had any extensive dental work? ☐ YES ☐ NO If so, please indicate:

☐ cosmetic dentistry ☐ oral surgery ☐ orthodontics ☐ periodontal therapy

☐ other _____

EYES and EARS	**Past Concern?**	**Current Intensity** 1 2 3 4 low high	**Length of Time** (years)	**Comments**
near sighted				
far sighted				
blurred vision				
dry eyes				
tearing				
itchy eyes				
eye pain				
redness in eyes				
eye discharge				
dark circles under eyes				
bothered by the sun				
eye infections				
glaucoma/cataracts				
diminished hearing				
ear aches				
ear infections				
ringing in ears (tinnitus)				
other eye/ear concerns				

Date of last eye exam? _____ Any eye procedures? _____ Any hearing aids? _____

RESPIRATORY SYSTEM	**Past Concern?**	**Current Intensity** 1 2 3 4 low high	**Length of Time** (years)	**Comments**
cough				
sinus congestion				
spitting up blood				
wheezing				
shortness of breath				
tonsillitis				
asthma				
bronchitis				
pneumonia				
tuberculosis				
other				

Date of last chest x-ray? _____

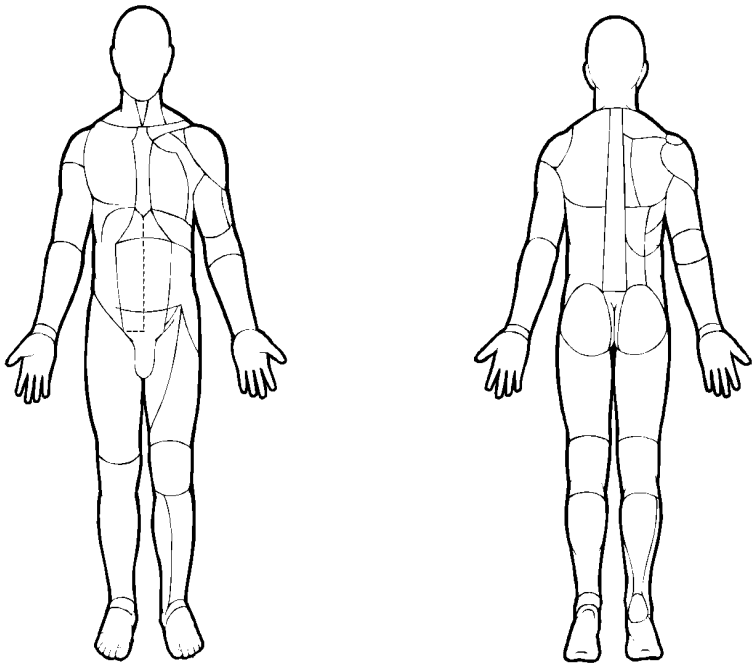
SKIN	**Past Concern?**	**Current Intensity** 1 2 3 4 low high	**Length of Time** (years)	**Comments**
dry/cracked skin				
moist/oily skin				
rashes				
Eczema/psoriasis				
dry scalp/dandruff				
hair thinning/loss				
acne/boils				
itching				
colour changes				
pale complexion				
changes in moles/warts				
lumps/cysts				
stretch marks				
excess body odour				
excessive sweating				
other skin concerns				

NERVOUS SYSTEM	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
fainting				
loss of balance				
tingling				
involuntary movements/twitches				
confusion				
speech problems				
memory problems				
seizures/convulsions				
other				

VASCULAR SYSTEM	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
hot hands/feet				
cold hands/feet				
deep leg pain				
leg cramps				
high blood pressure				
low blood pressure				
chest pain				
slow heart beat				
fast heart beat				
palpitations				
cyanosis (blue skin)				
extremity swelling				
extremity numbness				
varicose veins				
easy bleeding/bruising				
anaemia				
other				

MUSCLES and BONES	**Past Concern?**	**Current Intensity** 1 2 3 4 low high	**Length of Time** (years)	**Comments**
broken bones				
painful joints				
swollen joints				
lack of joint mobility				
muscle strain/sprain				
muscle spasms				
prolonged stiffness				
heavy feeling in limbs				
muscle weakness				
muscle atrophy (deterioration)				
low back pain				
weak/sore knees				
arthritis				

Please mark an 'x' to indicate areas where you feel pain, swelling or discomfort.



Have you had any falls or injuries? ☐ YES ☐ NO If yes, describe: _____

_____

How would you describe your posture? _____

Is there anything that affects your posture on an ongoing basis? _____

How would you describe your flexibility? _____

Do you have issues with the range of motion of any of your joints? ☐ YES ☐ NO If yes, describe:

_____

Date of last bone scan? _____ Results? _____

DIGESTIVE SYSTEM	**Past Concern?**	**Current Intensity** 1 2 3 4 low high	**Length of Time** (years)	**Comments**
change in appetite				
change in thirst				
change in taste				
trouble swallowing				
bitter taste				
nausea / vomiting				
gas or belching				
abdominal bloating				
heartburn/reflux				
constipation				
diarrhea				
hemorrhoids				
undigested food in stool				
blood in stool				
other				

BOWEL MOVEMENTS

On average, how many bowel movements do you have a day? _____

Do you strain to have a bowel movement? _____ What colour are your stools?_____

Describe the consistency / size of your bowel movements? _____

URINARY SYSTEM	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
Urinary pain/burning				
Increased frequency				
Urgency/inability to hold urine				
Frequent infections				
Blood in urine				
Kidney stones				
Other				

MALE REPRODUCTIVE SYSTEM	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
Hernias				
Testicular masses/pain				
Sexual difficulties				
Sexually transmitted infections				

Are you currently sexually active? ☐ YES ☐ NO Sexual preference? _____

Do you use birth control? If so, what type? _____

FEMALE REPRODUCTIVE SYSTEM	Past Concern?	Current Intensity 1 2 3 4 low high	Length of Time (years)	Comments
Bleeding /discharge between periods				
Pain with intercourse				
PMS				
Frequent fungal infections				
Sexually transmitted infections				

Age menses began: _____ Days flow lasts: _____ Days between periods: _____

What symptoms are associated with your period? _____

Any pain with your menses? ☐ YES ☐ NO

Number of pregnancies: _____ Number of live births: _____

Number of miscarriages: _____ Number of abortions: _____

Are you currently sexually active? ☐ YES ☐ NO Sexual preference? _____

Do you use birth control? If so, what type? _____

Date of last PAP? _____ Last menstrual period? _____

EMOTIONAL/ INTELLECTUAL CONCERNS	Past Concerns	Present Concerns
no free time		
mood swings		
overly emotional		
fears/phobias		
depressed		
inability to let things go		
jealousy		
cry often		
anger		
irritable		
hyperactive		
grief		
worry		
nervousness		
anxiety		
anxiety about exams/ public speaking		
burnout		
feeling out of control		
lack of concentration		
learning disability		

H. GENERAL INFORMATION ON DIET

On a scale of 1 (low) - 10 (high) how would you rate your diet? _____

Why: _____

On average how many meals do you eat a day? 1 2 3 4 5 + 5

What is the largest meal: breakfast lunch dinner What time is the last meal? _____

Are there any foods that you crave? _____

Are there any foods that you avoid? _____

Is any specific diet regime followed? ____vegetarian ____vegan ____other _____

How often do you eat processed food? What type are they?

_____

_____

Do you enjoy preparing food? ☐ YES ☐ NO

Do you enjoy food? ☐ YES ☐ NO

Who prepares your food? _____

Do you eat at *(circle all that apply)*: HOME SCHOOL WORK

Which statement describes you best?

☐ I look for quick, convenient food choices when grocery shopping and making meals.

☐ I like to eat natural, whole and fresh food whenever I can.

☐ Someone else is usually responsible for what I eat.

Please list what you would typically have for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Other information about your nutrition: _____

DIETARY BREAKDOWN

Using the scale provided, identify the number of times a week that you eat the following. Scale: less than once per week, 1 - 7 times per week, > 7 times per week.

	Types you eat / drink?	<1/wk	1-7/wk	>7/wk
FRUITS e.g. citrus, berries, apple etc.				
VEGETABLES e.g. root vegies, vine vegies, greens, pickles etc.				
PROTEIN SOURCES / MEAT e.g. nuts, seeds, legumes, eggs, white and red meats.				
MILK PRODUCTS e.g. soya milk, cow's milk, goat's milk, cheese, ice cream etc.				
GRAINS e.g. oats, quinoa, multi grain, wholegrain, rice, bread etc.				
OILS e.g. butter, margarines, vegetable oils etc.				
CAFFEINATED BEVERAGES e.g. coffee, tea, soft drinks, etc.				
WATER e.g. tap, filtered, spring water or herbal tea.				
OTHER BEVERAGES e.g. fruit or vegetable juices etc.				
ALCOHOL e.g. beer, wine, other alcoholic beverages.				

Thank you for completing this questionnaire.