

## Lifestyle Assessment Short Form

### OVERALL HEALTH

**1. Please circle your current overall LEVEL of HEALTH.**

0      1   2   3   4   5   6   7   8   9      10  
 Very      Excellent  
 poor health      health

### SLEEP

**2. OVER THE LAST TWO WEEKS, how many hours of sleep did you average in a 24-hour period?**

- a. Less than 4 hours
- b. 4-5 hours
- c. 6 hours
- d. 7-8 hours
- e. 9 or more hours

**3. OVER THE LAST TWO WEEKS, how often did you feel tired or have difficulty staying awake during routine tasks in the day?**

- a. Not at all
- b. Several days
- c. More than half the days
- d. Nearly every day

### NUTRITION

**5. OVER THE LAST TWO WEEKS, how often have you eaten fast food, sugary drinks (e.g., soda, sports drinks, juice) or packaged foods (e.g., chips, candy, crackers, cookies)?**

- a. Not at all
- b. Several days
- c. More than half the days
- d. Nearly every day

**6. ON AN AVERAGE DAY, how many servings of whole fruits and vegetables do you eat (1 serving is about a handful and does not include fruit juice)?**

- a. Less than 2 servings
- b. 2-3 servings
- c. 4-5 servings
- d. More than 5 servings

### WEIGHT MANAGEMENT

**4. What do you think about your current weight?**

- a. I want to gain a lot of weight
- b. I want to gain a little weight
- c. I am happy with my weight
- d. I want to lose a little weight
- e. I want to lose a lot weight

### EXERCISE

**7. OVER THE LAST TWO WEEKS, how many days did you exercise at a moderate to strenuous intensity (e.g., brisk walking or enough movement to break a light sweat)?**

- a. Less than 1 time per week
- b. 1-2 times per week
- c. 3-4 times per week
- d. 5 or more times per week

**8. DURING AN AVERAGE SESSION, how many minutes do you exercise at a moderate to strenuous intensity (e.g., brisk walking or enough movement to break a light sweat)?**

- a. Less than 10 minutes
- b. 10-29 minutes
- c. 30-49 minutes
- d. 50 minutes or more

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## PURPOSE & CONNECTION / MENTAL HEALTH

9. Over the past 2 weeks, how often have you...	Not at all	Several days	More than half the days	Nearly every day
a. Felt like your life had purpose or meaning?	3	2	1	0
b. Connected with any support network (e.g. community, spiritual, friends/family, nature, yoga, or meditation)?	3	2	1	0
c. Been bothered by little interest or pleasure in doing things?	0	1	2	3
d. Been bothered by feeling down, depressed or hopeless?	0	1	2	3
e. Been bothered by feeling nervous, anxious or on edge?	0	1	2	3
f. Been bothered by worrying too much about different things?	0	1	2	3

## SMOKING/SUBSTANCE USE

**Have you used any of the following substances in the past year?**

**10. NICOTINE** (cigarettes, e-cigarettes/vaping, cigars)

Yes    No

If you marked "YES", how many cigarettes do you usually use? \_\_\_\_\_ a day

If you marked "YES", circle what level of concern you have regarding nicotine?

0	1	2	3	4	5
No Concern				High Concern	

**11. ALCOHOL** (beer, wine, liquor)

Yes    No

If you marked "YES", how much alcohol do you usually use? \_\_\_\_\_ a day

If you marked "YES", circle what level of concern you have regarding your alcohol use?

0	1	2	3	4	5
No Concern				High Concern	

**12. RECREATIONAL DRUGS** (cocaine, heroin, meth, etc.)

Yes    No

If you marked "YES", how much do you usually use? \_\_\_\_\_ a day

If you marked "YES", circle what level of concern you have regarding your recreational drug use?

0	1	2	3	4	5
No Concern				High Concern	

**13. MARIJUANA**

Yes    No

If you marked "YES", how much marijuana do you usually use? \_\_\_\_\_ a day

If you marked "YES", circle what level of concern you have regarding your marijuana use?

0	1	2	3	4	5
No Concern				High Concern	

## MOTIVATION

**14. Please rank the top THREE areas you are most motivated to change in order to improve your current overall LEVEL OF HEALTH (1 being most motivated).**

Sleep _____	Weight Management _____	Nutrition _____
Exercise _____	Purpose & Connection _____	Mental Health _____
Substance Use _____		

**What motivates you to be healthier?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_