Genesis
Health
Revolution

Natural Ways
To Take Back Your Health

Health Coaching
Participant Questionnaire

	NAME:	DATE:	
	GENDER:	AGE:	
	Please answer the following questions to help us learn more about your nutrition and physical health.		
	Diet and Nutrition Habits		
1	Do you follow any special diet? If yes, please explain what type of diet that you are following._____		
2	Do you have any food allergies/intolerances/sensitivities? If yes, please list what foods you have trouble with._____		
3	Do you skip breakfast, lunch or dinner?	YES	NO
4	Do you often feel hungry in-between meals?	YES	NO
5	If you do feel hungry between meals, do you ever have a snack to get thru to the next meal?	YES	NO
6	Do you ever eat to the point where you feel uncomfortable or out of control?	YES	NO
7	Do you have a history of, or are currently struggling with, an eating disorder, binge eating or emotional eating?	YES	NO
8	On average, how many uninterrupted meals do you have per week?	_____Meals	
9	On average, how many servings of dairy do you consume each day?	_____Servings	
10	On average, how many servings of fruit do you consume each day?	_____Servings	
11	On average, how many servings of vegetables do you consume each day?	_____Servings	
12	On average, how many servings of meat do you consume each day?	_____Servings	
13	On average, how many servings of grains do you consume each day?	_____Servings	
14	On average, how many caffeinated beverages do you consume each day?	_____Servings	
15	On average, how many alcoholic beverages do you consume each day?	_____Servings	
16	On average, how many Fruit Juice drinks do you consume each day?	_____Servings	
17	On average, how many glasses of water do you consume each day?	_____Servings	

18	Do you eat protein with every meal?	YES	NO
19	What types of protein do you eat? _____ _____ _____		
20	During a normal meal, is half the food on your plate fruits and vegetables?	YES	NO
21	On a scale of 1-10, how willing are you to eat more fruits and vegetables? (10=Very motivated; 1=No motivation at all)	_____(1-10)	
22	On a scale of 1-10, how willing are you to improve your nutrition habits and stick with it? (10=Very willing; 1=Not willing at all)	_____ (1-10)	
23	Do you have enough food to eat?	YES	NO
24	Do you sometimes go without food or are concerned where you will get food from?	YES	NO
	Lifestyle Habits		
25	Do you have cardiovascular disease?	YES	NO
26	Do you have high cholesterol or take medication for lowering cholesterol?	YES	NO
27	Do you have high blood pressure or take medication to lower blood pressure?	YES	NO
28	Do you have pre-diabetes or diabetes?	YES	NO
29	If so, is it type I or type 2 diabetes?	Type 1	Type 2
30	Have you ever been diagnosed with Obstructive Sleep Apnea?	YES	NO
31	Does anyone in your direct family have or had diabetes or cardiovascular disease?	YES	NO
32	Do you experience significant pain on a regular basis?	YES	NO
33	Have you lost or gained more than 10 pounds in the last 6 months?	YES	NO
34	Have you experienced unintentional weight loss or weight gain?	YES	NO
35	How many total hours sitting do you have each day?	_____Hours	
36	How many “screen time” hours per day do you have each day? This includes TV, Video Games, phone and Computer.	_____Hours	
37	Do you have trouble sleeping?	YES	NO
38	On Average, how many uninterrupted hours of sleep do you receive each night?	_____Hours	
39	Do you snore loudly? (louder than talking or loud enough to be heard thru closed doors.)	YES	NO

40	Has anyone ever observed you stop breathing during your sleep?	YES	NO
41	Do you often feel tired, fatigued, or sleepy during the daytime, even after a good night sleep?	YES	NO
42	Do you ever feel tired after eating a regular sized meal?	YES	NO
43	Do you have any problems with swallowing or chewing?	YES	NO
44	Do you have any problems with diarrhea or constipation?	YES	NO
45	On average, how many bowel movements do you have per day?	_____	
46	Do you smoke cigarettes?	YES	NO
47	Do you use chewing tobacco?	YES	NO
48	Do you vape?	YES	NO
49	If you answered yes above, how many years have you used tobacco?	_____	
50	On a scale of 1-10, how ready are you to quit smoking cigarettes? (10=extremely motivated; 1=no motivation at all)	_____(1-10)	
51	In the past 2 weeks, have you been feeling down, depressed, or hopeless?	YES	NO
52	During the past 2 weeks, have you had little interest or pleasure in your usual activities?	YES	NO
53	Do you have someone to talk to or go to for help when you do not feel well or are distressed?	YES	NO
54	Do you have people in your life who negatively affect your efforts to live a healthy lifestyle?	YES	NO
55	On a scale of 1–10, where 1 is low and 10 is high, how ready, willing, and able are to improve your healthy habits related to sleep, stress, or social support?	_____(1-10)	
	Activity and Exercise Habits		
56	On average, how often and how long do you exercise? Days per week: _____ Minutes per day: _____		
57	At what intensity (how hard) do you usually exercise? ☐ light (casual walk) ☐ moderate (brisk walk) ☐ vigorous (jog/run)		
58	What types of physical activity do you do? List: _____		
59	How often do you do muscle strengthening activities ? Days per week: _____ Minutes per day: _____		

60	Have you fallen in the past year?	YES	NO
61	Do you feel unsteady when you are walking?	YES	NO
62	How concerned are you about the impact of your weight on your health? □ very unconcerned □ unconcerned □ neutral □ concerned □ very concerned		
63	Would you like to change your weight?	YES	NO
64	If yes, how would you like to change your weight? _____ _____ _____		
65	Have you ever tried to change/loose weight before?	YES	NO
	If yes, answer these questions:		
66	What methods did you use? _____		
67	How much did your weight change? _____		
68	How long did you maintain that weight?_____		
69	How much did you gain back?	_____Pounds	
70	Do you (or did you ever) take medication or supplements for weight loss?	YES	NO
71	On a scale of 1–10, where 1 is low and 10 is high, how ready, willing, and able are you to adopt health behaviors that help you maintain a healthy weight?	_____(1-10)	

Disclaimer!

The information shared on this website is for educational purposes and is not intended to be a substitute for professional medical advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified health provider with any questions you may have regarding a medical condition.

If you are on medication and are changing to a whole-food, plant-based diet, you should discuss with your healthcare provider the changes that you are making in your diet and how these changes may require an adjustment in medication dosage. It is important that you work with your doctor to monitor your condition and medication dosage during your change of dietary practices.

"Genesis Health Revolution" is a lifestyle health education and coaching ministry with the focus of teaching people how to take control of their physical, mental and spiritual health one choice at a time.

www.genesishealthrevolution.com