Health Coaching Participant Questionnaire

	NAME:	DATE:	
	GENDER:	AGE:	
	Please answer the following questions to help us learn more about your overall 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? Please circle meals that are skipped.	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 meat do you consume each day?	________Servings	
10	On average, how many servings of dairy do you consume each day?	________Servings	
11	On average, how many servings of processed food do you consume each day?	________Servings	
12	On average, how many servings of fruit do you consume each day?	________Servings	
13	On average, how many servings of vegetables do you consume each day?	________Servings	
14	On average, how many servings of nuts do you consume each day?	________Servings	
15	On average, how many servings of seeds do you consume each day?	________Servings	
16	On average, how many servings of grains do you consume each day?	________Servings	
17	On average, how many caffeinated beverages do you consume each day?	________Servings	

18	On average, how many alcoholic beverages do you consume each day?	________Servings	
19	On average, how many fruit juice beverages do you consume each day?	________Servings	
20	On average, how many glasses of water do you consume each day?	________Servings	
21	Do you eat protein with every meal?	YES	NO
22	What types of protein do you eat? ____ ____ ____		
23	During a normal meal, is half or more the food on your plate fruits and vegetables?	YES	NO
24	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)	
25	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)	
26	Do you have enough food in your home to eat?	YES	NO
27	Do you sometimes go without food or are concerned where you will get food from?	YES	NO
	Lifestyle Habits		
28	Do you have cardiovascular disease?	YES	NO
29	Do you have high cholesterol or take medication for lowering cholesterol?	YES	NO
30	Do you have high blood pressure or take medication to lower blood pressure?	YES	NO
31	Do you have pre-diabetes or diabetes?	YES	NO
32	If so, is it type I or type 2 diabetes?	Type 1	Type 2
33	Does anyone in your direct family have or had diabetes or cardiovascular disease?	YES	NO
34	Do you have trouble sleeping?	YES	NO
35	On Average, how many uninterrupted hours of sleep do you receive each night?	_________Hours	
36	Have you ever been diagnosed with Obstructive Sleep Apnea?	YES	NO
37	If you answered yes to # above, are you using a CPAP/BIPAP machine ?	YES	NO
38	Do you snore loudly? (louder than talking or loud enough to be heard thru closed doors.)	YES	NO
39	Has anyone ever observed you stop breathing during your sleep?	YES	NO

40	Do you often feel tired, fatigued, or sleepy during the daytime, even after a good night sleep?	YES	NO
41	Do you ever feel tired after eating a regular sized meal?	YES	NO
42	Do you experience significant chronic pain on a regular basis?	YES	NO
43	If you answered yes to # 42 above, on a scale of 1-10, 1 being the least and 10 being the worst, what would you rate your pain?	#	
44	Have you lost or gained more than 10 pounds in the last 6 months?	YES	NO
45	Have you experienced unintentional weight loss or weight gain? (If yes Please Circle Which)	YES	NO
46	How many total hours sitting do you have each day?	_________Hours	
47	How many "screen time" hours per day do you have each day? This includes TV, video games, phone and computer.	_________Hours	
48	Do you have any problems with swallowing or chewing? (If yes Please Circle Which)	YES	NO
49	Do you have any problems with diarrhea or constipation? (If yes Please Circle Which)	YES	NO
50	On average, how many bowel movements do you have per day?	__________	
51	Do you smoke cigarettes?	YES	NO
52	Do you use chewing tobacco?	YES	NO
53	Do you vape?	YES	NO
54	If you answered yes above, how many years have you used tobacco?	__________	
55	On a scale of 1-10, how ready are you to quit smoking cigarettes? (10=extremely motivated; 1=no motivation at all)	________(1-10)	
56	In the past 2 weeks, have you been feeling down, depressed, or hopeless?	YES	NO
57	During the past 2 weeks, have you had little interest or pleasure in your usual activities?	YES	NO
58	Do you have someone to talk to or go to for help when you do not feel well or are distressed?	YES	NO
59	Do you have people in your life who negatively affect your efforts to live a healthy lifestyle?	YES	NO
60	On a scale of 1–10, where 1 is low and 10 is high, how ready, willing, and able are you to improve your healthy habits related to sleep, stress, or social support?	________(1-10)	

Activity and Exercise Habits			
61	On average, how often and how long do you exercise? Days per week: ____________ Minutes per day: _____________		
62	At what intensity (how hard) do you usually exercise? ☐ light (casual walk) ☐ moderate (brisk walk) ☐ vigorous (jog/run)		
63	What types of physical activity do you do? List: ____		
64	How often do you do muscle strengthening activities ? Days per week: ____________ Minutes per day: _____________		
65	Have you fallen in the past year?	YES	NO
66	Do you feel unsteady when you are walking?	YES	NO
67	How concerned are you about the impact of your weight on your health? ☐ very unconcerned ☐ unconcerned ☐ neutral ☐ concerned ☐ very concerned		
68	Would you like to change your weight?	YES	NO
69	If yes, how do you think you can change your weight? ________________________ ____ ____		
70	Have you ever tried to change/loose weight before?	YES	NO
	If yes, answer these questions:		
71	What methods did you use? ____		
72	How much did your weight change? ____		
73	How long did you maintain that weight?_______________________________________		
74	How much did you gain back?	________Pounds	
75	Do you (or did you ever) take medication or supplements for weight loss?	YES	NO
76	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