# Lifestyle Assessment Short Form

## OVERALL HEALTH

1. Please circle your current overall LEVEL of HEALTH.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Very poor health</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

## 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
9. Over the past 2 weeks, how often have you…

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

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  _______

What motivates you to be healthier?

______________________________________________________________

______________________________________________________________

Patient Name:___________________________________________________________ DOB: ____________________

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