Healthy Living

Questionnaire

_____ Check this box if you are pregnant _____ Check this box if you have a pacemaker

*Using our body fat analyzer is not recommended if you currently have either of these conditions

Physical Activity

1. On average, how many days a week do you perform organized exercise? _____
2. When you exercise, is your breathing heavier and heart beating faster than normal? Please circle one.
   YES NO
3. On average, how many total minutes of physical activity or exercise do you perform on those days?
   _____

Nutrition

1. How many servings of fruit do you eat daily? _____
2. How many servings of vegetables do you eat daily? _____
3. How many times a day do you eat or drink sugary treats (e.g. soda, diet soda, cookies, candy)?
   _____

Tobacco

1. Do you use any tobacco products? (including e-cigs/vaping) Please circle one. YES NO

Stress

1. On a scale of 1-5 (1=low, 5=high) how much stress do you currently feel you are under? _____
2. On a scale of 1-5 (1= not well, 5= well) how well do you think you manage your stress? _____

Sleep

1. How many hours, on average, do you get of sleep each night? _____
2. On a scale of 1-5 (1=not restful, 5= very restful) how restful is the sleep you get? _____

Motivation

What motivates you to live a healthy lifestyle?

_____
_____