LIFESTYLE SURVEY

Please answer the following questions to the best of your ability. The information you provide will give the Center a better understanding of your ***current lifestyle****, in general, and as it relates to your* ***Nervous System****, in particular.*

(Circle One Y= yes, N=No. For explanations, continue on back of survey)

1. Y N Do you drink coffee? If , yes, is it decaffeinated? Y N, # of cups per day ____
2. Y N Do you drink soda? If yes, is it diet soda Y N # of sodas per day ___
3. Y N Do you drink alcohol? If yes, how many drinks per week ___
4. Y N Do you currently smoke?
5. Y N Have you ever smoked? How long? _____
6. Y N Do you exercise? If yes, how many times per week _____
7. Y N Do you have trouble sleeping on a regular basis?
8. Y N Do you take a sleeping aid? Occasionally? YN Regularly? YN
9. Y N Do you read in bed?
10. Y N Do you sit on the couch at home? If yes, how many hours a day?_____
11. Y N Do you sit at a computer? If yes, how many hours a day?_____
12. Y N Do you consider your diet to be healthy and well balanced?
13. Y N Do you eat fast foods on a regular basis?
14. Y N Do you eat sugar on a regular basis?
15. Y N Are you comfortable at your current weight?
16. Y N Do you have difficulty losing weight?
17. Y N Do you have difficulty gaining weight?
18. YN Are you interested in a Doctor Supervised Weight Control Program?
19. Y N Are you comfortable with your current lifestyle; diet, exercise program?
20. Y N Are you interested in learning about programs to improve health?

Other information that you would like the doctor to be aware of:_____

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Thank you!

NAME: DATE: