LifeStyle Evaluation

ReNu Wellness

Date *

Month Day Year

Name *

First Name Last Name

Email *

example@example.com

Gender *

Date of Birth *

Month Day Year

Age *

Phone Number *

Area Code Phone Number

Height *

Bone Size *

Life Situation

Marital Status *

Do you have children? *

How many?

How old are they?

How many people live in your household?

Stress

Which of the following best describes your current stress(es)? *

- ☐ Family
- ☐ Financial
- ☐ Work
- ☐ Personal
- ☐ Illness
- ☐ Travel
- ☐ Sleep Disruption
- ☐

Are these stresses keeping you from following your nutrition and lifestyle program? *

How are you currently managing your stress (e.g.,meditation, yoga, deep breathing)? *

Have you heard of Mindfulness Meditation? *

Exercise

How many times per week do you exercise? *

For how long? *

What are you doing (be specific)? *

What are your athletic goals? *

Are you working with a trainer? *

Who is your trainer?

Sleep

How many hours of sleep are you getting per night? *

Do you take naps during the day? *

What is your quality of sleep? *

How do you feel upon walking? *

Weight Management

What was your weight 1 year ago? *

What is your current weight? *

What is your goal weight *

Have you been on a diet before? *

Please specify which diet(s) and why you think it didn't work for you:

Nutrition

What are your nutritional goals right now? *

Which best describes what you are doing? *

- ☐ Not eating enough vegetables
- ☐ Eating too many breads / grains / crackers / granola bars
- ☐ Not drinking enough water
- ☐ Eating too many packaged / processed foods
- ☐ Not eating enough protein
- ☐ Eating too many sweets / candies / chocolate
- ☐ Eating large portions at meals
- ☐ Eating at restaurants / fast food too often
- ☐ Skipping Meals
- ☐ Drinking your calories (juice, lattes, coffee, energy drinks)
- ☐ Eating fatty or deep fried foods
- ☐ Time crunch - buying easy to prepare food

☐

Please list all dietary restrictions or food preferences (example: gluten-free, vegetarian, etc.). *

Are there any foods to which you are particularly sensitive (example: cause excessive gas, bloating, stuffiness, or congestion, etc.)? *

What are your favourite foods? *

Who does most of the cooking in your house? *

Exactly how much money do you spend on groceries per month? *

How many times per week do you shop for groceries? *

How many meals do you eat in restaurants and/or fast food places per week? *

Stimulants / Sugars / Chemicals

Indicate if you are consuming any of the following:

Type a question

- ☐ Coffee
- ☐ Decaf coffee
- ☐ Black tea
- ☐ Green tea
- ☐ Dairy
- ☐ Fruit juice
- ☐ Pop
- ☐ Diet pop
- ☐ Marijuana (THC)
- ☐ Alcohol
- ☐ Tobacco in any form
- ☐ Added sweeteners
- ☐ Artificial sweeteners

Nutritional / Natural Supplements:

Please identify and list the products you are using. (Example: vitamins, minerals, herbs, enzymes, nutrition / protein supplements)

Indicate the supplement, brand, and dosage

Supplement	Brand name	Dosage

Over-the-counter / prescription medications:

Please identify and list the brands you are using. (Example: blood pressure control, cholesterol-lowering, anti-depressant, insulin management, anti-inflammatory, etc.)

Indicate the medication name, reason for usage, and dosage

Medication	Reason	Dosage

Daily Routine

Please fill out the following timetable with your most normal daily schedule listing the time you wake up, work to when you have breaks, work out, eat, attend to house chores or hobbies, and go to sleep.

What are you normally doing?

	Week Day	Weekend Day
5am		
6am		
7am		
8am		
9am		
10am		
11am		
12pm		
1pm		
2pm		
3pm		
4pm		
5pm		
6pm		
7pm		
8pm		
9pm		
10pm		
11pm		
12am		