

# HORIZON HEALTHCARE

Fairfield, Illinois

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## EXERCISE/LIFESTYLE QUESTIONNAIRE

Do you exercise regularly? Yes No  
If so, how many days per week? \_\_\_\_\_ How long? \_\_\_\_\_

What type of exercise	Frequency	Duration
Walking/Jogging	_____	_____
Bicycling	_____	_____
Weight training	_____	_____
Organized sports	_____	_____
Other	_____	_____

How many hours do you regularly sleep each night? \_\_\_\_\_

How would you describe your job setting?  
Sedentary limited activity active strenuous

How would you describe your activity level outside of your workplace?  
Sedentary limited activity active strenuous

How would describe your level of fitness? Very fit fit needs work very out of shape

Which meals do you usually eat daily? Breakfast Lunch Supper  
Do you often skip meals? Yes No  
Do you binge after skipping a meal? Yes No

Do you snack? Yes No How many times daily? \_\_\_\_\_  
What types of snacks do you prefer? Salty Sweet Greasy Fruit/Veggies

Do you snack while doing other activities such as watching TV? Yes No  
Do you eat when not hungry? Yes No  
Do you eat when angry, sad, lonely, etc? Yes No

How many times per week do you eat meals away from home? \_\_\_\_\_  
How many of these meals are fast food? \_\_\_\_\_

Please list any vitamins or dietary supplements you are taking: \_\_\_\_\_  
\_\_\_\_\_

Are your parents or siblings overweight or obese? Yes No

What has been your lowest adult weight? \_\_\_\_\_ Highest adult weight? \_\_\_\_\_

What weight would you consider your ideal? \_\_\_\_\_