Serenity Spaces

Lifestyle Questionnaire

Name:

Date:

Contact Information:

Phone:

Email:

HEALTHY LIFESTYLE QUESTIONS

1. How healthy are you?

☐ Not healthy ☐ Moderately healthy ☐ Healthy ☐ Very healthy

2. How often do you participate in at least 30 minutes of vigorous, continuous movement per week? _____

3. For each of the following activities rate whether you strongly disagree, disagree, are neutral, agree, or strongly agree that they are an important part of a healthy lifestyle:

Going for a walk

☐ Strongly disagree ☐ Disagree ☐ Neutral Agree ☐ Strongly agree

Spending time with friends

☐ Strongly disagree ☐ Disagree ☐ Neutral Agree ☐ Strongly agree

E ating a serving of ORGANIC, biodynamic or wild crafted fruit

☐ Strongly disagree ☐ Disagree ☐ Neutral Agree ☐ Strongly agree

Doing something you THOROUGHLY enjoy

☐ Strongly disagree ☐ Disagree ☐ Neutral Agree ☐ Strongly agree

EATING 1 -2 BOWLS of fresh Salad Greens every day

☐ Strongly disagree ☐ Disagree ☐ Neutral Agree ☐ Strongly agree

Do you agree that your language choices direct affect your health & well-being?

☐ Strongly disagree ☐ Disagree ☐ Neutral Agree ☐ Strongly agree

4. In your opinion, what is a healthy lifestyle? Please describe it

5. What could you do to make your lifestyle healthy? (include things that you are already doing)

6. Are you on any prescription drugs? If so, pls list them here and the timelines for taking them:

Do you use recreational drugs? ☐ YES ☐ NO

7. What do you most often eat for:

Breakfast

Lunch

Supper / Dinner

8. What is your favourite beverage?

9. How often do you drink alcohol and if you do, what exactly do you drink?

10. Approximately how long do you sleep each night?

11. Do you have trouble falling asleep? ☐ YES ☐ NO

12. Do you wake up most nights during the night? If yes…..For how long? ☐ YES ☐ NO

13. Do you meditate? ☐ YES ☐ NO

If yes, for how long on an average?

How many times a day?

14. Do you find yourself shouting or arguing lot? ☐ YES ☐ NO

15. Do you crave companionship? ☐ YES ☐ NO

16. Do you crave silence? ☐ YES ☐ NO

17. Do you often feel like checking out? ☐ YES ☐ NO

18. Do you like yourself? ☐ YES ☐ NO

19. How would you rate your level of self-acceptance?

☐ Low ☐ Moderate ☐ High ☐ Very High

20. What do you perceive Life Skills Coaching to be?

21.How motivated are you to make the suggested changes that will be created for your wellbeing?

☐ Very motivated ☐ Slightly motivated ☐ Not motivated at all

22. What are the days and times that you can make yourself available for Phone sessions and for SKYPE/Zoom (face to face conference call) sessions. These include exercise, yoga asanas and a health promoting series of movement.

WOMEN ONLY

23. Are you still menstruating? ☐ YES ☐ NO

a) Do you have painful or debilitating menstrual periods ☐ YES ☐ NO

b) For how long?

24. Are you pregnant now? ☐ YES ☐ NO

25.Has a medical doctor checked for nutritional deficiencies? If so what is the result of these tests?

a) May I contact the doctor to coordinate with him/her?

26. What is the biggest problem/challenge that you are facing now?

27.What is the number one problem that I can help you solve?

Please send this back to serenityspaces@yahoo.com ASAP.
Payments for sessions can be made through PayPal on our website: www.serenityspaces.org