Longs Peak Family Practice

Longs Peak Family Practice Lifestyle Assessment

Patient Name: _____ Date of Birth_____ Date_____

1. Do you have any health goals that you would like us to help you with? _____
   _____
2. Do you exercise? What form of exercise and how many times per week?_____
   _____
3. If you don't exercise, what is preventing you? _____
   _____
4. Do you drink alcohol? YES/NO If yes, how many drinks weekly? _____
   Do you ever binge drink (>4 drinks/day for F, >5 drinks/day for M) YES/NO
5. Do you use tobacco/vaping products? YES/NO If yes, do you want us to try and help you quit? YES/NO
   Have you used tobacco/vaping in the past? YES/NO What, when, and how much? _____
   _____
6. Do you use marijuana or other drugs? YES/NO If so, what type, how often? _____
   _____
7. Please list any vitamins and supplements you take:_____
   _____
8. Do you drink soda, juice, or other beverages with sugar? YES/NO
   What kind and how many per day? _____
9. Are you happy with your weight? YES/NO
   If not, what is your goal? _____
10. Do you feel safe where you live? YES/NO
11. Do you worry about not having enough money for groceries? YES/NO
12. If you have a partner, do you feel safe with him or her? YES/NO
13. Do you feel stressed a lot? YES/NO
    What is your stress level on a scale of 1 (low) to 10 (high)? _____
    What are your stressors and what are you doing to manage your stress?
    _____
    _____
14. Do you have problems sleeping? YES/NO
    How many hours a night do you sleep? _____
    Do you feel rested in the morning? YES/NO
    Do you fall asleep at work, school, or behind the wheel of a car? YES/NO
    Do you snore? YES/NO
    Do you stop breathing at night? YES/NO
    Have you ever been evaluated for sleep apnea? YES/NO