B.P.R. Therapy, Mediation & Coaching Services

Health Questionnaire

Eating Habits

How many meals do you typically eat in a day? 1 2 3 4 5 6

How many meals have you been eating per day? 1 2 3 4 5 6

Of what does breakfast typically consist? _____

Of what does lunch typically consist? _____

Of what does dinner typically consist?_____

What does snacks or other meals consists of normally? _____

_____

Have you struggled with managing your weight? Yes or No

Are eating disorders apart of your or your families' history? Yes or No

Sleeping Habits

How many hours of sleep do you normally get? 4- 5 6 7 8 9+

How many hours of sleep have you been getting as of late? 4- 5 6 7 8 9+

Do you have any trouble sleeping? Yes or No

Explain: _____

Have you ever been on any medications or had any treatments for sleeping? Yes or No

If yes, what _____and when _____

Exercise

Do you exercise regularly? Yes or No

How many days a week do you exercise? 1 2 3 4 5 6 7

What type of exercises? Walk Run Lift Weights Yoga Aerobics Classes

Other: _____

Leisure Activity

What activities define your leisure time? _____

_____

Normally, how many days a week do you have leisure time? 2- 3 4 5 6 7

Normally, how many hours in a day do you spend doing leisure activities? 2- 3 4 5 6+

As of late, how many days a week do you have leisure time? 2- 3 4 5 6 7+

As of late, how hours in a day do you spend doing leisure activities? 2- 3 4 5 6 7+

Do you feel that your leisure time is adequate? Yes or No

If no, what interferes with your leisure time? _____

Religiosity/Spirituality

What religion do you identify with, if any? _____

What are your religious or spiritual practices? _____

_____

How often do you partake in your religious or spiritual practices in a week? 3- 4 5 6+

How many minutes or hours do you put into your religious practices per day? _____

_____

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Is your religions or spirituality time adequate? Yes or No

Please, explain: _____

_____

Other

How often are you bathing? Daily Every other day about every 3 days less than that

Are you taking your medications a prescribed? Yes or No

Have you consumed alcohol, tobacco, marijuana, caffeine, other legal or illegal substance in the last 7 days?

Yes or No

If yes, how many days with in the last week? 1 2 3 4 5 6 7

How many social activities have you attended in the last week? 1 2 3 4 5 6+