LiVe Well Lifestyle and Health Risk Questionnaire

Your Name:_____ Age:_____ [SB6] Sex:_____ [SB8] Date:_____

Provider notes: Height (inches): _____ Weight (lbs): _____ BMI: _____ [SB5]
Waist circumference (inches): _____ Neck circumference (inches): _____ [SB7]

Physical Activity

On average, **how many days per week** do you exercise or do physical activity? [HELP2, PAVS]	days per week: _____
On average, **how many minutes of physical activity or exercise** do you perform on each of those days? [HELP2, PAVS]	minutes per day: _____
At what intensity (how hard) do you usually exercise? [HELP2, PAVS]	☐ light (casual walk) ☐ moderate (brisk walk) ☐ vigorous (jog/run)
What types of physical activity do you do? [HELP2] List:	
How often do you do **muscle strengthening** activities or exercises?	days per week: _____ minutes per day: _____
How many **"screen-time" hours** do you have each day: TV, video games, sitting at the computer (*not* counting work and school)? [HELP2]	screen-time hours per day: _____
How many **total hours sitting** do you have each day (*including* at work and school)?	total sitting hours per day: _____
On a scale of 1–10, where 1 is low and 10 is high, how ready, willing, and able are you to improve your **activity** habits and stick to it?	(1–10): _____

Provider notes:

Nutrition

On average, how many days a week do you eat a healthy **breakfast**? [HELP2]	days per week: _____
On average, how many 12-ounce servings of **sweetened drinks** do you have each **day**? [HELP2]	servings per day: _____ servings per week: _____
On average, how many servings of **fruits and vegetables** do you eat each day? [HELP2]	total servings per day: _____ (fruits:_____/day; veggies:_____/day)
On average, how many **meals per week** do you eat with your family? [HELP2]	meals per week: _____
On average, how many servings of **dairy** do you have each day?	servings per day: _____
On average, how many drinks of **alcohol** do you have each **day**? [HELP2] (1 drink = 12-ounce beer, 5-ounce wine, 1.5-ounce liquor)	drinks per day: _____ drinks per week: _____
How often do you eat while doing other things like watching TV?	☐ rarely ☐ occasionally ☐ often
Do you ever eat in secret?	☐ no ☐ yes
On a scale of 1–10, where 1 is low and 10 is high, how ready, willing, and able are you to improve your **nutrition** habits and stick to it?	(1–10): _____

Provider notes:

Pat Qst 50113

(Reviewed 04/16/18) CPM015b - 04/18

Intermountain® LiVe Well

Sleep, Mental Health, Social Support

How many **hours of sleep** do you typically get (including naps)?[HELP2] hours per day: _____

Do you **snore** loudly (louder than talking or loud enough to be heard through closed doors)?[SB1] ☐ no ☐ yes

Do you often feel **tired,** fatigued, or sleepy during the daytime, even after a "good" night's sleep?[SB1] ☐ no ☐ yes

Has anyone ever **observed** you stop breathing during your sleep?[SB3] ☐ no ☐ yes

In the past 2 weeks, have you been feeling down, depressed, or hopeless?[HELP2] ☐ no ☐ yes

During the past 2 weeks, have you had little interest or pleasure in your usual activities?[HELP2] ☐ no ☐ yes

Who do you most commonly talk to or go to for help when you do not feel well or you are distressed?[HELP2]

☐ I usually don't talk to anyone
☐ My support is exhausted or burnt out
☐ I talk to a friend, clergyman, church leader, spouse, or partner

Do you have people in your life who negatively affect your efforts to live a healthy lifestyle? ☐ no ☐ yes who?

On a scale of 1–10, where 1 is low and 10 is high, how ready, willing, and able are you to improve your healthy habits related to **sleep, stress, or social support**? (1–10):_____

Provider notes:

Weight

Do you think you are: ☐ underweight ☐ about right ☐ overweight ☐ obese ☐ very obese

Would you like to lose weight? ☐ no ☐ yes If yes, how many pounds would you like to lose? _____

Have you tried to lose weight before? ☐ no ☐ yes If yes, answer the questions below:

What methods did you use? _____
Were you successful? ☐ no ☐ yes How much weight did you lose? _____ pounds
How long did you keep it off? _____ How much did you gain back? _____ pounds
Do you (or did you ever) take medication or supplements for weight loss? ☐ no ☐ yes
If yes, what did you take: _____

On a scale of 1–10, where 1 is low and 10 is high, how ready, willing, and able are you to **lose weight and/or maintain weight** you already lost? (1–10):_____

Provider notes:

Other Lifestyle Risk Factors and Conditions

Do **you** have any of the following health conditions? ☐ heart disease ☐ high blood pressure ☐ high cholesterol ☐ type 2 diabetes ☐ obstructive sleep apnea ☐ depression

Do any of your **immediate family members** have any of the following, and if so, who?

☐ heart disease - who: _____ ☐ diabetes - who: _____
☐ obesity - who: _____ ☐ depression - who: _____

Do you use **tobacco**?[HELP2] ☐ never ☐ former ☐ current If former or current, answer the questions below:
Date last used: _____ What kind(s)?_____ How much per day? [HELP2] _____ How many years? [HELP2] _____

List all medications or supplements you take: [HELP2] _____

What other concerns do you have about your health or health habits? _____

Provider notes:

Intermountain Healthcare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Se proveen servicios de interpretación gratis. Hable con un empleado para solicitarlo. 我們將根據您的需求提供免費的口譯服務。請找尋工作人員協助。

PAVS = PAVS questions; SBx = part of Stop Bang screen; HELP2 = fields in HELP2 preventive tab

Intermountain® LiVe Well