



Who referred you to the Lifestyle Medicine Clinic? _____

What does Lifestyle Medicine mean to you? _____

On a scale of 1-10 (1 = poor health, 10 = excellent health), how do you rank your current state of health?

1 2 3 4 5 6 7 8 9 10

On a scale of 1-10 (1 = unable to perform, 10 = perform easily), how easy is it for you to perform daily activities such as working, cooking, shopping, house chores?

1 2 3 4 5 6 7 8 9 10

On a scale of 1-10 (1 = unable to perform, 10 = perform easily), how easy is it for you to be active such as gardening/yard work, exercise, climbing stairs?

1 2 3 4 5 6 7 8 9 10

What are your top 3 health problems/concerns:

1. _____
2. _____
3. _____

What are your goals for working with the Lifestyle Medicine clinic?

Goal #1: _____

Goal #2: _____

Goal #3: _____

On a scale of 1-10, how confident are you in the ability to achieve: (circle)

Goal #1: 1 2 3 4 5 6 7 8 9 10

Goal #2: 1 2 3 4 5 6 7 8 9 10

Goal #3: 1 2 3 4 5 6 7 8 9 10

What are 3 challenges/barriers that may affect your Lifestyle Medicine goals?

Challenge #1: _____

Challenge #2: _____

Challenge #3: _____

Have you previously worked with any of the following: (circle)

Lifestyle Medicine Provider

Nutritionist

Health Coach

Personal Trainer

Mental/Behavioral Health Provider

Other comments/concerns: _____

Name: _____ **DOB:** _____