“What Is Your HQ™?”

Health Quotient Questionnaire for

Name: _____ Date: _____ Age:_____

Your Lifestyle Coach will complete this section:

Resting Heart Rate:_____ Blood Pressure:_____ Weight:_____

Body Measurements: Chest: _____ R. Arm: _____ Waist: _____

Hips: _____ R. Thigh: _____

Total HQ Score: _____= %

We all know that I.Q. (Intelligence Quotient) was developed to measure one’s intelligence. E.Q. (Emotional Quotient), developed by Daniel Golman in 1995, was developed to measure the success of an individual based on emotional strength, or “Emotional Intelligence.” This H.Q.™ *(Health Quotient Questionnaire)* was developed by ***Eden Lifestyle Coaching*** to highlight the strengths and weaknesses of your current lifestyle and to find out your "health intelligence."

As with all personal information discussed with your Lifestyle Coach, the information on this questionnaire is kept **completely confidential**. Read each question carefully and consider your best response. A “0” is considered "never" and a “5” is a strong response or regular reaction. Mark N/A if you feel the question is not applicable to you at this time.

Fitness:

1. Do I daily incorporate sweat-producing exercise into my week?	0 1 2 3 4 5
2. Do I *enjoy* being active?	0 1 2 3 4 5
3. Do I seek out ways to increase activity in my day?	0 1 2 3 4 5
4. Do I feel physically strong?	0 1 2 3 4 5
5. What is my activity level throughout each day?	0 1 2 3 4 5
6. Do I have energy at the end of most days?	0 1 2 3 4 5
7. Do I feel flexible and agile?	0 1 2 3 4 5
8. Do I do strength training?	0 1 2 3 4 5
9. Do I do cardiovascular training (heart & lungs) 3-5x's/week?	0 1 2 3 4 5
10. Do I find I am easily out of breath? (i.e. going up stairs)	0 1 2 3 4 5(s)

11.How would I rate my overall fitness level? 0 1 2 3 4 5
12. Am I happy with my body shape and size? 0 1 2 3 4 5
13. Am I open to having a fitness trainer help me get started? Y N

Personal Nutrition:

1. Do I eat at least three meals every single day? 0 1 2 3 4 5
2. Do I incorporate healthy snacks? 0 1 2 3 4 5
3. Do I consume 6-10 servings of fresh, living fruits & vegetables daily? 0 1 2 3 4 5
4. Do I eat whole-grain breads/pastas? 0 1 2 3 4 5
5. Do I *enjoy* eating healthy? 0 1 2 3 4 5
6. Do I physically feel well after I eat? 0 1 2 3 4 5
7. Do I emotionally feel well about the way I am eating? 0 1 2 3 4 5
8. Am I motivated to make changes where they are needed? 0 1 2 3 4 5
9. Do I read food labels and ingredients lists? 0 1 2 3 4 5
10. How much water do I drink per day? (÷ the # of cups by 2 to =score) 0 1 2 3 4 5
11. Do I use filtered/purified water? 0 1 2 3 4 5
12. Do I take any vitamin or mineral supplements, herbs or "nutraceuticals?" 0 1 2 3 4 5
1. Do I have a "sweet tooth" or ever crave sweets? 0 1 2 3 4 5
2. Do I eat when I am not hungry? 0 1 2 3 4 5
3. Do I cook or reheat foods with a microwave? 0 1 2 3 4 5
4. How many times a week do I eat out? 0 1 2 3 4 5
5. How often do I consume pop, iced tea or powdered/instant drinks? 0 1 2 3 4 5
6. How much regular or decaffeinated tea/coffee do I drink a day? 0 1 2 3 4 5
7. Do I consume artificial sweeteners, aspartame or "sugar-free" products? 0 1 2 3 4 5
8. How much alcohol do I drink a week? 0 1 2 3 4 5
9. Do I consider myself to be overweight? 0 1 2 3 4 5
10. Do I eat after 7:30 PM? 0 1 2 3 4 5
11. How would I rate my overall eating habits? 0 1 2 3 4 5
12. Do I eat quickly or do I chew my food well and take my time? _____
13. What kind of fat/oils do I use? (circle) olive flax hemp coconut butter sunflower corn safflower canola other: _____
14. What foods do I most enjoy eating or snacking on? _____
15.What foods do I crave? _____
16. Would it benefit me/my family to have meal planning? Y N

Personal Health Issues:

1. Do I fall asleep easily? 0 1 2 3 4 5
2. Do I regularly wake up feeling refreshed? 0 1 2 3 4 5
3. On average, how many hours of solid sleep do I get per night?_____
4. What are the hours I typically sleep from? _____ to _____

4. Do I smoke? If yes, how many/day? _____ Y N
5. Do I have problems with gas, bloating, constipation, diarrhea? (circle)
6. How many bowel movements do I have each day? 0 1 2 3 4 5
7. Are my stools: hard, with straining; soft, like mashed potatoes; runny/watery? (circle)
8. How many mercury (black/gray) fillings are in my mouth? 0 1 2 3 4 5+
9. Do I have any root canals in my mouth? If so, how many? 0 1 2 3 4 5
10. Do I grind or clench my teeth? Y N
11. Is my tongue ever coated white or gray? 0 1 2 3 4 5
12. Do I experience itching of any kind? (skin, ears, nasal, vaginal, rectal?) 0 1 2 3 4 5
13. Do I have any skin issues? (eczema, fungal infections, psoriasis, etc?) 0 1 2 3 4 5
14. Do I have any ridges or white spots on my finger nails? 0 1 2 3 4 5
15. Do I get headaches? 0 1 2 3 4 5
16. Do I have allergies/sensitivities? Y N
If yes, to what substances?_____
17. Are my menstrual cycles regular? Y N NA
18. Do I experience menstrual pain/bloating? 0 1 2 3 4 5
19. Do I experience chronic/acute pain of any kind? 0 1 2 3 4 5
20. Am I open to using alternative therapies?_____

Home Organization:

1. Am I happy with my living space? 0 1 2 3 4 5
2. Do I enjoy being at home? 0 1 2 3 4 5
3. Do I enjoy being in every room or space of my home? 0 1 2 3 4 5
4. Do I feel my whole home is organized? 0 1 2 3 4 5
5. Is my kitchen well organized? 0 1 2 3 4 5
6. Does my home/office run efficiently? 0 1 2 3 4 5
7. Do I have systems that work? (closet organizers, enough shelving) 0 1 2 3 4 5
8. Do I easily maintain my home after a cleaning day? 0 1 2 3 4 5
9. Does my living space make me *feel* well? 0 1 2 3 4 5
10. Does everyone in the family have consistently completed chores? 0 1 2 3 4 5

Psychological/Emotional

1. Am I a happy, positive person? 0 1 2 3 4 5
2. Do I wake up with a sense of *purpose* each day? 0 1 2 3 4 5
3. Do I feel positively motivated to do what I do each day? 0 1 2 3 4 5
4. Do I find it easy to smile? (even in spite of failure/difficulty) 0 1 2 3 4 5
5. Am I patient with myself? 0 1 2 3 4 5
6. Am I patient with others? 0 1 2 3 4 5
7. Do I have a best friend? 0 1 2 3 4 5
8. Do I have a strong support system (family, church, synagogue) 0 1 2 3 4 5

9. Do I have a sense of belonging? 0 1 2 3 4 5
10. Do I have strong convictions about things (& commit to them?) 0 1 2 3 4 5
11. Is my life a balance of work, rest, and play? 0 1 2 3 4 5
12. How often do I experience love and affection? 0 1 2 3 4 5

1. Do I experience a lot of marital or relational conflict? 0 1 2 3 4 5
2. Is my over-all stress level: Low Medium High 0 1 2 3 4 5
3. Am I an anxious person? 0 1 2 3 4 5
4. Do I ever struggle with feelings of guilt? 0 1 2 3 4 5
5. Do I struggle with feelings of deep anger? 0 1 2 3 4 5
6. Do I ever feel depressed or have extremely sad feelings? 0 1 2 3 4 5
7. Do I have strong feelings of fear or anxiety? 0 1 2 3 4 5
8. Do I have unresolved anger or unforgiveness toward anyone in my life? 0 1 2 3 4 5
9. Do I have any strategies to help overcome extremely negative emotions? Y N
   If yes, what do you do? _____
10. Do I have unique family/children issues that make my situation particularly stressful (illness, behaviour, other)? If yes, how so?
    _____
    _____

Medical

1. Am I presently on any prescription medication? Y N
2. Have I had a physical exam within the last year? Y N
3. Have I had any injuries that are affecting my health or well-being? Y N
4. Do I experience chronic or acute pain? Y N
   If so, describe _____
5. Do I have a chronic disease? Y N
6. Have I ever had high blood pressure before? (>130/85) Y N
7. What is my current blood pressure? _____

Environmental

1. Am I exposed to chemicals, dust, fumes, toxins or poor air quality? Y N
2. Do I use chemical cleaners in my house? Y N
3. Do I use perfumed laundry soaps, rinses or drier sheets? Y N
4. How much fresh, clean air do I get daily? _____
5. Have I recently painted, carpeted or done any home/work renovations? Y N
6. How many hours/day do I sit in front of a computer and T.V? _____
7. Have you tested your "electro-magnetic" levels? _____

Personal:

1. What are my hobbies? _____
2. Do I have a spouse/family to consider when planning/making changes? Y N
3. Is my spouse/family supportive of the lifestyle changes I am hoping to make? Y N
4. Rate the following areas of your life **in order of importance** from 1-7.
   Please also consider the amount of time and money you invest in their pursuit.

*Career	_____	*Leisure	_____
*Family	_____	*Religious	_____
*Financial Freedom	_____	*Social	_____
*Health/Well-Being	_____		

The following section is optional. Do not answer <u>any or all</u> of the questions you feel are too personal or not applicable.

Spiritual:

1. Do I have peace in my life?	0 1 2 3 4 5
2. Do I have a sense of *lasting purpose* in what I do?	0 1 2 3 4 5
3. Do I feel I was created for a purpose?	0 1 2 3 4 5
4. Do I feel I am fulfilling that purpose?	0 1 2 3 4 5
5. Do I have a sense of forgiveness for <u>any</u> wrongs I have committed?	0 1 2 3 4 5
6. Do I pray regularly?	0 1 2 3 4 5
7. Am I afraid of dying or talking about dying?	0 1 2 3 4 5

8. If I could ask God anything, what would it be?

_____.

9. If I have faith in something or Someone, how does it make a difference in my life?

_____.

Is there any other information you feel is pertinent or would be helpful for your Coach to know? Remember **<u>all</u>** information is kept strictly confidential

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