Lifestyle Medicine Questionnaire for Teenage Girls

Personal Information

* Indicates required question

1. Full Name *

2. Date of Birth *

Example: January 7, 2019

3. Email *

4. Phone number *

5. Preferred Language *

6. Who all are there living in your house ? *

7. Do you have a pet ? *

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ If yes, what is the name of the pet ?
- ◯ Other: _____

8. What are your personal health goals? *
(Select all that apply)

Check all that apply.

- ☐ Excellent physique
- ☐ Good stamina
- ☐ Better Focus/Concentration for studies
- ☐ Healthy & long life
- ☐ Illness & stress free life
- ☐ Other: _____

9. On a scale of 1-5, how would you rate the following- *

Mark only one oval per row.

	1	2	3	4	5
Physical health	◯	◯	◯	◯	◯
Emotional well being	◯	◯	◯	◯	◯
Social connections	◯	◯	◯	◯	◯
Spiritual fulfilment	◯	◯	◯	◯	◯

10. Self-reported height (cm):

_____

11. Self-reported weight (kg):

_____

12. Recent changes in weight over past 6 months: please specify any gains or losses - write N/A if unsure *

_____

13. BMI (if known):

_____

14. Self reported recent BP

_____

15. Self reported recent heart rate

_____

16. Do you have any ongoing health concern- *

Check all that apply.

- [ ] No
- [ ] Yes
- [ ] If Yes, please explain

17. Have you recently experienced growth spurt ? *

Mark only one oval.

- ◯ Yes
- ◯ No

18. Have you noticed any below given changes over the past few months ? *

Mark only one oval.

- ◯ Rounded /stoop shoulders
- ◯ Forward Head posture
- ◯ Knock Knees
- ◯ Bow Knees
- ◯ Upperback Slouch
- ◯ Straightening of lower back/ or Exaggerated spinal curve
- ◯ Flat feet
- ◯ Lax Joints /Hyperflexible joints
- ◯ Lack of balance
- ◯ Frequent Injuries that hamper with your daily physical activities
- ◯ Other: _____

19. Have you experienced any of the below:

Check all that apply.

- ☐ Muscle & Joint Pains (Growing Pains)
- ☐ Gain/Loss of Weight
- ☐ Increased Appetite
- ☐ Frequent Ankle sprains/ twists
- ☐ Instabiliy in knee / ankles
- ☐ Other: _____

20. What kind of sports or physical activities are you currently involved in?

Mark only one oval.

- ◯ Team Sports
- ◯ Gym/Strength Training
- ◯ Running
- ◯ Cycling
- ◯ Swimming
- ◯ Dance
- ◯ Aerobics
- ◯ Gymnastics
- ◯ Other: _____

21. How many hours a week do you engage in the above activities ?

_____

22. How many steps do you take per day : *

Check all that apply.

- ☐ < 5,000
- ☐ 5,000 - 7,499
- ☐ 7,500 - 9,999
- ☐ ≥ 10,000
- ☐ ≥ 12,500

23. Have you had any surgeries ? *
Please list with dates -

_____

24. Family Medical History - Has anyone in your family (siblings, parents or grandparents) been diagnosed with - *

Mark only one oval.

- ◯ Obesity
- ◯ Diabetes Mellitus
- ◯ High BP
- ◯ Heart Condition
- ◯ Cancer
- ◯ Stroke/ Other Neurological Conditions
- ◯ Mental Health Disorder
- ◯ Dementia (Alzheimer or Parkinson s disease)
- ◯ Musculoskeletal problem (spinal, joints or muscles problem)
- ◯ Other: _____

25. Are you on any regular medication? *

_____

_____

_____

_____

_____

26. Any history of allergy to food, drug or any chemical? *

_____

Lifestyle Domains

Sleep

27. On an average, how many hours do you sleep at a stretch in a day ? * Dropdown

Mark only one oval.

- Less than 7 hours
- 7-9 hours
- > 9 hours

28. How fresh do you feel after waking up ? *

1 2 3 4 5

☆ ☆ ☆ ☆ ☆

29. Do you wake up during the night ? If yes, how often and why ? *

30. Do you experience daytime sleepiness ? *

Mark only one oval.

- Not at all
- Occasionally
- Several days
- Nearly every day

31. How much time do you spend on the screen (in minutes) within 2 hrs before sleep ? *

Nutrition

Please provide the details related to food and dietary habits

32. Are you a *

Mark only one oval.

- ◯ Vegetarian (a person who doesn't eat meat, poultry and seafood)
- ◯ Vegan (a person who doesn't animal milk, eat meat, poultry, and seafood)
- ◯ Non-vegetarian (a person who eats meat, poultry and seafood)
- ◯ Ovo-vegetarian (a person who is a vegetarian but eats eggs)

33. On a typical day, which of the following meals do you usually consume? *

Check all that apply.

- ☐ Early morning (before breakfast: (Tea /Coffee/ Milk, Nuts, Fruits etc.)
- ☐ Breakfast
- ☐ Lunch
- ☐ Evening Snack
- ☐ Dinner
- ☐ Bedtime

34. On a usual day, how many glasses of water do you drink per day? *

Mark only one oval.

- ◯ <5 (<1.2 Litres)
- ◯ 5-10 (1.2- Litres)
- ◯ >10 (>2.5 Litres)

35. Who prepares your meals most of the time? *

Mark only one oval.

- ◯ Family member
- ◯ Cook
- ◯ Outside/Takeaway

36. Where do you mostly get your meals from? *

Mark only one oval.

- At home
- Outside

37. How often do you eat outside? *

Mark only one oval.

- Daily
- 2–3 times/week
- Once a week
- Occasionally

38. Do you frequently skip meals? *

Mark only one oval.

- Yes
- No
- Sometimes

39. Which major meals do you miss most often? *

Mark only one oval.

- Breakfast
- Lunch
- Dinner
- None

40. Do you follow any special diet among the following? *

Check all that apply.

- [ ] No Special Diet
- [ ] Intermittent Fasting (<12 hour fasting)
- [ ] Low/No Carbohydrate Diet
- [ ] Lactose-Free
- [ ] Keto-Diet
- [ ] Gluten-Free
- [ ] Other: _____

41. How often do you consume the following foods? *

Mark only one oval per row.

	Daily	2-3x/week	Sometimes	Never
Whole grains (atta, millets - bajra, jau, jowar etc, Oats, Quinoa)				
Dairy (milk, curd, yogurt, paneer, cheese)				
Pulses and legumes (dals and beans)				
Red meat (mutton, pork etc.)				
Fish and seafood				
Vegetables (raw and cooked)				
Fruits (raw and cooked)				
Sweets (confectionaries, Indian sweets, or desserts)				
Fried foods (Savoury snacks, Chips)				
Outside meals (Lunch, Dinner, Breakfast or evening/morning snacks)				

Beverages (Juice, Smoothies, Soft drinks)				

42. Do you sometimes eat more (or crave certain foods) when you're feeling stressed, sad, bored, or upset? *

Mark only one oval.

- Yes, often
- Sometimes
- Rarely
- No, never
- I'm not sure

43. What type of nutritional supplements do you consume? *

Mark only one oval.

- Protein supplements/ powders (e.g., whey, plant-based)
- Multivitamins
- Vitamin D
- Vitamin B12
- Calcium
- Iron
- Meal replacement shakes or bars
- None
- Other: _____

44. Rate the frequency of the following symptoms *

Mark only one oval per row.

	Often	Sometimes	Rarely	Never
Body aches/pains	◯	◯	◯	◯
Fatigue/Lethargy	◯	◯	◯	◯
Irregular appetite	◯	◯	◯	◯
Hair fall/Skin dryness	◯	◯	◯	◯
Acidity/Heartburn	◯	◯	◯	◯
Constipation/Loose stools	◯	◯	◯	◯
Bloating	◯	◯	◯	◯

Emotional Well-being

45. How would you rate your overall emotional well-being ? *

1	2	3	4	5
☆	☆	☆	☆	☆

46. How you have been feeling over the last 2 weeks- * (WHO-5 Well-Being Index)

Mark only one oval per row.

	All of the time- 5	Most of the time- 4	More than half of the time- 3	Less than half of the time- 2	Some of the time- 1	At no time- 0
I have felt cheerful and in good spiritis						
I have felt calm and relaxed						
I have felt active and energetic						
I woke up feeling fresh and rested						
My daily life has been filled with things that interest me						

47. What is your favourite pastime ? *

_____

48. What do you do to relax ? *

Mark only one oval.

- ◯ Watching a movie
- ◯ Hanging out with friends
- ◯ Eating favourite dish
- ◯ Playing sports
- ◯ Swimming
- ◯ Meditation
- ◯ Other: _____

Habits

49. Are you working on any habit to inculcate in your routine *

Mark only one oval.

- ◯ Exercise
- ◯ Healthy eating
- ◯ Book reading
- ◯ Meditation
- ◯ Any other, please specify
- ◯ Other: _____

50. Is there any habit you want to leave ? *

_____

Teenage Health (10-19 yrs old)

51. Does anything concern you about the way you look (e.g.physique, acne, unwanted hair or hair fall) ? *

Mark only one oval.

- Yes
- No
- Maybe

52. If Yes, please share details-

_____

53. Does any of the following bother you? *

Mark only one oval.

- Self-Esteem
- Stress
- Academic Pressure
- Safety issue including online safety
- Family issue
- Relationship issue
- Exercise & Fitness
- Other

Menstrual History

54. Have you started your periods

Mark only one oval.

- No
- Yes

55. Age at first period (Menarche) *

_____

56. Please share your experience of menstruation- *

Mark only one oval.

- ◯ Regular Periods
- ◯ Irregular Periods
- ◯ Heavy Periods
- ◯ Painful Periods
- ◯ Abdominal Bloating
- ◯ Headache
- ◯ Mood changes
- ◯ Sleep problem during periods

57. Do you take any medication during periods (to reduce bleeding or painkiller) ? *

_____

58. Do you take any hormonal medication (like pill) ?

_____

59. Do you get any urinary problem (like UTI) ? *

Mark only one oval.

- ◯ No
- ◯ Yes
- ◯ Other: _____

60. What all the vaccines you have had ? *

61. Is there anything else you'd like to ask or talk about with your doctor? *

Motivation to Change

62. How important is it for you to make healthy lifestyle changes ? *

1 2 3 4 5

☆ ☆ ☆ ☆ ☆

63. How confident are you in your ability to make those changes ? *

1 2 3 4 5

☆ ☆ ☆ ☆ ☆

64. How many times a week you can spend time with us- *

Mark only one oval.

- Once a week
- 2-3 times/ week
- Weekends
- Preferred time- Morning/evening

65. Where do you wish to see yourself in 3 months *
(in relevance to your Goals & Ability) :