

Metabolic Journey Questionnaire

Personal Information

* Indicates required question

1. Full Name *

2. Date of Birth *

Example: January 7, 2019

3. Email *

4. Phone number *

5. Occupation *

6. Preferred Language *

7. Relationship Status

Mark only one oval.

☐ Single

☐ Married

☐ In a relationship

8. Self-reported height (cm):

9. Self-reported weight (kg):

10. BMI (if known):

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

*

12. Self reported recent BP

13. Self reported recent heart rate

14. Do you have any medical illness ? *

Check all that apply.

- ☐ Type1 or Type2 DM
- ☐ Hypothyroidism/Hyperthyroidism
- ☐ High BP
- ☐ High Cholestrol
- ☐ Fatty Liver
- ☐ Any hormonal issue
- ☐ Any other
- ☐ Other: _____

15. Have you had any surgeries ? *

Please list with dates -

16. 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
- ☐ Autoimmune Disorder
- ☐ Other significant condition

17. Are you on any regular medication? *

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

Metabolic Symptoms

19. In the past 3 months, how often you have experienced the followings- *

Mark only one oval per row.

	never	occasionally	frequently	daily
Fatigue or low energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Craving for sugar or carbs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling hungry soon after eating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brain fog or poor concentration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mood swings or irritability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bloating or digestive issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty losing weight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble falling or staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Lifestyle Domains

20. What are the Physical Activities you are currently engaged in ? *

Check all that apply.

- ☐ Swimming
- ☐ Sports
- ☐ Workouts (Gym/Mat Exs/Group classes)
- ☐ Cycling/ walks

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

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

Check all that apply.

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

23. How many hours on average do you sit each day? *

24. 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)

25. On a usual day, how many meals do you have : *

Check all that apply.

- ☐ Early morning (before breakfast: Tea, nuts, fruits etc.)
- ☐ Breakfast
- ☐ Lunch
- ☐ Evening Tea
- ☐ Dinner
- ☐ Bedtime

26. How many glasses of water do you drink per day? *

Mark only one oval.

- ☐ <5
- ☐ 5-10
- ☐ >10

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

Mark only one oval.

- ☐ Self
- ☐ Family member
- ☐ Cook
- ☐ Outside/Takeaway

28. How often do you eat takeaway/outside? *

Mark only one oval.

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

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

Check all that apply.

- ☐ Gluten-Free
- ☐ Low/No Carbohydrate Diet
- ☐ Intermittent Fasting
- ☐ Low Salt Diet
- ☐ Lactose-Free
- ☐ Keto-Diet
- ☐ No Special Diet
- ☐ Other: _____

30. 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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dairy (milk, curd, yogurt, paneer, cheese)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pulses and legumes (dals and beans)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Red meat (mutton, pork etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fish and seafood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vegetables (raw and cooked)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fruits (raw and cooked)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sweets (Indian sweets and confectionery)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fried foods (Indian savouries, other snacks)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Outside meals (Lunch, Dinner, Breakfast or evening/morning snacks)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

Mark only one oval.

- ☐ Multivitamins
- ☐ Vitamin D
- ☐ Vitamin B12
- ☐ Calcium
- ☐ Iron
- ☐ Omega-3 / Fish oil
- ☐ Protein supplements/ powders (e.g., whey, plant-based)
- ☐ Probiotics
- ☐ Ayurvedic or herbal supplements
- ☐ Meal replacement shakes or bars
- ☐ Weight loss supplements
- ☐ None
- ☐ Other: _____

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

⌵ Dropdown

Mark only one oval.

- ☐ Less than 6 hours
- ☐ 6-7 hours
- ☐ 7-8 hours
- ☐ More than 8 hours

33. How would you rate quality of your sleep ? *

1	2	3	4	5
☆	☆	☆	☆	☆

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

35. Do you experience daytime sleepiness ? *

Mark only one oval.

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

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

1	2	3	4	5
☆	☆	☆	☆	☆

37. Do you smoke cigarette ? *

Mark only one oval.

- ☐ No
- ☐ Yes

38. Do you drink alcohol ? *

Mark only one oval.

☐ Yes

☐ No

Goals & Motivation

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

1 2 3 4 5



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

1 2 3 4 5



41. What do you feel is your biggest barrier to reaching your goals?

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

Mark only one oval.

☐ Once a week

☐ 2-3 times/ week

☐ Flexible hours

☐ Preferred time- Morning/evening

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

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